2023 Payment Policies

MVP Health Care® policy and procedure guidelines.

Updated May 11, 2023

MVP Payment Policies

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After-Hours

Last Reviewed Date: March 1, 2023

Policy

After-hour codes are used when a provider performs services in the office outside of normal business hours. MVP has determined normal business hours to mean 8: am – 6:00 pm EST, Monday through Friday. In accordance with Centers for Medicare and Medicaid Services (CMS) guidelines, MVP reimburses the following after-hours codes as inclusive with the Evaluation and Management (E&M) code that is billed. These CPT codes are not payable if they are the only CPT procedure(s) listed on the claim.

Reimbursement Guidelines

Code	Description	Reimbursement Guidelines
99050	Service(s) provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.	This code must be billed with an E&M to be reimbursable This code will not be reimbursable when submitted with preventive visit codes.
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	This code must be billed with an E&M code and is considered inclusive to the E&M. MVP does not reimburse separately for this code for Commercial and Medicare products. For Medicaid/HARP products, MVP will reimburse this code at the Medicaid rate.
99053	Service(s) provided between 10:00 pm and 8:00 am at 24-hour facility, in addition to basic service	This code must be billed with an E&M code and is considered inclusive to the E&M. MVP does not reimburse separately for this code.
99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	This code must be billed with an E&M code and is considered inclusive to the E&M. MVP does not reimburse separately for this code.
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service	This code must be billed with an E&M code and is considered inclusive to the E&M. MVP does not reimburse separately for this code.
99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service	This code must be billed with an E&M code and is considered inclusive to the E&M. MVP does not reimburse separately for this code.

Notification/Prior Authorization Requests

MVP Payment Polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

References

NYS Department of Health: health.ny.gov/health_care/medicaid/program/update/2008/2008-10.htm#enh

History

October 15, 2018	New policy, approved
December 1, 2020	Policy reviewed and approved without changes
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with no changes

Allergy Testing and Serum Preparation Claims

Last Reviewed Date: March 1, 2023

Policy

MVP will reimburse for allergy testing and serum preparation. The tests and units of doses are limited per Member every calendar year as outlined below:

Billing/Coding Guidelines

Code	Description	Rule
95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens	• Number of units/doses must be specified on the claim • First Year: Reimbursement is limited to 40 units/doses per claim and 160 units/doses per calendar year • Subsequent Years: Reimbursement is limited to 30 units per claim and 120 units/doses per calendar year
95004	Percutaneous tests (scratch, puncture, and prick) with allergenic extracts, immediate type reaction, including test interpretation and report	• Number of tests must be specified on the claim • Reimbursement is limited to 80 units per calendar year
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report	• Number of tests must be specified on the claim • Reimbursement is limited to 40 units per calendar year
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests	• Number of tests must be specified on the claim • Reimbursement is limited to 40 units per calendar year
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading	• Number of tests must be specified on the claim • Reimbursement is limited to 30 units per calendar year

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References

1. Noridian Healthcare Solutions, LLC. Local Coverage Determination (LCD): Allergy Testing (L34313). Original Effective Date 10/01/2015. Revision Effective Date 10/01/2019. Available: https://www.cms.gov/medicare-coverage-database/search.aspx

2. Noridian Healthcare Solutions, LLC. Local Coverage Article: Billing and Coding: Allergy Testing (A57181). Original Effective Date 10/01/2019. Available: https://www.cms.gov/ medicare-coverage-database/search.aspx

History

December 1, 2018	New Policy approved
September 1, 2019	Policy reviewed and approved with no changes
July 1, 2020	Policy reviewed and approved with changes
December 1, 2020	Policy reviewed and approved with changes
December 1, 2021	Policy reviewed and approved with changes
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with no changes

Evaluation and Management

Last Reviewed Date: March 1, 2023

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. In addition, MVP will follow the CMS 2021 E&M Coding Guidelines "Office and Other Outpatient Services." Medical records may be periodically requested to ensure appropriate documentation and accuracy of services billed. Member eligibility and benefit specifics should be verified prior to providing 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, or disease or its symptoms in a manner that is (a) 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: "Medically Necessary" or "Medical Necessity" means health care services that are: (a) necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap; and (b) recommended by the Member's treating provider; and (c) determined by MVP's or its designee to meet the following criteria, which may be subject to external review:

1. the services are appropriate and consistent with the diagnosis and treatment of the Member's medical condition;
2. the services are not primarily for the convenience of the Member, the Member's family, or the provider;
3. the services are required for the direct care and treatment of that condition;
4. the services are provided in accordance with general standards of good medical practice, as evidenced by reports in peer reviewed medical literature; reports and guidelines as published by nationally recognized health care organizations that include supporting scientific data; and, any other relevant information brought to MVP's attention; and
5. the services are provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and severity of symptoms.

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 Member's care today.

New Patient

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 other qualified health care professional of the exact same specialty and sub-specialty, who belongs to the same group Participating Provider Group (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 Authorization Requests

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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 co-pays/co-insurance/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 Payment Policy identified as Preventive Health Care Policy.

Payment of Evaluation and Management for Preventive and Sick Visits

Effective May 1, 2023, In accordance with industry standards, sick E&M visits (99202-99205, and 99211-99215) billed on the same date-of-service and by the same Provider as a preventive E&M visit will be reduced by 50% for the overlapping practice expense component, regardless of the presence of a 25 modifier.

E&M Codes and Sexual Assault Forensic Exam

If the claim indicates the primary reason for the exam is a diagnosis related to sexual assault or sexual abuse, the claim will be reimbursed in accordance with the New York State Office of Victims Services mandated regulations for victims of sexual assault and the forensic exam. This mandate, which is applicable to the New York Fully Insured and select ASO groups, should be billed with applicable CPT codes as outlined in the mandate located at: ovs.ny.gov/sites/default/files/general-form/fre-ppt-6-4-18.pdf. There should be no co-pay/co-insurance/cost share or deductible taken at time of service or applied unless the product is excluded.

Billing/Coding Guidelines

Multiple E&M Services on the Same Day

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

Code	Description	Rule
99381-99387	Preventative Medicine Evaluation and Management of an individual.	• MVP will reimburse for a preventive medicine visit; however will not reimburse for an office visit procedure including the following codes when performed on the same day as the preventive visits: 99201-99215, 92015, 92081, 92551, 92552, 92553, 92555, 92556, 92557, 92567, 99172, 99173, 95930, and 99174. • See member benefits to determine if these codes are reimbursable.
99391-99397	Preventative Medicine Evaluation and Management of an individual.	MVP 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: 99202-99215, 92015, 92081, 92551, 92552, 92553, 92555, 92556, 92557, 92567, 99172, 99173, 95930, and 99174. • See member benefits to determine if these codes are reimbursable.

Routine Screening Services Billed with E&M

Code	Description	Rule
G0102	Manual rectal neoplasm screening	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99202–99215. • MVP will reimburse for this procedure when it is the sole service provided.
36415	Collection of venous blood by venipuncture	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99202–99215 when the lab is performed in the office. MVP will reimburse separately for this procedure when the Lab work is sent to an external lab and billed with a modifier CG. • MVP will reimburse for this procedure when it is the sole service provided.
36416	Collection of capillary blood specimen i.e., finger, heel, ear stick	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99202–99215. • MVP will reimburse for this procedure when it is the sole service provided and modifier CG is submitted.
99000 & 99001	Lab specimen handling services	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99202–99215. • MVP will reimburse for this procedure when it is the sole service provided.
Q0091	Collection of pap smear specimen	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99202–99215. • MVP will reimburse for this procedure when it is the sole service provided.
92567	Tympanometry (impedance testing)	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99202–99215. • MVP will reimburse for this procedure when it is the sole service provided.
94760 & 94761	Pulse Oximetry Testing	• MVP will **not** Reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service.

Smoking Cessation Billed with E&M

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

E&M Billed During a Global Period

MVP will **not** separately reimburse for any E&M service when reported with major surgical procedure within a global period unless there is a "significant" problem which arises which is not considered a normal complication of recovery or an "unrelated" problem not associated with the procedure performed.

In alignment with CMS guidelines, Modifier 24 must be appended on the E&M service. Modifier 24 states: Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period.

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 to be related to the procedure performed can be subject to internal review.

For Non-Face-to-Face Evaluation and Management Services, Please refer to MVP's Virtual Check-in, Telehealth and Telemental Health Payment Policies

Diabetes Education

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

Osteopathic Manipulation

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

Immunization Administration

Code	Description	Rule
90460, 90461, 90471, 90472, 90473, 90474, G0008, G0009, G0010	Immunization administration services	MVP will only reimburse for immunization administration services when billed with 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 and to the medical policy for Allergy Testing and Serum Preparation Claims.
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

Code	Description	Rule
99201-99215	1st Prenatal E&M visit	The 1st prenatal visit is global to the total OB Delivery charges with the entire global OB allowable amount reimbursed on the Global delivery claim.
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
99051 – 99060	E&M After-Hour Procedures	Refer to the MVP After-Hours Payment Policy for guidelineson these codes. Please refer to your contractual agreement to determine if this rule applies.

Code	Description	Rule
99050	After-Hours Code	MVP will reimburse for this code without review unless submitted with preventative visit codes 99381-99397. Please refer to your contractual agreement to determine if this rule applies.

Urgent Care Visits

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

Consultation Visits

Code	Description	Rule
99241-99245	Office/Outpatient Consultation Procedures	MVP follows CMS Guidelines regarding the use of consultations and does **not** reimburse for these codes.
99251-99255	Inpatient Consultation Procedures	MVP follows CMS Guidelines regarding the use of consultations and does **not** reimburse for these codes.
99218-99220; 99234- 99235, 99236 and discharge code 99217	Hospital Observation Codes	• Only the provider who **"orders"** the observation services can bill observation codes. • Bill with the appropriate observation codes which are based on components for observation. The codes must meet the component requirements set forth by the CPT code guidelines.
99221-99223	Initial Hospital Visit	• An Initial Consultation in the hospital should be billed as an initial hospital visit. An AI modifier should be affixed to this code if the physician is the "principle physician of record" (i.e. admitting/attending) and is not performing a consultation. • MVP will allow one (1) visit per provider related to the same condition or diagnosis per day. The "volume of documentation" should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. • The duration of a visit is an ancillary factor and does not "control" the level of the service to be billed **unless more than 50% of the allowable time by setting occurs and this needs to be documented.** • These are timed and component-based codes. They must meet the components and time requirements set forth by the CPT code guidelines.
99281-99288	Evaluation and Management within the Emergency Room	• MVP does **not** reimburse for consultations. Please use the following codes to indicate that this is an evaluation and management service in place of a consultation in the Emergency room. • MVP will reimburse for these codes if the ER attending provides services and sends the Member 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 member should be admitted.

Code	Description	Rule
99221-99223	Evaluation and Management within the Emergency Room In the Emergency Room with an inpatient admission	• MVP will reimburse for these codes if a provider goes to the ER (must be present – no phone) to render a service and admits the Member. 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 Member. 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	MVP will reimburse for these codes as set forth by the CPT Code guidelines. MVP will reimburse these codes for established patients who do not meet the CPT Code guidelines for a "New" patient. Consultations are not reimbursed by MVP. Providers should use these codes when providing a consultation and documenting as such.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal	MVP will reimburse as follows: • When the patient visit is part of an **established physician plan of care** requiring medically necessary follow-up. • RNs or qualified ancillary staff cannot code higher than a 99211 for E&M services. • RNs or qualified ancillary staff cannot bill new problems or new patient visit code 99201. • A Provider and a RN or qualified ancillary staff **cannot both bill for an E&M office visit within the same day.**
99304, 99305, 99306	Initial Skilled Nursing Facility Visit	• MVP will reimburse for these codes as set forth by the CPT Code guidelines. • Consultations are not reimbursed by MVP. Providers should use these codes when providing a consultation and documenting as such. • If performing the initial evaluation Modifier "AI" must be affixed to the claim which will identify you as the "Principal Physician of Record" (e.g. admitting/attending SNF provider) vs. a provider rendering "specialty care."
99307-99310	Follow-up Skilled Nursing Facility Visit	MVP will reimburse for these codes as set forth by the CPT Code guidelines . Consultations are not reimbursed by MVP. Providers should use these codes when providing a consultation and documenting as such.

Discharge Services

Code	Description	Rule
99238	Inpatient Standard Discharge instructions typically 0-30 min	• These are timed and component based codes. They must meet the components and time requirements set forth by the CPT code guidelines. • For discharge services, please follow the state mandate on required documentation prior to discharging a Member.
99239	Inpatient discharge planning exceeds 30 minutes and is generally considered not a typical discharge	• These are timed and component based codes. They must meet the components and time requirements set forth by the CPT code guidelines. • For discharge services, please follow the state mandate on required documentation prior to discharging a Member. Provider must note "time" in the note that was spent above/beyond 30 minutes and provide explanation as to why the discharge was not typical.
99217	Observation Discharge of a Member	• 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 Member.

Code	Description	Rule
99234-99236	Observation or Inpatient Hospital Care where an Admission and Discharge are done on the same day	• These are timed and component-based codes. They must meet the components and time requirements set forth by the CPT code guidelines. • Don't allow a discharge code and a regular E&M subsequent inpatient code or observation code on the same day. • For discharge services, please follow the state mandate on required documentation prior to discharging a Member.

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 Member'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 Member;
- 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 Member 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 toward critical care time include:**

- Regular or periodic updates of the Member's condition;
- Emotional support for the family;
- Answering questions regarding the Member'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 Member, 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 Members in a Critical Care Unit;
- Members admitted to a critical care unit because **no other hospital beds** were available.

Code	Description	Rule
93561 & 93562	Interpretation of cardiac output measurements	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by physician providing the critical care services.
94760, 94761, 94762	Pulse Oximetry	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
71045 and 71046	Chest x-rays, professional component	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
99090	Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data)	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
43752 & 43753	Gastric intubation	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
92953	Transcutaneous pacing	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by physician providing the critical care services.
94002-94004, 94660, 94662	Ventilator management	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
36000, 36410, 36415, 36591	Vascular access procedures	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	MVP will reimburse for this procedure separately from critical care services.
31500	Endotracheal intubation	MVP will reimburse for this procedure separately from critical care services.
36555, 36556	Central line placement	MVP will reimburse for this procedure separately from critical care services.
36680	Intraosseous placement	MVP will reimburse for this procedure separately from critical care services.
32551	Tube thoracostomy	MVP will reimburse for this procedure separately from critical care services.
33210	Temporary transvenous pacemaker	MVP will reimburse for this procedure separately from critical care services.
93010	Electrocardiogram - routine ECG with at least 12 leads; interpretation and report only	MVP will reimburse for this procedure separately from critical care services.
99291 & 99292	Critical Care, Evaluation & Management of the critically ill or critically injured Member:	• MVP will **not** reimburse for this code if the time spent with the Member 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.

History

December 1, 2022	Policy approved
September 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with changes

Arthroscopic, Endoscopic, and other Non Gastro Intestinal Scope Procedures

Last Reviewed Date: March 1, 2023

Policy

When multiple Arthroscopic, Endoscopic, and other Non Gastro Intestinal Scope Procedures within the same code family are performed on the same date of service, the procedure with the highest RVU will be reimbursed according to the provider fee schedule. The reimbursement of additional procedure will follow the Medicare reimbursement methodology by reducing payment for secondary procedures within the same CPT code family. This reimbursement rule follows Medicare methodology and applies to all product lines. This reimbursement rule does not apply to procedures in different code families; however, other reimbursement rules such as multiple procedure reimbursement reduction may apply.

Notification/Prior Authorization Requests

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Billing/Coding Guidelines

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

- Biliary Endoscopy
- Anoscopy
- Colonoscopy
- Sigmoidoscopy
- Small Bowel Endoscopy ERCP
- Esophagogastroduoenoscopy
- Esophagoscopy
- Shoulder Arthroscopy
- Elbow Arthroscopy
- Wrist Arthroscopy
- Knee Arthroscopy
- Laryngoscopy w/operating microscope
- Bronchoscope/wash
- Esophagoscopy flexible brush

- Diagnostic laparoscopy
- Cystoscopy
- Cystourethroscopy & or Pyeloscopy
- Hysteroscopy diagnostic separate procedure

History

June 1, 2018	New policy, approved
June 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes

Article 28 Split Billing

Last Reviewed Date: September 1, 2022

Policy

MVP 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 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 and 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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

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.

History

June 1, 2017	Policy approved
March 1, 2020	Policy reviewed and approved with no changes
June 1, 2020	Policy reviewed and approved with no changes
September 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes

Audiology Services

Last Reviewed Date: March 1, 2023

Policy

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

Definitions

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

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

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

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

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, Meniére's disease, sudden idiopathic sensorineural hearing loss, autoimmune inner ear disease, acoustic neuroma, demyelinating diseases, ototoxicity secondary to medications, or genetic vascular and viral conditions
- Failure of a screening test
- Diagnostic analysis of cochlear or brainstem implant and programming
- 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 not included as diagnostic tests, the 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	**4 units:**	53 minutes to < 68 minutes
2 units:	23 minutes to < 38 minutes	**5 units:**	68 minutes to < 83 minutes
3 units:	38 minutes to < 53 minutes	**6 units:**	83 minutes to < 98 minutes

References

CMS Therapy Services
ASHA Medicare CPT Coding Rules for Audiology Services

History

December1, 2018	New policy approved
December 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes

Audio-Only (Vermont Only)

Last Reviewed Date – June 1, 2021

Related Policies –

Telehealth Payment Policy
Telemental Health Payment Policy
Virtual Check-ins Payment Policy

Policy

MVP covers telephone (audio-only) services in the State of Vermont and will reimburse for telephone-only and equivalent, to in-person codes when provided through audio-only means.

Definitions

Current Procedural Terminology (CPT) - Medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations.

Evaluation Management (E&M) Codes - Coding is the use of CPT® codes from the range 99202-99499 to represent services provided by a physician or other qualified health care professional. As the name E/M indicates, these medical codes apply to visits and services that involve evaluating and managing patient health.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's Utilization Management Guides to determine if prior authorization is required, and the Benefit Interpretation Manual for MVP's clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Medical Claims

Procedure Codes	CPT Code Description	Place of Service	Modifier
In-person CPT codes performed through audio only means		99	V3

E&M Codes	CPT Code Description	Place of Service	Modifier
99441	**Telephone E/M service; 5-10 minutes of medical discussion**	99	N/A
99442	**Telephone E/M service; 11-20 minutes of medical discussion**	99	N/A
99443	**Telephone E/M service; 21-30 minutes of medical discussion**	99	N/A

Non-Physician/APRN Behavioral Health Claims

Procedure Codes	Place of Service	Modifier
In-person CPT codes outlined in provider contract delivered through audio only means.	99	V3

- Non-Physician/APRN Behavioral Health Providers will be reimbursed for all codes outlined in their contract when delivered through audio-only
- Non-Physician/APRN Behavioral Health Providers are not eligible to bill, and will not be reimbursed, for CPT codes 99441-99443
- Modifier V3 is required to be in the first position on codes for equivalent to in person delivered through audio-only means

Reimbursement Guidelines

Reimbursement for covered services will be at 75% of the medical providers physician fee schedule.

History

December 1, 2021 – New policy, approved
June 1, 2022 – Policy reviewed an approved with changes

Behavioral Health Non-Licensed Provider (Vermont Only)

Last Review Date: New Policy, effective July 1, 2021

Policy

In Vermont, reimbursement for services supplied by a Qualified Non-Licensed Psychotherapist can be billed and reimbursed when under the direct supervision of a Qualified Licensed Psychotherapist. MVP Medicare Advantage products are excluded from this policy.

Definitions

Qualified Licensed Practitioner: A Provider who is licensed and credentialed by MVP and is acting within the scope of his/her practice.

Qualified Non-Licensed Practitioner: A Provider that is actively working towards licensure as specified by his or her profession.

Supervised Billing: A Qualified Licensed Practitioner can bill for covered clinical services within his or her scope of practice provided by a Qualified Non-Licensed Practitioner when the Qualified Non-Licensed Practitioner is under the direct supervision of the Qualified Licensed Practitioner.

Notifications/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's Utilization Management Guides to determine if prior authorization is required and the Benefit Interpretation Manual for MVPs clinical guidelines. These resources can be accessed by signing into your account at **mvphealthcare.com**.

Billing/Coding Guidelines

Qualified Non-Licensed Practitioners registered on the roster of Non-Licensed & Non-Certified Psychotherapists per VT state statute should bill supervised billing eligible claims to MVP as follows:

- In Box 24j of the CMS 1500 form, list the NPI and taxonomy code of the supervising licensed clinician appropriate to the degree of the unlicensed provider.
- In Box 31 of the CMS 1500 form, list the name and degree/title of the supervising provider.
    - The supervising clinician must be a licensed practitioner with the same degree level (i.e., Masters or Doctorate) as the unlicensed clinician.

One of the following modifiers must be appended to the billed CPT codes:

Modifier	Practitioner Level	Rule
HO	Master's degree level	This is required when the claim is for supervised billing when the eligible unlicensed practitioner rendering the service is a Master's degree level.

Modifier	Practitioner Level	Rule
HP	Doctorate level	This is required when the claim is for supervised billing when the eligible unlicensed practitioner rendering the service is a Doctorate degree level.

Reimbursement Guidelines

Non-Reimbursable Services

- These are services performed by a non-licensed provider who cannot practice independently and is not actively working toward licensure.
- MVP Medicare Members are not eligible to receive services performed by a non-licensed provider even under the supervision of a licensed provider.

References

https://sos.vermont.gov/media/0jyhuiuj/amh-rules-adopted-final-sos-jan-2015.pdf

https://legislature.vermont.gov/statutes/fullchapter/26/078

9.103-supervised-billing-adopted-rule.pdf (vermont.gov)

History

June 1, 2021 New Policy, Approved

Consistency of Denials

Last Reviewed Date: March 1, 2023

Related Policy: Radiology

Policy

MVP requires authorizations for select services as identified in MVP's Utilization Management Guides. When an authorization is required, this authorization applies to all Technical, Professional, Global and/or Facility claims submitted for the service. If service(s) requiring an authorization are provided without prior approval, then all technical, professional, global and/or facility claims associated with those services will be denied administratively.

MVP will apply this administrative denial to Outpatient Surgical Services.

MVP will apply this administrative denial to the Radiology code set as defined in the Radiology Payment Policy.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

History

September 1, 2022	New policy, approved
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes

Contrast Materials

Last Reviewed Date: September 1, 2022

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. 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 its use was limited to occasional patients based on 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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

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

HCPCS Code: Gadolinium

A9579	Injection, gadolinium-based magnetic reso-nance 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: Non-Ionic, Low 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

History

December 1, 2016	Policy approved
December 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes

COVID-19 Lab Testing

Last Reviewed Date – June 1, 2022

Related Policies – Preoperative Lab Testing

COVID-19 LAB TESTING

Policy

MVP will provide coverage for COVID-19 diagnostic/viral testing as well as antibody testing. The testing must be medically appropriate for the diagnosis and treatment of COVID-19.

Definitions

This policy is to define the coverage, reimbursement and billing guidelines for COVID-19 viral and antibody testing. This policy applies to participating and non-participating practitioners, facilities, laboratories and pharmacies and all lines of business.

Billing/Coding Guidelines

MVP encourages health care providers to use reliable FDA-authorized tests. A virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person has been exposed to COVID-19, and according to the FDA, this test should not be used to diagnose a current infection.

Applicable COVID-19 codes can be found in CPT codes as published by the AMA, or HCPCS codes as published by CMS.

Providers should follow CDC ICD–10–CM Official Coding Guidelines when selecting a diagnosis code to ensure proper reporting.

Reimbursement Guidelines

Testing that is ordered or performed solely for purposes of pandemic control or re-opening the economy, and not based on a determination by a provider that the test is medically appropriate for the diagnosis and treatment of an individual member, is not covered. This includes tests performed on an asymptomatic individual solely to assess health status as required by parties such as a government/public health agency, employer, common carrier, school, camp, or when ordered upon the request of a member solely to facilitate the member's desire to self-assess COVID-19 immune status.

The following diagnosis codes will be denied when submitted for COVID-19 testing.

Primary Diagnosis Code	Primary Diagnosis Code Description
Z02.0	Encounter for examination for admission to educational institution
Z02.1	Medical diagnosis of encounter for pre-employment examination
Z02.4	Encounter for examination for driving license
Z02.5	Encounter for examination for participation in sport
Z02.79	A diagnosis of encounter for issue of other medical certificate
Z02.89	Encounter for other administrative examinations

Primary Diagnosis Code	Primary Diagnosis Code Description
Z02.9	Encounter for administrative examinations, unspecified
Z56.89	Specify a medical diagnosis of other problems related to employment
Z56.9	a medical diagnosis of unspecified problems related to employment

Claims will be reviewed post-payment. A post-payment review may result in no change to the initial determination or a revised determination. Post-payment reviews are to ensure claim/billing accuracy and completeness, and are not medical necessity reviews.

These services are subject to audit and policy updates at MVP's discretion. Commercial Plan Members will be held liable for claims that deny based upon this policy. Providers will bear responsibility for testing claim denials of Medicare Advantage and Medicaid Managed Care Members.

MVP will cover the testing when required by applicable law and regulation.

Examples of services not reimbursable per administrative policy are below. These codes are examples of inappropriate diagnoses received by MVP and are not all inclusive.

Primary Diagnosis Code	Primary Diagnosis Code Description
Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out
Z76	Persons encountering health services in other circumstances
Z01.89	Encounter for other specified special examinations
Z13.9	Encounter for screening, unspecified
Z71.89	Other specified counseling
Z71.82	Exercise counseling
R68.89	Other general symptoms and signs
B34.9	Viral infection, unspecified
E55.9	Vitamin D deficiency, unspecified
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
E03.9	Hypothyroidism, unspecified
Z56.5	Uncongenial work environment
Z00.00	Encounter for general adult medical examination without abnormal findings
K21.9	Gastro-esophageal reflux disease without esophagitis
E11.9	Type 2 diabetes mellitus without complications
R10.9	Unspecified abdominal pain
N23	Unspecified renal colic

Primary Diagnosis Code	Primary Diagnosis Code Description
N39.0	Urinary tract infection, site not specified
R73.03	Prediabetes
M54.5	Low back pain
E78.2	Mixed hyperlipidemia
R07.89	Other chest pain
K62.89	Other specified diseases of anus and rectum
N89.8	Other specified noninflammatory disorders of vagina
M25.50	Pain in unspecified joint
Z20.818	Contact with and (suspected) exposure to other bacterial communicable diseases
R42	Dizziness and giddiness
Z09	Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
K80.00	Calculus of gallbladder with acute cholecystitis without obstruction
R07.9	Chest pain, unspecified
N93.9	Abnormal uterine and vaginal bleeding, unspecified
K29.00	Acute gastritis without bleeding
I24.9	Acute ischemic heart disease, unspecified
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
E78.5	Hyperlipidemia, unspecified
E16.2	Hypoglycemia, unspecified
J11.1	Influenza due to unidentified influenza virus with other respiratory manifestations
Z29.9	Encounter for prophylactic measures, unspecified
Z119	Encounter for screening for infectious and parasitic diseases, unspecified

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

References

CMS Guidelines https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit

AMA Resources https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians

CDC Interim Guidelines for COVID-19 Antibody Testing:
https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests-guidelines.html#anchor_1590264293982

American Medical Association's Serological Testing for SARS-CoV-2 Antibodies:
https://www.ama-assn.org/delivering-care/public-health/serological-testing-sars-cov-2-antibodies

Infectious Diseases Society of America's IDSA COVID19 Antibody Testing Primer:
https://www.idsociety.org/globalassets/idsa/public-health/covid-19/idsa-covid-19-antibody-testing-primer.pdf

Association of Public Health Laboratories and Council of State and Territorial Epidemiologists, Public Health Considerations: Serologic Testing for COVID-19, Version 1 – May 7, 2020:
https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/Serologic-Testing-for-COVID-19.pdf

History

December 1, 2020	New policy, approved
June 1, 2022	Policy reviewed and approved with no change

Default Pricing

Last Reviewed Date: March 1, 2023

Policy

When a reimbursement rate has not been assigned by MVP, by the parties' executed contract, by Centers for Medicare and Medicaid Services (CMS), or by NYS Medicaid, one will be established based upon a gap pricing method that is an acceptable industry standard. If there is not an accepted industry standard, MVP will reimburse according to default pricing based upon a percentage of billed charges ("Default Pricing"). . If a code does not have an assigned rate, the default rate will be applied.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also confirm Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Reimbursement Guidelines

Under Default Pricing, MVP will pay up to 30% of billed charges unless otherwise provided for in the parties executed contract, or assigned by Centers for Medicare & Medicaid Services or NYS Medicaid.

