



**SECTION 15:
PAYMENT POLICIES**

SECTION 15: PAYMENT POLICIES

Effective December 1, 2016

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MVP Health Care Payment Policy

Anesthesia

Type of Policy: Payment
Last Reviewed: 12/01/2016
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 online at www.mvphhealthcare.com/provider/onlineresources 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.medicarehic.com/providers/pubs/AnesthesiaBillingGuide1.pdf



MVP Health Care Payment Policy

Audiology Services

Type of Policy:	Payment
Last Reviewed Date:	12/1/2016
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* online at www.mvphealthcare.com/provider/onlineresources 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 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;

- 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, Menière'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/



MVP Health Care Payment Policy

Chronic Care Management (CCM) - Medicare Only

Type of Policy:	Payment
Last Reviewed Date:	03/01/2017
Related Policies:	N/A

Policy

MVP will reimburse for Chronic Care Management under CPT code 99487, 99489, 99490, and G0506 for Medicare products only. Claims submitted for all other products will deny. Providers that are receiving care management or transformation funding payment as part of a Patient Centered Medical Home (PCMH), Accountable Care Organization (ACO), or other collaborative care shared savings or shared risk arrangement, may **not** bill for chronic care management for any MVP products including Medicare. All claims submitted by providers that are part of these arrangements will deny.

A patient is eligible to receive CCM if he or she has been diagnosed with 2 or more chronic conditions expected to persist at least 12 months (or until death) that place the individual at significant risk of death, acute exacerbation/decompensation, or functional decline.

Definitions

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

Billing / Coding Guidelines

Physicians (regardless of specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse midwives (or the provider to which such individual has reassigned his/her billing rights) are eligible to bill for CCM. Other non-physician practitioners and limited-license Practitioners (e.g., clinical psychologists, social workers) are not eligible.

MVP will pay only one claim for CCM per member per calendar month. This practitioner must only report either complex or non-complex CCM for a given patient for the month (not both).

A provider cannot bill for CCM unless and until the provider secures the member's written consent. Specifically, the member must acknowledge in writing that the provider has explained the following:

- The nature of CCM
- How CCM may be accessed
- That only one provider at a time can furnish CCM for the member
- The member's health information will be shared with other providers for care coordination purposes
- The member may stop CCM at any time by revoking consent, effective at end of then-current calendar month
- The member will be responsible for any associated copayment or deductible.

A copy of the signed consent form must be maintained in the member's medical record. If a member revokes his or her consent to receive CCM from a specific provider, that provider cannot bill for CCM after the then-current calendar month. The provider may bill for CCM for the month in which the revocation is made, if the provider has furnished 20+ minutes of non-face-to-face care management services for the member.

In the context of CCM, CMS identifies the following types of services performed on a member's behalf as counting toward the 20-minute requirement:

- performing medication reconciliation and overseeing the member's self-management of medications;
- ensuring receipt of all recommended preventive services; and
- monitoring the member's condition (physical, mental, social).

This list, however, is not exclusive; other types of services may count toward the 20-minute requirement.

The provider must document in the member's record:

- Date and amount of time spent providing non-face- to face services (preferably start/stop time)
- Clinical staff furnishing services (with credentials)
- Brief description of services

Time spent providing services on different days or by different clinical staff members in the same month may be aggregated to total 20 minutes. However, if two staff members are furnishing services at the same time, only the time spent by one individual may be counted. Time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement; nor may time be carried over from a prior month.

Some services are considered non-reimbursable with CCM services: transitional care management (CPT 99495 and 99496), home healthcare supervision (HCPCS G0181), hospice care supervision (HCPCS G0182), and certain end-stage renal disease (ESRD) services (CPT 90951-90970).

Initiating Visit

For new patients or patients not seen within one year prior to the commencement of CCM, Medicare requires initiation of CCM services during a face-to-face visit with the billing practitioner (an Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE], or other face-to-face visit with the billing practitioner). This initiating visit is not part of the CCM service and is separately billed. Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code G0506 (Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services [billed separately from monthly care management services] [Add-on code, list separately in addition to primary service]). G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation.

CCM Capability Requirements

The five capabilities include: (1) Use a certified EHR for specified purposes; (2) Maintain an electronic care plan; (3) Ensure member access to care; (4) Facilitate transitions of care; and (5) Coordinate care. When a provider submits a claim for CCM, the provider is, in effect, attesting to the fact the provider has each of these capabilities for providing CCM.

Use of a certified EHR for specified purposes

A provider is not required to be a meaningful user of a certified EHR technology, but is required to use "CCM certified technology" (i.e., for 2015, an EHR that satisfies either the 2011 or 2014 edition of the certification criteria for the EHR Incentive Programs) to meet the following core technology capabilities:

- Structured recording of demographics, problems, medications, and medication allergies, all consistent with 45 CFR 170.314(a)(3)-(7)
- Creation of summary care record consistent with 45 CFR 170.314(e)(2)

The provider must be able to transmit the summary care record electronically for purposes of care coordination. A facsimile transmission is not acceptable. Additionally, a provider must use CCM certified technology to fulfill any CCM requirement that references a health or medical record. Specifically, the following must be documented in the member's record using CCM certified technology:

- Member consent
- Provision of care plan to Member
- Communication to and from home and community-based providers regarding member's psychosocial needs and functional deficits (care coordination)

Maintain an electronic care plan

The provider must develop and regularly update (at least annually) an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of the member's needs. The plan should include a list of current practitioners and suppliers that are regularly involved in providing medical care to the member, the assessment of the member's functional status related to chronic health conditions, the assessment of whether the member suffers from any cognitive limitations or mental health conditions that could impair self-management, and an assessment of the member's preventive health care needs. The plan should address all health issues (not just chronic conditions) and be congruent with the member's choices and values.

While required to bill for CCM, the preparation and updating of the care plan is not part of the reimbursable service. Instead, these activities may be billed separately as an evaluation and management service (e.g., an annual wellness visit, the initial preventive physical examination, or regular office visit), provided the applicable requirements are satisfied

The following have been identified as items typically included in a care plan

- Problem list; expected outcome and prognosis; measurable treatment goals
- Symptom management and planned interventions (including all recommended Preventive care services)
- Community/social services to be accessed
- Plan for care coordination with other providers
- Medication management (including list of current medications and allergies; reconciliation with review of adherence and potential interactions; oversight of patient self-management)

- Responsible individual for each intervention
- Requirements for periodic review/revision

MVP requires a provider to use some form of electronic technology tool or services in fulfilling the care plan element," but acknowledges that "certified EHR technology is limited in its ability to support electronic care planning at this time." Accordingly, providers "must have flexibility to use a wide range of tools and services beyond EHR technology now available in the market to support electronic care planning.

There are three requirements with respect to electronic access to the member's care plan:

1. The care plan must be electronically accessible on a 24/7 basis to all care team members furnishing CCM services billed by the provider.

- E.g., remote access to EHR, web-based access to care management application, web-based access to an electronic health information exchange (HIE) (facsimile is not sufficient)

2. The provider "must electronically share care plan information as appropriate with other providers" caring for the member.

- E.g., secure messaging, participation in HIE (facsimile not sufficient)

3. The provider must make available a paper or electronic copy of the care plan to the member.

- Must be documented in CCM certified technology

Ensure member access to care

A provider furnishing CCM must:

- Provide a means for the member to access a provider on the care team on a 24/7 basis to address acute/urgent needs in a timely manner
- Ensure the member is able to get successive routine appointments with a designated practitioner or member of care team.
- Provide enhanced opportunities for member-provider (or caregiver-provider) communication by telephone and asynchronous consultation methods (e.g., secure messaging, internet), although the member is not required to use these methods.

Facilitate transitions of care

A provider must have the capability to do the following:

- Follow-up with the member after an ER visit.
- Provide post-discharge transitional care management (TCM) services as necessary (although the provider cannot bill for TCM and CCM during the same month).
- Coordinate referrals to other clinicians.
- Share information electronically with other clinicians as appropriate (see prior discussion of summary care record and electronic care plan).

Coordinate care

The provider must have the capability to coordinate with home and community based clinical service providers to meet the member's psychosocial needs and functional deficits (including providers of home health and hospice, outpatient therapies, durable medical equipment, transportation services, and nutrition services). The provider's communication with these service providers must be documented in CCM certified technology.

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

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* online at www.mvphealthcare.com/provider/onlineresources 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.

<u>HCPCS Code</u>	<u>Gadolinium</u>
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



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

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual online at <https://content.mvphealthcare.com/provider/onlineresources.html> 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

Diabetic Management

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>



MVP Health Care Payment Policy

Diagnosis Matching Edits

Type of Policy: Payment
Last Reviewed Date: 7/1/2016
Related Policies: N/A

Policy

MVP Health Care follows the diagnosis matching edits in accordance with the Medicare Local Coverage Determinations (LCD) for Upstate New York 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>

Please note: Diagnosis codes for these procedures will be updated for ICD-10 as of October 1, 2015.

Definitions

Medical Necessity:

CMS/Medicare Definition is:

“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.”

Billing/Coding Guidelines:

Transthoracic Echocardiography:

To access the appropriate diagnoses to be used with these Procedure codes use Document ID #L27360 – Contract # 13282 on the CMS website.

Code	Description	Rule
93303, 93304, 99320, 99321, 93325, C8921, C8922	Transthoracic echocardiography for congenital cardiac anomalies; Group 2	<ul style="list-style-type: none"> • 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, 93321, 93325, C8923-C8924, C8929	Real time Transthoracic echocardiography; Group 1	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.
93350-93352, C8928, C8930,	Echocardiography, transthoracic, real-time with image documentation (2D),	<ul style="list-style-type: none"> • MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or

	includes M-mode recording, when performed, during rest and cardiovascular stress test. Group 4	<p>the claim will be denied due to Medical Necessity.</p> <ul style="list-style-type: none"> • The Upstate New York Local Coverage Determinations for these codes. • Pediatric Cardiology Specialty is excluded from this edit.
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Facet Joint Injections and Denervation:

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.	<ul style="list-style-type: none"> • 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.
64633,64634,64635,64636	Destruction by neurolytic agent, paravertebral facet joint nerve; Cervical, Thoracic, Lumbar, or Sacral.	<ul style="list-style-type: none"> • 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:

To access the appropriate diagnoses to be used with these Procedure codes use Document ID # L33386 – Contract # 13282 on the CMS website.

Code	Description	Rule
51785, 92265, 95860, 95861, 95863, 95864,	Nerve Conduction Studies (NCS) and Electromyography	<ul style="list-style-type: none"> • MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage

95865, 95866, 95867, 95868, 95869, 95870, 95872, 95873, 95874, 95885, 95886, 95887, ,95905, 95907, 95908, 95909, 95910, 95911, 95912, 95913 95933, G0255	Group 1	<p>Determination or the claim will be denied due to Medical Necessity.</p> <ul style="list-style-type: none"> • The Upstate New York Local Coverage Determinations for these codes.
95937	Neuromuscular Junction Testing Group 2	<ul style="list-style-type: none"> • 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 # L28142 - Contract # 13282 on the CMS website.