History

September 1, 2022	New policy, approved
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with no changes

Diabetic Management and Nutritional Counseling

Last Reviewed Date: December 1, 2022

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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

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 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	**CMS reserves the right to add or remove diagnosis codes associated with its NCDs to implement those NCDs in the most efficient manner within the confines of the policy.**
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
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma
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
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye

E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3291	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye
E08.3292	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye
E08.3293	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3391	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E08.3392	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E08.3393	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3491	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye
E08.3492	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye
E08.3493	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral

E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral
E08.37X1	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, right eye
E08.37X2	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, left eye
E08.37X3	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, bilateral
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
E08.641	Diabetes mellitus due to underlying condition with hypoglycemia with coma
E08.649	Diabetes mellitus due to underlying condition with hypoglycemia without coma
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)
E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma
E09.11	Drug or chemical induced diabetes mellitus with ketoacidosis with coma
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
E09.321	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E09.3211	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E09.3212	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E09.3213	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E09.329	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E09.3291	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye

E09.3292	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E09.3293	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E09.331	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E09.3311	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E09.3312	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E09.3313	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E09.339	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E09.3391	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E09.3392	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E09.3393	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E09.341	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E09.3411	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E09.3412	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E09.3413	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E09.349	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E09.3491	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E09.3492	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E09.3493	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E09.351	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema
E09.3511	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E09.3512	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E09.3513	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral

E09.3521	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E09.3522	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E09.3523	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E09.3531	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E09.3532	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E09.3533	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E09.3541	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E09.3542	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E09.3543	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E09.3551	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E09.3552	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E09.3553	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E09.359	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema
E09.3591	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E09.3592	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E09.3593	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E09.37X1	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E09.37X2	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E09.37X3	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
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
E09.641	Drug or chemical induced diabetes mellitus with hypoglycemia with coma
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
E10.11	Type 1 diabetes mellitus with ketoacidosis with 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
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3291	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E10.3292	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E10.3293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral

E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E10.3392	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E10.3393	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E10.3493	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye

E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E10.37X1	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E10.37X2	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E10.37X3	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
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
E10.641	Type 1 diabetes mellitus with hypoglycemia with coma
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)
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma
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
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E11.3291	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E11.3293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E11.3392	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E11.3393	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E11.3491	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E11.3492	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye

E11.3493	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E11.37X1	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E11.37X2	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E11.37X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
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
E11.641	Type 2 diabetes mellitus with hypoglycemia with coma
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)
E13.01	Other specified diabetes mellitus with hyperosmolarity with coma
E13.10	Other specified diabetes mellitus with ketoacidosis without coma
E13.11	Other specified diabetes mellitus with ketoacidosis with 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
E13.3211	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E13.3212	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye

E13.3213	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3291	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E13.3292	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E13.3293	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3311	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E13.3312	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E13.3313	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3391	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E13.3392	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E13.3393	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3411	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E13.3412	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E13.3413	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3491	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E13.3492	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E13.3493	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3511	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E13.3512	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E13.3513	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E13.3521	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E13.3522	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E13.3523	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E13.3531	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E13.3532	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E13.3533	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral

E13.3541	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E13.3542	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E13.3543	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E13.3551	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E13.3552	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E13.3553	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E13.3591	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E13.3592	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E13.3593	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E13.37X1	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E13.37X2	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E13.37X3	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
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
E13.641	Other specified diabetes mellitus with hypoglycemia with coma
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
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)
N18.31	Chronic kidney disease, stage 3a (CMS: only for a GFR <51)
N18.32	Chronic kidney disease, stage 3b
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5 (severe)
O24.011	Pre-existing type 1 diabetes mellitus, in pregnancy, first trimester
O24.012	Pre-existing type 1 diabetes mellitus, in pregnancy, second trimester
O24.013	Pre-existing type 1 diabetes mellitus, in pregnancy, third trimester
O24.03	Pre-existing type 1 diabetes mellitus, in the puerperium
O24.111	Pre-existing type 2 diabetes mellitus, in pregnancy, first trimester
O24.112	Pre-existing type 2 diabetes mellitus, in pregnancy, second trimester
O24.113	Pre-existing type 2 diabetes mellitus, in pregnancy, third trimester
O24.13	Pre-existing type 2 diabetes mellitus, in the puerperium
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.415	Gestational diabetes mellitus in pregnancy, controlled by oral hypoglycemic drugs
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
O24.425	Gestational diabetes mellitus in childbirth, controlled by oral hypoglycemic drugs

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
O24.435	Gestational diabetes mellitus in puerperium, controlled by oral hypoglycemic drugs
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
O24.83	Other pre-existing diabetes mellitus in the puerperium
Z48.22	Encounter for aftercare following kidney transplant

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 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	**CMS reserves the right to add or remove codes associated with its NCDs to implement those NCDs in the most efficient manner within the confines of the policy.**
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
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
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye
E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3291	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye
E08.3292	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye
E08.3293	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3391	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E08.3392	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E08.3393	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3491	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye
E08.3492	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye

E08.3493	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral
E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract
E08.37X1	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, right eye
E08.37X2	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, left eye
E08.37X3	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, bilateral
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)
E09.21	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

E09.3211	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E09.3212	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E09.3213	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3291	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E09.3292	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E09.3293	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3311	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E09.3312	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E09.3313	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3391	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E09.3392	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E09.3393	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3411	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E09.3412	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E09.3413	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3491	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E09.3492	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E09.3493	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3511	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E09.3512	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye

E09.3513	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E09.3521	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E09.3522	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E09.3523	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E09.3531	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E09.3532	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E09.3533	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E09.3541	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E09.3542	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E09.3543	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E09.3551	Drug or chemical induced Diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E09.3552	Drug or chemical induced Diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E09.3553	Drug or chemical induced Diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E09.3591	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E09.3592	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E09.3593	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E09.36	Drug or chemical induced Diabetes mellitus with diabetic cataract
E09.37X1	Drug or chemical induced Diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E09.37X2	Drug or chemical induced Diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E09.37X3	Drug or chemical induced Diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
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
E10.21	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
E10.3211	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E10.3212	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E10.3213	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3291	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye

E10.3292	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E10.3293	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3311	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E10.3312	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E10.3313	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3391	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E10.3392	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E10.3393	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3411	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E10.3412	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E10.3413	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3491	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E10.3492	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E10.3493	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3511	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E10.3512	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E10.3513	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E10.3521	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E10.3522	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E10.3523	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E10.3531	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E10.3532	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E10.3533	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E10.3541	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E10.3542	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye

E10.3543	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E10.3551	Type 1 Diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E10.3552	Type 1 Diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E10.3553	Type 1 Diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E10.3591	Type 1 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E10.3592	Type 1 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E10.3593	Type 1 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E10.36	Type 1 Diabetes mellitus with diabetic cataract
E10.37X1	Type 1 Diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E10.37X2	Type 1 Diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E10.37X3	Type 1 Diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
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
E11.3211	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E11.3212	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E11.3213	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3291	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E11.3292	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E11.3293	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3311	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E11.3312	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E11.3313	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3391	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E11.3392	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E11.3393	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3411	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E11.3412	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E11.3413	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3491	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E11.3492	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E11.3493	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral

E11.3511	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E11.3512	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E11.3513	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E11.3521	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E11.3522	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E11.3523	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E11.3531	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E11.3532	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E11.3533	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E11.3541	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E11.3542	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E11.3543	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E11.3551	Type 2 Diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E11.3552	Type 2 Diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E11.3553	Type 2 Diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E11.3591	Type 2 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E11.3592	Type 2 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E11.3593	Type 2 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E11.36	Type 2 Diabetes mellitus with diabetic cataract
E11.37X1	Type 2 Diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E11.37X2	Type 2 Diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E11.37X3	Type 2 Diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
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)
E13.21	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
E13.3211	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E13.3212	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E13.3213	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral

E13.3291	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E13.3292	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E13.3293	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3311	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E13.3312	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E13.3313	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3391	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E13.3392	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E13.3393	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3411	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E13.3412	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E13.3413	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3491	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E13.3492	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E13.3493	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3511	Other specified Diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E13.3512	Other specified Diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E13.3513	Other specified Diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E13.3521	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E13.3522	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E13.3523	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E13.3531	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E13.3532	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E13.3533	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral

E13.3541	Other specified Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E13.3542	Other specified Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E13.3543	Other specified Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E13.3551	Other specified Diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E13.3552	Other specified Diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E13.3553	Other specified Diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E13.3591	Other specified Diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E13.3592	Other specified Diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E13.3593	Other specified Diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E13.36	Other specified Diabetes mellitus with diabetic cataract
E13.37X1	Other specified Diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E13.37X2	Other specified Diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E13.37X3	Other specified Diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
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
O24.011	Pre-existing type 1 Diabetes mellitus, in pregnancy, first trimester
O24.012	Pre-existing type 1 Diabetes mellitus, in pregnancy, second trimester
O24.013	Pre-existing type 1 Diabetes mellitus, in pregnancy, third trimester
O24.03	Pre-existing type 1 Diabetes mellitus, in the puerperium
O24.111	Pre-existing type 2 Diabetes mellitus, in pregnancy, first trimester
O24.112	Pre-existing type 2 Diabetes mellitus, in pregnancy, second trimester
O24.113	Pre-existing type 2 Diabetes mellitus, in pregnancy, third trimester
O24.13	Pre-existing type 2 Diabetes mellitus, in the puerperium
O24.410	Gestational Diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational Diabetes mellitus in pregnancy, insulin controlled
O24.415	Gestational Diabetes mellitus in pregnancy, controlled by oral hypoglycemic drugs
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
O24.425	Gestational Diabetes mellitus in childbirth, controlled by oral hypoglycemic drugs
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
O24.435	Gestational Diabetes mellitus in puerperium, controlled by oral hypoglycemic drugs
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
O24.83	Other pre-existing Diabetes mellitus in the puerperium

Reimbursement Guidelines

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

References

MVP Credentialing and Recredentialing of Practitioners

CMS National and Local Coverages Indexes:
cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx

cms.gov/medicare-coverage-database/details/ncd-details.aspx?ncdid=252

History

June 1, 2017	Policy approved
June 1, 2020	Policy reviewed and approved with no changes
September 1, 2021	Policy reviewed and approved with changes
December 1, 2022	Policy reviewed and approved with no changes

Diagnosis Matching Edits

Last Reviewed Date: December 1, 2022

Policy

MVP Health Care follows the diagnosis matching edits in accordance with Medicare Local Coverage Determinations (LCD) or National Coverage Determinations (NCD), in addition to guidelines established by Physician Medical Societies 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 cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

Definitions

Medical Necessity (CMS Medicare's 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.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Participating Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Participating Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Transthoracic Echocardiography

To access the appropriate diagnoses to be used with these Procedure codes, use Document ID #L33577 – Contract # 13282 or Article A56781 on the CMS website.

Code	Description	Rule
93303 **93304** **C8921** **C8922**	Transthoracic echocardiography for congenital cardiac anomalies; Group 2	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to medical necessity. • The Upstate New York Local Coverage Determinations for these codes • Pediatric Cardiology Specialty is excluded from this edit
93306-93308 **C8923-C8924** **C8929**	Real time transthoracic echocardiography; Group 1	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to medical necessity. • The Upstate New York Local Coverage Determinations for these codes. • Pediatric Cardiology Specialty is excluded from this edit

Code	Description	Rule
93308 **C8924**	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study. Group 3	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to medical necessity. • The Upstate New York Local Coverage Determinations for these codes • Pediatric Cardiology Specialty is excluded from this edit
93350-93352 **C8928** **C8930**	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test. Group 4	• MVP requires the correct diagnosis be submitted with the claim in accordance with the 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

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

To access the appropriate diagnoses to be used with these Procedure codes, use Document ID #35936 – Contract # 13282 or Article A57826 on the CMS website.

Code	Description	Rule
64490-64495	Diagnostic or Therapeutic agent injections with image guidance. Cervical,Thoracic, Lumbar, or Sacral	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to medical necessity. • The Upstate New York Local Coverage Determinations for these codes
64633 **64634** **64635** **64636** **64625**	Destruction by neurolytic agent, paravertebral facet joint nerve; Cervical, Thoracic, Lumbar, or Sacral	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to medical necessity. • The Upstate New York Local Coverage Determinations for these codes

Nerve Conduction Studies and electromyography

To access the appropriate diagnoses to be used with these Procedure codes use Document ID # L35098– Contract # 13282 or Article A57668 on the CMS website.

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

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

Corneal Pachymetry

To access the appropriate diagnoses to be used with these Procedure codes, useDocument ID # L33630 corneal pachymetry - Contract # 13282 or Article A56548 on the CMS website.

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

Visual Fields Testing

To access the appropriate diagnoses to be used with these Procedure codes use Document ID # L33574 – Contract # 13282 or Article A56551 on the CMS website.

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

Antibody Herpes Simplex Virus (Type 1 and Type 2)

Only an appropriate diagnoses should be used with these procedure codes in accordance with the United States Preventive Services Task Force, and the American Academy of Family Physicians. Please see Appendix for the appropriate diagnosis codes.

Code	Description	Rule
86695	Herpes Simplex, type 1	MVP requires the correct diagnosis be submitted with the claim in accordance with the American Academy of Family Physicians or the claim will be denied due to medical necessity
86696	Herpies Simplex, type 2	MVP requires the correct diagnosis be submitted with the claim in accordance with clinical guidance.

Vitamin D 25 and Vitamin D1.25

To access the appropriate diagnoses to be used with these Procedure codes, use Document ID LCD #L 37535 – Contract # 13201 or Article A57736 on the CMS website.

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

Erythrocyte Sedimentation Rate RBC Automated

To access the appropriate diagnoses to be used with procedure codes in accordance with the American Society for Clinical Pathology Refer to the Appendix for appropriate diagnosis codes.

Code	Description	Rule
85652	Sedimentation rate; erythrocyte; automated	MVP requires the correct diagnosis be submitted with the claim in accordance with the American Society for Clinical Pathology or the claim will be denied due to medical due to medical necessity.

Gammaglobulin IGE, Allergen Spec IGE, Crude Allergan Extract and Allergen Spec IGE Recombinant/ Purified component, (each)

To access the appropriate diagnoses to be used with procedure codes in accordance with the American Academy of Allergy, Asthma & Immunology. Refer to the Appendix for the appropriate diagnosis codes.

Code	Description	Rule
82785	Assay of Gammaglobulin IGE	MVP requires the correct diagnosis be submitted with the claim in accordance with clinical guidance.
86003	Allergen Specific IGE ; quantitative or semiquantitative, crude allergen extract, each	
86008	Allergen Specific IGE quantitative or semiquantitative, recombinant/purified component, (each)	

Folic Acid

Only an appropriate diagnoses should be used with these procedure codes in accordance with the American Society for Clinical Pathology. Refer to the Appendix for appropriate diagnosis codes.

Code	Description	Rule
82746	Assay of Folic Acid Serum	MVP requires the correct diagnosis be submitted with the claim in accordance with clinical guidance.

Cyanocobalamin-Vitamin B12

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

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

Gonadotropin Follicle Stimulating Hormone

To access the appropriate diagnoses to be used with these procedure codes in accordance with the American Society for Reproductive Medicine. Refer to the Appendix for appropriate diagnosis codes.

Code	Description	Rule
83001	Gonadotropin Follicle Stimulating	MVP requires the correct diagnosis be submitted with the claim in accordance with the American Society for Reproductive Medicine or the claim will be denied due to medical necessity.

Thyroid Stimulating Hormone Testing (TSH)

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

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

Triiodothyronine

To access the appropriate diagnoses to be used with procedure codes in accordance with the American Society for Clinical Pathology & the Endocrine Society. Refer to the Appendix for appropriate diagnosis codes.

Code	Description	Rule
84480	Assay of Triiodothyronine T3; Total TT3	MVP requires the correct diagnosis be submitted with the claim or the claim will be denied due to medical necessity. Refer to the Appendix for appropriate diagnosis codes.
84481	Assay of Triiodothyronine Free	Refer to the Appendix for appropriate diagnosis codes.

References

Medicare Coverage Database Advanced Search:
cms.gov/medicare-coverage-database/search/advanced-search.aspx

Appendix

This Appendix contains the reimbursable diagnosis codes for the laboratory services listed below.

Laboratory Services

- Follicle Stimulating Hormone
- Herpes Simplex Virus
- Gammaglobulin IGE
- Erythrocyte Sedimentation Rate
- Folic Acid
- Triiodothyronine -T3 Free
- Triiodothyronine -T3 Total

Follicle Stimulating Hormone

Code	Description
C50112	Malignant neoplasm of central portion of left female breast
C50211	Malignant neoplasm of upper-inner quadrant of right female breast
C50212	Malignant neoplasm of upper-inner quadrant of left female breast
C50411	Malignant neoplasm of upper-outer quadrant of right female breast
C50412	Malignant neoplasm of upper-outer quadrant of left female breast
C50512	Malignant neoplasm of lower-outer quadrant of left female breast
C50811	Malignant neoplasm of overlapping sites of right female breast
C50911	Malignant neoplasm of unspecified site of right female breast
C50911	Malignant neoplasm of unspecified site of right female breast
C50912	Malignant neoplasm of unspecified site of left female breast
C50919	Malignant neoplasm of unspecified site of unspecified female breast
C569	Malignant neoplasm of unspecified ovary
C719	Malignant neoplasm of brain, unspecified
C73	Malignant neoplasm of thyroid gland
C773	Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes
C8330	Diffuse large B-cell lymphoma, unspecified site
D0512	Intraductal carcinoma in situ of left breast
D352	Benign neoplasm of pituitary gland
D497	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
D6862	Lupus anticoagulant syndrome
E032	Hypothyroidism due to medicaments and other exogenous substances
E038	Other specified hypothyroidism

Code	Description
E039	Hypothyroidism, unspecified
E063	Autoimmune thyroiditis
E0789	Other specified disorders of thyroid
E079	Disorder of thyroid, unspecified
E10649	Type 1 diabetes mellitus with hypoglycemia without coma
E1065	Type 1 diabetes mellitus with hyperglycemia
E1159	Type 2 diabetes mellitus with other circulatory complications
E221	Hyperprolactinemia
E230	Hypopituitarism
E236	Other disorders of pituitary gland
E237	Disorder of pituitary gland, unspecified
E240	Pituitary-dependent Cushing's disease
E241	Nelson's syndrome
E271	Primary adrenocortical insufficiency
E2740	Unspecified adrenocortical insufficiency
E278	Other specified disorders of adrenal gland
E280	Estrogen excess
E282	Polycystic ovarian syndrome
E28310	Symptomatic premature menopause
E28319	Asymptomatic premature menopause
E2839	Other primary ovarian failure
E288	Other Ovarian dysfunction
E289	Ovarian dysfunction, unspecified
E349	Endocrine disorder, unspecified
F520	Hypoactive sexual desire disorder
L680	Hirsutism
M069	Rheumatoid arthritis, unspecified
M3500	Sicca syndrome, unspecified
N800	adenomyosis
N803	Endometriosis of pelvic peritoneum
N809	Endometriosis, unspecified
N910	Primary amenorrhea
N911	Secondary amenorrhea
N912	Amenorrhea, unspecified
N914	Secondary oligomenorrhea
N915	Oligomenorrhea, unspecified
N920	Excessive and frequent menstruation with regular cycle

Code	Description
N921	Excessive and frequent menstruation with irregular cycle
N925	Other specified irregular menstruation
N926	Irregular menstruation, unspecified
N938	Other specified abnormal uterine and vaginal bleeding
N939	Abnormal uterine and vaginal bleeding, unspecified
N9489	Other specified conditions associated with female genital organs and menstrual cycle
N96	Recurrent pregnancy loss
N970	female infertility with anovulation
N971	female infertility, tubal
N978	Female infertility of other origin
N979	Female infertility, unspecified
O0990	Supervision of high-risk pregnancy, unspecified, unspecified trimester
R6882	Decreased libido
R871	Abnormal level of hormones in specimens from female genital organs
R891	Abnormal level of hormones in specimens from other organs, systems, and tissues
R946	Abnormal results of thyroid function studies
Z01818	Encounter for other preprocedural examination
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z09	Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
Z1329	Encounter for screening for other suspected endocrine disorder
Z3141	Encounter for fertility testing
Z3149	Encounter for other procreative investigation and testing
Z3169	Encounter for other general counseling and advice on procreation
Z3183	Encounter for assisted reproductive fertility procedure cycle
Z3189	Encounter for other procreative management
Z331	Pregnant state, incidental
Z5112	Encounter for antineoplastic immunotherapy
Z5181	Encounter for therapeutic drug level monitoring
Z79818	Long term (current) use of other agents affecting estrogen receptors and estrogen levels
Z79899	Other long term (current) drug therapy
Z853	Personal history of malignant neoplasm of breast
E1165	Type 2 diabetes mellitus with hyperglycemia
E119	Type 2 diabetes mellitus without complications
B181	Chronic viral hepatitis B without delta-agent
B1910	Unspecified viral hepatitis B without hepatic coma
B1920	Unspecified viral hepatitis C without hepatic coma
B20	Human immunodeficiency virus [HIV] disease

Code	Description
D251	Intramural leiomyoma of uterus
D259	Leiomyoma of uterus, unspecified
E033	Postinfectious hypothyroidism
E041	Nontoxic single thyroid nodule
E042	Nontoxic multinodular goiter
E213	Hyperparathyroidism, unspecified
E890	Postprocedural hypothyroidism
F3281	Premenstrual dysphoric disorder
F329	Major depressive disorder, single episode, unspecified
F331	Major depressive disorder, recurrent, moderate
F39	Unspecified mood [affective] disorder
F410	Panic disorder [episodic paroxysmal anxiety]
F419	Anxiety disorder, unspecified
G43709	Chronic migraine without aura, not intractable, without status migrainosus
G43909	Migraine, unspecified, not intractable, without status migrainosus
K7210	Chronic hepatic failure without coma
K900	Celiac disease
L638	Other alopecia areata
L639	Alopecia areata, unspecified
L650	Telogen effluvium
L658	Other specified nonscarring hair loss
L659	Nonscarring hair loss, unspecified
L682	Localized hypertrichosis
L700	Acne vulgaris
L709	Acne, unspecified
N6452	Nipple discharge
N6459	Other signs and symptoms in breast
N761	Subacute and chronic vaginitis
N83202	Unspecified ovarian cyst, left side
N83209	Unspecified ovarian cyst, unspecified side
N840	Polyp of corpus uteri
N841	Polyp of cervix uteri
N8500	Endometrial hyperplasia, unspecified
N859	Noninflammatory disorder of uterus, unspecified
N898	Other specified noninflammatory disorders of vagina
N943	Premenstrual tension syndrome
N944	Primary dysmenorrhea

Code	Description
N946	Dysmenorrhea, unspecified
R102	Pelvic and perineal pain
R1030	Lower abdominal pain, unspecified
R1904	Left lower quadrant abdominal swelling, mass, and lump
R1909	Other intra-abdominal and pelvic swelling, mass, and lump
R232	Flushing
R3129	Other microscopic hematuria
R430	Anosmia
R531	Weakness
R5381	Other malaise
R5382	Chronic fatigue, unspecified
R5383	Other fatigue
R61	Generalized hyperhidrosis
R630	Anorexia
R700	Elevated erythrocyte sedimentation rate
R7303	Prediabetes
R7309	Other abnormal glucose
R748	Abnormal levels of other serum enzymes
R7989	Other specified abnormal findings of blood chemistry
R799	Abnormal finding of blood chemistry, unspecified
R87810	Cervical high risk human papillomavirus (HPV) DNA test positive
R9389	Abnormal findings on diagnostic imaging of other specified body structures
R945	Abnormal results of liver function studies
T783XXA	Angioneurotic edema, initial encounter
Z0000	Encounter for general adult medical examination without abnormal findings
Z0001	Encounter for general adult medical examination with abnormal findings
Z01411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z01419	Encounter for gynecological examination (general) (routine) without abnormal findings
Z0189	Encounter for other specified special examinations
Z1231	Encounter for screening mammogram for malignant neoplasm of breast
Z124	Encounter for screening for malignant neoplasm of cervix
Z1273	Encounter for screening for malignant neoplasm of ovary
Z130	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z13228	Encounter for screening for other metabolic disorders
Z170	Estrogen receptor positive status [ER+]
Z3009	Encounter for other general counseling and advice on contraception
Z3041	Encounter for surveillance of contraceptive pills

Code	Description
Z3042	Encounter for surveillance of injectable contraceptive
Z30430	Encounter for insertion of intrauterine contraceptive device
Z30431	Encounter for routine checking of intrauterine contraceptive device
Z30432	Encounter for removal of intrauterine contraceptive device
Z3200	Encounter for pregnancy test, result unknown
Z3202	Encounter for pregnancy test, result negative
Z510	Encounter for antineoplastic radiation therapy
Z6832	Body mass index (BMI) 32.0-32.9, adult
Z7689	Persons encountering health services in other specified circumstances
Z8041	Family history of malignant neoplasm of ovary
Z8639	Personal history of other endocrine, nutritional and metabolic disease
Z8742	Personal history of other diseases of the female genital tract
Z9013	Acquired absence of bilateral breasts and nipples
Z975	Presence of (intrauterine) contraceptive device
Z9884	Bariatric surgery status
C9000	Multiple myeloma not having achieved remission
D329	Benign neoplasm of meninges, unspecified
D500	Iron deficiency anemia secondary to blood loss (chronic)
D509	Iron deficiency anemia, unspecified
D519	Vitamin B12 deficiency anemia, unspecified
D563	Thalassemia minor
D649	Anemia, unspecified
D751	Secondary polycythemia
E0500	Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
E0590	Thyrotoxicosis, unspecified without thyrotoxic crisis or storm
E061	Subacute thyroiditis
E639	Nutritional deficiency, unspecified
E6601	Morbid (severe) obesity due to excess calories
E663	Overweight
E669	Obesity, unspecified
E7800	Pure hypercholesterolemia, unspecified
E782	Mixed hyperlipidemia
E785	Hyperlipidemia, unspecified
E83110	Hereditary hemochromatosis
E83118	Other hemochromatosis
E8350	Unspecified disorder of calcium metabolism
E875	Hyperkalemia

Code	Description
I4891	Unspecified atrial fibrillation
I959	Hypotension, unspecified
J449	Chronic obstructive pulmonary disease, unspecified
L293	Anogenital pruritus, unspecified
L298	Other pruritus
L299	Pruritus, unspecified
L400	Psoriasis vulgaris
M791	Myalgia
M7910	Myalgia, unspecified site
Q281	Other malformations of precerebral vessels
R42	Dizziness and giddiness
R51	Headache
G629	Polyneuropathy, unspecified
G8929	Other chronic pain
I10	Essential (primary) hypertension
I2510	Atherosclerotic heart disease of native coronary artery without angina pectoris
K529	Noninfective gastroenteritis and colitis, unspecified
R631	Polydipsia
R634	Abnormal weight loss
R635	Abnormal weight gain
E15	Nondiabetic hypoglycemic coma
E162	Hypoglycemia, unspecified
N200	Calculus of kidney
N3090	Cystitis, unspecified without hematuria
N368	Other specified disorders of urethra
N390	Urinary tract infection, site not specified
N644	Mastodynia
R000	Tachycardia, unspecified
R002	Palpitations
R52	Pain, unspecified
H1830	Unspecified corneal membrane change
N3010	Interstitial cystitis (chronic) without hematuria
N760	Acute vaginitis
N930	Postcoital and contact bleeding
R300	Dysuria
R309	Painful micturition, unspecified

Herpes Simplex Virus

Code	Description
Z135	Encounter for screening for eye and ear disorders
Z0442	Encounter for examination and observation following alleged child rape
Z01411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z0001	Encounter for general adult medical examination with abnormal findings
T7421XA	Adult sexual abuse, confirmed, initial encounter
S1012XA	Blister (nonthermal) of throat, initial encounter
S00521A	Blister (nonthermal) of lip, initial encounter
R051	Acute cough
R052	Subacute cough
R053	Chronic cough
R054	Cough syncope
R058	Other specified cough
R059	Cough unspecified
R945	Abnormal results of liver function studies
R599	Enlarged lymph nodes, unspecified
R591	Generalized enlarged lymph nodes
R509	Fever, unspecified
R29818	Other symptoms and signs involving the nervous system
R29810	Facial weakness
R221	Localized swelling, mass and lump, neck
R21	Rash and other nonspecific skin eruption
R202	Paresthesia of skin
R102	Pelvic and perineal pain
O99353	Diseases of the nervous system complicating pregnancy, third trimester
O0993	Supervision of high-risk pregnancy, unspecified, third trimester
O0992	Supervision of high-risk pregnancy, unspecified, second trimester
O0991	Supervision of high-risk pregnancy, unspecified, first trimester
O0990	Supervision of high-risk pregnancy, unspecified, unspecified trimester
O09899	Supervision of other high-risk pregnancies, unspecified trimester
O09893	Supervision of other high-risk pregnancies, third trimester
O09892	Supervision of other high-risk pregnancies, second trimester
O09891	Supervision of other high-risk pregnancies, first trimester
N9489	Other specified conditions associated with female genital organs and menstrual cycle
N9089	Other specified noninflammatory disorders of vulva and perineum
N907	Vulvar cyst
N898	Other specified noninflammatory disorders of vagina