Code	Description	Rule
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	<ul style="list-style-type: none"> • 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 # L26367 – Contract # 13282 on the CMS website.

Code	Description	Rule
92081	Visual field examination,	<ul style="list-style-type: none"> • MVP requires the correct diagnosis be submitted with the claim in

	<p>unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)</p>	<p>accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity.</p> <ul style="list-style-type: none"> • The Upstate New York Local Coverage Determinations for these codes.
92082	<p>Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)</p>	<ul style="list-style-type: none"> • 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.
92083	<p>Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static</p>	<ul style="list-style-type: none"> • 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.

	determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	
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MVP Health Care Payment Policy

Durable Medical Equipment

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

MVP does not authorize used equipment for purchase.

Coverage is limited to standard equipment only. Any request for equipment that is not considered to be standard i.e., deluxe must include documentation which clearly demonstrates the medical necessity for the requested deluxe equipment. If it is determined that the deluxe item is not medically necessary and the member elects to go with the deluxe item, the basic coverage would be applied to the deluxe item and the member would have to cover the difference out-of-pocket. Provider must maintain a signed waiver on file, available to MVP upon request.

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.
- 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.

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 www.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* at the following link www.mvphealthcare.com/provider/dme.html.

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	<ul style="list-style-type: none"> • 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 • 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	<ul style="list-style-type: none"> • 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.

		<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 1 per three months
A7027	Combo oral/nasal mask	<ul style="list-style-type: none"> • 1 per three months
A7028	Oral cushion for combo oral nasal mask	<ul style="list-style-type: none"> • 2 per one month
A7029	Nasal pillows	<ul style="list-style-type: none"> • 2 per one month
A7030	Full Face Masks	<ul style="list-style-type: none"> • 1 per three months
A7031	Face mask interface	<ul style="list-style-type: none"> • 1 per month
A7032	Replacement Cushions	<ul style="list-style-type: none"> • 2 per one month
A7033	Replacement Pillows	<ul style="list-style-type: none"> • 2 per one month
A7034	CPAP Masks	<ul style="list-style-type: none"> • 1 per three months
A7035	CPAP Headgears	<ul style="list-style-type: none"> • 1 per six months
A7036	CPAP Chin Straps	<ul style="list-style-type: none"> • 1 per six months
A7037	CPAP Tubing	<ul style="list-style-type: none"> • 1 per three months
A7038	CPAP Filters	<ul style="list-style-type: none"> • 2 per one month
A7039	CPAP non-disposable filters	<ul style="list-style-type: none"> • 1 per six months
A7046	Water chamber	<ul style="list-style-type: none"> • 1 per six months
A7047	Oral interface used with respiratory suction pump	<ul style="list-style-type: none"> • Not covered

DME Equipment

Code	Description	Rule
E0935	Continuous Passive Motion Device	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • MVP Healthcare will not reimburse for diabetic shoes when billed for more than 2 units (1 pair) within a calendar year (A5500). • MVP healthcare 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

		<p>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.</p> <ul style="list-style-type: none"> • Medicaid Managed Care Plans: allow one pair per year when medical policy criteria are met.
A5512-A5513	Diabetic Shoe Inserts	<ul style="list-style-type: none"> • MVP Healthcare 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	<ul style="list-style-type: none"> • MVP does not cover these codes.

Code	Description	Rule
L3000- L3214, L3224 L3649	Foot Orthotics	<ul style="list-style-type: none"> • Foot orthotics are 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • MVP does not purchase Oxygen or Oxygen Equipment.
E0445	Oximeters	<ul style="list-style-type: none"> • MVP allows monthly payment. Probes are inclusive during the rental period.
A4606	Oximeter Replacement Probe	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Submit with HCPCS DME code to indicate a purchase
RR	Rental use	<ul style="list-style-type: none"> • Submit with HCPCS DME code to indicate a rental
		<ul style="list-style-type: none"> •
RT	Right Side	<ul style="list-style-type: none"> • Submit with HCPCS DME procedure code to indicate item ordered for right side.
LT	Left Side	<ul style="list-style-type: none"> • Submit with HCPCS DME procedure code to indicate item ordered for left side.
UE	Used Equipment	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Submit with HCPCS DME procedure codes

	tracheostomy supply	
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic	<ul style="list-style-type: none"> • Submit with HCPCS DME procedure codes
AW	Item furnished in conjunction with a surgical dressing	<ul style="list-style-type: none"> • Submit with HCPCS DME procedure codes
RA	Replacement of a DME, orthotic or prosthetic item	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • MVP covers the purchase of this item according to the providers 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)	<ul style="list-style-type: none"> • MVP covers the purchase of this item according to the providers 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. • This item is not covered for MVP Medicare plans.
A4230	Infusion Set, Cannula Type	<ul style="list-style-type: none"> • 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 • 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	<ul style="list-style-type: none"> • 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 • 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	<ul style="list-style-type: none"> • 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 • 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	Covered as diabetic supplies and can be

	Remover	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 Pump Supply Code: A4230-A4232.
K0552	Supplies for the External Infusion Pump	Invalid for submission for all MVP plans.

Blood Glucose Monitoring

Code	Description	Rule
E0607	Blood Glucose Monitor	<ul style="list-style-type: none"> • 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-A9278	Continuous Blood Glucose Monitor	<ul style="list-style-type: none"> • Covered under the member's diabetic benefit and can be billed to MVP. Refer to MVP's Medical Policy for coverage information. • A9276 is billed at a per diem rate of one unit per day. • Exception: MVP does not cover this item for MVP Medicare products. Please refer to the MVP's MEDICAL POLICY for additional coverage information.
A4259 and A4253	<p>Blood Glucose testing supplies.*</p> <p>Prior authorization requests for blood glucose test strips exceeding the quantity limit should be faxed to:</p> <p>1-800-376-6373 (Commercial or Medicaid) 1-800-401-0915 (Medicare)</p>	<ul style="list-style-type: none"> • 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

	Prior authorization is required for non-preferred test strips (commercial and Medicaid members).	benefits manager) <ul style="list-style-type: none"> Non-insulin dependent:200 test strips and lancets every month or 300 test strips every 3 months (must be billed through pharmacy benefits manager)
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Tracheostomy Care Supplies

Code	Description	Rule
A7520-A7522	Tracheostomy/ Laryngectomy Tube	<ul style="list-style-type: none"> MVP does cover this code under the member's DME benefit
L8501	Tracheostomy Speaking Valve	<ul style="list-style-type: none"> MVP does cover this code under the member's DME benefit.
A4625 and A4629	Tracheostomy Care Kit	<ul style="list-style-type: none"> MVP does cover this code if the member's contract covers disposable medical supplies.
A4623	Tracheostomy disposable inner cannula	<ul style="list-style-type: none"> MVP does cover this item if the member's contract covers disposable medical supplies.
A4626	Tracheostomy cleaning brush	<ul style="list-style-type: none"> MVP does cover this item if the member's contract covers disposable medical supplies.
A4649	Tracheostomy Foam Holder/ Tie	<ul style="list-style-type: none"> MVP does cover this item if the member's contract covers disposable medical supplies.
A4217	Sterile water/ saline for Irrigation 5 ml	<ul style="list-style-type: none"> MVP does cover this item if the member's contract covers disposable medical supplies.

A7525	Tracheostomy Mask	<ul style="list-style-type: none"> MVP does cover this item if the member's contract covers disposable medical supplies.
A4625	Tracheal Suction Catheter (not closed)	<ul style="list-style-type: none"> MVP does cover this item if the member's contract covers disposable medical supplies.
A7523	Tracheostomy Shower Protector	<ul style="list-style-type: none"> MVP does cover this item if the member's contract covers disposable medical supplies.

A7524	Tracheostomy Plug/ Button,	<ul style="list-style-type: none"> • MVP does cover this item if the member's contract covers disposable medical supplies.
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Ostomy Supplies

Code	Description	Rule
A4361-A4435 A5051-A5093 A5119-A5200	Ostomy codes	<ul style="list-style-type: none"> • 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.

Medicare Ostomy LCD link -

[www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/Ostomy Supplies L33828](http://www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/Ostomy%20Supplies%20L33828)

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 Department's minimum quality standards or if independent testing results are not maintained and provided upon request.

<https://www.emedny.org/>



MVP Health Care Payment Policy

Elective Delivery (For Providers and Facilities)

Type of Policy:	Payment
Last Reviewed Date:	6/1/2017
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.

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* online at <https://content.mvphealthcare.com/provider/onlineresources.html> to determine if a service requires an authorization.

Billing / Coding Guidelines

For Provider Claims

Claims submitted with the following CPT codes will require a modifier to indicate gestation: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622.

The following modifiers must be submitted on the obstetric delivery codes above:

- U8- Delivery prior to 39 weeks of gestation
- U9- Delivery at 39 weeks of gestation or later
- UB- spontaneous obstetrical deliveries occurring between 37-39 weeks gestation

Claims will be paid or denied based on the following guidelines:

- When billing for spontaneous obstetrical deliveries occurring between 37-39 weeks gestation, practitioners should report ICD-10 diagnosis code O80 as the primary diagnosis code with the U8 modifier AND the UB modifier. Full payment will be made in this circumstance.
- Full payment will be made when modifier U9 is submitted or when modifier U8 is billed with an acceptable diagnosis.

- A 50 percent reduction will apply when modifier U8 is billed and an acceptable diagnosis is not documented.
- The claim will be denied if no modifier is documented on the claim.

Acceptable diagnoses for delivery prior to 39 weeks gestation can be found in the NYS Medicaid elective delivery 39-week policy at the following link. MVP will use the diagnosis list that is in effect for the date of delivery. A provider may appeal the 50 percent reduction by submitting appropriate documentation for review.

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

*Indications other than those listed by NYS DOH may also be appropriate with clinical justification.

Documentation in the medical record must be present that indicates gestation age and any supporting diagnosis codes.

For Facility Claims

Claims submitted for hospital inpatient stays associated with delivery will require a condition code for payment. The following condition codes must be submitted on the delivery procedure codes:

- Condition code 81- C-sections or inductions performed at less than 39 weeks gestation for medical necessity.
- 82- Gestation less than 39 weeks, elective C-section or induction
- 83- Gestation 39 weeks or greater

Claims will be paid or denied based on the following guidelines:

- If condition code 81 is reported with an acceptable primary diagnosis code, the claim will be paid in full. If this condition code is reported with a primary diagnosis code that does not support medical necessity, the claim will be reduced by 50 percent. For condition code 81 ONLY, diagnosis code O80 (Normal Delivery) will be considered an acceptable primary diagnosis code, and the claim should be paid in full.
- Full payment will be made if the condition code 83 is present or when condition code 82 is billed with an acceptable diagnosis.
- A 50 percent reduction will apply when condition code 82 is billed and an acceptable diagnosis code is not documented.
- The claim will be denied if no condition code is documented on the claim.

Acceptable diagnoses for delivery prior to 39 weeks gestation can be found in the NYS Medicaid elective delivery 39-week policy at the following links. MVP will use the diagnosis list that is in effect for the date of delivery. A provider may appeal the 50 percent reduction by submitting appropriate documentation for review.