Code	Description
N7681	Mucositis (ulcerative) of vagina and vulva
N766	Ulceration of vulva
N765	Ulceration of vagina
N762	Acute vulvitis
N760	Acute vaginitis
N5089	Other specified disorders of the male genital organs
N50819	Testicular pain, unspecified
N492	Inflammatory disorders of scrotum
N489	Disorder of penis, unspecified
N4889	Other specified disorders of penis
N485	Ulcer of penis
N481	Balanitis
N368	Other specified disorders of urethra
M792	Neuralgia and neuritis, unspecified
L989	Disorder of the skin and subcutaneous tissue, unspecified
L309	Dermatitis, unspecified
L293	Anogenital pruritus, unspecified
L089	Local infection of the skin and subcutaneous tissue, unspecified
K759	Inflammatory liver disease, unspecified
K6289	Other specified diseases of anus and rectum
K146	Glossodynia
K1379	Other lesions of oral mucosa
K1370	Unspecified lesions of oral mucosa
K130	Diseases of lips
K121	Other forms of stomatitis
K120	Recurrent oral aphthae
K068	Other specified disorders of gingiva and edentulous alveolar ridge
H15012	Anterior scleritis, left eye
H109	Unspecified conjunctivitis
G9009	Other idiopathic peripheral autonomic neuropathy
G629	Polyneuropathy, unspecified
G510	Bell's palsy
E299	Testicular dysfunction, unspecified
D849	Immunodeficiency, unspecified
B349	Viral infection, unspecified
B20	Human immunodeficiency virus [HIV] disease
B189	Chronic viral hepatitis, unspecified

Code	Description
B179	Acute viral hepatitis, unspecified
B009	Herpesviral infection, unspecified
B009	Herpesviral infection, unspecified
B0089	Other herpesviral infection
B0052	Herpesviral keratitis
B002	Herpesviral gingivostomatitis and pharyngotonsillitis
B001	Herpesviral vesicular dermatitis
B000	Eczema herpeticum
A64	Unspecified sexually transmitted disease
A609	Anogenital herpesviral infection, unspecified
A601	Herpesviral infection of perianal skin and rectum
A6009	Herpesviral infection of other urogenital tract
A6004	Herpesviral vulvovaginitis
A6002	Herpesviral infection of other male genital organs
A6000	Herpesviral infection of urogenital system, unspecified

Gammaglobulin IGE

Code	Description
B4481	Allergic bronchopulmonary aspergillosis
B449	Aspergillosis, unspecified
B49	Unspecified mycosis
H01119	Allergic dermatitis of unspecified eye, unspecified eyelid
H1010	Acute atopic conjunctivitis, unspecified eye
H1013	Acute atopic conjunctivitis, bilateral
H1030	Unspecified acute conjunctivitis, unspecified eye
H1032	Unspecified acute conjunctivitis, left eye
H1033	Unspecified acute conjunctivitis, bilateral
H10403	Unspecified chronic conjunctivitis, bilateral
H1045	Other chronic allergic conjunctivitis
H6503	Acute serous otitis media, bilateral
H6523	Chronic serous otitis media, bilateral
H68103	Unspecified obstruction of Eustachian tube, bilateral
H6990	Unspecified Eustachian tube disorder, unspecified ear
H6992	Unspecified Eustachian tube disorder, left ear
J0100	Acute maxillary sinusitis, unspecified
J0140	Acute pansinusitis, unspecified
J0141	Acute recurrent pansinusitis

Code	Description
J0190	Acute sinusitis, unspecified
J0191	Acute recurrent sinusitis, unspecified
J028	Acute pharyngitis due to other specified organisms
J029	Acute pharyngitis, unspecified
J0390	Acute tonsillitis, unspecified
J208	Acute bronchitis due to other specified organisms
J209	Acute bronchitis, unspecified
J300	Vasomotor rhinitis
J301	Allergic rhinitis due to pollen
J302	Other seasonal allergic rhinitis
J305	Allergic rhinitis due to food
J3081	Allergic rhinitis due to animal (cat) (dog) hair and dander
J3089	Other allergic rhinitis
J309	Allergic rhinitis, unspecified
J310	Chronic rhinitis
J311	Chronic nasopharyngitis
J320	Chronic maxillary sinusitis
J321	Chronic frontal sinusitis
J322	Chronic ethmoidal sinusitis
J324	Chronic pansinusitis
J328	Other chronic sinusitis
J329	Chronic sinusitis, unspecified
J339	Nasal polyp, unspecified
J343	Hypertrophy of nasal turbinates
J3489	Other specified disorders of nose and nasal sinuses
J3503	Chronic tonsillitis and adenoiditis
J353	Hypertrophy of tonsils with hypertrophy of adenoids
J392	Other diseases of pharynx
J40	Bronchitis, not specified as acute or chronic
J411	Mucopurulent chronic bronchitis
J441	Chronic obstructive pulmonary disease with (acute) exacerbation
J449	Chronic obstructive pulmonary disease, unspecified
J4520	Mild intermittent asthma, uncomplicated
J4521	Mild intermittent asthma with (acute) exacerbation
J4530	Mild persistent asthma, uncomplicated
J4531	Mild persistent asthma with (acute) exacerbation
J4540	Moderate persistent asthma, uncomplicated

Code	Description
J4541	Moderate persistent asthma with (acute) exacerbation
J4550	Severe persistent asthma, uncomplicated
J4551	Severe persistent asthma with (acute) exacerbation
J4552	Severe persistent asthma with status asthmaticus
J45901	Unspecified asthma with (acute) exacerbation
J45909	Unspecified asthma, uncomplicated
J45990	Exercise induced bronchospasm
J45991	Cough variant asthma
J45998	Other asthma
J470	Bronchiectasis with acute lower respiratory infection
J479	Bronchiectasis, uncomplicated
J679	Hypersensitivity pneumonitis due to unspecified organic dust
J8410	Pulmonary fibrosis, unspecified
J84112	Idiopathic pulmonary fibrosis
J849	Interstitial pulmonary disease, unspecified
J9601	Acute respiratory failure with hypoxia
J9801	Acute bronchospasm
J984	Other disorders of lung
J988	Other specified respiratory disorders
K120	Recurrent oral aphthae
K1370	Unspecified lesions of oral mucosa
K146	Glossodynia
K200	Eosinophilic esophagitis
K210	Gastro-esophageal reflux disease with esophagitis
K219	Gastro-esophageal reflux disease without esophagitis
K2900	Acute gastritis without bleeding
K2970	Gastritis, unspecified, without bleeding
K5221	food protein induced enterocolitis
K5229	Other allergic and dietetic gastroenteritis and colitis
K52832	Lymphocytic colitis
K529	Noninfective gastroenteritis and colitis, unspecified
K9049	Malabsorption due to intolerance, not elsewhere classified
K909	Intestinal malabsorption, unspecified
L2081	Atopic neurodermatitis
L2082	Flexural eczema
L2083	Infantile (acute) (chronic) eczema
L2084	Intrinsic (allergic) eczema

Code	Description
L2089	Other atopic dermatitis
L209	Atopic dermatitis, unspecified
L230	Allergic contact dermatitis due to metals
L237	Allergic contact dermatitis due to plants, except food
L2389	Allergic contact dermatitis due to other agents
L239	Allergic contact dermatitis, unspecified cause
L259	Unspecified contact dermatitis, unspecified cause
L272	Dermatitis due to ingested food
L290	Pruritus ani
L293	Anogenital pruritus, unspecified
L298	Other pruritus
L299	Pruritus, unspecified
L309	Dermatitis, unspecified
L400	Psoriasis vulgaris
L500	Allergic urticaria
L501	Idiopathic urticaria
L502	Urticaria due to cold and heat
L503	Dermatographic urticaria
L506	Contact urticaria
L508	Other urticaria
L509	Urticaria, unspecified
L710	Perioral dermatitis
R040	Epistaxis
R05	Cough
R051	Acute cough
R052	Subacute cough
R053	Chronic cough
R054	Cough syncope
R058	Other specified cough
R059	Cough unspecified
R062	Wheezing
R0981	Nasal congestion
R0982	Postnasal drip
S30861A	Insect bite (nonvenomous) of abdominal wall, initial encounter
S40869A	Insect bite (nonvenomous) of unspecified upper arm, initial encounter
S60561A	Insect bite (nonvenomous) of right hand, initial encounter
T360X5A	Adverse effect of penicillins, initial encounter

Code	Description
T63421A	Toxic effect of venom of ants, accidental (unintentional), initial encounter
T63441A	Toxic effect of venom of bees, accidental (unintentional), initial encounter
T63441D	Toxic effect of venom of bees, accidental (unintentional), subsequent encounter
T63444A	Toxic effect of venom of bees, undetermined, initial encounter
T63451A	Toxic effect of venom of hornets, accidental (unintentional), initial encounter
T63461D	Toxic effect of venom of wasps, accidental (unintentional), subsequent encounter
T63481A	Toxic effect of venom of other arthropod, accidental (unintentional), initial encounter
T6391XA	Toxic effect of contact with unspecified venomous animal, accidental (unintentional), initial encounter
T6391XS	Toxic effect of contact with unspecified venomous animal, accidental (unintentional), sequela
T65811A	Toxic effect of latex, accidental (unintentional), initial encounter
T7800XA	Anaphylactic reaction due to unspecified food, initial encounter
T7800XD	Anaphylactic reaction due to unspecified food, subsequent encounter
T7800XS	Anaphylactic reaction due to unspecified food, sequela
T7801XA	Anaphylactic reaction due to peanuts, initial encounter
T7801XD	Anaphylactic reaction due to peanuts, subsequent encounter
T7802XA	Anaphylactic reaction due to shellfish (crustaceans), initial encounter
T7802XD	Anaphylactic reaction due to shellfish (crustaceans), subsequent encounter
T7803XS	Anaphylactic reaction due to other fish, sequela
T7804XD	Anaphylactic reaction due to fruits and vegetables, subsequent encounter
T7805XA	Anaphylactic reaction due to tree nuts and seeds, initial encounter
T7805XD	Anaphylactic reaction due to tree nuts and seeds, subsequent encounter
T7807XD	Anaphylactic reaction due to milk and dairy products, subsequent encounter
T7808XA	Anaphylactic reaction due to eggs, initial encounter
T7808XD	Anaphylactic reaction due to eggs, subsequent encounter
T781XXA	Other adverse food reactions, not elsewhere classified, initial encounter
T781XXD	Other adverse food reactions, not elsewhere classified, subsequent encounter
T781XXS	Other adverse food reactions, not elsewhere classified, sequela
T782XXA	Anaphylactic shock, unspecified, initial encounter
T782XXD	Anaphylactic shock, unspecified, subsequent encounter
T782XXS	Anaphylactic shock, unspecified, sequela
T783XXA	Angioneurotic edema, initial encounter
T783XXD	Angioneurotic edema, subsequent encounter
T7840XA	Allergy, unspecified, initial encounter
T7840XD	Allergy, unspecified, subsequent encounter
T7840XS	Allergy, unspecified, sequela
T7849XA	Other allergy, initial encounter
T7849XS	Other allergy, sequela

Code	Description
Z0182	Encounter for allergy testing
Z0189	Encounter for other specified special examinations
Z572	Occupational exposure to dust
Z579	Occupational exposure to unspecified risk factor
Z77118	Contact with and (suspected) exposure to other environmental pollution
Z77120	Contact with and (suspected) exposure to mold (toxic)
Z8619	Personal history of other infectious and parasitic diseases
Z87892	Personal history of anaphylaxis
Z880	Allergy status to penicillin
Z881	Allergy status to other antibiotic agents' status
Z888	Allergy status to other drugs, medicaments, and biological substances status
Z889	Allergy status to unspecified drugs, medicaments, and biological substances status
Z91010	Allergy to peanuts
Z91011	Allergy to milk products
Z91012	Allergy to eggs
Z91013	Allergy to seafood
Z91018	Allergy to other foods
Z91030	Bee allergy status
Z91038	Other insect allergy status
Z91040	Latex allergy status
Z9109	Other allergy status, other than to drugs and biological substances

Erythrocyte Sedimentation Rate

Code	Description
C029	Malignant neoplasm of tongue, unspecified
C099	Malignant neoplasm of tonsil, unspecified
C169	Malignant neoplasm of stomach, unspecified
C182	Malignant neoplasm of ascending colon
C187	Malignant neoplasm of sigmoid colon
C189	Malignant neoplasm of colon, unspecified
C210	Malignant neoplasm of anus, unspecified
C220	Liver cell carcinoma
C229	Malignant neoplasm of liver, not specified as primary or secondary
C3411	Malignant neoplasm of upper lobe, right bronchus, or lung
C3412	Malignant neoplasm of upper lobe, left bronchus, or lung
C3490	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C4022	Malignant neoplasm of long bones of left lower limb

Code	Description
C419	Malignant neoplasm of bone and articular cartilage, unspecified
C4330	Malignant melanoma of unspecified part of face
C4359	Malignant melanoma of other part of trunk
C439	Malignant melanoma of skin, unspecified
C44309	Unspecified malignant neoplasm of skin of other parts of face
C4491	Basal cell carcinoma of skin, unspecified
C481	Malignant neoplasm of specified parts of peritoneum
C50111	Malignant neoplasm of central portion of right female breast
C50112	Malignant neoplasm of central portion of left female breast
C50211	Malignant neoplasm of upper-inner quadrant of right female breast
C50212	Malignant neoplasm of upper-inner quadrant of left female breast
C50311	Malignant neoplasm of lower-inner quadrant of right female breast
C50312	Malignant neoplasm of lower-inner quadrant of left female breast
C50411	Malignant neoplasm of upper-outer quadrant of right female breast
C50412	Malignant neoplasm of upper-outer quadrant of left female breast
C50511	Malignant neoplasm of lower-outer quadrant of right female breast
C50519	Malignant neoplasm of lower-outer quadrant of unspecified female breast
C50811	Malignant neoplasm of overlapping sites of right female breast
C50812	Malignant neoplasm of overlapping sites of left female breast
C50911	Malignant neoplasm of unspecified site of right female breast
C50912	Malignant neoplasm of unspecified site of left female breast
C50919	Malignant neoplasm of unspecified site of unspecified female breast
C539	Malignant neoplasm of cervix uteri, unspecified
C541	Malignant neoplasm of endometrium
C549	Malignant neoplasm of corpus uteri, unspecified
C562	Malignant neoplasm of left ovary
C574	Malignant neoplasm of uterine adnexa, unspecified
C61	Malignant neoplasm of prostate
C649	Malignant neoplasm of unspecified kidney, except renal pelvis
C662	Malignant neoplasm of left ureter
C679	Malignant neoplasm of bladder, unspecified
C720	Malignant neoplasm of spinal cord
C779	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C782	Secondary malignant neoplasm of pleura
C787	Secondary malignant neoplasm of liver and intrahepatic bile duct
C7951	Secondary malignant neoplasm of bone
C800	Disseminated malignant neoplasm, unspecified

Code	Description
C8100	Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
C8104	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of axilla and upper limb
C8110	Nodular sclerosis Hodgkin lymphoma, unspecified site
C8111	Nodular sclerosis Hodgkin lymphoma, lymph nodes of head, face, and neck
C8112	Nodular sclerosis Hodgkin lymphoma, intrathoracic lymph nodes
C8114	Nodular sclerosis Hodgkin lymphoma, lymph nodes of axilla and upper limb
C8170	Other Hodgkin lymphoma, unspecified site
C8172	Other Hodgkin lymphoma, intrathoracic lymph nodes
C8178	Other Hodgkin lymphoma, lymph nodes of multiple sites
C8190	Hodgkin lymphoma, unspecified, unspecified site
C8191	Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C8192	Hodgkin lymphoma, unspecified, intrathoracic lymph nodes
C8194	Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb
C8197	Hodgkin lymphoma, unspecified, spleen
C8199	Hodgkin lymphoma, unspecified, extranodal and solid organ sites
C8207	Follicular lymphoma grade I, spleen
C8209	Follicular lymphoma grade I, extranodal and solid organ sites
C8210	Follicular lymphoma grade II, unspecified site
C8211	Follicular lymphoma grade II, lymph nodes of head, face, and neck
C8226	Follicular lymphoma grade III, unspecified, intrapelvic lymph nodes
C8251	Diffuse follicle center lymphoma, lymph nodes of head, face, and neck
C8258	Diffuse follicle center lymphoma, lymph nodes of multiple sites
C8280	Other types of follicular lymphoma, unspecified site
C8290	Follicular lymphoma, unspecified, unspecified site
C8300	Small cell B-cell lymphoma, unspecified site
C8330	Diffuse large B-cell lymphoma, unspecified site
C8333	Diffuse large B-cell lymphoma, intra-abdominal lymph nodes
C8338	Diffuse large B-cell lymphoma, lymph nodes of multiple sites
C8339	Diffuse large B-cell lymphoma, extranodal and solid organ sites
C8388	Other non-follicular lymphoma, lymph nodes of multiple sites
C8400	Mycosis fungoides, unspecified site
C8448	Peripheral T-cell lymphoma, not classified, lymph nodes of multiple sites
C84A3	Cutaneous T-cell lymphoma, unspecified, intra-abdominal lymph nodes
C8510	Unspecified B-cell lymphoma, unspecified site
C8580	Other specified types of non-Hodgkin lymphoma, unspecified site
C8589	Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites
C8590	Non-Hodgkin lymphoma, unspecified, unspecified site

Code	Description
C8591	Non-Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C8593	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C880	Waldenström macroglobulinemia
C9000	Multiple myeloma not having achieved remission
C9001	Multiple myeloma in remission
C9002	Multiple myeloma in relapse
C9110	Chronic lymphocytic leukemia of B-cell type not having achieved remission
C9111	Chronic lymphocytic leukemia of B-cell type in remission
C9112	Chronic lymphocytic leukemia of B-cell type in relapse
C9140	Hairy cell leukemia not having achieved remission
C9141	Hairy cell leukemia, in remission
C9190	Lymphoid leukemia, unspecified not having achieved remission
C91Z0	Other lymphoid leukemia not having achieved remission
C91Z2	Other lymphoid leukemia, in relapse
C9200	Acute myeloblastic leukemia, not having achieved remission
C946	Myelodysplastic disease, not classified
D376	Neoplasm of uncertain behavior of liver, gallbladder, and bile ducts
D392	Neoplasm of uncertain behavior of placenta
D3A00	Benign carcinoid tumor of unspecified site
D3A019	Benign carcinoid tumor of the small intestine, unspecified portion
D550	Anemia due to glucose-6-phosphate dehydrogenase [G6PD] deficiency
D560	Alpha thalassemia
D563	Thalassemia minor
D5700	Hb-SS disease with crisis, unspecified
D582	Other hemoglobinopathies
D61810	Antineoplastic chemotherapy induced pancytopenia
D61818	Other pancytopenia
D619	Aplastic anemia, unspecified
D62	Acute posthemorrhagic anemia
D630	Anemia in neoplastic disease
D631	Anemia in chronic kidney disease
D638	Anemia in other chronic diseases classified elsewhere
D6481	Anemia due to antineoplastic chemotherapy
D6489	Other specified anemias
D649	Anemia, unspecified
D680	Von Willebrand's disease
D682	Hereditary deficiency of other clotting factors

Code	Description
D684	Acquired coagulation factor deficiency
D6859	Other primary thrombophilia
D6861	Antiphospholipid syndrome
D6862	Lupus anticoagulant syndrome
D6869	Other thrombophilia
D688	Other specified coagulation defects
D689	Coagulation defect, unspecified
D690	Allergic purpura
D692	Other nonthrombocytopenic purpura
D693	Immune thrombocytopenic purpura
D696	Thrombocytopenia, unspecified
D698	Other specified hemorrhagic conditions
D699	Hemorrhagic condition, unspecified
D702	Other drug-induced agranulocytosis
D708	Other neutropenia
D709	Neutropenia, unspecified
D71	Functional disorders of polymorphonuclear neutrophils
D721	Eosinophilia
D72819	Decreased white blood cell count, unspecified
D72820	Lymphocytosis (symptomatic)
D72821	Monocytosis (symptomatic)
D72823	Leukemoid reaction
D72824	Basophilia
D72828	Other elevated white blood cell count
D72829	Elevated white blood cell count, unspecified
D7289	Other specified disorders of white blood cells
D729	Disorder of white blood cells, unspecified
D751	Secondary polycythemia
D7589	Other specified diseases of blood and blood-forming organs
D801	Nonfamilial hypogammaglobulinemia
D802	Selective deficiency of immunoglobulin A [IgA]
D809	Immunodeficiency with predominantly antibody defects, unspecified
D824	Hyperimmunoglobulin E [IgE] syndrome
D831	Common variable immunodeficiency with predominant immunoregulatory T-cell disorders
D839	Common variable immunodeficiency, unspecified
D841	Defects in the complement system
D849	Immunodeficiency, unspecified

Code	Description
D860	Sarcoidosis of lung
D862	Sarcoidosis of lung with sarcoidosis of lymph nodes
D863	Sarcoidosis of skin
D8687	Sarcoid myositis
D8689	Sarcoidosis of other sites
D869	Sarcoidosis, unspecified
D890	Polyclonal hypergammaglobulinemia
D891	Cryoglobulinemia
D892	Hypergammaglobulinemia, unspecified
D8989	Other specified disorders involving the immune mechanism, not elsewhere classified
D899	Disorder involving the immune mechanism, unspecified
E0821	Diabetes mellitus due to underlying condition with diabetic nephropathy
E0842	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E099	Drug or chemical induced diabetes mellitus without complications
E1010	Type 1 diabetes mellitus with ketoacidosis without coma
E1029	Type 1 diabetes mellitus with other diabetic kidney complication
E10319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E103293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E1040	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10621	Type 1 diabetes mellitus with foot ulcer
E10622	Type 1 diabetes mellitus with other skin ulcer
E1065	Type 1 diabetes mellitus with hyperglycemia
E108	Type 1 diabetes mellitus with unspecified complications
E109	Type 1 diabetes mellitus without complications
E1121	Type 2 diabetes mellitus with diabetic nephropathy
E1122	Type 2 diabetes mellitus with diabetic chronic kidney disease
E1129	Type 2 diabetes mellitus with other diabetic kidney complication
E113219	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye
E113293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E1140	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E1142	Type 2 diabetes mellitus with diabetic polyneuropathy
E1149	Type 2 diabetes mellitus with other diabetic neurological complication
E1151	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E1159	Type 2 diabetes mellitus with other circulatory complications
E11610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E11621	Type 2 diabetes mellitus with foot ulcer
E11622	Type 2 diabetes mellitus with other skin ulcer

Code	Description
E11628	Type 2 diabetes mellitus with other skin complications
E1165	Type 2 diabetes mellitus with hyperglycemia
E1169	Type 2 diabetes mellitus with other specified complication
E118	Type 2 diabetes mellitus with unspecified complications
E119	Type 2 diabetes mellitus without complications
E1310	Other specified diabetes mellitus with ketoacidosis without coma
E13621	Other specified diabetes mellitus with foot ulcer
E13628	Other specified diabetes mellitus with other skin complications
E138	Other specified diabetes mellitus with unspecified complications
E139	Other specified diabetes mellitus without complications
E161	Other hypoglycemia
E162	Hypoglycemia, unspecified
E213	Hyperparathyroidism, unspecified
E221	Hyperprolactinemia
E230	Hypopituitarism
E232	Diabetes insipidus
E233	Hypothalamic dysfunction, not elsewhere classified
E237	Disorder of pituitary gland, unspecified
E249	Cushing's syndrome, unspecified
E270	Other adrenocortical overactivity
E2740	Unspecified adrenocortical insufficiency
E279	Disorder of adrenal gland, unspecified
E700	Classical phenylketonuria
E7204	Cystinosis
E7210	Disorders of sulfur-bearing amino-acid metabolism, unspecified
E849	Cystic fibrosis, unspecified
E854	Organ-limited amyloidosis
E8581	Light chain (AL) amyloidosis
E859	Amyloidosis, unspecified
E8809	Other disorders of plasma-protein metabolism, not elsewhere classified
E8840	Mitochondrial metabolism disorder, unspecified
G0491	Myelitis, unspecified
G060	Intracranial abscess and granuloma
G061	Intraspinal abscess and granuloma
G062	Extradural and subdural abscess, unspecified
G10	Huntington's disease
G114	Hereditary spastic paraplegia

Code	Description
G20	Parkinson's disease
G255	Other chorea
G2579	Other drug induced movement disorders
G2581	Restless legs syndrome
G2582	Stiff-man syndrome
G35	Multiple sclerosis
G379	Demyelinating disease of central nervous system, unspecified
G43001	Migraine without aura, not intractable, with status migrainosus
G43009	Migraine without aura, not intractable, without status migrainosus
G43011	Migraine without aura, intractable, with status migrainosus
G43019	Migraine without aura, intractable, without status migrainosus
G43101	Migraine with aura, not intractable, with status migrainosus
G43109	Migraine with aura, not intractable, without status migrainosus
G43111	Migraine with aura, intractable, with status migrainosus
G43409	Hemiplegic migraine, not intractable, without status migrainosus
G43701	Chronic migraine without aura, not intractable, with status migrainosus
G43709	Chronic migraine without aura, not intractable, without status migrainosus
G43711	Chronic migraine without aura, intractable, with status migrainosus
G43719	Chronic migraine without aura, intractable, without status migrainosus
G43809	Other migraine, not intractable, without status migrainosus
G43811	Other migraine, intractable, with status migrainosus
G43819	Other migraine, intractable, without status migrainosus
G43901	Migraine, unspecified, not intractable, with status migrainosus
G43909	Migraine, unspecified, not intractable, without status migrainosus
G43919	Migraine, unspecified, intractable, without status migrainosus
G43A0	Cyclical vomiting, in migraine, not intractable
G43B0	Ophthalmoplegic migraine, not intractable
G44001	Cluster headache syndrome, unspecified, intractable
G44009	Cluster headache syndrome, unspecified, not intractable
G44019	Episodic cluster headache, not intractable
G44021	Chronic cluster headache, intractable
G44031	Episodic paroxysmal hemicrania, intractable
G44039	Episodic paroxysmal hemicrania, not intractable
G44049	Chronic paroxysmal hemicrania, not intractable
G441	Vascular headache, not elsewhere classified
G44201	Tension-type headache, unspecified, intractable
G44209	Tension-type headache, unspecified, not intractable

Code	Description
G44219	Episodic tension-type headache, not intractable
G44229	Chronic tension-type headache, not intractable
G44319	Acute post-traumatic headache, not intractable
G44329	Chronic post-traumatic headache, not intractable
G4440	Drug-induced headache, not elsewhere classified, not intractable
G4451	Hemicrania continua
G4452	New daily persistent headache (NDPH)
G4453	Primary thunderclap headache
G4459	Other complicated headache syndrome
G4482	Headache associated with sexual activity
G4489	Other headache syndrome
G450	Vertebro-basilar artery syndrome
G453	Amaurosis fugax
G454	Transient global amnesia
G459	Transient cerebral ischemic attack, unspecified
G500	Trigeminal neuralgia
G501	Atypical facial pain
G509	Disorder of trigeminal nerve, unspecified
G510	Bell's palsy
G529	Cranial nerve disorder, unspecified
G540	Brachial plexus disorders
G545	Neuralgic amyotrophy
G549	Nerve root and plexus disorder, unspecified
G587	Mononeuritis multiplex
G589	Mononeuropathy, unspecified
G600	Hereditary motor and sensory neuropathy
G603	Idiopathic progressive neuropathy
G608	Other hereditary and idiopathic neuropathies
G609	Hereditary and idiopathic neuropathy, unspecified
G610	Guillain-Barre syndrome
G6181	Chronic inflammatory demyelinating polyneuritis
G6189	Other inflammatory polyneuropathies
G619	Inflammatory polyneuropathy, unspecified
G621	Alcoholic polyneuropathy
G6289	Other specified polyneuropathies
G629	Polyneuropathy, unspecified
G63	Polyneuropathy in diseases classified elsewhere

Code	Description
G7000	Myasthenia gravis without (acute) exacerbation
G719	Primary disorder of muscle, unspecified
G7241	Inclusion body myositis [IBM]
G7249	Other inflammatory and immune myopathies, not elsewhere classified
G7289	Other specified myopathies
G729	Myopathy, unspecified
G801	Spastic diplegic cerebral palsy
G809	Cerebral palsy, unspecified
G8220	Paraplegia, unspecified
G8250	Quadriplegia, unspecified
G8310	Monoplegia of lower limb affecting unspecified side
G909	Disorder of the autonomic nervous system, unspecified
G919	Hydrocephalus, unspecified
G92	Toxic encephalopathy
G920	Immune effector cell-associated neurotoxicity syndrome
G9200	Immune effector cell-associated neurotoxicity syndrome, grade unspecified
G9201	Immune effector cell-associated neurotoxicity syndrome, grade 1
G9202	Immune effector cell-associated neurotoxicity syndrome, grade 2
G9203	Immune effector cell-associated neurotoxicity syndrome, grade 3
G9204	Immune effector cell-associated neurotoxicity syndrome, grade 4
G9205	Immune effector cell-associated neurotoxicity syndrome, grade 5
G928	Other toxic encephalopathy
G929	Unspecified toxic encephaloopathy
G932	Benign intracranial hypertension
G933	Postviral fatigue syndrome
G9340	Encephalopathy, unspecified
G9341	Metabolic encephalopathy
G9349	Other encephalopathy
G935	Compression of brain
G9389	Other specified disorders of brain
G959	Disease of spinal cord, unspecified
G988	Other disorders of nervous system
H019	Unspecified inflammation of eyelid
H02401	Unspecified ptosis of right eyelid
H02402	Unspecified ptosis of left eyelid
H0266	Xanthelasma of left eye, unspecified eyelid
H04123	Dry eye syndrome of bilateral lacrimal glands