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

*Indications other than those listed by NYS DOH may also be appropriate with clinical justification.

Documentation in the medical record must be present that indicates gestation age and any supporting diagnosis codes.

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.emedny.org/ProviderManuals/Physician/PDFS/ICD-10 Medicaid Update 2.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



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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

		<p>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</p>
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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 patient's 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 than 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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,	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Emergency Room physicians will not be reimbursed for EKG interpretation.
93005	Electrocardiogram, routine	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • Emergency Room physicians will not be reimbursed for EKG interpretation.
93040	Rhythm ECG, 1-3 leads; with interpretation and report	<ul style="list-style-type: none"> • Emergency Room physicians will not be reimbursed for EKG interpretation.
93041	Rhythm ECG, 1-3 leads; tracing only without interpretation and report	<ul style="list-style-type: none"> • Emergency Room physicians will not be reimbursed for EKG interpretation.
93042	Rhythm ECG, 1-3 leads; interpretation and report only	<ul style="list-style-type: none"> • Emergency Room physicians will not be reimbursed for EKG interpretation.

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



MVP Health Care Payment Policy

Evaluation and Management

Type of Policy:	Payment
Last Reviewed Date:	6/1/2017
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* online at <https://content.mvphealthcare.com/provider/onlineresources.html> to determine if a service requires an authorization.

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.	<ul style="list-style-type: none"> • 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,

		<p>99173, 95930, and 99174.</p> <ul style="list-style-type: none"> • See member benefits to determine if these codes are reimbursable.
99391-99397	Preventative Medicine Evaluation and Management of an individual.	<ul style="list-style-type: none"> • 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, 0065T, 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • MVP will not reimburse for these procedure codes. • Exception: Please check the member benefits to determine if this is 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.

Telemedicine

Telemedicine is defined as the following criteria:

- An interactive telecommunications system is required. Interactive telecommunication systems are multimedia communication that, at a minimum, include audio and video equipment permitting real-time consultation among the member and consulting practitioner;
- 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;
- The location of the member at the time the professional service via telemedicine visits 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; or
- The use of a telecommunications system may be used in lieu of a face-to-face encounter 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.

Telemedicine- 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.
- Telemedicine does not include the use of audio-only telephone, email, or fax.
- Tele-ophthalmology or tele-dermatology services may be provided by store and forward means.
- The distant site health care provider must document the reason the services are being provided by store and forward means.

Code	Description	Rule
98969	E-visit using internet or similar electronic communication network	<ul style="list-style-type: none"> • MVP will not reimburse for this service. • Exception: Per state mandate this procedure will be reimbursed in New Hampshire only.
99441-99443	Telephone and Management Services provide by a	<ul style="list-style-type: none"> • MVP will not reimburse for this service.

	physician	<ul style="list-style-type: none"> • Exception: Per state mandate this procedure will be reimbursed in the state of New Hampshire only.
Q3014	Telehealth originating site facility fee	<ul style="list-style-type: none"> • The Originating Provider should bill this code when performing telemedicine through means listed in VT telemedicine mandate. • MVP will not reimburse for this service in any region except the state of Vermont per state mandate.
Modifier GT	Via interactive audio and video telecommunication systems.	<ul style="list-style-type: none"> • The distant provider should bill this modifier when performing telemedicine through means listed in VT telemedicine mandate along with the applicable office visit code. • This should be used when real time telemedicine services are performed • MVP will not reimburse for this service in any region except the state of Vermont per state mandate.
Modifier GQ	Via asynchronous telecommunications systems	<ul style="list-style-type: none"> • The distant provider should bill this modifier when performing telemedicine through means listed in VT telemedicine mandate along with the applicable office visit code. • This should be used when store and forward telemedicine services are performed. • MVP will not reimburse for this service in any region except the state of Vermont per state mandate.

Diabetes Education

Code	Description	Rule
98960-98962	Education and training for self-management of Diabetes.	<ul style="list-style-type: none"> • 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.
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Osteopathic Manipulation

Code	Description	Rule
98925, 98926, 98927, 98928, 98929	Osteopathic Manipulation	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> MVP will only reimburse for immunization administration services when billed with a " Z23 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	1 st 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 <u>not</u> reimburse for these codes.
99251-99255	Inpatient Consultation Procedures.	MVP follows CMS Guidelines regarding the use of consultations and does <u>not</u> reimburse for these codes.
99218-99220; 99234-99235 and discharge code 99217	Hospital Observation Codes	<ul style="list-style-type: none"> • Only the provider who "<u>orders</u>" 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	<ul style="list-style-type: none"> • 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

		<p>ancillary factor and does not “control” the level of the service to be billed <u>unless more than 50% of the allowable time by setting occurs and this need to be documented.</u></p> <ul style="list-style-type: none"> • These are timed and component based codes. They must meet the components and time requirements set forth by the CPT code guidelines
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Code	Description	Rule
99281-99288	Evaluation and Management within the Emergency Room.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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 visit for the evaluation and management of an established patient	<ul style="list-style-type: none"> • MVP will reimburse for these codes as set forth by the CPT Code guidelines. • MVP will reimburse these codes

		<p>for established patients who do not meet the CPT Code guidelines for a "New" patient.</p> <ul style="list-style-type: none"> • Consultations are not reimbursed by MVP. Providers should use these codes when providing a consultation and documenting as such.
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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.	<p>MVP will reimburse as follows:</p> <ul style="list-style-type: none"> • When the patient visit is part of an <u>established physician plan of care</u> 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 <u>cannot both bill for an E&M office visit within the same day.</u>
99304, 99305, 99306	Initial Skilled Nursing Facility Visit.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.
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Discharge Services

Code	Description	Rule
99238	Inpatient Standard Discharge instructions typically 0-30 min.	<ul style="list-style-type: none"> • 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 <u>exceeds 30 minutes</u> and is generally considered not a typical discharge.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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 Hospital Care where an Admission and Discharge are done on the same day	<ul style="list-style-type: none"> • These are timed and component based codes. They must meet the components and time requirements set forth by the CPT

		<p>code guidelines.</p> <ul style="list-style-type: none"> • 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.
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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 pt 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.
71010, 71015, 71020)	Chest x-rays, professional component	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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 & 91105	Gastric intubation	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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, 36591	Vascular access procedures	<ul style="list-style-type: none"> 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.
92950	CPR	<ul style="list-style-type: none"> MVP will reimburse for this

		procedure separately from critical care services.
31500	Endotracheal intubation	<ul style="list-style-type: none"> MVP will reimburse for this procedure separately from critical care services.
36555, 36556	Central line placement	<ul style="list-style-type: none"> MVP will reimburse for this procedure separately from critical care services.
36680	Intraosseous placement	<ul style="list-style-type: none"> MVP will reimburse for this procedure separately from critical care services.
32551	Tube thoracostomy	<ul style="list-style-type: none"> MVP will reimburse for this procedure separately from critical care services.
33210	Temporary transvenous pacemaker	<ul style="list-style-type: none"> MVP will reimburse for this procedure separately from critical care services.
93010	Electrocardiogram - routine ECG with at least 12 leads; interpretation and report only	<ul style="list-style-type: none"> 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:	<ul style="list-style-type: none"> 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.



MVP Health Care Payment Policy

Home Infusion Policy

Type of Policy:	Payment
Last Reviewed Date:	3/1/17
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.

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.

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.

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 safe 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* online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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

	and equipment (drugs and nursing visits coded separately), per diem	considered global to the per diem except nursing visits and drugs.
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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> These services are considered global to the per diem except nursing visits and drugs.

	necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
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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.

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

		<p>Enteral Therapy Benefit Interpretations for additional information.</p>
<p>S9342</p>	<p>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</p>	<ul style="list-style-type: none"> • 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.
<p>B4102</p>	<p>Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit *</p>	<ul style="list-style-type: none"> • 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

		<p>Medicare members.</p> <ul style="list-style-type: none"> • 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.
<p>B4103</p>	<p>Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit *</p>	<ul style="list-style-type: none"> • 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.
<p>B4104</p>	<p>Additive for enteral formula (e.g., fiber) *</p>	<ul style="list-style-type: none"> • The enteral formula must be obtained from an MVP participating pharmacy.

		<ul style="list-style-type: none"> • 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.
<p>B4149</p>	<p>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</p>	<ul style="list-style-type: none"> • 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

		<p>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.</p> <ul style="list-style-type: none"> • 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.
<p>B4150</p>	<p>Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit</p>	<ul style="list-style-type: none"> • 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

		<p>obtain enteral nutrition items from a participating DME vendor.</p> <ul style="list-style-type: none"> • 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.
<p>B4152</p>	<p>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</p>	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.

	<p>and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit</p>	<ul style="list-style-type: none"> • 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.
<p>B4155</p>	<p>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 uni</p>	<ul style="list-style-type: none"> • 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

		<p>services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas.</p> <ul style="list-style-type: none"> • 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.
<p>B4157</p>	<p>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</p>	<ul style="list-style-type: none"> • 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.

		<ul style="list-style-type: none"> • 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.
<p>B4158</p>	<p>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</p>	<ul style="list-style-type: none"> • 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.
<p>B4159</p>	<p>Enteral formula, for</p>	<ul style="list-style-type: none"> • The enteral formula must be

	<p>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</p>	<p>obtained from an MVP participating pharmacy.</p> <ul style="list-style-type: none"> • 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.
<p>B4160</p>	<p>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,</p>	<ul style="list-style-type: none"> • 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.

	<p>100 calories = 1 unit</p>	<ul style="list-style-type: none"> • 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.
<p>B4161</p>	<p>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</p>	<ul style="list-style-type: none"> • 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

		<p>feeding bags, associated with enteral formulas.</p> <ul style="list-style-type: none"> • 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.
<p>B4162</p>	<p>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</p>	<ul style="list-style-type: none"> • 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

		<p>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.</p>
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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	
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	
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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	
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	
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)	
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	

<p>S9355</p>	<p>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</p>	
<p>S9490</p>	<p>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</p>	
<p>S9361</p>	<p>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</p>	
<p>S9558</p>	<p>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</p>	
<p>S9537</p>	<p>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</p>	

	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	
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	
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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)	
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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	<ul style="list-style-type: none"> Payable at 50%
SJ	Third or more concurrently administered infusion therapy	<ul style="list-style-type: none"> Payable at 50%
SS	Home infusion services provided in the infusion suite of the IV therapy provider	<ul style="list-style-type: none"> 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 with out 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

References

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



MVP Health Care Payment Policy

Incident To Guidelines

Type of Policy: Payment
Last Reviewed Date: 12/01/2016
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 online at www.mvphealthcare.com/provider/onlineresources 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.

References:

CMS Medicare Benefit Policy Manual- Chapter 15

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf



MVP Health Care Payment Policy

Infusion Payment Policy

Type of Policy:	Payment
Last Reviewed Date:	3/1/17
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.

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* online at www.mvphealthcare.com/provider/onlineresources to determine if a service or medication requires an authorization.

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.

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	<ul style="list-style-type: none"> • Drugs over \$50 must be reviewed by MVP and 1 of the following pieces of information must be submitted: <ul style="list-style-type: none"> ○ An invoice for the drug must be submitted with the claim. <li style="text-align: center;">OR ○ 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 prior authorization is required for the medication.**

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. ZOFTRAN® (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) & 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.



MVP Health Care Payment Policy

Interpreter Services - Medicaid Products Only

Type of Policy:	Payment
Last Reviewed Date:	12/01/2016
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 online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

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



MVP Health Care Payment Policy

JW Modifier Policy

Type of Policy:	Payment - for Physicians and Facilities
Last Reviewed Date:	3/1/16
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

Please refer to the *Utilization Management Guides* and the *Benefit Interpretation Manual* online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

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



MVP Health Care Payment Policy

Locum Tenens

Type of Policy: Payment
Last Reviewed Date: 03/1/2017
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 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 for a physician that has left the practice:

A physician practice may retain a substitute physician to take over when a regular physician has left the practice and will not return. The Locum Tenens must register 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.

Locum Tenens for a physician that has left the practice:

The substitute physician generally has no practice of his own and moves from area to area as needed. The physician practice 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 (i.e., Certified Registered Nurse Anesthetists (CRNAs), Physical Therapists (PTs), etc.).

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the *Benefit Interpretation Manual* online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

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 six months. If there is a break after the initial six months 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 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. Also, a physician who has left the group and for whom the group has engaged a locum tenens physician as a temporary replacement may still be considered a member of the group until a permanent replacement is obtained.

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 has left the group and for whom the group has hired the locum tenens physician as a replacement.

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

The Locum Tenens must register with MVP Health Care in order to receive a provider number and bill for their services. Locum Tenens are required to bill using their individual type one NPI number and physician practice Tax ID number. The Locum Tenens may be required to sign a contract for reimbursement.

The Locum Tenens may only be registered for a six months period. Locum Tenens staying with the practice longer than six months must be credentialed.

References

MVP Credentialing and Recredentialing of Practitioners



MVP Health Care Payment Policy

Mid-Level Payment Policy

Type of Policy: Payment

Last Reviewed Date: 12/1/2016

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 online at www.mvphealthcare.com/provider/documents/Provider_Resource_Manual

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



MVP Health Care Payment Policy

Modifier Policy (for Physician)

Type of Policy:	Payment
Last Reviewed Date:	6/1/2017
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 online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization

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
<p>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.</p>	<p>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.</p> <p>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 <i>WZ- Cl - XTEN - CPT modifier disallowed - Medical documentation required.</i></p> <p>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:</p> <ul style="list-style-type: none"> • Claim Adjustment Review Form; • Operative report <p>MVP may request additional information when the operative report does not clearly demonstrate the additional work performed. This may include:</p> <ul style="list-style-type: none"> • 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) <p>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.</p>	<ul style="list-style-type: none"> • 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
<p>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.</p>	<ul style="list-style-type: none"> • E&M and Office Procedure: <ul style="list-style-type: none"> ○ 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. 	<ul style="list-style-type: none"> • 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 where there are a combination of a physician and technical component.	<ul style="list-style-type: none"> When the physician component is reported separately, the service may be identified by adding Modifier 26 to the usual procedure number. 	<ul style="list-style-type: none"> 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 where there are a combination of a physician and technical component.	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 150 percent of the providers contracted rate.

Modifier 51

Description	Rule	Reimbursement
<p>When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, 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).</p>	<ul style="list-style-type: none"> • 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). 	<ul style="list-style-type: none"> • 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 etc).

Modifier 52

Description	Rule	Reimbursement
<p>Used when a service or procedure is partially reduced or eliminated at the 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.</p>	<ul style="list-style-type: none"> • Report this modifier when the procedure was discontinued after the patient was prepared and brought to 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 one (1) unit 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. 	<ul style="list-style-type: none"> • Modifier 52 is reimbursed at the lesser of 50 percent of charges or contracted rate

Modifier 53

Description	Rule	Reimbursement
<p>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.</p> <p>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 anesthesia, see Modifiers 73 and 74.</p>	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Modifier 53 is reimbursed at the lesser of 50 percent of charges or contracted rate.

Modifier 54

Description	Rule	Reimbursement
<p>Used when one physician performs preoperative and/or postoperative management and another physician performs a surgical procedure.</p>	<ul style="list-style-type: none"> This should only be added to the claim with the surgical code. 	<ul style="list-style-type: none"> Modifier 54 is reimbursed at the lesser of 80 percent of charges

Modifier 55

Description	Rule	Reimbursement
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<p>Used when one physician performs postoperative management and another physician performs a surgical procedure.</p>	<ul style="list-style-type: none"> • This modifier should only be used by the physician billing for the postoperative management. 	<ul style="list-style-type: none"> • Modifier 55 is reimbursed the lesser of 10 percent of charges or contracted rate.
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Modifier 56

Description	Rule	Reimbursement
<p>Used when one physician performs preoperative care and evaluation and another physician performs a surgical procedure.</p>	<ul style="list-style-type: none"> • This modifier should only be used by the physician billing for the preoperative care and evaluation. 	<ul style="list-style-type: none"> • Modifier 56 is reimbursed at the lesser of 10 percent of charges or contracted rate.

Modifier 59, XE, XS, XP, XU

Description	Rule	Reimbursement
<p>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.</p> <p>Modifier 59- Distinct Procedural Service</p> <p>Modifier XE- Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter</p> <p>Modifier XS- Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure</p> <p>Modifier XP- Separate Practitioner, A</p>	<p>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.</p> <p>MVP may request additional information when the operative report does not clearly demonstrate that the procedures should be unbundled. This may include:</p> <ul style="list-style-type: none"> • Documentation that demonstrates why 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; <p>Rationale for why the use of Modifiers 59, XE, XS, XP, XU is not required but provider may submit to facilitate claims processing .</p> <p>When another already established modifier is appropriate it should be used rather than</p>	<ul style="list-style-type: none"> • Claims that are determined to meet the clinical criteria as a separate identifiable procedure will be paid at the physician contracted rate.

<p>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</p>	<p>Modifier 59. Only if another descriptive modifier is unavailable, and the use of Modifier 59 best explains the circumstances, should Modifier 59 be used.</p> <p>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.</p>	
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Modifier 62

Description	Rule	Reimbursement
<p>Used when two surgeons work together as primary surgeons performing distinct part(s) of a procedure.</p>	<ul style="list-style-type: none"> • 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 80 or Modifier 82 should be used as appropriate. 	<ul style="list-style-type: none"> • Modifier 62 is reimbursed at 62.5 percent of the providers contracted rate.

Modifier 73- For Facility Use Only

Description	Rule	Reimbursement
<p>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</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Modifier 73 is reimbursed at 50 percent of the facilities contracted rate.

<p>(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).</p>	<p>must be taken to the room where the procedure is to be performed in order to report this modifier.</p> <ul style="list-style-type: none"> • 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. 	
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Modifier 74- For Facility Use Only

Description	Rule	Reimbursement
<p>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).</p>	<ul style="list-style-type: none"> • 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 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. 	<ul style="list-style-type: none"> • Modifier 74 is reimbursed at 100 percent of the facilities contracted rate.

Modifier 76

Description	Rule	Reimbursement
<p>Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Will be reimbursed at the lesser of 100 percent of charges or contracted rate.

(This modifier is allowable for radiology services. It may also be used with surgical or medical codes in appropriate circumstances.)	<p>original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.</p> <ul style="list-style-type: none"> • This modifier should not be appended to an E/M service. • Documentation is required. 	
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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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Will be reimbursed at the lesser of 80 percent of charges or contracted rate.

Modifier AS, 80, 81, 82

Description	Rule	Reimbursement
<p>Modifier AS - Physician assistant, nurse practitioner for assistant at surgery</p> <p>Modifier 80 - Assistant Surgeon Surgical assistant services may be identified by adding Modifier 80 to the usual procedure number(s).</p> <p>Modifier 81 - Minimum Assistant Surgeon Minimum surgical assistant services are identified by adding Modifier 81 to the usual procedure number.</p> <p>Modifier 82 - Assistant Surgeon (when qualified resident surgeon not</p>	<ul style="list-style-type: none"> • 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. • 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. 	<ul style="list-style-type: none"> • Modifier AS is reimbursed at 15 percent of the providers contracted rate. • Modifiers 80-82 are reimbursed at 20 percent of the providers contracted rate. • If more than one of these modifiers is billed for the same service it will result in a coding error denial.

<p>available) The unavailability of a qualified resident surgeon is a prerequisite for use of Modifier 82 appended to the usual procedure code number(s).</p>		
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Modifier CG

Description	Rule	Reimbursement
<p>Policy criteria applies</p>	<ul style="list-style-type: none"> When submitting a venipuncture claim when laboratory work is sent to an external lab modifier CG is required. 	<ul style="list-style-type: none"> Claims submitted without the modifier will be denied as global.

Modifier CH-CN

Description	Rule	Reimbursement
<p>Functional G-codes and corresponding severity modifiers are used in the required reporting on specified therapy claims</p>	<ul style="list-style-type: none"> 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 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. 	<ul style="list-style-type: none"> Medicare claims submitted prior to 12/14/16-without the severity modifiers will be denied. Medicare claims received after 12/14/16 no longer require functional G codes and corresponding modifiers in order for PT/ST/OT to be reimbursed.

Modifier FX

Description	Rule	Reimbursement
Modifier indicating that during an X-ray film was utilized.	<ul style="list-style-type: none"> The provider should use an FX modifier when the X-ray uses film. 	<ul style="list-style-type: none"> A 20% in payment reduction is applied to the technical component (and the technical component of the global fee) for x-rays furnished using film.

Modifier GN-GP

Description	Rule	Reimbursement
Therapy modifier indicating the discipline of the plan of care	<ul style="list-style-type: none"> The provider should use GP, GO or GN for PT, OT and SLP services, respectively 	<ul style="list-style-type: none"> Claims submitted without the therapy modifier will be denied

Modifier KX

Description	Rule	Reimbursement
Requirements specified in the medical policy have been met.	<ul style="list-style-type: none"> 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 \$1,980 therapy cap. By attaching the KX modifier, the provider is attesting that the services billed: <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Reimbursement would be made at contracted fee schedule rate.

Modifier PT

Description	Rule	Reimbursement
<p>This modifier should be used when a CRC screening test has been converted to diagnostic test or other procedure</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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
<p>Services furnished by a locum tenens physician</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Reimbursement would be made at the regular physician’s fee schedule.

Modifier QK, QY, QX

Description	Reimbursement
<p>Modifier QK - Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals</p>	<ul style="list-style-type: none"> • Modifier QK will be reimbursed at the lesser of 50 percent of charges or the contracted rate
<p>Modifier QY - Medical direction of</p>	<ul style="list-style-type: none"> • Modifier QY will be reimbursed at the lesser of 50

one certified registered nurse anesthetist (CRNA) by an anesthesiologist	percent of charges or the contracted rate.
Modifier QX - CRNA service: with medical direction by a physician	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • A percentage of reduction based on date of service will apply when modifier U8 is billed and an acceptable diagnosis is not documented. DOS 07/15/15-06/30/16=25% reduction DOS 07/01/16 and after =50% reduction
Modifier U9 – Delivery at 39 weeks of gestation or later	<ul style="list-style-type: none"> • Full payment will be made when modifier U9 is submitted
Modifier UB - Spontaneous obstetrical deliveries occurring between 37-39 weeks gestation	<ul style="list-style-type: none"> • Full payment will be made when modifier UB and U8 are billed with one of the specified diagnosis codes from New York State Department of Health.