Code	Description
H04129	Dry eye syndrome of unspecified lacrimal gland
H05013	Cellulitis of bilateral orbits
H05113	Granuloma of bilateral orbits
H0520	Unspecified exophthalmos
H05223	Edema of bilateral orbit
H15001	Unspecified scleritis, right eye
H15002	Unspecified scleritis, left eye
H15003	Unspecified scleritis, bilateral
H15009	Unspecified scleritis, unspecified eye
H15012	Anterior scleritis, left eye
H15013	Anterior scleritis, bilateral
H15039	Posterior scleritis, unspecified eye
H15101	Unspecified episcleritis, right eye
H15103	Unspecified episcleritis, bilateral
H15112	Episcleritis periodica fugax, left eye
H159	Unspecified disorder of sclera
H16001	Unspecified corneal ulcer, right eye
H16002	Unspecified corneal ulcer, left eye
H16072	Perforated corneal ulcer, left eye
H16203	Unspecified keratoconjunctivitis, bilateral
H1712	Central corneal opacity, left eye
H2000	Unspecified acute and subacute iridocyclitis
H20012	Primary iridocyclitis, left eye
H20013	Primary iridocyclitis, bilateral
H20019	Primary iridocyclitis, unspecified eye
H20021	Recurrent acute iridocyclitis, right eye
H20022	Recurrent acute iridocyclitis, left eye
H2012	Chronic iridocyclitis, left eye
H2013	Chronic iridocyclitis, bilateral
H209	Unspecified iridocyclitis
H3022	Posterior cyclitis, left eye
H3023	Posterior cyclitis, bilateral
H3093	Unspecified chorioretinal inflammation, bilateral
H31001	Unspecified chorioretinal scars, right eye
H3411	Central retinal artery occlusion, right eye
H3412	Central retinal artery occlusion, left eye
H3413	Central retinal artery occlusion, bilateral

Code	Description
H34231	Retinal artery branch occlusion, right eye
H34232	Retinal artery branch occlusion, left eye
H348112	Central retinal vein occlusion, right eye, stable
H348130	Central retinal vein occlusion, bilateral, with macular edema
H348320	Tributary (branch) retinal vein occlusion, left eye, with macular edema
H348321	Tributary (branch) retinal vein occlusion, left eye, with retinal neovascularization
H348392	Tributary (branch) retinal vein occlusion, unspecified eye, stable
H35062	Retinal vasculitis, left eye
H35069	Retinal vasculitis, unspecified eye
H353221	Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
H353222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
H35352	Cystoid macular degeneration, left eye
H35353	Cystoid macular degeneration, bilateral
H3552	Pigmentary retinal dystrophy
H3581	Retinal edema
H43392	Other vitreous opacities, left eye
H4389	Other disorders of vitreous body
H44001	Unspecified purulent endophthalmitis, right eye
H44119	Panuveitis, unspecified eye
H44139	Sympathetic uveitis, unspecified eye
H44539	Leucocoria, unspecified eye
H44811	Hemophthalmos, right eye
H4602	Optic papillitis, left eye
H4612	Retrobulbar neuritis, left eye
H469	Unspecified optic neuritis
H47011	Ischemic optic neuropathy, right eye
H47012	Ischemic optic neuropathy, left eye
H47013	Ischemic optic neuropathy, bilateral
H47019	Ischemic optic neuropathy, unspecified eye
H4710	Unspecified papilledema
H47211	Primary optic atrophy, right eye
H47293	Other optic atrophy, bilateral
H47512	Disorders of visual pathways in (due to) inflammatory disorders, left side
H4901	Third [oculomotor] nerve palsy, right eye
H4902	Third [oculomotor] nerve palsy, left eye
H4910	Fourth [trochlear] nerve palsy, unspecified eye
H4911	Fourth [trochlear] nerve palsy, right eye

Code	Description
H4912	Fourth [trochlear] nerve palsy, left eye
H4913	Fourth [trochlear] nerve palsy, bilateral
H4920	Sixth [abducent] nerve palsy, unspecified eye
H4921	Sixth [abducent] nerve palsy, right eye
H4922	Sixth [abducent] nerve palsy, left eye
H5022	Vertical strabismus, left eye
H53121	Transient visual loss, right eye
H53122	Transient visual loss, left eye
H53123	Transient visual loss, bilateral
H53129	Transient visual loss, unspecified eye
H53131	Sudden visual loss, right eye
H53132	Sudden visual loss, left eye
H53143	Visual discomfort, bilateral
H5316	Psychophysical visual disturbances
H5319	Other subjective visual disturbances
H532	Diplopia
H5340	Unspecified visual field defects
H53411	Scotoma involving central area, right eye
H53451	Other localized visual field defect, right eye
H53459	Other localized visual field defect, unspecified eye
H53461	Homonymous bilateral field defects, right side
H538	Other visual disturbances
H539	Unspecified visual disturbance
H543	Unqualified visual loss, both eyes
H5440	Blindness, one eye, unspecified eye
H5461	Unqualified visual loss, right eye, normal vision left eye
H5462	Unqualified visual loss, left eye, normal vision right eye
H547	Unspecified visual loss
H5710	Ocular pain, unspecified eye
H5711	Ocular pain, right eye
H5712	Ocular pain, left eye
H5713	Ocular pain, bilateral
H578	Other specified disorders of eye and adnexa
H579	Unspecified disorder of eye and adnexa
H60392	Other infective otitis externa, left ear
H60501	Unspecified acute noninfective otitis externa, right ear
H61031	Chondritis of right external ear

Code	Description
H61032	Chondritis of left external ear
H61033	Chondritis of external ear, bilateral
H61039	Chondritis of external ear, unspecified ear
H7010	Chronic mastoiditis, unspecified ear
H70212	Acute petrositis, left ear
H7090	Unspecified mastoiditis, unspecified ear
H7093	Unspecified mastoiditis, bilateral
H7192	Unspecified cholesteatoma, left ear
H8110	Benign paroxysmal vertigo, unspecified ear
H8113	Benign paroxysmal vertigo, bilateral
H8120	Vestibular neuronitis, unspecified ear
H8122	Vestibular neuronitis, left ear
H81391	Other peripheral vertigo, right ear
H8309	Labyrinthitis, unspecified ear
H903	Sensorineural hearing loss, bilateral
H9041	Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H9042	Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H9121	Sudden idiopathic hearing loss, right ear
H9122	Sudden idiopathic hearing loss, left ear
H9123	Sudden idiopathic hearing loss, bilateral
H918X1	Other specified hearing loss, right ear
H918X2	Other specified hearing loss, left ear
H9190	Unspecified hearing loss, unspecified ear
H9191	Unspecified hearing loss, right ear
H9193	Unspecified hearing loss, bilateral
H9313	Tinnitus, bilateral
H9319	Tinnitus, unspecified ear
H93A9	Pulsatile tinnitus, unspecified ear
I00	Rheumatic fever without heart involvement
I110	Hypertensive heart disease with heart failure
I129	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I1310	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I309	Acute pericarditis, unspecified
I313	Pericardial effusion (noninflammatory)
I319	Disease of pericardium, unspecified

Code	Description
I330	Acute and subacute infective endocarditis
I339	Acute and subacute endocarditis, unspecified
I38	Endocarditis, valve unspecified
I400	Infective myocarditis
I420	Dilated cardiomyopathy
I422	Other hypertrophic cardiomyopathy
I428	Other cardiomyopathies
I429	Cardiomyopathy, unspecified
I442	Atrioventricular block, complete
I5020	Unspecified systolic (congestive) heart failure
I5021	Acute systolic (congestive) heart failure
I5022	Chronic systolic (congestive) heart failure
I5030	Unspecified diastolic (congestive) heart failure
I5031	Acute diastolic (congestive) heart failure
I5032	Chronic diastolic (congestive) heart failure
I5033	Acute on chronic diastolic (congestive) heart failure
I5042	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I5043	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
I509	Heart failure, unspecified
I514	Myocarditis, unspecified
I517	Cardiomegaly
I519	Heart disease, unspecified
I610	Nontraumatic intracerebral hemorrhage in hemisphere, subcortical
I619	Nontraumatic intracerebral hemorrhage, unspecified
I6200	Nontraumatic subdural hemorrhage, unspecified
I63412	Cerebral infarction due to embolism of left middle cerebral artery
I6350	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery
I63511	Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery
I639	Cerebral infarction, unspecified
I6783	Posterior reversible encephalopathy syndrome
I6789	Other cerebrovascular disease
I679	Cerebrovascular disease, unspecified
I682	Cerebral arteritis in other diseases classified elsewhere
I7300	Raynaud's syndrome without gangrene
I7301	Raynaud's syndrome with gangrene
I7381	Erythromelalgia
I773	Arterial fibromuscular dysplasia

Code	Description
I776	Arteritis, unspecified
I880	Nonspecific mesenteric lymphadenitis
I889	Nonspecific lymphadenitis, unspecified
I890	Lymphedema, not elsewhere classified
I951	Orthostatic hypotension
I959	Hypotension, unspecified
I96	Gangrene, not elsewhere classified
I998	Other disorder of circulatory system
I999	Unspecified disorder of circulatory system
J9610	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
K111	Hypertrophy of salivary gland
K1120	Sialoadenitis, unspecified
K1121	Acute sialoadenitis
K117	Disturbances of salivary secretion
K118	Other diseases of salivary glands
K119	Disease of salivary gland, unspecified
K120	Recurrent oral aphthae
K121	Other forms of stomatitis
K1230	Oral mucositis (ulcerative), unspecified
K130	Diseases of lips
K1370	Unspecified lesions of oral mucosa
K1379	Other lesions of oral mucosa
K141	Geographic tongue
K146	Glossodynia
K200	Eosinophilic esophagitis
K5000	Crohn's disease of small intestine without complications
K50011	Crohn's disease of small intestine with rectal bleeding
K50012	Crohn's disease of small intestine with intestinal obstruction
K50014	Crohn's disease of small intestine with abscess
K50018	Crohn's disease of small intestine with other complication
K50019	Crohn's disease of small intestine with unspecified complications
K5010	Crohn's disease of large intestine without complications
K50111	Crohn's disease of large intestine with rectal bleeding
K50113	Crohn's disease of large intestine with fistula
K50118	Crohn's disease of large intestine with other complication
K50119	Crohn's disease of large intestine with unspecified complications
K5080	Crohn's disease of both small and large intestine without complications

Code	Description
K50811	Crohn's disease of both small and large intestine with rectal bleeding
K50812	Crohn's disease of both small and large intestine with intestinal obstruction
K50813	Crohn's disease of both small and large intestine with fistula
K50814	Crohn's disease of both small and large intestine with abscess
K50818	Crohn's disease of both small and large intestine with other complication
K50819	Crohn's disease of both small and large intestine with unspecified complications
K5090	Crohn's disease, unspecified, without complications
K50911	Crohn's disease, unspecified, with rectal bleeding
K50913	Crohn's disease, unspecified, with fistula
K50918	Crohn's disease, unspecified, with other complication
K50919	Crohn's disease, unspecified, with unspecified complications
K5100	Ulcerative (chronic) pancolitis without complications
K51011	Ulcerative (chronic) pancolitis with rectal bleeding
K51018	Ulcerative (chronic) pancolitis with other complication
K51019	Ulcerative (chronic) pancolitis with unspecified complications
K5120	Ulcerative (chronic) proctitis without complications
K51211	Ulcerative (chronic) proctitis with rectal bleeding
K51219	Ulcerative (chronic) proctitis with unspecified complications
K5130	Ulcerative (chronic) rectosigmoiditis without complications
K51311	Ulcerative (chronic) rectosigmoiditis with rectal bleeding
K5150	Left sided colitis without complications
K51511	Left sided colitis with rectal bleeding
K51518	Left sided colitis with other complication
K5180	Other ulcerative colitis without complications
K51818	Other ulcerative colitis with other complication
K51819	Other ulcerative colitis with unspecified complications
K5190	Ulcerative colitis, unspecified, without complications
K51911	Ulcerative colitis, unspecified with rectal bleeding
K51918	Ulcerative colitis, unspecified with other complication
K51919	Ulcerative colitis, unspecified with unspecified complications
K5221	Food protein-induced enterocolitis syndrome
K5222	Food protein-induced enteropathy
K5229	Other allergic and dietetic gastroenteritis and colitis
K523	Indeterminate colitis
K5281	Eosinophilic gastritis or gastroenteritis
K5282	Eosinophilic colitis
K52831	Collagenous colitis

Code	Description
K52832	Lymphocytic colitis
K52839	Microscopic colitis, unspecified
K5289	Other specified noninfective gastroenteritis and colitis
K529	Noninfective gastroenteritis and colitis, unspecified
K551	Chronic vascular disorders of intestine
K559	Vascular disorder of intestine, unspecified
K6389	Other specified diseases of intestine
K639	Disease of intestine, unspecified
K654	Sclerosing mesenteritis
K900	Celiac disease
K9041	Non-celiac gluten sensitivity
L109	Pemphigus, unspecified
L120	Bullous pemphigoid
L121	Cicatricial pemphigoid
L139	Bullous disorder, unspecified
L2084	Intrinsic (allergic) eczema
L2089	Other atopic dermatitis
L209	Atopic dermatitis, unspecified
L218	Other seborrheic dermatitis
L219	Seborrheic dermatitis, unspecified
L400	Psoriasis vulgaris
L401	Generalized pustular psoriasis
L403	Pustulosis palmaris et plantaris
L404	Guttate psoriasis
L4050	Arthropathic psoriasis, unspecified
L4052	Psoriatic arthritis mutilans
L4053	Psoriatic spondylitis
L4059	Other psoriatic arthropathy
L408	Other psoriasis
L409	Psoriasis, unspecified
L413	Small plaque parapsoriasis
L433	Subacute (active) lichen planus
L438	Other lichen planus
L500	Allergic urticaria
L501	Idiopathic urticaria
L503	Dermatographic urticaria
L508	Other urticaria

Code	Description
L509	Urticaria, unspecified
L511	Stevens-Johnson syndrome
L519	Erythema multiforme, unspecified
L52	Erythema nodosum
L539	Erythematous condition, unspecified
L88	Pyoderma gangrenosum
L921	Necrobiosis lipoidica, not elsewhere classified
L928	Other granulomatous disorders of the skin and subcutaneous tissue
L930	Discoid lupus erythematosus
L931	Subacute cutaneous lupus erythematosus
L932	Other local lupus erythematosus
L940	Localized scleroderma [morphea]
L941	Linear scleroderma
L943	Sclerodactyly
L949	Localized connective tissue disorder, unspecified
L959	Vasculitis limited to the skin, unspecified
L97128	Non-pressure chronic ulcer of left thigh with other specified severity
L97312	Non-pressure chronic ulcer of right ankle with fat layer exposed
L97319	Non-pressure chronic ulcer of right ankle with unspecified severity
L97409	Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity
L97412	Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed
L97429	Non-pressure chronic ulcer of left heel and midfoot with unspecified severity
L97503	Non-pressure chronic ulcer of other part of unspecified foot with necrosis of muscle
L97509	Non-pressure chronic ulcer of other part of unspecified foot with unspecified severity
L97511	Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin
L97512	Non-pressure chronic ulcer of other part of right foot with fat layer exposed
L97514	Non-pressure chronic ulcer of other part of right foot with necrosis of bone
L97519	Non-pressure chronic ulcer of other part of right foot with unspecified severity
L97522	Non-pressure chronic ulcer of other part of left foot with fat layer exposed
L97524	Non-pressure chronic ulcer of other part of left foot with necrosis of bone
L97526	Non-pressure chronic ulcer of other part of left foot with bone involvement without evidence of necrosis
L97529	Non-pressure chronic ulcer of other part of left foot with unspecified severity
L97818	Non-pressure chronic ulcer of other part of right lower leg with other specified severity
L97829	Non-pressure chronic ulcer of other part of left lower leg with unspecified severity
L97909	Non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity
L97911	Non-pressure chronic ulcer of unspecified part of right lower leg limited to breakdown of skin
L97919	Non-pressure chronic ulcer of unspecified part of right lower leg with unspecified severity

Code	Description
L982	Febrile neutrophilic dermatosis [Sweet]
L98499	Non-pressure chronic ulcer of skin of other sites with unspecified severity
L989	Disorder of the skin and subcutaneous tissue, unspecified
M0230	Reiter's disease, unspecified site
M0239	Reiter's disease, multiple sites
M0280	Other reactive arthropathies, unspecified site
M041	Periodic fever syndromes
M048	Other autoinflammatory syndromes
M05161	Rheumatoid lung disease with rheumatoid arthritis of right knee
M0520	Rheumatoid vasculitis with rheumatoid arthritis of unspecified site
M0540	Rheumatoid myopathy with rheumatoid arthritis of unspecified site
M0569	Rheumatoid arthritis of multiple sites with involvement of other organs and systems
M0570	Rheumatoid arthritis with rheumatoid factor of unspecified site without organ or systems involvement
M05711	Rheumatoid arthritis with rheumatoid factor of right shoulder without organ or systems involvement
M05732	Rheumatoid arthritis with rheumatoid factor of left wrist without organ or systems involvement
M05741	Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement
M05749	Rheumatoid arthritis with rheumatoid factor of unspecified hand without organ or systems involvement
M05771	Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement
M05772	Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement
M0579	Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
M0580	Other rheumatoid arthritis with rheumatoid factor of unspecified site
M05841	Other rheumatoid arthritis with rheumatoid factor of right hand
M0589	Other rheumatoid arthritis with rheumatoid factor of multiple sites
M059	Rheumatoid arthritis with rheumatoid factor, unspecified
M0600	Rheumatoid arthritis without rheumatoid factor, unspecified site
M06032	Rheumatoid arthritis without rheumatoid factor, left wrist
M06041	Rheumatoid arthritis without rheumatoid factor, right hand
M06062	Rheumatoid arthritis without rheumatoid factor, left knee
M06072	Rheumatoid arthritis without rheumatoid factor, left ankle, and foot
M0609	Rheumatoid arthritis without rheumatoid factor, multiple sites
M061	Adult-onset Still's disease
M06249	Rheumatoid bursitis, unspecified hand
M0630	Rheumatoid nodule, unspecified site
M064	Inflammatory polyarthropathy
M0680	Other specified rheumatoid arthritis, unspecified site
M06841	Other specified rheumatoid arthritis, right hand
M06871	Other specified rheumatoid arthritis, right ankle, and foot

Code	Description
M06872	Other specified rheumatoid arthritis, left ankle, and foot
M0688	Other specified rheumatoid arthritis, vertebrae
M0689	Other specified rheumatoid arthritis, multiple sites
M069	Rheumatoid arthritis, unspecified
M0760	Enteropathic arthropathies, unspecified site
M0800	Unspecified juvenile rheumatoid arthritis of unspecified site
M0829	Juvenile rheumatoid arthritis with systemic onset, multiple sites
M083	Juvenile rheumatoid polyarthritis (seronegative)
M0840	Pauciarticular juvenile rheumatoid arthritis, unspecified site
M0880	Other juvenile arthritis, unspecified site
M0889	Other juvenile arthritis, multiple sites
M0890	Juvenile arthritis, unspecified, unspecified site
M1000	Idiopathic gout, unspecified site
M10021	Idiopathic gout, right elbow
M10031	Idiopathic gout, right wrist
M10061	Idiopathic gout, right knee
M10062	Idiopathic gout, left knee
M10071	Idiopathic gout, right ankle, and foot
M10072	Idiopathic gout, left ankle, and foot
M10079	Idiopathic gout, unspecified ankle, and foot
M1009	Idiopathic gout, multiple sites
M1010	Lead-induced gout, unspecified site
M10249	Drug-induced gout, unspecified hand
M1040	Other secondary gout, unspecified site
M10472	Other secondary gout, left ankle, and foot
M109	Gout, unspecified
M1120	Other chondrocalcinosis, unspecified site
M11232	Other chondrocalcinosis, left wrist
M11239	Other chondrocalcinosis, unspecified wrist
M11261	Other chondrocalcinosis, right knee
M1129	Other chondrocalcinosis, multiple sites
M1180	Other specified crystal arthropathies, unspecified site
M1230	Palindromic rheumatism, unspecified site
M1239	Palindromic rheumatism, multiple sites
M1280	Other specific arthropathies, not elsewhere classified, unspecified site
M12811	Other specific arthropathies, not elsewhere classified, right shoulder
M12849	Other specific arthropathies, not elsewhere classified, unspecified hand

Code	Description
M129	Arthropathy, unspecified
M130	Polyarthritis, unspecified
M1310	Monoarthritis, not elsewhere classified, unspecified site
M13111	Monoarthritis, not elsewhere classified, right shoulder
M13161	Monoarthritis, not elsewhere classified, right knee
M13162	Monoarthritis, not elsewhere classified, left knee
M13171	Monoarthritis, not elsewhere classified, right ankle and foot
M1380	Other specified arthritis, unspecified site
M13832	Other specified arthritis, left wrist
M13839	Other specified arthritis, unspecified wrist
M13841	Other specified arthritis, right hand
M13842	Other specified arthritis, left hand
M13849	Other specified arthritis, unspecified hand
M13851	Other specified arthritis, right hip
M13861	Other specified arthritis, right knee
M13862	Other specified arthritis, left knee
M13872	Other specified arthritis, left ankle, and foot
M1388	Other specified arthritis, other site
M1389	Other specified arthritis, multiple sites
M14672	Charcôt's joint, left ankle and foot
M150	Primary generalized (osteo)arthritis
M151	Heberden's nodes (with arthropathy)
M154	Erosive (osteo)arthritis
M158	Other polyosteoarthritis
M159	Polyosteoarthritis, unspecified
M160	Bilateral primary osteoarthritis of hip
M180	Bilateral primary osteoarthritis of first carpometacarpal joints
M1990	Unspecified osteoarthritis, unspecified site
M1993	Secondary osteoarthritis, unspecified site
M1A00X0	Idiopathic chronic gout, unspecified site, without tophus (tophi)
M1A0710	Idiopathic chronic gout, right ankle, and foot, without tophus (tophi)
M1A09X0	Idiopathic chronic gout, multiple sites, without tophus (tophi)
M1A09X1	Idiopathic chronic gout, multiple sites, with tophus (tophi)
M1A1720	Lead-induced chronic gout, left ankle, and foot, without tophus (tophi)
M1A9XX0	Chronic gout, unspecified, without tophus (tophi)
M272	Inflammatory conditions of jaws
M300	Polyarteritis nodosa

Code	Description
M301	Polyarteritis with lung involvement [Churg-Strauss]
M302	Juvenile polyarteritis
M310	Hypersensitivity angiitis
M3130	Wegener's granulomatosis without renal involvement
M3131	Wegener's granulomatosis with renal involvement
M314	Aortic arch syndrome [Takayasu]
M315	Giant cell arteritis with polymyalgia rheumatica
M316	Other giant cell arteritis
M317	Microscopic polyangiitis
M318	Other specified necrotizing vasculopathies
M320	Drug-induced systemic lupus erythematosus
M3210	Systemic lupus erythematosus, organ, or system involvement unspecified
M3212	Pericarditis in systemic lupus erythematosus
M3214	Glomerular disease in systemic lupus erythematosus
M3219	Other organ or system involvement in systemic lupus erythematosus
M328	Other forms of systemic lupus erythematosus
M329	Systemic lupus erythematosus, unspecified
M3310	Other dermatomyositis, organ involvement unspecified
M3320	Polymyositis, organ involvement unspecified
M3322	Polymyositis with myopathy
M3390	Dermatopolymyositis, unspecified, organ involvement unspecified
M3392	Dermatopolymyositis, unspecified with myopathy
M3393	Dermatopolymyositis, unspecified without myopathy
M3399	Dermatopolymyositis, unspecified with other organ involvement
M340	Progressive systemic sclerosis
M341	CR(E)ST syndrome
M3489	Other systemic sclerosis
M349	Systemic sclerosis, unspecified
M3500	Sicca syndrome, unspecified
M3501	Sicca syndrome with keratoconjunctivitis
M3502	Sicca syndrome with lung involvement
M3509	Sicca syndrome with other organ involvement
M351	Other overlap syndromes
M352	Behçet's disease
M353	Polymyalgia rheumatica
M355	Multifocal fibrosclerosis
M357	Hypermobility syndrome

Code	Description
M358	Other specified systemic involvement of connective tissue
M359	Systemic involvement of connective tissue, unspecified
M368	Systemic disorders of connective tissue in other diseases classified elsewhere
N049	Nephrotic syndrome with unspecified morphologic changes
N052	Unspecified nephritic syndrome with diffuse membranous glomerulonephritis
N057	Unspecified nephritic syndrome with diffuse crescentic glomerulonephritis
N059	Unspecified nephritic syndrome with unspecified morphologic changes
N069	Isolated proteinuria with unspecified morphologic lesion
N10	Acute pyelonephritis
N12	Tubulo-interstitial nephritis, not specified as acute or chronic
N179	Acute kidney failure, unspecified
N182	Chronic kidney disease, stage 2 (mild)
N183	Chronic kidney disease, stage 3 (moderate)
N184	Chronic kidney disease, stage 4 (severe)
N185	Chronic kidney disease, stage 5
N186	End stage renal disease
N189	Chronic kidney disease, unspecified
N200	Calculus of kidney
N2889	Other specified disorders of kidney and ureter
N289	Disorder of kidney and ureter, unspecified
N3001	Acute cystitis with hematuria
N3010	Interstitial cystitis (chronic) without hematuria
N3090	Cystitis, unspecified without hematuria
N3289	Other specified disorders of bladder
N342	Other urethritis
N368	Other specified disorders of urethra
N399	Disorder of urinary system, unspecified
N710	Acute inflammatory disease of uterus
N730	Acute parametritis and pelvic cellulitis
N738	Other specified female pelvic inflammatory diseases
N739	Female pelvic inflammatory disease, unspecified
O368210	Fetal anemia and thrombocytopenia, first trimester, not applicable or unspecified
O99012	Anemia complicating pregnancy, second trimester
R051	Acute cough
R052	Subacute cough
R053	Chronic cough
R054	Cough syncope

Code	Description
R058	Other specified cough
R059	Cough unspecified
R29818	Other symptoms and signs involving the nervous system
R29898	Other symptoms and signs involving the musculoskeletal system
R2990	Unspecified symptoms and signs involving the nervous system
R2991	Unspecified symptoms and signs involving the musculoskeletal system
R51	Headache
R634	Abnormal weight loss
R768	Other specified abnormal immunological findings in serum
R769	Abnormal immunological finding in serum, unspecified
R779	Abnormality of plasma protein, unspecified
T883XXD	Malignant hyperthermia due to anesthesia, subsequent encounter
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z09	Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
Z4732	Aftercare following explantation of hip joint prosthesis
Z4781	Encounter for orthopedic aftercare following surgical amputation
Z4789	Encounter for other orthopedic aftercare
Z4822	Encounter for aftercare following kidney transplant
Z4823	Encounter for aftercare following liver transplant
Z48812	Encounter for surgical aftercare following surgery on the circulatory system
Z48815	Encounter for surgical aftercare following surgery on the digestive system
Z4889	Encounter for other specified surgical aftercare
Z5111	Encounter for antineoplastic chemotherapy
Z5112	Encounter for antineoplastic immunotherapy

Folic Acid

Code	Description
D510	Vitamin B12 deficiency anemia due to intrinsic factor deficiency
D511	Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria
D513	Other dietary vitamin B12 deficiency anemia
D518	Other vitamin B12 deficiency anemias
D519	Vitamin B12 deficiency anemia, unspecified
D528	Other folate deficiency anemias
D529	Folate deficiency anemia, unspecified
D531	Other megaloblastic anemias, not elsewhere classified
D538	Other specified nutritional anemias
D539	Nutritional anemia, unspecified

Code	Description
D649	Anemia, unspecified
D696	Thrombocytopenia, unspecified
D8689	Sarcoidosis of other sites
D869	Sarcoidosis, unspecified
E08311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E0840	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E088	Diabetes mellitus due to underlying condition with unspecified complications
E089	Diabetes mellitus due to underlying condition without complications
E1010	Type 1 diabetes mellitus with ketoacidosis without coma
E1022	Type 1 diabetes mellitus with diabetic chronic kidney disease
E1029	Type 1 diabetes mellitus with other diabetic kidney complication
E10319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E103293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E103299	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye
E103391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E1040	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E1042	Type 1 diabetes mellitus with diabetic polyneuropathy
E1049	Type 1 diabetes mellitus with other diabetic neurological complication
E10621	Type 1 diabetes mellitus with foot ulcer
E10649	Type 1 diabetes mellitus with hypoglycemia without coma
E1065	Type 1 diabetes mellitus with hyperglycemia
E108	Type 1 diabetes mellitus with unspecified complications
E109	Type 1 diabetes mellitus without complications
E1100	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E1110	Type 2 diabetes mellitus with ketoacidosis without coma
E1121	Type 2 diabetes mellitus with diabetic nephropathy
E1122	Type 2 diabetes mellitus with diabetic chronic kidney disease
E1129	Type 2 diabetes mellitus with other diabetic kidney complication
E11319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E113293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E113411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E1136	Type 2 diabetes mellitus with diabetic cataract
E1137X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E1139	Type 2 diabetes mellitus with other diabetic ophthalmic complication
E1140	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E1141	Type 2 diabetes mellitus with diabetic mononeuropathy
E1142	Type 2 diabetes mellitus with diabetic polyneuropathy