Modifier CT

Description	Reimbursement
Modifier CT	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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: 4/1/2014
Related Policies: 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* online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

Billing / Coding Guidelines

Multiple Surgery Rule

Code	Description	Rule
10021-69990	Surgical Procedural Codes	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"><li data-bbox="760 212 1425 243">• This code will be exempt from the multiple surgery rule.

References



MVP Health Care Payment Policy

NDC Policy

Type of Policy: Payment
Last Reviewed Date: 3/1/2017
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/betosdescodes.pdf> ; <https://www.findacode.com/hcpcs/HPCPS-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.

Definitions

NDC – National Drug Code

Referral / Notification/ Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

Billing/Coding Guidelines:

Instructions for filling out CMS 1500 form
<ul style="list-style-type: none"> NDC should be entered in the shaded area of fields 24A – 24G for the corresponding procedure code
<ul style="list-style-type: none"> The following should be included in order <ul style="list-style-type: none"> Report the N4 qualifier (left justified) followed immediately by: <ul style="list-style-type: none"> 11 digit NDC (no hyphens) One space followed immediately by: <ul style="list-style-type: none"> Unit of measurement qualifier: <ul style="list-style-type: none"> F2 – International Unit GR – Gram ML – Milliliter UN - Unit Unit Quantity
<p>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.</p> <p>Examples:</p> <ul style="list-style-type: none"> 1234.56 2 99999999.999
<p>Example : N412345678901 UN1234.567</p>

NDC Code:

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

Instructions for filling out UB 04 form
<ul style="list-style-type: none"> NDC should be entered into field 43
<ul style="list-style-type: none"> The following should be included in order <ul style="list-style-type: none"> Report the N4 qualifier (left justified) followed immediately by: <ul style="list-style-type: none"> 11 digit NDC (no hyphens) followed immediately by: <ul style="list-style-type: none"> Unit of measurement qualifier: <ul style="list-style-type: none"> F2 – International Unit GR – Gram ML – Milliliter UN - Unit Unit Quantity (floating decimal, limited to three digits to the right of the decimal)
<p>Example : N412345678901UN1234.567</p>

Instructions for Electronic Claim Format				
<ul style="list-style-type: none"> 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
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 UN - Unit

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	<u>First</u> segment to make it 5-4-2	4-4-2=1234-1234-12 becomes 5-4-2=01234-1234-12	N401234123412
5-3-2	<u>Second</u> segment to make it 5-4-2	5-3-2=12345-123-12 becomes 5-4-2=12345-0123-12	N401234123412
5-4-1	<u>Third</u> segment to make it 5-4-2	5-4-1=12345-1234-1 becomes 5-4-2=12345-1234-01	N401234123412
3-2-1	<u>First, second, and third</u> 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.



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: 6/1/2017
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 online at <https://content.mvphealthcare.com/provider/onlineresources.html> to determine if a service requires an authorization.

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



MVP Health Care Payment Policy

Observation Services for Facility and Provider

Type of Policy:	Payment
Last Reviewed Date:	03/1/2017
Related Policies:	N/A

Policy

MVP no longer requires 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 www.mvphealthcare.com/provider/onlineresources 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 case services submitted with routine pregnancy diagnosis
- Retaining a member for socioeconomic factors
- Custodial care

References

www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2014-01-14-midnight.html?DLPage=4&DLSort=0&DLSortDir=descending

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: 12/01/2016
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* online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

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.

Gold 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*

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf, Section 10.3



MVP Health Care Payment Policy

Physical Therapy (PT)

Type of Policy: Payment
Last Reviewed Date: 12/01/2016
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 Authorizations Requests

Please refer to the Utilization Management Guides and the *Benefit Interpretation Manual* online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

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 either 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

Gold 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*

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf, Section 10.3



MVP Health Care Payment Policy

Place of Service Assignment

Type of Policy:	Payment
Last Reviewed Date:	12/1/2016
Related Policies:	N/A

Policy

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), MVP must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction includes a POS code from the POS code set maintained by the Centers for Medicare & Medicaid Services (CMS). The correct POS code assignment is also required on the paper CMS-1500 Claim Form (or its electronic equivalent).

Definitions

At the time a place of service code is developed, CMS determines whether a facility or non-facility RVU is appropriate for that setting in the Resource Based Relative Value Scale (RBRVS) fee schedule. Under RBRVS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to members. These place of service guidelines apply to all MVP products.

Notification / Prior Authorization Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

Billing/Coding Guidelines

The POS code to be used by the physician and other supplier will be assigned as the same setting in which the member received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the RBRVS and anesthesia services, this rule will apply to the overwhelming majority of RBRVS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician /practitioner will be the setting in which the member received the (Technical Component (TC) of the service.

- For example: A member receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary's MRI from his/her office location – POS code 22 will be used on the physician's claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

There are two exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the member is receiving care as a registered inpatient or an outpatient of a hospital, regardless of where the member encounters the face-to-face service. The correct POS code assignment will be for that setting in which the member is receiving inpatient care or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22).

Reporting the inpatient hospital POS code 21 or the outpatient hospital POS code 22, is a minimum requirement for purposes of triggering the facility payment under the RBRVS when services are provided to a registered inpatient or an outpatient of a hospital respectively.

When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician's office or a SNF. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity which could be described by an existing POS code, the providers are to use the Mobile Unit POS code 15. MVP will apply the non-facility rate to payments for services designated as being furnished in POS code 15 and apply the appropriate facility or non-facility rate for the POS code designated when a code other than the mobile unit code is indicated.

A physician or practitioner's office, even if mobile, qualifies to serve as a telehealth originating site. Assuming such an office also fulfills the requirement that it be located in either a rural health Professional Shortage Area as defined under Section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a Metropolitan Statistical Area as defined in Section 1886(d)(2)(D) of the Social Security Act, the originating physician's office should use POS code 11 (Office) in order to ensure appropriate payment for services on the list of Medicare Telehealth Services.

Reimbursement Guidelines

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

References

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

MVP Split Billing Payment Policy



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 online at <https://content.mvphealthcare.com/provider/onlineresources.html> 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 Health Care Policy

Type of Policy: Payment

Last Reviewed Date: 6/1/17

Related Polices: N/A

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 may have exclusions to Federal Healthcare Reform; providers should check the member's benefits to determine if preventive services apply to their plan.

*Please note, 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.

Definitions

Age Definitions:

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

Adults – The Affordable Care Act (ACA) covered preventive services are provided to members 19 and older.

Referral / Notification/ Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual online at <https://content.mvphealthcare.com/provider/onlineresources.html> to determine if a service requires an authorization.

Billing/Coding Guidelines:

Description/ Recommendation	Code	Description	Billing Rule
Adult Aortic Aneurysm Screening: recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked	76706	Medical Services Adult aortic aneurysm screening	No copayment for one (1) time screening men aged 65 to 75 who have ever smoked when billed with appropriate code (left).
Bacteriuria screening: pregnant women. 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.	Medical Services 87086, 87088	Medical Services Bacteriuria screening: pregnant women	Medical Services No copayment for bacteriuria screening in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit when billed with the appropriate CPT code (left) and one pregnancy related diagnosis codes (below).
Breast Cancer Screening. 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.	Medical 99386, 99387, 99396, 99397 77063, 77067, G0202 99401, 99402, 99403, 99404 Facility 99386, 99387, 99396,	Medical Initial comprehensive preventive medicine evaluation and management code set and Periodic comprehensive preventative medicine reevaluation and management code set Mammography code set Preventive medicine counseling and/or risk factor reduction interventions Facility Initial comprehensive preventive medicine	Medical No Copayment for screening mammography in woman over the age of 40 when billed with appropriate codes (left) Facility No Copayment for screening mammography in woman over the age of 40 a when billed with general preventive service codes (below) clinic and with the professional revenue code in accordance with standard

	<p>99397</p> <p>77063, 77067, G0202,</p> <p>99401, 99402, 99403, 99404</p>	<p>evaluation and management code set and Periodic comprehensive preventative medicine reevaluation and management code set</p> <p>Preventive medicine counseling and/or risk factor reduction interventions</p>	<p>revenue code billing practices</p>
<p>Breast Cancer Chemoprevention: 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.</p>	<p>99385, 99386, 99387, 99395, 99396, 99397</p>	<p>Initial comprehensive preventative medicine evaluation and management code set</p> <p>Periodic comprehensive reevaluation and management code set</p>	<p>No copayment to discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention when billed with appropriate codes (left).</p>
			<p>For generic tamoxifen and raloxifene for the primary prevention of breast cancer for women age 35 and older who are at increased risk refer to the MVP Preventive Services-Medication policy.</p>
<p>BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: Primary care</p>	<p>96040, S0265</p>	<p>BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing</p>	<p>No copayment for women to discuss positive BRCA testing when billed with appropriate code (left) Modifier 33 must be</p>

<p>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.</p>	<p>99401, 99402, 99403, 99404</p> <p>81211, 81212, 81214, 81215, 81216, 81217, 81162</p>	<p>Preventive medicine counseling and/or risk factor reduction interventions</p> <p>BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing</p>	<p>appended to the code(96040, S0265) to consider it preventative.</p> <p>No copayment for screening for women whose family history may be associated with an increased risk for potentially harmful BRCA mutations when billed with the appropriate code (left).</p>
<p><u>Cervical Cancer Screening:</u> recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years</p>	<p><u>Medical & Facility</u></p> <p>88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, 88175, G0101, G0123, G0124, G0141, G0143, G0144,</p>	<p><u>Medical & Facility</u></p> <p>Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician Cervical Cancer Screening</p>	<p><u>Medical & Facility</u></p> <p>No copayment for cervical cancer screening in women when billed with appropriate CPT code (left)</p> <p>Screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years</p>

	<p>G0145, G0147, G0148, P3000, P3001, Q0091</p>		
<p>Colorectal Cancer Screening: recommend screening for colorectal cancer starting at age 50 years and continuing until age 75 years.</p>	<p><u>Medical and Facility</u> 45300, 45303, 45305, 45307, 45309, 45315, 45317, 45320, 45321, 45327, 45330, 45331, 45332, 45333, 45334, 45337, 45338, 45341, 45342, 45347, 45378, 45379, 45380, 45382, 45383, 45384, 45385, 45386, 45387</p>	<p><u>Medical and Facility</u> Colorectal Cancer Screening</p>	<p><u>Medical and Facility</u> No copay for screening for colorectal cancer in adults, age 50 years to age 75 years when billed with appropriate CPT code (left) , and either</p> <p>One of the following ICD 10 codes are billed at the line level in the principal diagnosis position; Z12.10, Z12.11, Z12.12, Z12.13, Z80.0, Z83.71, Z83.79, Z85.030, Z85.038, Z85.040, Z85.048, Z85.060, Z85.068, Z85.09, Or attached with Modifier 33 or Modifier PT</p>

	<p>81528, 82270, 82274. G0104, G0105, G0106, G0120, G0121, G0122, G0328. S0285</p> <p>ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests</p>		<p>No copay for screening for colorectal cancer in adults, age 50 years to age 75 years when billed with appropriate CPT code (left) , and</p> <p>No Modifier 33 or Modifier PT required.</p> <p>No copayment for Medical or Facility services when One of the following ICD 10 codes are billed at the line level in the principal diagnosis position; Z12.10, Z12.11, Z12.12, Z12.13, Z80.0, Z83.71, Z83.79, Z85.030, Z85.038 Z85.040, Z85.048, Z85.060, Z85.068, Z85.09,</p>
<p><u>Hypothyroidism Screening (newborns)</u> The USPSTF recommends screening for congenital hypothyroidism in newborns.</p>	<p>84437</p>	<p>Hypothyroidism screening in newborns</p>	<p>No copayment for congenital hypothyroidism screening in newborns when billed with appropriate CPT code (left).</p>
<p><u>Gonorrhea Screening</u></p>	<p>87590,</p>		<p>No copayment for screening for</p>

<p><u>Sexually Active Women:</u> recommends screening for gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection.</p>	<p>87591, 87592</p>		<p>gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection when billed with the appropriate codes (left). Modifier 33 must be attached to the code to be considered preventative</p>
<p><u>Contraceptive Use and Counseling</u></p>	<p>11980, 11981, 11982, 11983</p> <p>96372</p> <p>S4993</p> <p>57170, 58300, 58301, 58600, 58611, 58671, 96372, S4981, S4989, S4993, A4261, A4266, J7297, J7298, J7300, J7303,</p>	<p>Contraceptive devices and services</p>	<p>No copayment for contraceptive use and counseling for women when billed with appropriate code (left) and diagnosis code billed in the principal diagnosis position; Z30.15, Z30.017, Z30.19 Z30.44 and Z30.49</p> <p>No copayment 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, Zs0.49, Z30.9</p> <p>No copayment for contraceptive use and counseling for women when billed with appropriate code (left) and diagnosis code billed in the principal diagnosis position; Z30.11</p> <p>No copayment for contraceptive use and counseling for women when billed with appropriate code (left)</p>

	J7304, J7306, J7307		
Falls prevention in older adults: exercise or physical therapy: recommend exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	97110, 97112	Physical therapy services	No copayment for older adults for exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are increased risk for falls when billed with appropriate codes (left) and diagnosis code billed in the principal diagnosis position; Z91.81 Modifier 33 must be attached to the code to be considered preventative
Falls prevention in older adults: vitamin D: recommend vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	N/A	Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	No copayment for over-the-counter (OTC) vitamin D (600IU-800IU) for community-dwelling adults age 65 years and older who are at increased risk for falls. A written prescription for vitamin D (600IU -800IU) is required.
Hepatitis C virus infection screening: adults: recommend 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.	86803, 86804, G0472	Hepatitis C antibody testing	No copayment for one-time screening for HCV infection in adults born between 1945 and 1965 when billed with appropriate code (left);
Hepatitis B screening: pregnant women: Recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	Medical & Facility 87340	Medical & Facility Hepatitis B testing	No copayment for screening for hepatitis B virus infection in pregnant women at their first prenatal visit when billed with appropriate code (left).(87340)
Hepatitis B screening: nonpregnant adolescents and adults: recommends screening for hepatitis B virus infection in persons at high risk for infection.	Medical & Facility G0499	Medical & Facility Hepatitis B testing	No copayment for screening for hepatitis B virus infection in nonpregnant adolescents and adults at high risk for infection. when billed with appropriate code (left).(G0499)

<p><u>HIV Screening (At Risk Adults, Adolescents, and Pregnant Women):</u> Recommend 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.</p>	<p><u>Medical & Facility</u> 86701, 86702, 86703, 87390, 87535, 87534, 87536, S3645</p>	<p><u>Medical</u> HIV testing</p>	<p><u>Medical & Facility</u> No copayment for screening HIV infection in adolescents and adults ages 15 to 65 years. No copayment for screening HIV infection younger adolescents and older adults who are at increased risk should also be screened. Submit bill with appropriate code (left)</p>
<p><u>HIV Screening: Pregnant Women:</u> The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.</p>	<p><u>Medical & Facility</u> 86701, 86702, 86703, 87390, 87535, 87534, 87536, S3645</p>	<p><u>Medical</u> HIV testing</p>	<p><u>Medical & Facility</u> No copayment 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 (left)</p>
<p><u>Intimate partner violence screening: women of childbearing age:</u> <u>recommend 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.</u></p>	<p><u>Medical & Facility</u> <u>99385, 99386, - 99387</u> 99395, 99396, 99397 99401, 99402, 99403, 99404</p>	<p><u>Medical & Facility</u> Initial comprehensive preventive medicine evaluation and management code set Periodic comprehensive preventive medicine reevaluation and management code set Preventive medicine counseling and/or risk factor reduction interventions</p>	<p><u>Medical & Facility</u> No copay when screening screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. when submitted with the appropriate CPT code (left).</p>

<u>Cholesterol abnormalities screening:</u> men 35 and older; recommend screening men age 35 years and older for lipid disorders	82465, 83718, 84478	Cholesterol screening	No copayment for cholesterol abnormalities screening in men 35 and older when billed with the appropriate code (left) or Women ages 20-45 when submitted with the appropriate preventative diagnosis codes Modifier 33 must be attached to the code to be considered preventative
<u>Cholesterol abnormalities screening:</u> men younger than 35; recommend screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	82465, 83718, 84478	Cholesterol screening	No copayment for cholesterol abnormalities screening in men 20 to 35 when billed with the appropriate code (left)
<u>Cholesterol abnormalities screening:</u> women 45 and older; recommend screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease	82465, 83718, 84478	Cholesterol screening	No copayment for cholesterol abnormalities screening in women 45 and older when billed with the appropriate code (left).
<u>Cholesterol abnormalities screening:</u> women 45 and younger; recommend screening women age 45 years and younger for lipid disorders if they are at increased risk for coronary heart disease	82465, 83718, 84478	Cholesterol screening	No copayment for cholesterol abnormalities screening in women 45 and younger when billed with the appropriate code (left).
<u>Lung Cancer Screening,</u> 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	G0297	Lung cancer screening	No copayment for annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years when billed with appropriate code (left). Prior authorization is required for

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.	G0296		G0297. . No copayment for counseling to discuss lung cancer screening when billed with appropriate code (left) and ICD 10 code billed in the principal diagnosis position; Z87.891
<u>Skin Cancer Behavioral Counseling:</u> recommend counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	99383, 99384, 99385, 99393, 99394, 99395 99401, 99402, 99403, 99404	Initial comprehensive preventive medicine evaluation and management code set Periodic comprehensive preventive medicine reevaluation and management code set Preventive medicine counseling and/or risk factor reduction interventions	No copayment for counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer when billed with the appropriate code (left).
<u>Osteoporosis screening: women:</u> recommend screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	<u>Medical & Facility</u> 77080, 77081	<u>Medical & Facility</u> Osteoporosis screening	<u>Medical & Facility</u> No copayment for screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors when billed with appropriate code (left).
<u>Gonorrhea prophylactic medication: newborns:</u> recommend prophylactic	<u>Medical & Facility</u> N/A	<u>Medical & Facility</u> prophylactic ocular topical medication for	<u>Medical & Facility</u> Prophylactic ocular topical medication for all newborns for

<u>ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.</u>		all newborns for the prevention of gonococcal ophthalmia neonatorum.	the prevention of gonococcal ophthalmia neonatorum is considered global to infant nursery care inpatient admission.
Phenylketonuria Screening (newborns): recommend screening for phenylketonuria in newborns	84030	Phenylketonuria screening	Screening for phenylketonuria in newborns. No copay for newborns under 30 days old.
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 <u>59400</u> <u>59510</u> <u>59610</u> <u>59618</u>	Medical & Facility <u>Preventive medicine counseling and/or risk factor reduction interventions</u>	Medical & Facility No copayment for initiating over the counter aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia when billed with appropriate code (left). 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: 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 copayment for Rh incompatibility screening for all pregnant women during their first visit for pregnancy-related care when billed with appropriate code (left) and appropriate Pregnancy related ICD 10 diagnosis code set billed in the principal diagnosis position.; (below)
Rh incompatibility screening: 24–28 weeks' gestation: 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.	Medical & Facility 86901	Medical & Facility Blood typing; Rh (D)antibody testing	Medical & Facility No copayment for Rh incompatibility screening: 24–28 weeks' gestation when billed with appropriate code (left) and appropriate Pregnancy related ICD 10 diagnosis code set billed in the principal diagnosis position; (below)

<u>Hemoglobinopathiescreening:newborns:</u> The USPSTF recommends screening for sickle cell disease in newborns.	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).
<u>Syphilis Screening:</u> pregnant women recommend that clinicians screen all pregnant women for syphilis infection.	86592, 86593, 87164, 87166, 87285	Syphilis Infection Screening	No copay for syphilis screening in all pregnant women when submitted with appropriate code (left)
<u>Syphilis Screening: nonpregnant persons</u> recommend screening for syphilis infection in persons who are at increased risk for infection.	86592, 86593, 87164, 87166, 87285	Syphilis screening	No copayment for syphilis infection screening for persons at increased risk for syphilis infection. .
<u>Tobacco Use Counseling and Interventions:</u> <u>Nonpregnant adults.</u> 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.	99406, 99407, S9453	Tobacco use counseling and interventions:	No copayment for tobacco use screening for all adults. Reimbursement restricted to the following specialties: <ul style="list-style-type: none"> ○ Primary Care Physicians: <ul style="list-style-type: none"> ▪ Family Practice ▪ Internal Medicine ▪ General Practitioners ○ Specialists: <ul style="list-style-type: none"> ▪ OB/GYN ▪ Pediatricians Services included in Preventative E&M codes
<u>Tobacco Use Counseling and Interventions:</u> <u>pregnant women.</u> The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco	99406, 99407, S9453	Tobacco use Counseling and Interventions:	No copayment for tobacco use screening for all pregnant women. Reimbursement restricted to the following specialties: <ul style="list-style-type: none"> ○ Primary Care Physicians: <ul style="list-style-type: none"> ▪ Family Practice ▪ Internal Medicine ▪ General Practitioners ○ Specialists: <ul style="list-style-type: none"> ▪ OB/GYN

			<ul style="list-style-type: none"> ▪ Pediatricians Services included in Preventative E&M codes
<p><u>Tobacco Use Interventions: Children and Adolescents.</u> The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.</p>	99383, 99384, 99385, 99393, 99394	Tobacco use interventions:	No copayment for tobacco use interventions for children and adolescents. When billed with appropriate codes (left).
<p><u>Diabetes Screening.</u> 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.</p>	82947, 82950, 82951, 82952, 82948	Diabetes screening testing.	No copayment for screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese when submitted. with the appropriate codes (left).
<p><u>Visual acuity screening in children:</u> The USPSTF recommends 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.</p>	<u>Medical & Facility</u> 99173	<u>Medical & Facility</u> Visual acuity screening in children.	<u>Medical & Facility</u> No copayment for vision screening for all children at least once those under age 5 years, to detect the presence of amblyopia or its risk factors when billed with appropriate code (left).
<p><u>Alcohol misuse: screening and counseling.</u> The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and</p>	G0442, G0443, G0444, H0001, H0049	Annual wellness visit	No copayment for screening for alcohol misuse for adults age 18 years or older when billed with the appropriate code (left)