Code	Description
E1143	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E1149	Type 2 diabetes mellitus with other diabetic neurological complication
E1151	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E1159	Type 2 diabetes mellitus with other circulatory complications
E11610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E11621	Type 2 diabetes mellitus with foot ulcer
E1165	Type 2 diabetes mellitus with hyperglycemia
E1169	Type 2 diabetes mellitus with other specified complication
E118	Type 2 diabetes mellitus with unspecified complications
E119	Type 2 diabetes mellitus without complications
E1300	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E1322	Other specified diabetes mellitus with diabetic chronic kidney disease
E138	Other specified diabetes mellitus with unspecified complications
E139	Other specified diabetes mellitus without complications
E538	Deficiency of other specified B group vitamins
E539	Vitamin B deficiency, unspecified
E569	Vitamin deficiency, unspecified
E639	Nutritional deficiency, unspecified
E7211	Homocystinuria
E7212	Methylenetetrahydrofolate reductase deficiency
F0390	Unspecified dementia without behavioral disturbance
F509	Eating disorder, unspecified
G309	Alzheimer's disease, unspecified
G40109	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus
G40209	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
G40219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
G40309	Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40409	Other generalized epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40804	Other epilepsy, intractable, without status epilepticus
G4089	Other seizures
G40901	Epilepsy, unspecified, not intractable, with status epilepticus
G40909	Epilepsy, unspecified, not intractable, without status epilepticus
G40911	Epilepsy, unspecified, intractable, with status epilepticus
G40919	Epilepsy, unspecified, intractable, without status epilepticus
G40B09	Juvenile myoclonic epilepsy, not intractable, without status epilepticus

Code	Description
G609	Hereditary and idiopathic neuropathy, unspecified
G629	Polyneuropathy, unspecified
G63	Polyneuropathy in diseases classified elsewhere
G7000	Myasthenia gravis without (acute) exacerbation
H44139	Sympathetic uveitis, unspecified eye
H44539	Leucocoria, unspecified eye
H4612	Retrobulbar neuritis, left eye
H463	Toxic optic neuropathy
H469	Unspecified optic neuritis
K120	Recurrent oral aphthae
K121	Other forms of stomatitis
K1230	Oral mucositis (ulcerative), unspecified
K130	Diseases of lips
K1379	Other lesions of oral mucosa
K140	Glossitis
K141	Geographic tongue
K146	Glossodynia
K149	Disease of tongue, unspecified
K5000	Crohn's disease of small intestine without complications
K50011	Crohn's disease of small intestine with rectal bleeding
K50018	Crohn's disease of small intestine with other complication
K5010	Crohn's disease of large intestine without complications
K50111	Crohn's disease of large intestine with rectal bleeding
K50118	Crohn's disease of large intestine with other complication
K50119	Crohn's disease of large intestine with unspecified complications
K5080	Crohn's disease of both small and large intestine without complications
K50811	Crohn's disease of both small and large intestine with rectal bleeding
K50813	Crohn's disease of both small and large intestine with fistula
K50818	Crohn's disease of both small and large intestine with other complication
K5090	Crohn's disease, unspecified, without complications
K50913	Crohn's disease, unspecified, with fistula
K50919	Crohn's disease, unspecified, with unspecified complications
K5100	Ulcerative (chronic) pancolitis without complications
K51011	Ulcerative (chronic) pancolitis with rectal bleeding
K5120	Ulcerative (chronic) proctitis without complications
K51211	Ulcerative (chronic) proctitis with rectal bleeding
K5130	Ulcerative (chronic) rectosigmoiditis without complications

Code	Description
K51311	Ulcerative (chronic) rectosigmoiditis with rectal bleeding
K51419	Inflammatory polyps of colon with unspecified complications
K5180	Other ulcerative colitis without complications
K51818	Other ulcerative colitis with other complication
K5190	Ulcerative colitis, unspecified, without complications
K51911	Ulcerative colitis, unspecified with rectal bleeding
K51918	Ulcerative colitis, unspecified with other complication
K51919	Ulcerative colitis, unspecified with unspecified complications
K523	Indeterminate colitis
K52831	Collagenous colitis
K52832	Lymphocytic colitis
K5289	Other specified noninfective gastroenteritis and colitis
K529	Noninfective gastroenteritis and colitis, unspecified
K900	Celiac disease
K9049	Malabsorption due to intolerance, not elsewhere classified
K9089	Other intestinal malabsorption
K909	Intestinal malabsorption, unspecified
K912	Postsurgical malabsorption, not elsewhere classified
K929	Disease of digestive system, unspecified
L2089	Other atopic dermatitis
L209	Atopic dermatitis, unspecified
L219	Seborrheic dermatitis, unspecified
L282	Other prurigo
L298	Other pruritus
L299	Pruritus, unspecified
L301	Dyshidrosis [pompholyx]
L309	Dermatitis, unspecified
L400	Psoriasis vulgaris
L401	Generalized pustular psoriasis
L4050	Arthropathic psoriasis, unspecified
L4059	Other psoriatic arthropathy
L409	Psoriasis, unspecified
L439	Lichen planus, unspecified
L499	Exfoliation due to erythematous condition involving 90 or more percent of body surface
L819	Disorder of pigmentation, unspecified
L930	Discoid lupus erythematosus
L989	Disorder of the skin and subcutaneous tissue, unspecified

Code	Description
M0579	Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
M05849	Other rheumatoid arthritis with rheumatoid factor of unspecified hand
M0589	Other rheumatoid arthritis with rheumatoid factor of multiple sites
M059	Rheumatoid arthritis with rheumatoid factor, unspecified
M06041	Rheumatoid arthritis without rheumatoid factor, right hand
M0609	Rheumatoid arthritis without rheumatoid factor, multiple sites
M064	Inflammatory polyarthropathy
M0680	Other specified rheumatoid arthritis, unspecified site
M069	Rheumatoid arthritis, unspecified
M0829	Juvenile rheumatoid arthritis with systemic onset, multiple sites
M1000	Idiopathic gout, unspecified site
M10031	Idiopathic gout, right wrist
M10472	Other secondary gout, left ankle, and foot
M109	Gout, unspecified
M119	Crystal arthropathy, unspecified
M129	Arthropathy, unspecified
M130	Polyarthritis, unspecified
M3210	Systemic lupus erythematosus, organ, or system involvement unspecified
M3214	Glomerular disease in systemic lupus erythematosus
M328	Other forms of systemic lupus erythematosus
M329	Systemic lupus erythematosus, unspecified
M3390	Dermatopolymyositis, unspecified, organ involvement unspecified
M3392	Dermatopolymyositis, unspecified with myopathy
M349	Systemic sclerosis, unspecified
M3500	Sicca syndrome, unspecified
M3501	Sicca syndrome with keratoconjunctivitis
M353	Polymyalgia rheumatica
M359	Systemic involvement of connective tissue, unspecified
M450	Ankylosing spondylitis of multiple sites in spine
M455	Ankylosing spondylitis of thoracolumbar region
M461	Sacroiliitis, not elsewhere classified
M4690	Unspecified inflammatory spondylopathy, site unspecified
N186	End stage renal disease
N19	Unspecified kidney failure
O0901	Supervision of pregnancy with history of infertility, first trimester
O09291	Supervision of pregnancy with other poor reproductive or obstetric history, first trimester
O0940	Supervision of pregnancy with grand multiparity, unspecified trimester

Code	Description
O0942	Supervision of pregnancy with grand multiparity, second trimester
O0943	Supervision of pregnancy with grand multiparity, third trimester
O09521	Supervision of elderly multigravida, first trimester
O09522	Supervision of elderly multigravida, second trimester
O09523	Supervision of elderly multigravida, third trimester
O09893	Supervision of other high-risk pregnancies, third trimester
O0992	Supervision of high-risk pregnancy, unspecified, second trimester
O0993	Supervision of high-risk pregnancy, unspecified, third trimester
O10912	Unspecified pre-existing hypertension complicating pregnancy, second trimester
O163	Unspecified maternal hypertension, third trimester
O24011	Pre-existing type 1 diabetes mellitus, in pregnancy, first trimester
O24919	Unspecified diabetes mellitus in pregnancy, unspecified trimester
O26843	Uterine size-date discrepancy, third trimester
O26891	Other specified pregnancy related conditions, first trimester
O26893	Other specified pregnancy related conditions, third trimester
O2691	Pregnancy related conditions, unspecified, first trimester
O358XX0	Maternal care for other (suspected) fetal abnormality and damage, not applicable or unspecified
O3680X0	Pregnancy with inconclusive fetal viability, not applicable or unspecified
O368210	Fetal anemia and thrombocytopenia, first trimester, not applicable or unspecified
O99011	Anemia complicating pregnancy, first trimester
O99012	Anemia complicating pregnancy, second trimester
O99013	Anemia complicating pregnancy, third trimester
O99019	Anemia complicating pregnancy, unspecified trimester
O99281	Endocrine, nutritional, and metabolic diseases complicating pregnancy, first trimester
O99841	Bariatric surgery status complicating pregnancy, first trimester
O99842	Bariatric surgery status complicating pregnancy, second trimester
O99843	Bariatric surgery status complicating pregnancy, third trimester
R200	Anesthesia of skin
R202	Paresthesia of skin
R203	Hyperesthesia
R208	Other disturbances of skin sensation
R209	Unspecified disturbances of skin sensation
R231	Pallor
R233	Spontaneous ecchymoses
R238	Other skin changes
R269	Unspecified abnormalities of gait and mobility
R413	Other amnesia

Code	Description
Z1321	Encounter for screening for nutritional disorder
Z3401	Encounter for supervision of normal first pregnancy, first trimester
Z3402	Encounter for supervision of normal first pregnancy, second trimester
Z3403	Encounter for supervision of normal first pregnancy, third trimester
Z3481	Encounter for supervision of other normal pregnancy, first trimester
Z3482	Encounter for supervision of other normal pregnancy, second trimester
Z3483	Encounter for supervision of other normal pregnancy, third trimester
Z3490	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z3491	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z3492	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z3493	Encounter for supervision of normal pregnancy, unspecified, third trimester
Z369	Encounter for antenatal screening, unspecified
Z79899	Other long term (current) drug therapy
Z940	Kidney transplant status
Z941	Heart transplant status
Z944	Liver transplant status
Z9884	Bariatric surgery status
Z992	Dependence on renal dialysis

Triiodothyroxine-T3 Free

Code	Description
C73	Malignant neoplasm of thyroid gland
C7989	Secondary malignant neoplasm of other specified sites
C799	Secondary malignant neoplasm of unspecified site
D34	Benign neoplasm of thyroid gland
D497	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
D510	Vitamin B12 deficiency anemia due to intrinsic factor deficiency
D539	Nutritional anemia, unspecified
D6489	Other specified anemias
D649	Anemia, unspecified
D8989	Other specified disorders involving the immune mechanism, not elsewhere classified
E009	Congenital iodine-deficiency syndrome, unspecified
E010	Iodine-deficiency related diffuse (endemic) goiter
E02	Subclinical iodine-deficiency hypothyroidism
E030	Congenital hypothyroidism with diffuse goiter
E031	Congenital hypothyroidism without goiter
E032	Hypothyroidism due to medicaments and other exogenous substances

Code	Description
E034	Atrophy of thyroid (acquired)
E038	Other specified hypothyroidism
E039	Hypothyroidism, unspecified
E040	Nontoxic diffuse goiter
E041	Nontoxic single thyroid nodule
E042	Nontoxic multinodular goiter
E049	Nontoxic goiter, unspecified
E0500	Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
E0510	Thyrotoxicosis with toxic single thyroid nodule without thyrotoxic crisis or storm
E0520	Thyrotoxicosis with toxic multinodular goiter without thyrotoxic crisis or storm
E0521	Thyrotoxicosis with toxic multinodular goiter with thyrotoxic crisis or storm
E0530	Thyrotoxicosis from ectopic thyroid tissue without thyrotoxic crisis or storm
E0540	Thyrotoxicosis factitia without thyrotoxic crisis or storm
E0580	Other thyrotoxicosis without thyrotoxic crisis or storm
E0590	Thyrotoxicosis, unspecified without thyrotoxic crisis or storm
E0591	Thyrotoxicosis, unspecified with thyrotoxic crisis or storm
E060	Acute thyroiditis
E061	Subacute thyroiditis
E063	Autoimmune thyroiditis
E065	Other chronic thyroiditis
E069	Thyroiditis, unspecified
E0789	Other specified disorders of thyroid
E079	Disorder of thyroid, unspecified
E1029	Type 1 diabetes mellitus with other diabetic kidney complication
E1040	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E1051	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E1065	Type 1 diabetes mellitus with hyperglycemia
E108	Type 1 diabetes mellitus with unspecified complications
E109	Type 1 diabetes mellitus without complications
E1121	Type 2 diabetes mellitus with diabetic nephropathy
E1122	Type 2 diabetes mellitus with diabetic chronic kidney disease
E1129	Type 2 diabetes mellitus with other diabetic kidney complication
E113293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E1140	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E1142	Type 2 diabetes mellitus with diabetic polyneuropathy
E1159	Type 2 diabetes mellitus with other circulatory complications
E1165	Type 2 diabetes mellitus with hyperglycemia

Code	Description
E1169	Type 2 diabetes mellitus with other specified complication
E118	Type 2 diabetes mellitus with unspecified complications
E119	Type 2 diabetes mellitus without complications
E1300	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E139	Other specified diabetes mellitus without complications
E209	Hypoparathyroidism, unspecified
E220	Acromegaly and pituitary gigantism
E221	Hyperprolactinemia
E229	Hyperfunction of pituitary gland, unspecified
E230	Hypopituitarism
E278	Other specified disorders of adrenal gland
E279	Disorder of adrenal gland, unspecified
E28310	Symptomatic premature menopause
E2839	Other primary ovarian failure
E291	Testicular hypofunction
E7800	Pure hypercholesterolemia, unspecified
E781	Pure hyperglyceridemia
E782	Mixed hyperlipidemia
E784	Other hyperlipidemia
E7841	Elevated Lipoprotein(a)
E7849	Other hyperlipidemia
E785	Hyperlipidemia, unspecified
E8351	Hypocalcemia
E8352	Hypercalcemia
E871	Hypo-osmolality and hyponatremia
E890	Postprocedural hypothyroidism
E892	Postprocedural hypoparathyroidism
F3130	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disorder, current episode depressed, severe, without psychotic features
F315	Bipolar disorder, current episode depressed, severe, with psychotic features
F3160	Bipolar disorder, current episode mixed, unspecified
F3170	Bipolar disorder, currently in remission, most recent episode unspecified
F3181	Bipolar II disorder
F319	Bipolar disorder, unspecified
F322	Major depressive disorder, single episode, severe without psychotic features
F3281	Premenstrual dysphoric disorder

Code	Description
F3289	Other specified depressive episodes
F329	Major depressive disorder, single episode, unspecified
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate
F332	Major depressive disorder, recurrent severe without psychotic features
F333	Major depressive disorder, recurrent, severe with psychotic symptoms
F339	Major depressive disorder, recurrent, unspecified
F341	Dysthymic disorder
F3481	Disruptive mood dysregulation disorder
F3489	Other specified persistent mood disorders
F39	Unspecified mood [affective] disorder
F410	Panic disorder [episodic paroxysmal anxiety]
F411	Generalized anxiety disorder
F418	Other specified anxiety disorders
F419	Anxiety disorder, unspecified
G250	Essential tremor
G3184	Mild cognitive impairment, so stated
G4700	Insomnia, unspecified
G4730	Sleep apnea, unspecified
G4739	Other sleep apnea
G479	Sleep disorder, unspecified
G5603	Carpal tunnel syndrome, bilateral upper limbs
G609	Hereditary and idiopathic neuropathy, unspecified
G933	Post viral fatigue syndrome
H0520	Unspecified exophthalmos
H05242	Constant exophthalmos, left eye
H4900	Third [oculomotor] nerve palsy, unspecified eye
H4920	Sixth [abducent] nerve palsy, unspecified eye
H4922	Sixth [abducent] nerve palsy, left eye
I10	Essential (primary) hypertension
I129	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I1310	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
J9691	Respiratory failure, unspecified with hypoxia
K5090	Crohn's disease, unspecified, without complications
K582	Mixed irritable bowel syndrome
K5900	Constipation, unspecified

Code	Description
L299	Pruritus, unspecified
L601	Onycholysis
L608	Other nail disorders
L630	Alopecia (capitis) totalis
L639	Alopecia areata, unspecified
L649	Androgenic alopecia, unspecified
L658	Other specified nonscarring hair loss
L659	Nonscarring hair loss, unspecified
L80	Vitiligo
M3210	Systemic lupus erythematosus, organ, or system involvement unspecified
M329	Systemic lupus erythematosus, unspecified
M3500	Sicca syndrome, unspecified
M3501	Sicca syndrome with keratoconjunctivitis
M359	Systemic involvement of connective tissue, unspecified
M360	Dermato(poly)myositis in neoplastic disease
M797	Fibromyalgia
M818	Other osteoporosis without current pathological fracture
N910	Primary amenorrhea
N911	Secondary amenorrhea
N912	Amenorrhea, unspecified
N914	Secondary oligomenorrhea
N915	Oligomenorrhea, unspecified
N920	Excessive and frequent menstruation with regular cycle
N925	Other specified irregular menstruation
N926	Irregular menstruation, unspecified
N945	Secondary dysmenorrhea
N946	Dysmenorrhea, unspecified
O905	Postpartum thyroiditis
O99280	Endocrine, nutritional, and metabolic diseases complicating pregnancy, unspecified trimester
O99281	Endocrine, nutritional, and metabolic diseases complicating pregnancy, first trimester
O99282	Endocrine, nutritional, and metabolic diseases complicating pregnancy, second trimester
O99283	Endocrine, nutritional, and metabolic diseases complicating pregnancy, third trimester
R000	Tachycardia, unspecified
R001	Bradycardia, unspecified
R002	Palpitations
R0600	Dyspnea, unspecified
R0609	Other forms of dyspnea

Code	Description
R0683	Snoring
R070	Pain in throat
R1310	Dysphagia, unspecified
R194	Change in bowel habit
R197	Diarrhea, unspecified
R200	Anesthesia of skin
R202	Paresthesia of skin
R208	Other disturbances of skin sensation
R251	Tremor, unspecified
R252	Cramp and spasm
R270	Ataxia, unspecified
R279	Unspecified lack of coordination
R404	Transient alteration of awareness
R410	Disorientation, unspecified
R413	Other amnesia
R4182	Altered mental status, unspecified
R4189	Other symptoms and signs involving cognitive functions and awareness
R419	Unspecified symptoms and signs involving cognitive functions and awareness
R4582	Worries
R490	Dysphonia
R509	Fever, unspecified
R52	Pain, unspecified
R531	Weakness
R5381	Other malaise
R5382	Chronic fatigue, unspecified
R5383	Other fatigue
R600	Localized edema
R609	Edema, unspecified
R61	Generalized hyperhidrosis
R634	Abnormal weight loss
R635	Abnormal weight gain
R6889	Other general symptoms and signs
R7303	Prediabetes
R946	Abnormal results of thyroid function studies
Z09	Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
Z79891	Long term (current) use of opiate analgesic
Z79899	Other long term (current) drug therapy

Code	Description
Z85850	Personal history of malignant neoplasm of thyroid
Z862	Personal history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z8639	Personal history of other endocrine, nutritional and metabolic disease

Triiodothyronine-T3 Total

Principal Diagnosis	Principal Diagnosis Description
C569	Malignant neoplasm of unspecified ovary
C7989	Secondary malignant neoplasm of other specified sites
C7A8	Other malignant neuroendocrine tumors
D34	Benign neoplasm of thyroid gland
D352	Benign neoplasm of pituitary gland
D497	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
D510	Vitamin B12 deficiency anemia due to intrinsic factor deficiency
D539	Nutritional anemia, unspecified
D6489	Other specified anemias
D649	Anemia, unspecified
D8989	Other specified disorders involving the immune mechanism, not elsewhere classified
E010	Iodine-deficiency related diffuse (endemic) goiter
E011	Iodine-deficiency related multinodular (endemic) goiter
E018	Other iodine-deficiency related thyroid disorders and allied conditions
E02	Subclinical iodine-deficiency hypothyroidism
E030	Congenital hypothyroidism with diffuse goiter
E031	Congenital hypothyroidism without goiter
E032	Hypothyroidism due to medicaments and other exogenous substances
E033	Postinfectious hypothyroidism
E034	Atrophy of thyroid (acquired)
E038	Other specified hypothyroidism
E039	Hypothyroidism, unspecified
E040	Nontoxic diffuse goiter
E041	Nontoxic single thyroid nodule
E042	Nontoxic multinodular goiter
E048	Other specified nontoxic goiter
E049	Nontoxic goiter, unspecified
E0500	Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
E0501	Thyrotoxicosis with diffuse goiter with thyrotoxic crisis or storm
E0520	Thyrotoxicosis with toxic multinodular goiter without thyrotoxic crisis or storm

Principal Diagnosis	Principal Diagnosis Description
E0521	Thyrotoxicosis with toxic multinodular goiter with thyrotoxic crisis or storm
E0540	Thyrotoxicosis factitia without thyrotoxic crisis or storm
E0580	Other thyrotoxicosis without thyrotoxic crisis or storm
E0590	Thyrotoxicosis, unspecified without thyrotoxic crisis or storm
E0591	Thyrotoxicosis, unspecified with thyrotoxic crisis or storm
E061	Subacute thyroiditis
E063	Autoimmune thyroiditis
E064	Drug-induced thyroiditis
E069	Thyroiditis, unspecified
E071	Dyshormogenetic goiter
E0789	Other specified disorders of thyroid
E079	Disorder of thyroid, unspecified
E0810	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E0840	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E089	Diabetes mellitus due to underlying condition without complications
E099	Drug or chemical induced diabetes mellitus without complications
E1010	Type 1 diabetes mellitus with ketoacidosis without coma
E1021	Type 1 diabetes mellitus with diabetic nephropathy
E1040	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E1042	Type 1 diabetes mellitus with diabetic polyneuropathy
E10621	Type 1 diabetes mellitus with foot ulcer
E1065	Type 1 diabetes mellitus with hyperglycemia
E1069	Type 1 diabetes mellitus with other specified complication
E108	Type 1 diabetes mellitus with unspecified complications
E109	Type 1 diabetes mellitus without complications
E1121	Type 2 diabetes mellitus with diabetic nephropathy
E1122	Type 2 diabetes mellitus with diabetic chronic kidney disease
E1129	Type 2 diabetes mellitus with other diabetic kidney complication
E1140	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E1142	Type 2 diabetes mellitus with diabetic polyneuropathy
E1143	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E1151	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E1159	Type 2 diabetes mellitus with other circulatory complications
E11610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E1165	Type 2 diabetes mellitus with hyperglycemia
E1169	Type 2 diabetes mellitus with other specified complication
E118	Type 2 diabetes mellitus with unspecified complications

Principal Diagnosis	Principal Diagnosis Description
E119	Type 2 diabetes mellitus without complications
E1300	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E139	Other specified diabetes mellitus without complications
E208	Other hypoparathyroidism
E221	Hyperprolactinemia
E229	Hyperfunction of pituitary gland, unspecified
E230	Hypopituitarism
E236	Other disorders of pituitary gland
E272	Addisonian crisis
E2740	Unspecified adrenocortical insufficiency
E291	Testicular hypofunction
E319	Polyglandular dysfunction, unspecified
E440	Moderate protein-calorie malnutrition
E441	Mild protein-calorie malnutrition
E7800	Pure hypercholesterolemia, unspecified
E7801	Familial hypercholesterolemia
E781	Pure hyperglyceridemia
E782	Mixed hyperlipidemia
E7841	Elevated Lipoprotein(a)
E7849	Other hyperlipidemia
E785	Hyperlipidemia, unspecified
E8351	Hypocalcemia
E8352	Hypercalcemia
E8359	Other disorders of calcium metabolism
E871	Hypo-osmolality and hyponatremia
E890	Postprocedural hypothyroidism
E892	Postprocedural hypoparathyroidism
F0390	Unspecified dementia without behavioral disturbance
F0633	Mood disorder due to known physiological condition with manic features
F064	Anxiety disorder due to known physiological condition
F310	Bipolar disorder, current episode hypomanic
F3110	Bipolar disorder, current episode manic without psychotic features, unspecified
F3112	Bipolar disorder, current episode manic without psychotic features, moderate
F3113	Bipolar disorder, current episode manic without psychotic features, severe
F312	Bipolar disorder, current episode manic severe with psychotic features
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disorder, current episode depressed, severe, without psychotic features

Principal Diagnosis	Principal Diagnosis Description
F315	Bipolar disorder, current episode depressed, severe, with psychotic features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disorder, current episode mixed, severe, without psychotic features
F3175	Bipolar disorder, in partial remission, most recent episode depressed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified
F320	Major depressive disorder, single episode, mild
F321	Major depressive disorder, single episode, moderate
F322	Major depressive disorder, single episode, severe without psychotic features
F3281	Premenstrual dysphoric disorder
F3289	Other specified depressive episodes
F329	Major depressive disorder, single episode, unspecified
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate
F332	Major depressive disorder, recurrent severe without psychotic features
F333	Major depressive disorder, recurrent, severe with psychotic symptoms
F338	Other recurrent depressive disorders
F339	Major depressive disorder, recurrent, unspecified
F3481	Disruptive mood dysregulation disorder
F39	Unspecified mood [affective] disorder
F410	Panic disorder [episodic paroxysmal anxiety]
F411	Generalized anxiety disorder
F418	Other specified anxiety disorders
F419	Anxiety disorder, unspecified
G250	Essential tremor
G300	Alzheimer's disease with early onset
G301	Alzheimer's disease with late onset
G309	Alzheimer's disease, unspecified
G3184	Mild cognitive impairment, so stated
G4700	Insomnia, unspecified
G4739	Other sleep apnea
G5601	Carpal tunnel syndrome, right upper limb
G5602	Carpal tunnel syndrome, left upper limb
G5603	Carpal tunnel syndrome, bilateral upper limbs

Principal Diagnosis	Principal Diagnosis Description
G609	Hereditary and idiopathic neuropathy, unspecified
H0520	Unspecified exophthalmos
H05241	Constant exophthalmos, right eye
H0589	Other disorders of orbit
H4920	Sixth [abducent] nerve palsy, unspecified eye
H4921	Sixth [abducent] nerve palsy, right eye
H532	Diplopia
I10	Essential (primary) hypertension
I129	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I471	Supraventricular tachycardia
I480	Paroxysmal atrial fibrillation
I481	Persistent atrial fibrillation
I482	Chronic atrial fibrillation
I4891	Unspecified atrial fibrillation
I499	Cardiac arrhythmia, unspecified
I5020	Unspecified systolic (congestive) heart failure
I5022	Chronic systolic (congestive) heart failure
I5023	Acute on chronic systolic (congestive) heart failure
I5030	Unspecified diastolic (congestive) heart failure
I5032	Chronic diastolic (congestive) heart failure
I5042	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I509	Heart failure, unspecified
I517	Cardiomegaly
J9601	Acute respiratory failure with hypoxia
K5900	Constipation, unspecified
K5901	Slow transit constipation
K5909	Other constipation
L299	Pruritus, unspecified
L630	Alopecia (capitis) totalis
L638	Other alopecia areata
L639	Alopecia areata, unspecified
L648	Other androgenic alopecia
L649	Androgenic alopecia, unspecified
L650	Telogen effluvium
L658	Other specified nonscarring hair loss
L659	Nonscarring hair loss, unspecified
M3210	Systemic lupus erythematosus, organ, or system involvement unspecified

Principal Diagnosis	Principal Diagnosis Description
M329	Systemic lupus erythematosus, unspecified
M349	Systemic sclerosis, unspecified
M3500	Sicca syndrome, unspecified
M3501	Sicca syndrome with keratoconjunctivitis
M351	Other overlap syndromes
M359	Systemic involvement of connective tissue, unspecified
M6080	Other myositis, unspecified site
M791	Myalgia
M7910	Myalgia, unspecified site
M818	Other osteoporosis without current pathological fracture
N910	Primary amenorrhea
N911	Secondary amenorrhea
N912	Amenorrhea, unspecified
N913	Primary oligomenorrhea
N914	Secondary oligomenorrhea
N915	Oligomenorrhea, unspecified
N920	Excessive and frequent menstruation with regular cycle
N921	Excessive and frequent menstruation with irregular cycle
N926	Irregular menstruation, unspecified
N944	Primary dysmenorrhea
N946	Dysmenorrhea, unspecified
O905	Postpartum thyroiditis
O99280	Endocrine, nutritional, and metabolic diseases complicating pregnancy, unspecified trimester
O99281	Endocrine, nutritional, and metabolic diseases complicating pregnancy, first trimester
O99283	Endocrine, nutritional, and metabolic diseases complicating pregnancy, third trimester
R000	Tachycardia, unspecified
R001	Bradycardia, unspecified
R002	Palpitations
R0600	Dyspnea, unspecified
R0609	Other forms of dyspnea
R0683	Snoring
R0989	Other specified symptoms and signs involving the circulatory and respiratory systems
R1310	Dysphagia, unspecified
R1319	Other dysphagia
R194	Change in bowel habit
R197	Diarrhea, unspecified
R200	Anesthesia of skin

Principal Diagnosis	Principal Diagnosis Description
R201	Hypoesthesia of skin
R202	Paresthesia of skin
R208	Other disturbances of skin sensation
R238	Other skin changes
R251	Tremor, unspecified
R252	Cramp and spasm
R253	Fasciculation
R259	Unspecified abnormal involuntary movements
R270	Ataxia, unspecified
R292	Abnormal reflex
R400	Somnolence
R410	Disorientation, unspecified
R413	Other amnesia
R4182	Altered mental status, unspecified
R450	Nervousness
R4702	Dysphasia
R4781	Slurred speech
R4789	Other speech disturbances
R509	Fever, unspecified
R530	Neoplastic (malignant) related fatigue
R531	Weakness
R5381	Other malaise
R5382	Chronic fatigue, unspecified
R5383	Other fatigue
R600	Localized edema
R609	Edema, unspecified
R61	Generalized hyperhidrosis
R630	Anorexia
R632	Polyphagia
R634	Abnormal weight loss
R635	Abnormal weight gain
R6889	Other general symptoms and signs
R7303	Prediabetes
R946	Abnormal results of thyroid function studies
Z7984	Long term (current) use of oral hypoglycemic drugs
Z79899	Other long term (current) drug therapy
Z85850	Personal history of malignant neoplasm of thyroid

Principal Diagnosis	Principal Diagnosis Description
Z862	Personal history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z8639	Personal history of other endocrine, nutritional and metabolic disease
C73	Malignant neoplasm of thyroid gland
M797	Fibromyalgia
Z8632	Personal history of gestational diabetes

History

March 1, 2020	Policy reviewed and approved with changes
December 1, 2020	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with changes
September 1, 2021	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with changes
December 1, 2022	Policy reviewed and approved with changes

Durable Medical Equipment

Last Reviewed Date: March 1, 2023
Related Policies: Home Infusion Policy

DURABLE MEDICAL EQUIPMENT

Policy

The DME and Orthotics & Prosthetics Coverage and Purchasing Guidelines apply to all MVP participating DME, Orthotics, prosthetics, and specialty providers 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.