<p>provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.</p>			
<p><u>Depression (Adults, including Pregnant and Postpartum Women) Screening</u> (When staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up)</p>	<p><u>Medical & Facility</u> G0439, G0444, G0447, and G0473 99401, 99402, 99403, 99404</p>	<p><u>Medical & Facility</u> Annual wellness visit Preventive medicine counseling and/or risk factor reduction interventions</p>	<p><u>Medical & Facility</u> No copay for screening for depression in adults, including pregnant and postpartum women when billed with appropriate codes (left)</p>
<p><u>Depression Screening Adolescents</u> (Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.)</p>	<p><u>Medical & Facility</u> G0439, G0444, G0447, and G0473 99401, 99402, 99403, 99404</p>	<p><u>Medical & Facility</u> Annual wellness visit Preventive medicine counseling and/or risk factor reduction interventions</p>	<p><u>Medical & Facility</u> No copay for screening for depression in the adults, including pregnant and postpartum women when billed with appropriate codes (left)</p>
<p><u>Sexually transmitted infections counseling.</u> The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted</p>	<p>99401, 99402, 99403, 99404</p>	<p>Preventive medicine counseling and/or risk factor reduction interventions</p>	<p>No copayment for intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections when submitted with the appropriate code (left) No copay in females with Cervical</p>

infections.			Dysplasia Sexually Active Females
<p><u>Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors:</u></p> <p>The USPSTF recommends 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.</p>	99401, 99402, 99403, 99404	<p><u>Medical & Facility</u></p> <p>Preventive medicine counseling and/or risk factor reduction interventions</p>	<p><u>Medical & Facility</u></p> <p>No copay for healthy diet and physical activity counseling for overweight or obese adults with cardiovascular risk factors when billed with the appropriate code (left)</p>
<p><u>Aspirin preventive medication:</u> adults aged 50 to 59 years with a $\geq 10\%$ 10-year cardiovascular risk. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.</p>	99401, 99402, 99403, 99404	Preventive medicine counseling and/or risk factor reduction interventions	<p>No copayment for initiating over the counter aspirin as preventive medication for adults aged 50-59 with a $\geq 10\%$ 10-year cardiovascular risk. when billed with the appropriate counseling service code (left) A written prescription for aspirin is required:</p> <ul style="list-style-type: none"> Age limit ≥ 50 (men) Age limit ≥ 50 (women) QL of 100 units/fill Generics only Single ingredient OTC dosages 325mg or less
<p><u>Breastfeeding counseling.</u></p> <p>The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.</p>	99401, 99402, 99403, 99404	Preventive medicine counseling and/or risk factor reduction interventions	No copayment for discussion of interventions during pregnancy and after birth to promote and support breastfeeding when billed with the appropriate counseling service code (left).
<p><u>Chlamydia screening: women.</u> The USPSTF recommends screening for chlamydia in sexually active</p>	87270, 87320, 87490, 87491,	<u>Chlamydia screening: women.</u>	<u>No copayment screening for chlamydia in sexually active women age 24 years or younger and in older women who are at</u>

<p><u>Gestational diabetes mellitus screening:</u> The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.</p>	<p>82977</p>	<p>Gestational diabetes mellitus screening.</p>	<p>No Copayment for screening for gestational diabetes in females when billed with CPT code 82977 with diagnosis code billed in the principal diagnosis position; Z13.1</p>
<p><u>High blood pressure in adults: screening.</u> 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.</p>	<p>99401, 99402, 99403-, 99404</p>	<p>Preventive medicine counseling and/or risk factor reduction interventions</p>	<p>No copayment when screening for high blood pressure during the preventative care visit for adults over age 18 when billed with the appropriate code (left).</p>
<p><u>Obesity Screening and counseling: children:</u> recommend 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.</p>	<p><u>Medical & Facility</u> 99383, 99384, 99385, 99386, - 99387 99393 99394, 99395, 99397 99401, 99402, 99403, 99404 G0447</p>	<p><u>Medical & Facility</u> Initial comprehensive preventive medicine evaluation and management code set code set Periodic comprehensive preventive medicine reevaluation and management code set code set Preventive medicine counseling and/or risk factor reduction interventions</p>	<p><u>Medical & Facility</u> No copay when screening and counseling children 6 years and older for obesity when submitted with the appropriate CPT code (left).</p>

<p><u>Obesity, Screening and counseling: adults:</u> recommend screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.</p>	<p><u>Medical & Facility</u> 99385, 99386, - 99387 99395, 99396, 99397 99401, 99402, 99403, 99404 G0447</p>	<p><u>Medical & Facility</u> Initial comprehensive preventive medicine evaluation and management code set Periodic comprehensive preventive medicine reevaluation and management code set Preventive medicine counseling and/or risk factor reduction interventions</p>	<p><u>Medical & Facility</u> No copay when screening and counseling adults for obesity when submitted with the appropriate CPT code (left).</p>
<p><u>Pediatric and Adult Preventive Exams</u></p>	<p>99381, 99382, 99383, 99384, 99385, 99386, 99387</p>	<p>Initial comprehensive preventive medicine evaluation and management code set</p>	<p>No copayment for a routine preventative exam when billed with the appropriate CPT code (left).</p>
	<p>99391, 99392, 99393, 99394, 99395, 99397</p>	<p>Periodic comprehensive preventive medicine reevaluation and management code set</p>	<p>No copayment for a routine preventative exam when billed with the appropriate CPT code (left).</p>
	<p>G0438</p>	<p>Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit</p>	<p>No copay for a routine preventative exam when billed with the appropriate CPT code (left).</p>

	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 (left).
	99401, 99402, 99403, 99404	E&M Codes Preventive medicine counseling and/or risk factor reduction interventions	No copay for a routine preventative exam.
<u>Immunizations for Adults and Children</u> - 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	No copay when immunization is provided based on ACIP guidelines
	90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	No copay when immunization is provided based on ACIP guidelines
	90632	Hepatitis A vaccine, adult dosage, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90636	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90644	Meningococcal conjugate vaccine,	No copay when immunization is provided based on ACIP

		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	guidelines
	90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use	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	No copay when immunization is provided based on ACIP guidelines
	90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90650	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 3 dose schedule, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90653	influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	No copay when immunization is provided based on ACIP guidelines
	90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free,	No copay when immunization is provided based on ACIP guidelines

		when administered to children 6-35 months of age, for intramuscular use	
	90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90657	Influenza virus vaccine, trivalent (IIV3), split virus, when administered to children 6-35 months of age, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90658	Influenza virus vaccine, trivalent (IIV3), split virus, when administered to individuals 3 years of age and older, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	No copay when immunization is provided based on ACIP guidelines
	90661	Influenza virus vaccine (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use	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	No copay when immunization is provided based on ACIP guidelines
	90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use	No copay when immunization is provided based on ACIP guidelines

	90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	No copay when immunization is provided based on ACIP guidelines
	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
	80680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use	No copay when immunization is provided based on ACIP guidelines
	90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use	No copay when immunization is provided based on ACIP guidelines
	90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	No copay when immunization is provided based on 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	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	No copay when immunization is provided based on ACIP guidelines
	90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to individuals 3 years of age and older, for	No copay when immunization is provided based on ACIP guidelines

		intramuscular use	
	90696	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP - Hib - IPV), for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	No copay when immunization is provided based on ACIP guidelines
	90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	No copay when immunization is provided based on ACIP guidelines
	90713	Poliovirus vaccine,	No copay when immunization is

		inactivated (IPV), for subcutaneous or intramuscular use	provided based on ACIP guidelines
	90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90716	Varicella virus vaccine, live, for subcutaneous use	No copay when immunization is provided based on ACIP guidelines
	90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use	No copay when immunization is provided based on 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	No copay when immunization is provided based on ACIP guidelines
	90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use	No copay when immunization is provided based on ACIP guidelines

	90736	Zoster (shingles) vaccine, live, for subcutaneous injection	No copay when immunization is provided based on ACIP guidelines
	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	J3530	Nasal vaccine inhalation	No copay when immunization is provided based on ACIP guidelines
	Q2034	Influenza virus vaccine, split virus, for intramuscular use (Agriflu)	No copay when immunization is provided based on ACIP guidelines
	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA)	No copay when immunization is provided based on ACIP guidelines
	Q2036	Influenza virus vaccine, split virus, when	No copay when immunization is provided based on ACIP

		administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL)	guidelines
	Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLUVIRIN)	No copay when immunization is provided based on ACIP guidelines
	Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)	No copay when immunization is provided based on ACIP guidelines
	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)	No copay when immunization is provided based on ACIP guidelines
<u>Immunization Administration</u>	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 copayment 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	No copayment when submitted with the an appropriate CPT code (left) and immunization code (above).

		administered (List separately in addition to code for primary procedure)	
	90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	No copayment when submitted with an appropriate immunization code (above).
	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 copayment when submitted with an appropriate immunization code (above).
	90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	No copayment 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 copayment when submitted with an appropriate immunization code (above).
	G0008	Administration of influenza virus vaccine	No copayment when submitted with an appropriate immunization code (above).
	G0009	Administration of pneumococcal vaccine	No copayment when submitted with an appropriate immunization code (above).