Durable Medical Equipment (DME) Rental vs. Purchase

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. Monthly rentals cannot exceed capped rental period of 10 or 13-months of continuous use. At that time (end of 10 or 13-month rental) ownership of the equipment passes to the member.

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

DME rental fees will cover the cost of maintenance, repairs, replacement, supplies and accessories during the rental. Equipment delivery services and set-up, education and training for patient and family, and nursing visits, are not eligible for separate reimbursement.

MVP will only pay for the remainder of the capped consecutive rental period when the rental started under a previous insurer and the item is medically necessary. The DME provider would need to indicate the start date and how many months were rented under the previous insurer when requesting prior authorization for the continued rental through MVP.

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 provider's contracted rate with MVP.

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:

- Medicare Payment Guidelines for some DME as indicated in this document.
- MVP follows the Pricing, Data, Analysis and Coding (PDAC) Contractor for assignment of HCPCS codes and product classification: https://www4.palmettogba.com/pdac_dmecs/
- MVP does not cover spare or back-up equipment. Claims for backup equipment will be denied as not medically necessary.
- This policy relates to the payment of DME items and equipment only; please refer to MVP 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.

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 Member'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 disabled).

However, an institution may not be considered a Member's 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

HCPCS Modifiers: MVP requires the use of the following Medicare modifiers:

MVP requires the use of the following Medicare modifiers:

Code	Description	Rule
NU	Purchased/new equipment	• Submit with HCPCS DME code to indicate a purchase
RR	Rental use	• Submit with HCPCS DME code to indicate a rental

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

Referral/Notification/Prior Authorization Requests

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

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

The list is updated periodically and is located on the MVP website in the Provider section, under Reference Library. You can access the document by clicking here.

Items and/or services requiring prior authorization:

- Complete the Prior Authorization Request Form (PARF)
- Can be submitted online or faxed to **1-888-452-5947** unless otherwise noted below
- Be sure to include 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. Call **1-800-684-9286**
- 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.

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 follows the allowed units of service published by Medicare. Code K0739 should be billed with one unit of service for each 15 minutes. Suppliers are not paid for travel time, equipment pickup and/or delivery, or postage.

If the repair is urgent and can be completed on site, submit a prior authorization request with the actual number of repair units required within three calendar days and we will approve this for the date that the work was completed. Please make sure you state the actual date the work was completed.

If the repair cannot be completed on site and/or parts are needed, submit a prior authorization request with the anticipated number of repair units and parts and we will review this request.

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

Replacement DME

Replacement requests and 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.

Repair or replacement of durable medical equipment which becomes unusable or nonfunctioning because of individual misuse, abuse, or neglect is not covered under MVP contracts.

Replacement of DME due to manufacturer recall are the responsibility of the manufacturer. Replacement DME only due to changes in technology without improved outcomes are not medically necessary and will result in claims denials.

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	No prior authorization is required. The initial CPAP rental is for up to three months. In order to continue rental, DME providers must contact Members and confirm compliance via objective reporting from the device and maintain copies of member compliance records per CMS's document retention requirements. Adherence to PAP therapy is defined as use of PAP >4 hours per night on 70% of the nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. Member compliance and DME provider record retention may be subject to retrospective review. 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.	No prior authorization is required. The initial BiPAP rental is for up to three months. In order to continue rental, DME providers must contact Members and confirm compliance via objective reporting from the device and maintain copies of member compliance records per CMS's document retention requirements. Adherence to PAP therapy is defined as use of PAP >4 hours per night on 70% of the nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. Member compliance and DME provider record retention may be subject to retrospective review. Please refer to MVP's Medical Policy to determine medical necessity and rules regarding BiPAP machine compliance. • All BiPAP machines are a 13-month rental. • All heated humidifiers are a 10-month rental.
A4604	Tubing with integrated heating element	• 1 per three months
A7027	Combo oral/nasal mask	• 1 per three months
A7028	Oral cushion for combo oral nasal mask	• 2 per one month
A7029	Nasal pillows	• 2 per one month
A7030	Full Face Masks	• 1 per three months
A7031	Face mask interface	• 1 per month
A7032	Replacement Cushions	• 2 per one month
A7033	Replacement Pillows	• 2 per one month

Code	Description	Rule
A7034	CPAP Masks	• 1 per three months
A7035	CPAP Headgears	• 1 per six months
A7036	CPAP Chin Straps	• 1 per six months
A7037	CPAP Tubing	• 1 per three months
A7038	CPAP Filters	• 2 per one month
A7039	CPAP non-disposable filters	• 1 per six months
A7046	Water chamber	• 1 per six months
A7047	Oral interface used with respiratory suction pump	• Not covered for Commercial, ASO and Medicaid Plans

DME Equipment

Code	Description	Rule
E0935	Continuous Passive Motion Device	• One unit equals one day of rental. • Coverage is limited to 21 days following surgery. • Please refer to MVP Medical Policy for additional information.
A5500–A5501	Diabetic Shoes	• MVP will not reimburse for diabetic shoes when billed for more than 2 units (1 pair) within a calendar year (A5500). • MVP will not reimburse for custom molded diabetic shoes with inserts when billed for more. • 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. A5500- RT x 1; A5500-LT x1 for one pair. • Medicaid Managed Care Plans: allow one pair per year when medical policy criteria are met.
A5512-A5513	Diabetic Shoe Inserts	• MVP 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. A5513- RT x 3; A5513-LT x3 for three pair. • Medicaid Managed Care Plans: allowed one pair per year when medical policy criteria are met.
A5508 & A5510	Diabetic Shoes	• MVP does not cover these codes.

Code	Description	Rule
L3000-L3214 L3224 L3649	Foot Orthotics	• Foot orthotics are not covered unless the contract specifically states they are covered. Refer to the specific plan 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: Follows the New York State Medicaid Program Durable Medical Equipment, Prosthetics, Orthotics and Supplies Procedures Codes and Coverage Guidelines • 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 Respiratory Equipment

Code	Description	Rule
E0424, E0431, E0433, E0434, E0439, E0441, E0442, E0443, E0444, E1390, E1391, E1392,E1405, E1406, K0738	Oxygen Equipment and Supplies.	• MVP does not follow the Medicare 36 month cap for oxygen. This applies to all lines of business. • MVP allows monthly payment for oxygen equipment as long as medically necessary.
E0425, E0430, E0435, E0440, E1353, E1355	Oxygen Equipment and Supplies.	• MVP does not purchase Oxygen or Oxygen Equipment.
E0445	Oximeters	• MVP allows monthly payment. Probes are inclusive during the rental period.
A4606	Oximeter Replacement Probe	• Commercial Plans: Covered if contract allows disposable medical supplies and oximeter is owned by Member. • Medicaid Managed Care Plans: Included in rental of oximeter device
E0465, E0466, E0467	Ventilators for home use	• The monthly rental payment for items in this pricing category is all-inclusive meaning there is no separate payment by MVP for any options, accessories or supplies used with a ventilator • All necessary maintenance, servicing, repairs, and replacement are also included in the monthly rental • Backup equipment must be distinguished from multiple medically necessary items which are defined as identical or similar devices, each of which meets a different medical need for the beneficiary. Although MVP does not pay separately for backup equipment, MVP will make a separate payment for a second piece of equipment if it is required to serve a different medical purpose that is determined by the beneficiary's medical needs.

Transcutaneous Electrical Nerve Stimulation (TENS)

Code	Description	Rule
E0720, E0730	Transcutaneous electrical nerve stimulation (TENS) Device.	• MVP allows for the purchase of TENS units. • These cannot be prescribed by Chiropractors or therapists; they must be prescribed by a physician. • Medicaid Managed Care Plans are not covered for E0720.
A4556,A4557, A4595 and A4630	Transcutaneous electrical nerve stimulations (TENS) Supplies.	• Supplies are not covered as a DME benefit. 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

Medicaid Managed Care and HARP plans

Effective April 1, 2023, providers are no longer able to bill MVP Medicaid Managed Care Plan or HARP members for pharmacy and pharmacy related durable medical equipment and supplies. This includes certain DME, enteral and parenteral nutrition, family planning supplies, medical/surgical supplies, miscellaneous supplies, and hearing aid batteries as designated by the New York State Department of Health. The full list of codes that must be billed to Medicaid Fee-For-Service is located at here (refer to the **OTC and Supply Fee Schedule**).

Providers should bill these codes directly to New York State Medicaid Fee-For-Service using the Medicaid member client identification number (CIN) beginning April 1, 2023. Claims submitted directly to MVP for items that are carved out to Fee-For-Service will be denied as not a Covered Benefit.

Commercial, Medicare and ASO plans

Required medical/dressing supplies can be obtained by the Member from an MVP-contracted DME provider with a physician's prescription. MVP will not reimburse for disposable medical and surgical supplies unless Member's 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
Various HCPCS codes	Disposable Supplies; Medical and Surgical Supplies	• Commercial Products: MVP will not reimburse for these supplies unless the contract allows disposable medical supplies coverage. • Providers should check the Member's benefits to determine if this is covered under their plan. • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service • To determine if an item is considered disposable medical and surgical supplies, please call the MVP Customer Care Center.

Nebulizers

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

External Infusion Supplies

Code	Description	Rule
E0784	Insulin Pump	• MVP covers the purchase of this item according to the provider's contract. • Providers should check the Member's benefits to determine how these are covered under their individual plan. • Refer to MVP's Medical Policies for additional information.
A9274	External Ambulatory Delivery System (Disposable Insulin Pump)	• MVP covers the purchase of this item according to the provider's contract. • Providers should check the Member's benefits to determine how these are covered under their individual plan. • Allowed up to 30 per month; up to 90 units once every 90 days. • There is a 5 day grace period allowed for shipping/billing on the 85th day. • This item is not covered under Medicare Part B, coverage may be available under Medicare Part D pharmacy benefits.
A4230	Infusion Set – Cannula Type	• Covered as diabetic management supplies and can be billed to MVP. • These supplies may also be obtained from an MVP participating pharmacy. • Allowed up to 20 per month; up to 60 units once every 90 days • There is a 5 day grace period allowed for shipping/billing on the 85th day. • Vermont Exchange (on and off) Products: Diabetic Supplies are covered under the member pharmacy benefit and must be submitted through an MVP pharmacy carrier. • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service
A4231	Infusion Set – Needle Type	
A4232	Syringe/reservoirs	
A4224, A4225	Supplies for insulin pump	• Covered as diabetic management supplies but all inclusive and includes cannula and all supplies for insulin pump.
K0552, A4221, A4222	Supplies for External Infusion Pum	• Invalid for submission for all MVP plans. • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service

Blood Glucose Monitoring

Review rules to determine if billed through MVP Medical or Pharmacy Benefit:

Code	Description	Rule
E0607	Blood Glucose Monitor	• MVP will not reimburse DME providers for Blood Glucose Monitoring machines • Blood Glucose Monitors must be obtained from an MVP participating pharmacy or through one of the preferred monitor free access program
A4259 and A4253	Blood Glucose testing supplies.	• Blood Glucose Supplies must be obtained from an MVP participating pharmacy for all lines of business. • Prior authorization is required for non- preferred test strips
A4238	Sensor; for use with Continuous Glucose Monitoring System	• 1 unit = 1 month supply • 3 month supply = 3 unit of service • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service • Covered benefit for Commercial, ASO Products, and Medicare plans
E2102	Receiver (monitor) for use with adjunctive Continuous Glucose Monitoring System	• Only one (1) Receiver allowed at one time; no duplicates or back-up allowed • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service • Commercial, Medicare,ASO covered under the Member diabetic benefit and can be billed to MVP through the medical benefit. Refer to MVP Medical Policy for coverage information
A4239	Supply allowance for non-adjunctive glucose monitor (CGM), includes all supplies and accessories	• 1 unit = 1 month supply • 3 month supply = 3 unit of service • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service • Covered benefit for Commercial, ASO Products, and Medicare plans
E2103	Receiver (monitor) for use with non-adjunctive continuous glucose monitor system	• Only one (1) Receiver allowed at one time; no duplicates or back-up allowed • Covered benefit for Commercial, ASO Products, and Medicare plans • Must meet FDA approval as Therapeutic CGMS. See MVP Medical Policy for details • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service

Tracheostomy Care Supplies

Code	Description	Rule
A7520-A7522	Tracheostomy/ Laryngectomy Tube	• MVP does cover this code under the Member's DME benefit
L8501	Tracheostomy Speaking Valve	• MVP does cover this code under the Member's DME benefit
A4625 and A4629	Tracheostomy Care Kit	• MVP does cover this code if the Member's contract covers disposable medical supplies
A4623	Tracheostomy disposable inner cannula	• MVP does cover this item if the Member's contract covers disposable medical supplies • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service

Code	Description	Rule
A4626	Tracheostomy cleaning brush	• MVP does cover this item if the Member's contract covers disposable medical supplies; cannot be billed at the same time as A4625 and A4629.
A4625	Tracheal Suction Catheter (not closed)	• MVP does cover this item if the Member's contract covers disposable medical supplies • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service
A7523	Tracheostomy Shower Protector	• MVP does cover this item if the Member's contract covers disposable medical supplies • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service
A7524	Tracheostomy Plug/ Button	• MVP does cover this item if the Member's contract covers disposable medical supplies

Ostomy Supplies

Code	Description	Rule
A4361-A4435 A5051-A5093 A5119-A5200	Ostomy codes.	• MVP does reimburse for these items under the Member's DME benefits. These items do not require the disposable coverage or rider • MVP follows the Medicare guidelines for quantity limits • May be provided from either MVP participating DME or pharmacy providers • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service

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

Medicare Ostomy LCD link:
https://med.noridianmedicare.com/documents/2230703/7218263/Ostomy+Supplies+LCD+and+PA/

Incontinence Supplies

• MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service

The following Incontinence supplies are not reimbursed/not covered for Commercial, ASO and Medicare plans: A4335, A4554, T4521, T4522, T4523, T4524, T4529, T4530, T4533, T4535, T4537, T4539, T4540, T4543.

Prosthetics

The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable to MVP Health Care under the prosthetic benefit: evaluation of the residual limb and gait, fitting of the prosthesis, cost of base component parts and labor contained in HCPCS base codes, repairs due to normal wear or tear within 90 days of delivery, adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the Member's functional abilities.

Repairs to a prosthesis are covered when necessary to make the prosthesis functional.

Code L7510 is used to bill for any "minor" materials (i.e., those without specific HCPCS codes) used to achieve the adjustment and/or repair.

Code L7520 is used to bill for labor associated with adjustments and repairs that either do not involve replacement parts or that involve replacement parts billed with code L7510. Code L7520 must not be billed for labor time involved in the replacement of parts that are billed with a specific HCPCS code. Labor is included in the allowance for those codes.

Except for items described by specific HCPCS codes, there should be no separate billing and there is no separate payment for a component or feature of a microprocessor-controlled knee or foot, including but not limited to real time gait analysis, continuous gait assessment, or electronically controlled static stance regulator.

Payment for a prosthesis is included in the payment to a hospital if:

- The prosthesis is provided to a Member during an inpatient hospital stay prior to the day of discharge
- The Member uses the prosthesis for reasonable and necessary inpatient treatment or rehabilitation

Orthotic and Scoliosis Bracing

There is no separate payment if CAD-CAM or 3-D printing technology is used to fabricate an orthosis. Reimbursement is included in the allowance of the codes for custom fabricated orthoses. Fabrication of an orthosis using CAD/CAM or similar technology without the creation of a positive model with minimal self-adjustment at delivery is considered as off-the-shelf (OTS).

There is no separate allowance for the following (included in orthosis):

- Additional fabrication time of an orthosis
- Consult and evaluation
- Digital scanning and casting
- Fabricating an orthosis
- Fitting of orthosis
- Follow up appointments
- Model modification
- Use of CAD-CAM technology
- X-Ray evaluation

The use of HCPCS code L0999 (addition to spinal orthosis, not otherwise specified) or L1499 (spinal orthosis, not otherwise specified) must not be used to bill for any features or functions included in the base code nor should it be used when a specific L-code exists. Use of these two codes in these circumstances is considered incorrect coding (unbundling).

HCPCS codes L1499 and L0999 should not be used as base codes for a scoliosis orthosis.

There are 5 base Healthcare Common Procedure Codes (HCPCS) available to fully describe scoliosis braces. The Rigo Cheneau (WCR) (NYRC) brace, the custom Boston scoliosis brace, the Charleston brace, and the Providence brace are properly described by Healthcare Common Procedure Code System (HCPCS) code L1300.

Three HCPCS codes: L1005, L1300, and L1310 are all inclusive and are not billed with addition codes. The use of addition codes with these three codes will be considered incorrect coding (unbundling).

History

April 1, 2019	Policy approved
March 1, 2021	Policy reviewed and approved with changes
June 1, 2022	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with changes

Elective Delivery for Providers and Facilities

Last Reviewed Date: June 1, 2022

Policy

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

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

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

For Provider Claims

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

U7 – Delivery less than 39 weeks for medical necessity	**Full payment**
U8 – Delivery less than 39 weeks electively	**Reduced payment**
U9 – Delivery 39 weeks or greater	**Full payment**

Fee-for-Service Procedure Codes Requiring a Modifier

CPT Procedure Codes	Description
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps), and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery (with or without episiotomy and/or forceps); including postpartum care

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

For Facility Claims

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

Condition code 81 – C-sections or inductions performed at less than 39 weeks gestation for medical necessity.	**Full payment**
Condition code 82 – C-sections or inductions performed at less than 39 weeks gestation electively.	**Reduced payment**
Condition code 83 – C-sections or inductions performed at 39 weeks gestation or greater.	**Full payment**

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

Fee-For-Service ICD-10 Procedure Codes Requiring a Condition Code when a C-Section or Induction of Labor Occurs

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

CPT Procedure Codes	Description
10900ZC	Drainage of amniotic fluid, therapeutic from products of conception, open approach
10903ZC	Drainage of amniotic fluid, therapeutic from products of conception, open approach

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

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

References

New York State Medical Updates:
health.ny.gov/health_care/medicaid/program/update/2015/2015-04.htm

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

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

New York State Medicaid Obstetrical Deliveries Prior to 39 Weeks Gestation
https://www.emedny.org/ProviderManuals/communications/OBSTETRICAL_DELIVERIES_PRIOR_TO_39_WEEKS_GESTATION.pdf

ICD-10 Coding Changes
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

History

December 1, 2018	Policy approved
December 1, 2019	Policy approved with no changes
March 1, 2021	Policy reviewed and approved with no changes
June 1, 2022	Policy reviewed and approved with no changes

Emergency Department - Physician

Last Reviewed Date: December 1, 2022

Policy

All Emergency Department (ED) services 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 a 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

In New York, a medical emergency is defined as a medical or behavioral condition, when onset 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, 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:

A. Placing the member's physical or mental health in serious jeopardy; or

B. Serious impairment to bodily functions; or

C. Serious dysfunction of any bodily organ or part.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Evaluation and Management

Code	Description	Rule
99281	Evaluation and Management within the Emergency Room	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • a problem-focused history; • a problem-focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.
99282	Evaluation and Management within the Emergency Room	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283	Evaluation and Management within the Emergency Room	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	Evaluation and Management within the Emergency Room	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • a detailed history; • a detailed examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Evaluation and Management within the Emergency Room	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

Documentation of 99285 ED Services

All patient presenting problems must medically necessitate the extent of the history, exam and/or discussion noted.

The overall medical decision making will be the overarching criterion in determining if a visit is coded appropriately.

The volume of documentation alone will not be the sole determinant of whether 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:

> "Because of [insert reason] I was unable to secure a comprehensive HPI and/or perform a comprehensive examination today."

Possible conditions could be, but are 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.

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	This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate].
99218	Initial observation care per day for the evaluation and management of a patient	This code requires these three key components: • 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.
99219	Initial observation care, per day, for the evaluation and management of a patient	This code requires these three 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.

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

Infusion/Injection Services

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

EKGs

Code	Description	Rule
93040	Rhythm ECG, 1-3 leads; with interpretation and report	Emergency Room physicians will not be reimbursed for EKG interpretation.
93041	Rhythm ECG, 1-3 leads; tracing only without interpretation and report	Emergency Room physicians will not be reimbursed for EKG interpretation.
93042	Rhythm ECG, 1-3 leads; interpretation and report only	Emergency Room physicians will not be reimbursed for EKG interpretation.

Resources

CMS IOM Publication 100-04, Chapter 12, Section 30.6.11 and 30.6.12.H

History

June 1, 2019	Policy approved
June 1, 2020	Policy reviewed and approved with no changes
September 1, 2021	Policy reviewed and approved with changes
December 1, 2022	Policy reviewed and approved with no changes

EyeMed Payment Policy

Last Reviewed Date – December 1, 2022

Policy

MVP partner's with EyeMed to cover routine eye care for specific MVP Members. MVP will continue to cover claims for medical eye care. To determine what is covered by EyeMed or MVP, please review the CPT codes and Diagnosis codes that will be billed to each. To determine if a Members' plan utilizes the EyeMed network for routine vision care, review the Member's ID card for the EyeMed emblem, or review the Members benefits on the MVP online benefits display.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's Utilization Management Guides to determine if prior authorization is required, and the Benefit Interpretation Manual for MVP's clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Routine Only Eye Care

When the following CPT codes are billed, claims should be sent to EyeMed:

Vision CPT/HCPCS Codes	Description
92310	Fitting contact lens
92352	Fitting of spectacle prosthesis for aphakia
92353	Fitting of spectacle prosthesis for multifocal
92354	Fitting of spectacle mounted low vision aid
92355	Fitting of spectacle mounted low vision aid
S0500	Disposable contact lens, per lens
S0504	Single vision prescription lens (safety, athletic, or sunglass), per lens
S0506	Bifocal Cal vision prescription lens (safety, athletic, or sunglass), per lens
S0508	Trifocal vision prescription lens (safety, athletic, or sunglass), per lens
S0510	Non-prescription lens (safety, athletic, or sunglass), per lens
S0512	Daily wear specialty contact lens, per lens
S0514	Color contact lens, per lens

Vision CPT/HCPCS Codes	Description
S0580	Polycarbonate lens (list this code in addition to the basic code for the lens)
S0581	Nonstandard lens (list this code in addition to the basic code for the lens)
V2025	Eyeglasses deluxe frames
V2702	Deluxe lens feature
V2710	Glass/plastic slab off prism
V2715	Prism lens
V2718	Fresnell prism press-on lens
V2730	Special base curve
V2756	Eye glass case
V2760	Scratch resistant coating
V2761	Mirror coating, any type, solid, gradient, or equal, any lens material, per lens
V2770	Occluder lens
V2781	Progressive lens per lens
V2786	Specialty occupational multifocal lens, per lens
V2797	Vision supply, accessory and/or service component of another HCPCS vision code
V2799	Miscellaneous vision service

Medical Only Eye Care

When the following CPT codes are billed for medical eye care, claims would be sent directly to MVP:

Vision CPT/HCPCS Codes	Description
92018	Eye exam/evaluation, under general anesthesia; complete
92019	Eye exam/ evaluation, under general anesthesia; limited
92020	Gonioscopy w/medical dx evaluation
92025	Corneal topography
92060	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
92065	Orthoptic and/or preoptic training
92071	Fitting of contact lens for treatment of ocular surface disease

Vision CPT/HCPCS Codes	Description
92081	Visual field/medical exam; limited; unilateral or bilateral
92082	Exam visual field intermediate
92083	Visual field/medical exam; extended
92100	Serial tonometry/medical exam; Multiple measurements
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with unilateral, or bilateral, with interpretation and report
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with unilateral, or bilateral, with interpretation and report
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with unilateral, or bilateral, with interpretation and report
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report
92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation
92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with unilateral, or bilateral, with interpretation and report lateral
92227	Imaging of retina for detection or monitoring of disease
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review
92230	Ophthalmoscopy; fluorescein angioscopy
92235	Ophthalmoscopy, with DX eval; with multiframe procedures
92240	Indocyanine-green angiography with interpretation and report
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report
92250	Ophthalmoscopy; with fundus photography
92260	Ophthalmoscpy; with ophthalmodynamometer
92265	Oculoelectromyogrphy,1/mre musc/eye
92270	Electroretinography (ERG) with DX evaluation
92273	Electroretinography (ERG), with interpretation and report; full field -ie, fferg, flash erg, ganzfeld erg
92274	Electroretinography (ERG) with interpretation and report; multifocal -mferg
92283	Color vision exam, extended

Vision CPT/HCPCS Codes	Description
92284	Dark adaptation exam w/medical DX evaluation
92285	External Ocular photography, with DX evaluation
92286	Anterior seg. Photography; with DX evaluation; spec. Endo
92287	Anterior seg. Photography; fluorscn angio
92313	Prescribe/fit contact lens; corneoscleral
92314	Prescribe/fit contact lens, tech; cor, 2 eyes
92315	Prescribe/fit con. lens, tech; aphak,1eye
92316	Prescribe/fit con. lens, tech; corneal-apha
92317	Prescribe/fit contact lens, tech; corneoscl
92325	Modification of contact lens
92358	Prosth.service for aphakia, temporary
92371	Repr/refit spect; prosth. for aphakia
92499	Unlisted ophthalmological service or pro
C1841	Retinal prosthesis, includes all internal and external components
V2623	Plastic eye prosth custom
V2624	Polishing artificial eye
V2625	Enlargement of eye prosthesis
V2626	Reduction of eye prosthesis
V2627	Scleral cover shell
V2628	Fabrication & fitting
V2629	Prosthetic eye other type
V2785	Corneal tissue processing
V2787	Astigmatism correcting function of intraocular lens
V2788	Presbyopia correcting function of intraocular lens
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral, or bilateral, with interpretation and report
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report
0341T	Quantitative pupillometry with unilateral, or bilateral, with interpretation and report lateral

Vision CPT/HCPCS Codes	Description
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient-initiated data transmitted to a remote surveillance center for up to
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (dm)
2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: without evidence of retinopathy (dm)
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: without evidence of retinopathy (DM)

Routine and Medical Care with Diagnosis Specific Requirements

Bill to EyeMed

When billing the CPT/HCPCS codes below with one of the following routine ICD-10 codes claims should be billed to EyeMed:

CPT/HCPCS Codes	Claims
H5200	Hypermetropia, unspecified eye
H5201	Hypermetropia, right eye
H5202	Hypermetropia, left eye
H5203	Hypermetropia, bilateral
H5210	Myopia, unspecified eye
H5211	Myopia, right eye
H5212	Myopia, left eye
H5213	Myopia, bilateral
H52201	Unspecified astigmatism, right eye
H52202	Unspecified astigmatism, left eye
H52203	Unspecified astigmatism, bilateral
H52209	Unspecified astigmatism, unspecified eye
H52211	Irregular astigmatism, right eye
H52212	Irregular astigmatism, left eye