	G0010	Administration of hepatitis B vaccine	No copayment when submitted with an appropriate immunization code (above).
Hearing loss screening: newborns: The USPSTF recommends screening for hearing loss in all newborn infants.	<p>Medical 92251, 92560, 92552, 92585, 92586, 92587, 92588, V5008</p> <p>Facility 92251, 92560, 92552, 92585, 92586, 92587, 92588, V5008</p>	<p>Medical Hearing loss screening: newborns</p> <p>Facility Hearing loss screening: newborns</p>	<p>Medical No copay for screening loss in newborns when billed with appropriate code (left) along with ICD 10 codes billed in the principal diagnosis position; Z00.110, Z00.111, Z00.121, Z00.129.</p> <p>Facility No copay for screening hearing loss in newborns when billed with appropriate code (left.)</p>
<u>Sexually Transmitted Infections</u>	87270 87320	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	No copayment for sexually transmitted infection testing when performed as a preventative visit and submitted with appropriate CPT code (left).
	87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique	No copayment for sexually transmitted infection testing when performed as a preventative visit and submitted with appropriate CPT code (left).
	87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	No copayment for sexually transmitted infection testing when performed as a preventative visit and submitted with appropriate CPT code (left).
	87492	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis,	No copay when performed as a preventative visit.

		quantification	
	87590	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique	No copay when performed as a preventative visit. Modifier 33 must be appended to be considered preventative
	87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique	No copay when performed as a preventative visit.
	87592	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification	No copay when performed as a preventative visit.
	87110	Culture, chlamydia, any source	No copay when performed as a preventative visit.
<u>Lead Poisoning Screening</u>	83655	Lead Testing	No copayment 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
<u>Hemoglobin/Hematocrit Testing</u>	85014 85013	Blood count; hematocrit (Hct)	No copayment 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)	<p>No copayment for hemoglobin (Hgb) when performed on children under the age of 13 months as a preventative visit when billed with the appropriate CPT code (left).</p> <p>.</p> <p>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</p>
	86762	Antibody; rubella	<p>No copayment 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).</p> <p>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).</p> <p>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)...</p>

Women’s Preventative Health

Description/ Recommendation	Code	Description	Business Rule
Note: These services are			

<p>required to be covered as of 8/1/2012 for all members as a result of the Patient Protection and Affordable Care Act (PPACA). MVP will be giving members these benefits as their plans come up for renewal after 8/1/12. Providers must check the member's benefits before determining if these services will be covered in full.</p>			
	82977	Glutamyltransferase, gamma (GGT) s	No Copayment 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	
	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.
	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;	. No copay for woman.

		screening by automated system with manual rescreening under physician supervision	
	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
	88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, 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	No copay for woman

		rescreening under physician supervision	
	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
	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	No copay for woman

		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	No copay for woman
	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),	No copay for woman

		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	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
	87623 87624	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44) Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types	No Copayment for HPV testing in females over age 30 when billed with appropriate CPT code (left).

	87625	(eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	
	88174	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	
	99401, 99402, 99403, 99404	Preventive medicine counseling and/or risk factor reduction interventions	No Copayment for counseling on sexually transmitted infections for females when billed with appropriate CPT code (left)
	86701 86702 86703	Antibody; HIV-1 Antibody; HIV-2 Antibody; HIV-1 and HIV-2, single result	No Copayment for counseling and screening for HIV infection in females when billed with appropriate CPT codes (left).
	99401, 99402, 99403, 99404	Preventive medicine counseling and/or risk factor reduction interventions	No Copayment for contraceptive methods and counseling in females when billed with appropriate CPT codes
	58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or	No Copayment for female sterilization surgery for females when billed with the appropriate CPT codes (left)

	58605	<p>bilateral</p> <p>Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)</p>	
	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)	
	58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	
	58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	
	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 (left)
	E0602 E0603 E0604	See code description below	No Copayment for lactation counseling and equipment for females when billed with the appropriate CPT code (left)

			MVP will reimburse up to \$75 for the purchase of a Breast Pump. 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.
	E0602	Breast pump, manual, any type	See billing rule above
	E0603	Breast pump, electric (AC and/or DC), any type	See billing rule above
	E0604	Breast pump, hospital grade, electric (AC and/or DC), any type	See billing rule above
	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	MVP will cover this replacement part at no cost to the member for the first year of the child's life.
	A4283	Cap for breast pump bottle, replacement	MVP will cover this replacement part at no cost to the member for the first year of the child's life.
	A4284	Breast shield and splash protector for use with breast pump, replacement	MVP will cover this replacement part at no cost to the member for the first year of the child's life.
	A4285	Polycarbonate bottle for use with breast pump, replacement	MVP will cover this replacement part at no cost to the member for the first year of the child's life.
	A4286	Locking ring 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.
	S9443	Non physician doing a lactation class	No Copay for Females
	99211	Nurse visit usually under 5 minutes	No Copayment for supervision of lactation for females when billed by a physician with the appropriate E&M code (left) and
	99212	Office or other	

	99213, 99214, 99215	outpatient visit for the evaluation and management of an established patient	the following diagnosis codes billed in the principal diagnosis position; Z39.1
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Modifier PT and Modifier 33

<p><u>Modifier PT</u></p>	<p>This modifier should be used when a CRC screening test has been converted to diagnostic test or other procedure</p>	<p>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.</p>	<p>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.</p>
<p><u>Modifier 33*</u></p> <p><u>*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.</u></p>	<p>Preventive Services</p>	<p>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.</p>	<p>The member's copay/coinsurance/cost share for this service will be waived as appropriate.</p>

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)

Diagnostic Mammograms

Description/ Recommendation	Code	Description	Business Rule
<p>Medical Services New York State Insurance Law Chapter 74 of the Laws of 2016 Insurance Law requires no copayment for diagnostic imaging, ultrasounds, and MRI of the breast</p>	<p>Medical Services 76641, 76642, 77053, 77054, 77058* 77059* 77061, 77062, 77065, 77066, G0204, G0206, G0279</p>	<p>Medical Services Breast cancer screening and diagnostic codes</p>	<p>Medical Services No copayment for diagnostic imaging, ultrasounds, and MRI of the breast when billed with the appropriate CPT code (left) 77058* and 77059* require prior authorization via eviCore</p>

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
<p>Long-Acting Reversible Contraception (LARC) is covered for Medicaid and HARP products only when provided to women during their postpartum inpatient hospital stay.</p>	<p>J7300 J7301 J7306</p>	<p>Intrauterine copper contraceptive Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg</p>	<p>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 (left)</p>

	J7307	Levonorgestrel (contraceptive) implant system, including implants and supplies	
	J7297	Etonogestrel (contraceptive) implant system, including implant and supplies	
	J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration	
		Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year	

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.

Claims should be billed with the appropriate CPT procedure code or HCPCS code (see Colorectal Cancer Screening section above) for the colon cancer screening service and either:

Modifier 33 or Modifier PT attached to the procedure code

OR

One of these ICD 10 codes billed in the principal diagnosis position; (Z12.10, Z12.11, Z12.12, Z12.13, Z80.0, Z83.71, Z83.79, Z85.030, Z85.038 Z85.040, Z85.048, Z85.060, Z85.068, Z85.09)

Claims for services associated with colon cancer screening including laboratory tests, office visits, and anesthesia should be billed with the appropriate code for the associated service and one of the following diagnosis codes billed in the principal diagnosis position:

Z12.10, Z12.11, Z12.12, Z12.13, Z80.0, Z83.71, Z83.79, Z85.030, Z85.038
Z85.040, Z85.048, Z85.060, Z85.068, Z85.09

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, G0202, G0204, G0206, 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: 6/1/2017
Related Policies: 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* online at <https://content.mvphealthcare.com/provider/onlineresources.html> to determine if a service requires an authorization.

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 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.



MVP Health Care Payment Policy

Shared Split-Visit Guidelines

Type of Policy:	Payment
Last Reviewed Date:	07/01/2013
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.

Definitions

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 online at www.mvphhealthcare.com/provider/onlineresources to determine if a service requires an authorization.

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

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



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

Notification / Prior Authorizations Requests

Please refer to the *Utilization Management Guides* and the *Benefit Interpretation Manual* online at <https://content.mvphealthcare.com/provider/onlineresources.html> 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:	3/1/2017
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 online at <https://content.mvphealthcare.com/provider/onlineresources.html> to determine if a service requires an authorization.

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

Gold 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*

https://content.mvphealthcare.com/provider/documents/Provider_Resource_Manual/Q4_2016/MVP_Health_Care_ProviderResourceManualSection_5_UtilizationManagement.pdf, Section 10.3



MVP Health Care Payment Policy

TeleHealth

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

Policy

MVP pays for a limited number of services furnished by a physician or practitioner to an eligible member via a telecommunications system. For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter.

Definitions

The use of electronic information and telecommunications to provide health care services to a member from an Originating Site to a Distant Site as a substitution for an in-person visit. The member must be at an Originating Site unless they are being treated for a condition that requires Remote Patient Monitoring.

For a service to be considered eligible for TeleHealth coverage, the interactive audio and video telecommunications must be real-time communication with electronic transmission of the member's health information, or pre-recorded videos known as store and forward technology. The purpose of the electronic information and communication is to collect the member's health information and medical data for use in treatment and management of conditions that require frequent monitoring.

Services or communication by audio-only (telephone, fax, skype, etc.) do not qualify as a TeleHealth service.

An 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.

A 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 Dietitians. These services must be rendered by an in-plan provider.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

Billing / Coding Guidelines

BILLING AND PAYMENT FOR PROFESSIONAL SERVICES FURNISHED VIA TELEHEALTH

You should submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, “via interactive audio and video telecommunications systems” (for example, 99201 GT). By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the member was present at an eligible originating site when you furnished the telehealth service.

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. You should bill MVP for the originating site facility fee, which is a separately billable and will be reimbursed at a flat fee of \$25.00 for all providers and facilities.

Reimbursement Guidelines

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



MVP Health Care Payment Policy

TeleMedicine

Type of Policy:	Payment
Last Reviewed Date:	12/1/2016
Related Policies:	N/A

Policy

Effective January 1, 2017 Telemedicine will be covered under certain plans only when provided by is Online Care Network("OCN") providers and through the OCN affiliated online platform provided by American Well. Please check member benefits to ensure the member is covered for TeleMedicine.

Definitions

Telemedicine means the use of electronic information and communication technologies to deliver health Care services to Members at a distance including but not limited to Telemedicine Consultation, and communication utilizing the American Well American Well Platform. Notwithstanding the foregoing, Telemedicine Services explicitly excludes Telemedicine, Store and Forward Technology and Remote Patient Monitoring as defined in 18 NYCRR §505.38 Telehealth Services.

Telemedicine Consultation means a single synchronous online consultation provided by an OCN provider through the American Well platform to a covered Member.

"Covered Telemedicine" means the provision of specific Telemedicine Services as provided by OCN providers through a Telemedicine Consultation using the OCN affiliated online platform provided by American Well.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

Billing / Coding Guidelines

Providers that wish to be compensated for Telemedicine Services contract with OCN to become an OCN provider and provide services to covered Members via the American Well platform. 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 the American Well platform.

Reimbursement Guidelines

Please see Online Care Network agreement.

References

Payment Policy regarding Telehealth Services including Telemedicine, Store and Forward Technology and Remote Patient Monitoring as defined in 18 NYCRR §505.38 Telehealth Services is found in MVP Health Care Payment Policy for Telehealth.



MVP Health Care Payment Policy

Transitional Care Management - Gold Products Only

Type of Policy:	Payment
Last Reviewed Date:	09/01/2016
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), 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 Gold products. 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. 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 Authorization Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

Billing / Coding Guidelines

Transitional care management is only reimbursable for MVP Gold 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.

Providers cannot bill for other care coordination services (such as care plan oversight codes 99339, 99340, 99374 - 99380) provided during the TCM period.

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://ezinearticles.com/?99495-99496:-Two-New-Codes-to-Report-Transitional-Care-Management-\(TCM\)-Services&id=7509665](http://ezinearticles.com/?99495-99496:-Two-New-Codes-to-Report-Transitional-Care-Management-(TCM)-Services&id=7509665)



MVP Health Care Payment Policy

Vaccine Administration — Vermont Only

Type of Policy: Payment
Last Reviewed Date: 7/1/2016
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 online at www.mvphealthcare.com/provider/onlineresources to determine if a service requires an authorization.

Billing, Coding and Reimbursement Guidelines:

- Codes 90460, 90461, 90471-90474, G0008-G0010 must 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