CPT/HCPCS Codes	Claims
H52213	Irregular astigmatism, bilateral
H52219	Irregular astigmatism, unspecified eye
H52221	Regular astigmatism, right eye
H52222	Regular astigmatism, left eye
H52223	Regular astigmatism, bilateral
H52229	Regular astigmatism, unspecified eye
H5231	Anisometropia
H524	Presbyopia
H52521	Paresis of accommodation, right eye
H52522	Paresis of accommodation, left eye
H52523	Paresis of accommodation, bilateral
H52529	Paresis of accommodation, unspecified eye
H526	Other disorders of refraction
H527	Unspecified disorder of refraction
H53041	Amblyopia Suspect right eye
H53042	Amblyopia Suspect left eye
H53043	Amblyopia Suspect Bilateral
H53049	Amblyopia Suspect Unspecified eye
Z0100	Encounter for exam of eyes and vision w/o abnormal findings
Z0101	Encounter for exam of eyes and vision w abnormal findings
H52511	Internal ophthalmoplegia (complete) (total), right eye
H52512	Internal ophthalmoplegia (complete) (total), left eye
H52513	Internal ophthalmoplegia (complete) (total), bilateral
H52519	Internal ophthalmoplegia (complete) (total), unspecified eye
H52531	Spasm of accommodation, right eye
H52532	Spasm of accommodation, left eye
H52533	Spasm of accommodation, bilateral

CPT/HCPCS Codes	Claims
H52539	Spasm of accommodation, unspecified eye
H53001	Unspecified amblyopia, right eye
H53002	Unspecified amblyopia, left eye
H53003	Unspecified amblyopia, bilateral
H53009	Unspecified amblyopia, unspecified eye
H53011	Deprivation amblyopia, right eye
H53012	Deprivation amblyopia, left eye
H53013	Deprivation amblyopia, bilateral
H53019	Deprivation amblyopia, unspecified eye
H53021	Refractive amblyopia, right eye
H53022	Refractive amblyopia, left eye
H53023	Refractive amblyopia, bilateral
H53029	Refractive amblyopia, unspecified eye
H53031	Strabismic amblyopia, right eye
H53032	Strabismic amblyopia, left eye
H53033	Strabismic amblyopia, bilateral
H53039	Strabismic amblyopia, unspecified eye
H53141	Visual discomfort, right eye
H53142	Visual discomfort, left eye
H53143	Visual discomfort, bilateral
H53149	Visual discomfort, unspecified

Bill to MVP

When billing the CPT/HCPCS codes below with the ICD-10 Code of H5232, Aniseikonia, the claim should be billed to MVP:

Vision CPT/HCPCS Codes	Description
92002	Ophthalmologic. Serv; intermediate
92004	Eye exam, comprehansive,1or more session
92012	Eye exam; intermediate, estab. Pt

Vision CPT/HCPCS Codes	Description
92014	Comprehensive, established patient
92015	Determination of refractive state
92072	Fitting of contact lens for management of keratoconus, initial fitting
92311	Prescribe/fit contact lens, aphakia,1 eye
92312	Prescribe/fit contact lens, aphakia,2 eyes
92326	Replacement of contact lens
92340	Fit spectacle, not aphakia; monofocal
92341	Fit spectacles, not aphakia; bifocal
92342	Fit spectacles, not aphak; multifocal
92370	Repair/refit spectacles; except aphakia
S0590	Integral lens service, miscellaneous services reported separately
S0592	Comprehensive contact lens evaluation
S0620	Routine ophthalmological exam
S0621	Routine ophthalmological exam
V2020	Vision svcs frames purchases
V2100	Lens spherocylindrical single plano 4.00
V2101	Single vision spherocylindrical 4.12-7.00
V2102	Single vision spherocylindrical 7.12-20.00
V2103	Spherocylindrical 4.00d/12-2.00d
V2104	Spherocylinder4.00d/2.12-4d
V2105	Spherocylindrical 4.00d/4.25-6d
V2106	Spherocylindrical 4.00d/>6.00d
V2107	Spherocylindrical 4.25d/12-2d
V2108	Spherocylindrical 4.25d/2.12-4d
V2109	Spherocylindrical 4.25d/4.25-6d
V2110	Spherocylindrical 4.25d/over 6d
V2111	Spherocylinder7.25d/.25-2.25

Vision CPT/HCPCS Codes	Description
V2112	Spherocylinder7.25d/2.25-4d
V2113	Spherocylinder7.25d/4.25-6d
V2114	spherocylindrical over 12.00d
V2115	Lens lenticular bifocal
V2118	Lens aniseikonia single
V2121	Lenticular Lens, per Lens, single
V2199	Lens single vision
V2200	Lens spherocylindrical bifocal plano 4.00d
V2201	Lens spherocylindrical bifocal 4.12-7.0
V2202	Lens spherocylindrical bifocal 7.12-20.
V2203	Lens spherocylindrical bifocal 4.00d/.1
V2204	Lens spherocylindrical c 4.00d/2.1
V2205	Lens spherocylindrical bifocal 4.00d/4.2
V2206	Lens spherocylindrical bifocal 4.00d/Ove
V2207	Lens spherocylindrical bifocal 4.25-7d/.
V2208	Lens spherocylindrical bifocal 4.25-7/2.
V2209	Lens spherocylindrical bifocal 4.25-7/4.
V2210	Lens spherocylindrical bifocal 4.25-7/ova
V2211	Lens spherocylindrical bifocal 7.25-12/.25-
V2212	Lens spherocylindrical bifocal 7.25-12/2.2
V2213	Lens spherocylindrical bifocal 7.25-12/4.2
V2214	Lens spherocylindrical bifocal over 12.
V2215	Lens lenticular bifocal Cal
V2218	Lens aniseikonia bifocal
V2219	Lens bifocal Cal seg width over
V2220	Lens bifocal Cals add over 3.25d
V2221	Lenticular lens, per lens, bifocal Cal

Vision CPT/HCPCS Codes	Description
V2299	Lens bifocal Cal specialty
V2300	Lens spherocylindrical trifocal 4.00d
V2301	Lens supercollider trifocal 4.12-7.
V2302	Lens spherocylindrical trifocal 7.12-20
V2303	Lens supercollider trifocal 4.0/.12-
V2304	Lens spherocylindrical trifocal 4.0/2.25
V2305	Lens supercollider trifocal 4.0/4.25
V2306	Lens spherocylindrical trifocal 4.00/>6
V2307	Lens spherocylindrical trifocal 4.25-7/.
V2308	Lens spherocylindrical trifocal 4.25-7/2.
V2309	Lens spherocylindrical trifocal 4.25-7/4.
V2310	Lens spherocylindrical trifocal 4.25-7/>6
V2311	Lens spherocylindrical trifocal 7.25-12/.25-
V2312	Lens spherocylindrical trifocal 7.25-12/2.25
V2313	Lens spherocylindrical trifocal 7.25-12/4.25
V2314	Lens spherocylindrical trifocal over 12
V2315	Lens lenticular trifocal
V2318	Lens aniseikonia trifocal
V2319	Lens trifocal seg width > 28
V2320	Lens trifocals add over 3.25d
V2321	Lenticular lens, per lens, trifocal
V2399	Lens trifocal specialty
V2410	Lens variable a sphericity sing
V2430	Lens variable sphericity bi
V2499	Variable a sphericity lens
V2500	Contact lens pmma spherical
V2501	Contact lens pmma-toric/prism

Vision CPT/HCPCS Codes	Description
V2502	Contact lens pmma bifocal
V2503	Contact lens pmma color vision
V2510	Contact gas permeable spherical
V2511	Contact toric prism ballast
V2512	Contact lens gas perm bifocal
V2513	Contact lens extended wear
V2520	Contact lens hydrophilic
V2521	Contact lens hydrophilic toric
V2522	Contact lens hydrophile bifocal call
V2523	Contact lens hydrophile extend
V2530	Contact lens gas impermeable
V2531	Contact lens gas permeable
V2599	Contact lens/es other type
V2700	Balance lens
V2745	Addition to lens, tint, any color, solid, gradient, or equal, excludes photochromatic, any lens material, per lens
V2750	Anti-reflective coating
V2755	UV lens/es
V2762	Polarization, any lens material, per lens
V2780	Oversize lens/es
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2783	Lens, index greater than/equal to 1.66 plastic or greater than/equal to 1.80, excludes polycarbonate, per lens
V2784	Lens, polycarbonate or equal, qny index, per lens
V2744	Tint photochromatic lens/es
V2744U1	Tint photochromatic lens/es
V2744U2	Tint photochromatic lens/es
V2744U5	Tint photochromatic lens/es
V2744U6	Tint photochromatic lens/es

Vision CPT/HCPCS Codes	Description
V2744U7	Tint photochromatic lens/es
V2744U8	Tint photochromatic lens/es

History

December 1, 2021 – New policy, approved
December 1, 2022 Policy reviewed and approved with no changes

Eye Wear Coverage

MVP Health Care Medicaid Managed Care, Child Health Plus, HARP, and New York State Essential Plans 3 & 4 Only

Last Reviewed Date: September 1, 2022

Policy

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

Benefits

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

Notification / Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing / Coding Guidelines

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

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

References

eMedNY: Vision Care Policy Guidelines:
emedny.org/ProviderManuals/VisionCare/PDFS/VisionCare_Policy_Guidelines.pdf

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

March 1, 2019	Policy approved
March 1, 2020	Policy reviewed and approved with no changes
March 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes

Home Infusion

Last Reviewed Date: March 1, 2022
Related Policies: MVP Enteral Therapy
NDC Payment Policy
Benefit Interpretation Manual

Policy

All Emergency Department (ED) services 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 a 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

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.

Medical Necessity for Infusion Therapy

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

Infusion must be prescribed by an appropriately licensed prescriber as part of a treatment plan for a covered medical condition.

Administration of the drug via infusion therapy is medically necessary. Infusion therapy is prescribed only when the member's condition cannot be appropriately treated with alternative dosage forms of medication (e.g. oral, topical, or SQ) or the therapy is not available in alternative dosage forms and achieve the same or equivalent therapeutic effect.

All components of the infusion must meet medical necessity criteria and be medically necessary to treat the member's medical condition for the infusion to be covered.

Treatments can be safely administered in the home.

Services must be provided by a network/preferred home infusion therapy provider.

Peripherally Inserted Central Catheter (PICC) line placement does not guarantee approval or payment of the medication to be infused if the medication does not meet medical necessity criteria or requires prior authorization.

Types of Therapy

- Therapeutic (hydration or medication therapy – e.g. chemotherapy, IVIG)
- Prophylactic (Injections/infusions to prevent "side effects" – e.g. ondansetron)
- Nutritional (Parenteral / Enteral)

Total Parenteral Nutrition (TPN)

TPN is a form of nutrition that is delivered through a vein which may contain lipids, electrolytes, amino acids, trace elements, and vitamins.

Enteral Nutrition

Enteral nutrition is a form of nutrition that is delivered into the digestive system as a liquid. Enteral nutrition may be provided orally or through a feeding tube. Enteral products may be liquids or powders that are reconstituted to a liquid form. Refer to the MVP Enteral Policy for coverage criteria.

Per Diem Definition

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

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

Per Diem includes the following services/items:

1. Professional Pharmacy Services

- Continuing education to professional pharmacy staff
- Removal, storage, and disposal of infectious waste
- Maintaining accreditation

2. Dispensing

- Medication profile setup and drug utilization review
- Monitoring for potential drug interactions
- Sterile procedures including intravenous admixtures, clean room upkeep, vertical and horizontal laminar flow hood certification, and all other biomedical procedures necessary for a safe environment
- USP797 compliant sterile compounding of medications
- Patient counseling as required under OBRA 1990

3. Clinical Monitoring

- Development and implementation of pharmaceutical care plans
- Pharmacokinetic dosing
- Review and interpretation of patient test results

- Recommending dosage or medication changes based on clinical findings
- Initial and ongoing pharmacy patient assessment and clinical monitoring
- Measurement of field nursing competency with subsequent education and training
- Other professional and cognitive services as needed to clinically manage the patient pharmacy care

4. Care Coordination

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

5. Supplies and Equipment

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

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

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 Authorization Requests

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

Billing/Coding Guidelines

Anti-infective Therapy (antibiotics/antifungals/antivirals)

Code	Description	Rule
S9497	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are considered global to the per diem except nursing visits and drugs.
S9504	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are considered global to the per diem except nursing visits and drugs.
S9503	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are considered global to the per diem except nursing visits and drugs..
S9502	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• 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.
S9501	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are considered global to the per diem except nursing visits and drugs.

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

Chemotherapy

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

Enteral Nutrition Therapy

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

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

Code	Description	Rule
S9342	Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	• See above definition for per diem definition. Including or not limited to the HCPCS Code. • Enteral supplies (including but not limited to enteral feeding kits, pumps, and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles, and feeding bags, associated with enteral formulas. See MVP Enteral Therapy Benefit Interpretations for additional information.
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit* *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.	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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** - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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** - 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.

Code	Description	Rule
B4104	Additive for enteral formula (e.g., fiber)* *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.	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's *Benefit Interpretation Manual* to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps, and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles, and feeding bags, associated with enteral formulas. • **Exception** - Not covered for Medicare members. • **Exception** - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **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.

Code	Description	Rule
B4150	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	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **Exception** - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **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.

Code	Description	Rule
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **Exception** - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins, and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **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.

Code	Description	Rule
B4155	Enteral formula, nutritionally incomplete/ modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/ amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **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.
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **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.

Code	Description	Rule
B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **Exception** - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **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.

Code	Description	Rule
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **Exception** - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **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.

Code	Description	Rule
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agencies 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 if sole source nutrition. Enteral therapy may be obtained through a participating DME vendor, Home Infusion vendor, or PBM. • **Exception** - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

Hydration Therapy

Code	Description	Rule
S9374	Home infusion therapy, hydration therapy; 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9375	Home infusion therapy, hydration therapy; more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9376	Home infusion therapy, hydration therapy; more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9377	Home infusion therapy, hydration therapy; more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies (drugs and nursing visits coded separately), per diem	

Pain Management Infusion

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

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	

Code	Description	Rule
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	
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	

Code	Description	Rule
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	
S9355	Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9490	Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9361	Home infusion therapy, diuretic intravenous therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9558	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9537	Home therapy; hematopoietic hormone injection therapy (e.g., erythropoietin, G-CSF, GM- CSF); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9348	Home infusion therapy, sympathomimetic/ inotropic agent infusion therapy (e.g., Dobutamine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S5521	Home infusion therapy, all supplies (including catheter) necessary for a midline catheter insertion	
S5520	Home infusion therapy, all supplies (including catheter) necessary for a peripherally inserted central venous catheter (PICC) line insertion	

Code	Description	Rule
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	Documentation must be available for retrospective review. Should only be billed for a service or procedure that does not have a valid specific therapy code available.

J0640 (Leucovorin) and J0641 (Fusilev)

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

J0640 (Leucovorin)

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

J0641 (Fusilev) (requires prior authorization)

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

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

Code	Description	Rule
S5498	Home infusion therapy, catheter care/ maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem	

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

Home Nursing

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

Per Diem Code Modifiers

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

Nursing Services

Services are provided by an 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 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 online to the pharmacy benefits manager. Supplies required for the administration of the drug during the teaching visit are global to the service and are not reimbursable separately.

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

Billable Units

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

Code J0290 – Injection, ampicillin sodium, 500 mg

Injection, ampicillin sodium **500 mg/vial** = 1.0 billable unit	Injection, ampicillin sodium **1 gm/vial** = 2.0 billable units
Injection, ampicillin sodium **250 mg/vial** = 0.50 billable unit	Injection, ampicillin sodium **2 gm /vial** = 4.0 billable units
Injection, ampicillin sodium **125 mg/via**l = 0.25 billable unit	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 medications, 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

History

June 1, 2019	New policy, approved
June 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and apprroved with no changes

Incident to Guidelines

Last Reviewed Date: December 1, 2022

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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

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.

History

December 2, 2018	Policy approves
December 1, 2019	Policy reviewed and approved with no changes
September 1, 2021	Policy reviewed and approved with no changes
December 1, 2022	Policy reviewed and approved with no changes

Infusion Policy

Last Reviewed Date: March 1, 2022

Policy

MVP 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.

Medical Necessity for Infusion Therapy

Infused drug is determined to meet medical necessity criteria for infusion in office or outpatient facility site when home infusion is the preferred site of care. Refer to MVP Pharmacy policies for drugs subject to this requirement.

Types of Infusion

Push Technique: When medication is injected through a catheter placed in a vein or artery.

Intrathecal: When medication is injected into the spinal cord through a catheter placed through the space between the lower back bones (via lumbar puncture).

Medical Necessity for Infusion 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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP’s *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Drugs/Medications

MVP requires all providers to bill using the standard HCPCS and also the 11-digit National Drug Code (NDC) which represents the drug and drug strength, manufacturer and package size used/administered.

Some medications require prior authorization. Refer to the MVP Formulary for specific drugs that require prior authorization.

MVP will provide coverage for drugs that meet medical necessity criteria and meet the site of care requirements noted in this policy.

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

All components of the infusion/injection must meet medical necessity criteria and be medically necessary for the member's condition for the infusion/injection to be covered.

J0640 (Leucovorin) and J0641 (Fusilev)

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

J0640 (Leucovorin)

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

J0641 (Fusilev) (requires prior authorization)

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

Miscellaneous Drug Codes

Code	Description	Rule
A9699, J3490, J3590, J7199, J7599, J7699, J7799, J8499, J8999, J9999	Miscellaneous drug codes	Drugs over $50 must be reviewed by MVP and 1 of the following pieces of information must be submitted: • An invoice for the drug must be submitted with the claim. **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 are not limited to:

- Diluents/solution for administration of medication
- Flushing solution including heparin and saline

Refer to the MVP Formulary for medications that must be obtained from MVP's specialty pharmacy vendor. Diagnosis and quantity edits apply only when drugs are billed directly to MVP using the applicable J-code.

Peripherally Inserted Central Catheter (PICC) Line placement does not guarantee approval or payment of the medication to be infused if medication does not meet medical necessity criteria or requires prior authorization.

Drugs determined to be self-administrable and eligible for coverage under the Prescription Drug benefit.

Medicare Variation

All claims for enteral and parenteral products must meet the current NCD and/or LCD policies for coverage. All claims may be subject to retrospective review to determine coverage. Enteral nutrition which does not meet the coverage criteria identified in the NDC and/LCD and supplemental nutrition are not covered benefits under either Part B or Part D.

Parenteral nutrition, which does not meet the coverage criteria identified in the NCD and/or LCD, may be covered under the Part D benefit.

Intradialytic Parenteral Nutrition (IDPN) is considered a Part D compound and must be billed to the pharmacy vendor. Intraperitoneal Nutrition (IPN) is considered a Part B benefit, even when a pharmacy or home infusion vendor adds amino acids or other ingredients to the dialysate. Non- covered drugs such as sterile water are considered to be part of the per diem and should not be billed independently

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Velcade (bortezomib) Injection. Prescribing Information. Cambridge, MA: Millennium Pharm, Inc; 2012.

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Reclast (zoledronic acid Injection). Prescribing Information. East Hanover, NJ: Novartis Pharmaceutical Corporation; August 2011.

ZOFRAN® (ondansetron hydrochloride) Injection. Prescribing Information. Research Triangle Park, NC. GlaxoSmithKline; September 2011.

TAXOTERE® (docetaxel) Injection. Prescribing Information. Bridgewater, NJ: sanofi-aventis U.S. LLC. 2010.

National Government Services, Article for zoledronic acid (e.g. Zometa, Reclast) – related to LCD L25820 (A46096). Accessed 3/08/2012: cms.hhs.gov/mcd/results.asp?show=all&t=2009105112826.

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

History

March 1, 2019 New policy, approved
March 1, 2022 Policy reviewed and approved with no changes

Interpreter Services

Medicaid Products

Last Reviewed Date: March 1, 2023

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

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

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

NYS Medicaid Update: health.ny.gov/health_care/medicaid/program/update/2012/2012-10.htm

History

December 1, 2018	New policy, approved
December 1, 2019	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes

JW and JZ Modifiers

Last Reviewed Date: March 1, 2023

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

MVP Payment Polices are not a guarantee of payment. Providers must also confirm Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into the Provider's account at mvphealthcare.com.

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. The use of this modifier is not appropriate for drugs that are from multiple-dose containers. This program provides payment for the amount of drug or biological (hereafter "drug") 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 JW 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).

Under Medicare Part B only, the JZ modifier must be reported on a claim to attest that no amount of drug was discarded and eligible for payment. The JZ modifier is required when there are no discarded amounts of a single-dose container drug for which the JW modifier would be required if there were discarded amounts. The JZ modifier will be required on claims for single-dose container drugs to attest when there are no discarded amounts no later than July 1, 2023.

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 and JZ Modifier IS required if under Medicare Part B:

> 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. To attest that there was no waste, a JZ Modifier must be submitted.

References

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

Article - Billing and Coding: JW Modifier Billing Guidelines (A53024) (cms.gov)

Medicare Program Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy Frequently Asked Questions: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

History

September 1, 2018	New policy, approved
September 1, 2020	Policy reviewed and approved with no changes
December 1, 2021	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with chaanges
March 1, 2023	Policy reviewed and approved with changes

Laboratory Services

Last Reviewed Date: March 1, 2023

Policy

This policy describes the reimbursement methodology for outpatient laboratory tests.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Documentation Guidelines

According to CMS, the physician or other qualified health care professional who is treating the patient must order all diagnostic laboratory tests, using these results in the management of the patient's condition. Tests not ordered by the physician or other qualified health care professional are not reasonable and necessary.

The physician's or other qualified health care professional's documentation should clearly indicate all tests to be performed. The documentation must include the following:

- Progress notes or office notes signed by the physician or other qualified health care professional
- Physician or other qualified health care professional order/intent to order Laboratory results

Billing/Coding Guidelines

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

Place of Service

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

An Independent or Reference Laboratory must show the place where the sample was taken. If drawn in an Independent Lab or a Reference Lab, report POS 81.

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

Date of Service

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

In the CY 2018 Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule published Dec. 14, 2017, CMS established another exception to laboratory DOS policy for Advanced Diagnostic Laboratory Tests (ADLTs) and molecular pathology tests excluded from OPPS packaging policy so that the DOS is the date the test was performed, if certain conditions are met. Specifically, in the case of a molecular pathology test or an ADLT that meets the criteria of section 1834A(d)(5)(A) of the Social Security Act, the date of service must be the date the test was performed only if the following conditions are met:

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

Duplicate Services

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

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

Reference Laboratory

Reference Laboratory and Non-Reference Laboratory Providers

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

Pathologist and Physician Laboratory Providers

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

Reference Laboratory and Unrelated Reference Laboratory Provider

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

Modifier 90

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

Laboratory Services Performed In a Facility Setting

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

for patients under arrangements with a Reference Laboratory or pathology group, only the facility may be reimbursed for the services.

Drug Testing

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

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

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

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

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

Definitive Drug Testing

MVP has set a maximum of 18 units of definitive drug testing for codes G0480-G0483 per year.

Qualitative Drug Testing

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

Specimen Validity Test

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

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

Incomplete Laboratory Panels

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

Basic metabolic panel

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

Comprehensive metabolic panel

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

Electrolyte panel

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

Hepatic function panel

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

Renal function panel

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

Medicare Medically Unlikely Edits

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

Vitamin D Testing

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

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

Vitamin B Testing

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

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

Diagnosis Matching Edits

MVP will adopt laboratory to diagnosis matching edits and laboratory testing coverage changes as outlined below, based on specific evidence-based guidelines targeting reduction of low value care. Please see MVP Diagnosis Matching Edits for approved diagnoses.

CPT Code	CPT Code Description for Diagnosis Matching Edits
82746	Assay of Folic Acid Serum
82785	Assay of Gammaglobulin Ige
83001	Gonadotropin Follicle Stimulating Hormone
84480	Assay of Triiodothyronine T3 Total Tt3
84481	Assay of Triiodothyronine T3 Free
85652	Sedimentation Rate RBC Automated
86003	Allergen Spec IGE Crude Allergen Extract Each
86008	Allergen Spec IGE Recombinant/Purified Compnt Ea
86695	Antibody Herpes SMPLX Type 1
86696	Antibody Herpes SMPLX Type 2

Use of Non-Contracted Labs

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

Before usage of a non-par lab, you must:

1. Discuss options and costs with the member:
    - Review this policy and have the member sign a specific consent form regarding the usage of a non-par lab
    - Provide participating care provider alternatives and explain the reason for using the non-participating care provider
    - Discuss the cost of using a non-participating care provider
        - If the member has out-of-network benefits, they can use those benefits to see a non-participating care provider. However, they may pay more when using them.
        - Members who do not have out-of-network benefits may have to high costs or pay all the costs for the non-participating care provider.

Non-Covered Services

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

- Specimen collection
- Routine venipuncture charges made in conjunction with blood or related laboratory services or evaluation and management services
- Paternity blood tests
- NAbFeron (IFNb) antibody test
- Mandated drug testing (e.g., court-ordered, residential monitoring, non-medically necessary testing)
- Laboratory and pathology services submitted with unlisted CPT codes when an appropriate specific code is available
- Laboratory and pathology services provided at no charge by state agencies, including but not limited to pertussis and rubella
- Drugs, devices, treatments, procedures, laboratory and pathology tests that are experimental, unproven, or investigational and not supported by evidence-based medicine and established peer reviewed scientific data
- Employment drug screening
- NAB (neutralizing antibody testing) in multiple sclerosis patients
- Lipoprotein subclass testing in the evaluation of cardiovascular disease
- Quantitative urine drug testing where there has been no underlying qualitative test or where the qualitative test is negative

CPT Code	CPT Code Description	Laboratory Services Policy Updates	Reference
82150	ASSAY OF AMYLASE	Do not test for amylase in cases of suspected acute pancreatitis. Instead, test for lipase. MVP will deny the code below if billed on the same day as Lipase (83690).	Per the American Society for Clinical Pathology (see website for more details)
89300	SEMEN ALYS PRESENCE&/ MOTILITY SPRM HUHNER	Do not perform a postcoital test (PCT) for the evaluation of infertility. MVP will no longer cover the code listed below going forward.	Per the American Society of Reproductive Medicine (see website for more details).
89310	SEMEN ALYS MOTILITY&CNT X W/HUHNER TST		
86001	ALLERGEN SPECIFIC IGG QUAN/ SEMIQUAN EA ALLERGEN	The American Society of Clinical Pathology does not support the following codes when performing IgG lab testing	Per the American Society for Clinical Pathology (see website for more details)
86005	ALLERGEN SPEC IGE QUAL MULTIALLERGEN SCREEN		
85652	SEDIMENTATION RATE RBC AUTOMATED	Do not order an erythrocyte sedimentation rate (ESR) to look for inflammation in patients with undiagnosed conditions. Order a C-reactive protein (CRP) to detect acute phase inflammation. MVP will deny the code below if billed on the same day as CRP (86140).	Per the American Society for Clinical Pathology (see website for more details).
82747	ASSAY OF FOLIC ACID RBC	The American Society of Clinical Pathology does not support the following codes when performing Folic Acid lab testing	Per the American Society for Clinical Pathology (see website for more details)
86677	ANTIBODY HELICOBACTER PYLORI	Do not request serology for H. pylori. Use the stool antigen or breath tests instead. MVP will no longer cover the code listed below going forward.	Per the American Society for Clinical Pathology (see website for more details).

Reimbursement Guidelines

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

History

December 1, 2018	New policy, approved
December 1, 2019	Policy reviewed and approved with changes
October 1, 2020	Policy reviewed and approved with changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes

Locum Tenens

Last Reviewed Date: June 1, 2022

Policy

Locum Tenens for **a physician under leave of absence:**

Participating Provider Physicians may retain substitute physicians to take over their professional practices when the Participating Provider physicians are absent for reasons such as illness, pregnancy, vacation, deployment in armed forces, or continuing medical education. The Participating Provider physician can bill and receive payment for the substitute physician's Covered Services as though they performed the Covered Services themselves. The Locum Tenens cannot be an employee of the regular Participating Provider and should be paid for their services on a per diem or similar fee-for-time basis. Locum Tenens may only substitute for a Participating Provider physician for a maximum of 60 days. Locum Tenens can also cover for Participating Provider Physical Therapists.

Locum Tenens for **a physician that has left the practice:**

MVP does not allow Participating Provider practices to retain a substitute physician when a Participating Provider physician has left the Participating Provider practice and will not return. The Locum Tenens, if substituting for a Participating Provider who left a practice, must be contracted and Credentialed with MVP and bill under their own provider NPI, and will be reimbursed per the terms of the Provider Agreement with MVP. At MVPs sole discretion and any applicable Medicare Requirements, Participating Provider practice in a health professional shortage area, medically under-served area, or rural area may request an exception to this policy. If approved by MVP, the Locum Tenens provider is limited to the 60 days and is required to meet all MVP Registration requirements (in lieu of full Credentialing).

Definitions

Locum Tenens or Substitute Physician

A substitute physician who works in place of a Regular Physician when the Regular Physician has taken a leave of absence

Regular Physician

Includes a Participating Provider physician (or Physical Therapist) who is absent for reasons such as illness, pregnancy, vacation, deployment in armed forces, or continuing medical education.

MVP Policies/Notification/Prior Authorization Requests

MVP Payment Polices are not a guarantee of payment. Participating Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Participating Providers must also review MVP's Utilization Management Guides to determine if prior authorization is required and the Benefit Interpretation Manual for MVPs clinical guidelines. Locum Tenens are required to abide by all MVP P Protocols including the Benefits Interpretation Manual, Provider Resource Manual, and Payment Policies. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines for Locum Tenens

All claims for Covered Services should be submitted under the Member's Regular Physician if performance deficiencies and corrective actions related to performance issues. In addition, MVP reports any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

performed by a Locum Tenens provider. The Covered Services performed by a Locum Tenens are not restricted to the Regular Physician's office if the following guidelines are met:

- The Member had arranged or seeks to receive the Covered Services from the Regular Physician.
- The Regular Physician pays the Locum Tenens for their services on a per diem or similar fee-for-time basis.
- The Locum Tenens does not provide Covered Services to Members over a continuous period of more than sixty (60) days. If there is a break after the initial 60 days of Locum Tenens service, the same Locum Tenens may be used to provide services again.

The Regular Physician must bill using their NPI and enter the HCPCS Q6 modifier (services furnished by a Locum Tenens physician) after the procedure code. If the only Covered Services performed by a Locum Tenens are postoperative Covered Services furnished during the post-operative period covered, such Covered Services, HCPCS Q6 modifier is not required.

Participating Provider Group Claims

Participating Provider groups submitting claims for Covered Services provided to Members by a Locum Tenens physician for a Regular Physician must meet the requirements set forth in this Policy. For purposes of these requirements, per diem or similar fee-for-time compensation that the Participating Provider group pays the Locum Tenens physician is considered paid by the Regular Physician.

Participating Provider Group must keep accurate files of Covered Services provided by the Locum Tenens physician associated with the Locum Tenens physician's NPI and make this record available upon request.

Billing/Coding Guidelines for Locum Tenens for Physician Who has Left the Practice

Except as outline in this policy, Locum Tenens may not be used on a per-diem or similar fee-for-time basis to provide Covered Services on a temporary basis when a Participating Provider has left the practice. Providers filling in for a Participating Provider who has left the practice must follow all applicable MVP Credentialing or Registrations requirements based on their specialty and location of practice.

References

MVP Credentialing and Recredentialing of Practitioners

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

History

March 1, 2019	Policy approved
March 1, 2020	Changes to policy regarding health professional shortage area
March 1, 2021	Policy reviewed and approved with no changes
June 1, 2022	Policy reviewed and approved with no changes

Mental Health and Substance Use Disorder

Last Reviewed Date: March 1, 2023
Related Policies–MVP Behavioral Health Policy
MVP Claims Section

Policy

This policy applies to the Medicaid Managed Care Plans (including Health and Recovery Plans ("HARP"), Essential Health Plans, Exchange Plans, Child Health Plus (CHP) Plans, Commercial Plans, Medicare Advantage Plans, and Dual Eligible Special Needs Plans (D-SNP). Requirements for each are set forth below.

MVP reimburses Participating Providers for Medically Necessary Behavioral Health and Substance Use Disorders Covered Services. This policy documents administrative rules and requirements needed for behavioral health claim payment. Covered Services and payments are based on the Member's Benefit Plan terms in Provider Agreement. In addition to the guidelines in this policy, MVP uses claims payment rules supported by the American Medical Association, National Correct Coding Initiative, ClaimsXten, and other MVP administrative guidelines. For specific NYS Medicaid Managed Care CPT codes and rate codes by services, MVP follows the applicable State and Federal guidance.

Mental Health Parity

In accordance with federal and state laws and regulations, MVP has conducted non-quantitative treatment limitation ("NQTL") comparability and stringency analyses. MVP maintains these NQTL and other parity standards as operational policies that align with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), the Consolidated Appropriations Act of 2021, and various guidance issued by the NYS Department of Financial Services (DFS), NYS Department of Health (DOH), NYS Office of Mental Health (OMH) , and the U.S. Department of Labor.

Billing/Coding Guidelines

All Behavioral Health Participating Providers must submit claims using the correct forms and CPT and HCPCS codes and billing guidelines.

For those benefits covered by Commercial plans, MVP follows Medicare Advantage payment rules unless otherwise specified in the Provider Contract, State or Federal Regulations, should be listed or as outlined below. Medicaid, HARP and CHP reimbursement follows all relevant State-specific guidance and requirements and can be found below.

Electroconvulsive Therapy (ECT)

MVP will reimburse for electroconvulsive therapy when performed by a psychiatrist.

Transcranial Magnetic Stimulation (TMS)

MVP will reimburse psychiatrists for Transcranial Magnetic Stimulation.

Psychological and Neuropsychological Therapy

MVP will reimburse licensed physicians, doctorate-level psychologists, and qualified technicians for psychological and neuropsychological testing.

Evaluation and Management Codes

MVP will reimburse psychiatrists and psychiatric nurse practitioners according to the terms of their agreements with MVP. We expect claims to be submitted with the appropriate outpatient E&M CPT code selected from the E&M code range.

Inpatient Treatment

Medically necessary inpatient care is covered.

Residential Treatment Centers (RTC)

Medically necessary treatment provided in RTCs is covered, determined by line of business for which the Member is covered. Mental Health Residential is not covered for CHP, Medicaid Managed Care Plans, or Medicare Advantage Plans (including D-SNP). Substance Use Residential is not covered for Medicare Advantage Plans (including D-SNP).

Accepted Bill Types and Revenue codes for Managed Medicaid, CHP and HARP Members for Part 820 Residential Substance Use programs:

Bill Types: 731,762,763,861,086,891

Revenue Codes: 0900.0902.0911.0914.0944.0945.1002

Partial Hospitalization

Partial hospitalization services must be provided under the direct supervision of a physician pursuant to an individualized treatment plan, and the services must be essential for treatment of the patient's condition.

Outpatient Treatment

Medically necessary diagnostic and treatment services provided by Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) and OASAS clinics, physicians, including psychiatrists, as well as clinical psychologists, social workers, psychiatric nurse specialists, nurse practitioners, licensed professional counselor physicians' assistants are covered.

Managed Medicaid, CHP and HARP Variations:

All billing for Behavioral Health Services for Managed Medicaid, CHP and HARP Members must follow the New York State OMH 14 NYCRR Part 599 Clinic Treatment Programs Interpretive/Implementation Guidance, OASAS APG Clinical and Medicaid Billing Guidance, HARP/Mainstream Behavioral Health Billing and Coding Manual, CORE Benefit and Billing Guidance, the Children's Health and Behavioral Health Services Billing and Coding Manual and/or 29 I Health Facility Billing Guidance as applicable to the service being rendered.

Billing requirements are specific to service and facility type. Billing guidelines include, but are not limited to:

Ambulatory Behavioral Health Services.
Ambulatory Behavioral Health Services including, but not limited to Assertive Community Treatment (ACT), OMH licensed and OASAS Certified clinics, Continuing Day Treatment (CDT), Comprehensive Psychiatric Emergency Program (CPEP), Intensive Psychiatric Rehabilitation Treatment (IPRT), Partial Hospitalization (PHP) and Personalized Recovered Oriented Services (PROS), shall be reimbursed using APG rate-setting methodology or other government rates established and published by OMH. The lesser of billed charges or the rates set forth in the Provider Services Agreement or fee schedules, is not applicable to claims reimbursed using the APG methodology.

Adult Behavioral Health Home and Community Based Services (BH HCBS)
Services may only be billed for HARP Members meeting eligibility requirements as defined by NYS. Specific billing and coding requirements are attributable to all HCBS services and must follow NYS billing guidelines, including transportation requirements. Home and Community Based Services (HCBS) Overview.

Artical 29-I Health Facility (VFCA) Services
Article 29-I Health Facility services are available to Managed Medicaid under the age of 21 (effective July 1, 2021) and CHP Members (effective 1/1/2023). Specific billing and coding requirements are attributable to 29-I Health facilities. 29-I Health facilities must follow New York States 29-I Health Facility Billing guidelines.

Assertive Community Treatment (ACT), Young Adult and Youth Assertive Community Treatment
ACT, Young Adult ACT and Youth ACT services must be billed in accordance with NYS Billing guidelines. Effective 1/1/2023, ACT, Youth ACT and Young Adult ACT services are available to CHP Members and must be billed in accordance with NYS Billing guidelines.

Children's HCBS
Children's HCBS Services may only be billed for Members under the age of 21 that are eligible for waiver services. Specific billing and coding requirements are attributable to all Children's HCBS services and must follow NYS Children's Health and Behavioral Health Billing and Coding Manual. Allowable Service combinations can be found in the Billing guidance. Children's HCBS Billing Guidance

Children's Family Treatment and Support Services (CFTSS)
CFTSS Services may only be billed for Managed Medicaid Members under the age of 21 that meet applicable medical necessity criteria. CFTSS services must follow the specific billing and coding requirements indicated within the NYS Children's Health and Behavioral Health Billing and Coding Manual. Effective 1/1/2023, CFTSS services are available to CHP Members and must be billed in accordance with the same billing guidance. Children's HCBS Billing Guidance

Crisis Residence
Both Children's and Adult Crisis Residence services must be billed in accordance with the applicable Crisis Residence Program guidance.Crisis Residence services for youth ages 18-20 follow the Children's Crisis Residence billing guidance. Medicaid Managed Care

Comprehensive Psychiatric Emergency Program (CPEP)
All CPEP services must be billed in accordance with NYS billing guidance.

Community Oriented Recovery and Empowerment Services (CORE)
Services may only be billed for HARP Members. Specific billing and coding requirements are attributable to all CORE services and must follow NYS billing guidelines. CORE and BH HCBS Allowable Service Combinations and the CORE and other OASAS/OMH Service Allowable combinations can be found in the NYS CORE Billing guide. Community Oriented Recovery and Empowerment (CORE) Overview

Personalized Recovery Oriented Services (PROS)
PROS may be billed for Managed Medicaid or HARP Members that are 18 or over which meet applicable medical necessity criteria. PROS services must be billed in accordance with NYS billing guidelines to be reimbursable. Guidance can be found here.

Gambling Disorder Treatment
In accordance with NYS guidance, Providers must have the OASAS Gambling Designation in order to be eligible for reimbursement when providing problem gambling only services for Government program Members.

Claims
Electronic claims for the mental health or substance use programs outlined above will be submitted using the 837i (institutional) claim form. This will allow for use of rate codes which will inform the Plans as to the type of behavioral health program submitting the claim and the service(s) being provided. Rate code will be a required input to MEDS (the Medicaid Encounter Data System) for all outpatient MH/SUD services. Therefore, the Plan must accept rate code on all behavioral health outpatient claims and pass that rate code to MEDS. All other services will be reported to MEDS using the definitions in the MEDS manual.

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in "24" and following that immediately with the appropriate four-digit rate code. This is the standard mechanism historically and currently used in Medicaid FFS billing.

Billing requirements depend on the type of service provided; however, every electronic claim submitted will require at least the following:

- Use of the 837i claim form;
- Medicaid fee-for-service rate code;
- Valid procedure code(s);
- Procedure code modifiers (as needed); and
- Units of service.

For additional information on claims, please review the Claims section of MVPs Provider Resource Manual by clicking here.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's Utilization Management Guides to determine if prior authorization is required and the Benefit Interpretation Manual for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

References

https://omh.ny.gov/omhweb/bho/billing-services.html

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/billing.htm

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm

https://omh.ny.gov/omhweb/bho/hcbs.html

https://omh.ny.gov/omhweb/bho/core/

https://omh.ny.gov/omhweb/bho/crisis-intervention.html

History

December 1, 2019	New Policy, approved
December 1, 2021	Policy reviewed and approved with changes
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with changes

Mid-Level Payment Policy

Last Reviewed Date: March 1, 2023
Related Policies: Incident to Guidelines
NP/PA/CNS Billing in a Skilled Nursing Facility
Anesthesia
Payment Policy: Credentialing

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.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Payment Guidelines

General Guidelines

PA, NP, RNFA, CRNA, CNM Payment Policy: Payment for services rendered by these provider types, subject to the Incident. To see 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

History

December 1, 2018	New policy, approved
December 1, 2019	Policy reviewed and approved with no changes
June 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes

Modifier Policy for Physician

Last Reviewed Date: September 1, 2022

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.

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.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Modifier 22	Description
	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.

Rule

MVP cannot accept documentation electronically to support Modifier 22 at this time. Additional reimbursement will be considered when the operative report accompanies the paper claim.

Absent documentation to support the claim, Modifier 22 will be removed, and the claim will pay at the physician contracted rate with a payment code and description of WZ- Cl - XTEN - CPT modifier disallowed - Medical documentation required.

When documentation does not accompany the claim and the provider desires the additional 20 percent reimbursement beyond the normal fee schedule as outlined above, additional reimbursement will be considered when the following documentation is provided:

- Claim Adjustment Review Form;
- Operative report

MVP may request additional information when the operative report does not clearly demonstrate the additional work performed. This may include:

- Documentation that clearly illustrates the increased complexity of the services provided;
- Rationale for why the use of Modifier 22 is warranted, including the degree of difficulty above and beyond (0-100 percent)

If upon review of the documentation, Modifier 22 is deemed inappropriate, the modifier will be removed from the claim and provider will remain paid at their contracted rate.

Reimbursement

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

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.

Rule

Preventive and E&M

Documentation that satisfies the relevant criteria for both evaluation and management services and procedures to be reported will be required in the patient's medical record. Documentation is not required up front but may be requested on audit.

E&M and Office Procedure

Documentation that satisfies the relevant criteria for the respective E&M service and procedure to be reported will be required in the patient's chart. Documentation is not required up front but may be requested on audit.

Reimbursement

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 modifier 25 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 modifier 25 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

This modifier is used to report the physician component in procedures were there are a combination of a physician and technical component.

Rule

When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

Reimbursement

Providers will be paid at the contracted rate for the professional component.

Modifier TC

Description

This modifier is used to report the technical component alone in procedures were there are a combination of a physician and technical component.

Rule

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.

Reimbursement

Providers will be paid at the contracted rate for the technical component.

Modifier 50

Description

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.

Rule

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.

Reimbursement

150 percent of the provider's contracted rate.

Modifier 51

Description

When multiple procedures, other than E/M services, Physical Medicine, and Rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

Rule

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).

Reimbursement

When a procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, the appropriate reduction is applied to the codes (i.e. 100 percent, 50 percent, 50 percent, 50 percent, 50 percent etc.).

Modifier 52

Description

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.

Rule

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 two (2) units of service with modifier 52: RT or LT for indicator "2".

When a radiology procedure is reduced, the correct reporting is to assign the CPT code to the extent of the procedure performed. This modifier is used only to report a radiology procedure that has been reduced when no other code exists to report what has been done. Report the intended code with Modifier 52.

Reimbursement

Modifier 52 is reimbursed at the lesser of 50 percent of charges or contracted rate.

Modifier 53

Description

Used when the provider elects to terminate a surgical or diagnostic procedure due to extenuating circumstances or those that threatens the well being of the patient. In certain circumstances it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Note: For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

Rule

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.

Reimbursement

Modifier 53 is reimbursed at the lesser of 50 percent of charges or contracted rate.

Modifier 54

Description

Used when one physician performs preoperative and/or postoperative management and another physician performs a surgical procedure.

Rule

This should only be added to the claim with the surgical code.

Reimbursement

Modifier 54 is reimbursed at the lesser of 80 percent of charges or contracted rate.

Modifier 55

Description

Used when one physician performs postoperative management and another physician performs a surgical procedure.

Rule

This modifier should only be used by the physician billing for the postoperative management.

Reimbursement

Modifier 55 is reimbursed the lesser of 10 percent of charges or contracted rate.

Modifier 56

Description

Used when one physician performs preoperative care and evaluation and another physician performs a surgical procedure.

Rule

This modifier should only be used by the physician billing for the preoperative care and evaluation.

Reimbursement

Modifier 56 is reimbursed at the lesser of 10 percent of charges or contracted rate.

Modifiers 59, XE, XS, XP, XU

Description

These modifiers are used to identify procedures/ services, other than E&M services, that are not normally reported together, but are appropriate under the circumstances.

Modifier 59 Distinct Procedural Service

Modifier XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter

Modifier XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

Modifier XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

Modifier XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

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Rule

MVP cannot accept documentation electronically to support modifiers 59, XE, XS, XP, XU at this time. Additional reimbursement will be considered when the operative report accompanies the paper claim.

MVP may request additional information when the operative report does not clearly demonstrate that the procedures should be unbundled. This may include documentation that demonstrates why a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual was done; rationale for why the use of modifiers 59, XE, XS, XP, XU is warranted.

When another already established modifier is appropriate it should be used rather than modifier 59. Only if another descriptive modifier is unavailable, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E&M service. To report a separate and distinct E&M service with a non-E&M service performed on the same date, see modifier 25.

Reimbursement

Claims that are determined to meet the clinical criteria as a separate identifiable procedure will be paid at the physician contracted rate.

Modifier 62

Description

Used when two surgeons work together as primary surgeons performing distinct part(s) of a procedure.

Rule

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.

Reimbursement

Modifier 62 is reimbursed at 62.5 percent of the providers contracted rate.

Modifier 63

Description

Used when procedures are performed on neonates and infants up to a present body weight of 4kg which may involve significant increase in complexity for physicians and other health care professionals whose work is commonly associated with these patients

Rule

This circumstance may be reported by adding modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20100-69990 code series and 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93530, 93531, 93532, 93533, 93561, 93562, 93563, 93564, 93568, 93580, 93582, 93590, 93591, 93592, 93615, 93616 from the Medicine/Cardiovascular section. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections (other than those identified above from the Medicine/Cardiovascular section).

Reimbursement

Modifier 63 is reimbursed at 120% of the contracted rate

Modifier 73

For Facility Use Only

Description

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s), or general).

Rule

This code is to be used by the Hospital/Ambulatory Surgery Center when the procedure is discontinued.

This modifier is not used to indicate discontinued radiology procedures.

This modifier applies in extenuating circumstances and when the well-being of the patient is threatened. The patient must be taken to the room where the procedure is to be performed in order to report this modifier.

When one or more of the planned procedures is completed, report the completed procedure as usual. Any others that were planned and not started are not reported.

When none of the procedures that were planned are completed, the first procedure that was planned to be done is reported with this modifier.

Reimbursement

Modifier 73 is reimbursed at 50 percent of the facilities contracted rate.

Modifier 74

For Facility Use Only

Description

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.).

Rule

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.

Reimbursement

Modifier 74 is reimbursed at 100 percent of the facilities contracted rate.

Modifier 76

Description

Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

(This modifier is allowable for radiology services. It may also be used with surgical or medical codes in appropriate circumstances).

Rule

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

This modifier should not be appended to an E/M service.

Documentation is required.

Reimbursement

Will be reimbursed at the lesser of 100 percent of charges or contracted rate.

Modifier 78

Description

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.

Rule

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.

Reimbursement

Will be reimbursed at the lesser of 80 percent of charges or contracted rate.

Modifier AS, 80, 81, 82

Description

Modifier AS	Physician assistant, nurse practitioner for assistant at surgery
Modifier 80	Assistant Surgeon. Surgical assistant services may be identified by adding Modifier 80 to the usual procedure number(s).
Modifier 81	Minimum Assistant Surgeon. Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
Modifier 82	Assistant Surgeon (when qualified resident surgeon not available). The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

Rule

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 mvphealthcare.com to determine which codes MVP will reimburse.

Reimbursement

Modifier AS is reimbursed at 16 percent of the assistant surgeon's contracted fee schedule.

Modifiers 80-82 are reimbursed at 16 percent of the assistant surgeon's contracted fee schedule.

Modifier CG

Description

Policy criteria applies.

Rule

When submitting a venipuncture claim when laboratory work is sent to an external lab, modifier CG is required.

Reimbursement

Claims submitted without the modifier will be denied as global.

Modifier CH-CN

Description

Functional G-codes and corresponding severity modifiers are used in the required reporting on specified therapy claims.

Rule

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.

Reimbursement

Claims submitted without the severity modifiers will be denied.

Modifier CO-CQ

Description

Therapy modifier indicating a Physical Therapy Assistant or Occupational Therapy assistant performed a service in whole or in part.

Rule

- Services wholly furnished by PTAs and OTAs.
- In cases where one final 15-minute unit (of a multi-unit scenario) remains to be billed, the de minimis standard is applied to: • Services where the PTA/OTA furnishes 8 or more minutes of a 15-minute unit of service and the PT/OT furnishes less than 8 minutes – bill with the CQ/CO modifier as the de minimis standard is exceeded.
- Services where both the PTA/OTA and the PT/OT each provide less than 8 minutes of a service – bill with the CQ/CO modifier if the minutes furnished by the PTA/OTA exceed the de minimis standard.

Reimbursement

Claims submitted with these modifiers will be reimburses at 85% of charges or contracted rate.

Modifier GN-GP

Description

Therapy modifier indicating the discipline of the plan of care.

Rule

The provider should use GP, GO, or GN for PT, OT, and SLP services, respectively.

Reimbursement

Claims submitted without the therapy modifier will be denied.

Modifier KX

Description

Therapy modifier indicating that the services over the CMS therapy cap were medically necessary. Please refer to CMS.Gov for annual KX therapy caps.

Rule

The provider should use the KX modifier to the therapy procedure code (physical/speech and/or occupational) that is subject to CMS 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. Submission of medical records will be required to support the use of modifier KX. 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.

Modifier PT

Description

This modifier should be used when a CRC screening test has been converted to diagnostic test or other procedure.

Rule

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.

Reimbursement

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

Services furnished by a Locum Tenens physician.

Rule

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

Reimbursement

Reimbursement would be made at the regular physician's fee schedule.

Modifier QK, QY, QX

Description – QK

Modifier QK – Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals

Reimbursement – QK

Modifier QK will be reimbursed at the lesser of 50 percent of charges or the contracted rate.

Description – QY

Modifier QY – Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist

Reimbursement – QY

Modifier QY will be reimbursed at the lesser of 50 percent of charges or the contracted rate

Description – QX

Modifier QX – CRNA service: with medical direction by a physician

Reimbursement – QX

Modifier QX will be reimbursed at the lesser of 50 percent of charges or the contracted rate

Modifier U8, U9, UB

Description – U8

Modifier U8 – Delivery prior to 39 weeks gestation

Reimbursement – U8

A 75 percent reduction will apply when modifier U8 is billed and an acceptable diagnosis is not documented

Description – U9

Modifier U9 – Delivery at 39 weeks gestation or later

Reimbursement – U9

Full payment will be made when modifier U9 is submitted

Description – UB

Modifier UB- Spontaneous obstetrical deliveries occurring between 37-39 weeks gestation

Reimbursement – UB

Full payment will be made when modifier UB and U8 are billed

Modifier CT

Description

Modifier CT

Reimbursement

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

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

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

CPT 2019 Preventive Medicine Services Section

CPT 2019 Professional Edition, American Medical Association

Grider, Deborah, Coding with Modifiers, 5th Edition. American Medical Association. 2013

Medicare Claims Processing Manual Chapter 12 §§ 30.3.7, 40.2(A)(4)

History

June 1, 2019	Policy Approved
March 1, 2020	Policy reviewed with changes
June 1, 2020	Policy reviewed and approved with changes
December 1, 2020	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with changes

Multiple Surgery – VT Facilities Only

Last Reviewed Date: March 1, 2023

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.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Participating Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Participating Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Multiple Surgery Rule

Code	Description	Rule
10021-69990	Surgical Procedural Codes	• The primary procedure is identified by the higher priced allowed amount • The primary procedure performed in the operating room will be reimbursed at 100 percent of the contractual rate • Any subsequent surgical procedures performed in the operating room at the same time will be reduced to 50 percent of the contractual rate • Exemptions: Appendix D and E of the current year AMA Current Procedural Terminology (CPT) manual • Existing Clinical Edits will still apply to these claims
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	• This code will be exempt from the multiple surgery rule

History

September 1, 2018	New policy, approved
September 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes

NDC Policy

Last Reviewed Date: March 1, 2023

Policy

Only valid National Drug Code (NCD) numbers may be submitted. MVP requires the valid NDC and quantity to be included on all claims where a medication is administered for outpatient or professional setting with a procedure code beginning with J, or for codes that have an O1E or O1D BETOS designation. The BETOS designation can be referenced here.

When an NDC is submitted on any claim or; for any procedure, that NDC will be verified for accuracy, and the unit quantity will be reviewed to ensure it is not a value of zero.

Notification/Prior Authorization Requests

MVP Payment Polices are not a guarantee of payment. Providers must confirm Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into the Providers account at mvphealthcare.com.

Billing/Coding Guidelines

Instructions for filling out the Health Insurance Claim Form (CMS 1500)

Vailid NDC numbers should be entered in the respective fields 24A – 24G for the corresponding CPT codes.

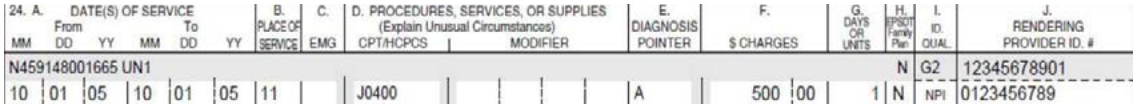
The following should be included in order:

- Report the N4 qualifier (left justified)
- Followed immediately by 11 digit NDC (no hyphens)
- One space
- Followed immediately by Unit or Basis for Measurement Code:

  F2 – International Unit ML – Milliliter
  GR – Gram UN - Unit

- Followed immediately by:
  - Unit Quantity – is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal.
  - Must be > 0 and <= 9,999,999.999.
  - Examples: 1234.56 2 9,999,999.999
- Example: N412345678901 UN1234.567

NDC Number



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

Instructions for filling out UB 04 claim form

NDC should be entered into field 43 - Revenue Code Description.

The following should be included in order:

- Report the N4 qualifier (left justified) followed immediately by:
- 11 digit NDC (no hyphens) followed immediately by:
- Unit or Basis for Measurement Code:

  F2 – International Unit ML – Milliliter
  GR – Gram UN - Unit

- followed immediately by:
  - Quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal.
  - Must be > 0 and <= 9,999,999.999.
  - Examples: 1234.56 2 9,999,999.999

Instructions for Electronic Claim Format

If you bill electronically, complete the drug identification and drug pricing segments in Loop 2410 following the instructions below:

Loop	Segment	Element Name	Information
2410	LIN 02	Product or Service ID Qualifier	Use qualifier N4 to indicate that entry of the 11 digit NDC in 5-4-2 format in LIN03
2410	LIN 03	Product or Service ID Qualifier	Include the 11-digit NDC (No hyphens)
2410	CTP 04	Quantity	Include the quantity for the NDC billed in LIN03 • Quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal • Must be > 0 and <= 9,999,999.999 • Examples: 123456 2 9,999,999.999
2410	CTP 05	Unit or Basis for Measurement Code	For the NDC billed in LIN03, include the unit or basis for measurement code using the appropriate code qualifier: FR – International Unit ML – Millimeter GR – Gram UN – Unit

NDC Formatting

A valid NDC is submitted as an 11-digit code without any hyphens.

However, you will rarely see 11 digits when referring to an NDC on a medication package. This is because the 11 digits of an NDC are separated into three (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 indicate 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 should remove hyphens, 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.

In order for MVP to process a claim for reimbursement, 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.

The following table provides illustrative examples on how to convert sample NDC numbers into the acceptable 5-4-2 format and how to enter them appropriately into a claim form by adding the N4 qualifier:

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

Choosing the Applicable NDC

If a drug has two (2) NDC numbers - one on the package and one on the vial, submit the NDC on the package rather than the number on the vial.

If the drug is a compound drug and does not have a single Federal NDC, individual components and their respective Federal NDC's numbers must be billed on separate lines with appropriate numbers of units.

If the drug is available in both medical and cosmetic packaging (e.g. Botox and Botox Cosmetic), use the appropriate NDC for the medical packaging. Submission of an NDC associated with the cosmetic product will result in a claim denial regardless of authorization status and diagnosis being treated.

References

NYSDOH Memo Update: Encounter Intake System (EIS) NDC Edit Logic EIS Edit 00237 Logic Change_09032021.pdf

History

February 1, 2018	New policy, approved
June 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with changes

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

Last Reviewed Date: March 1, 2023

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 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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines in a Skilled Nursing Facility

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 an 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 an 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 an SNF or NF bill the carrier directly for their services to facility residents.

Physician Assistants (PAs) who are employed by an 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 an NF is the same as in an 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 an 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 an 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

cms.gov/manuals/downloads/clm104c06.pdf

cms.gov/SurveyCertificationGenInfo/downloads/SCLetter04-08.pdf

www.cms.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf

cms.gov/SNFPPS/05_ConsolidatedBilling.asp www.cms.gov/MLNMattersArticles/downloads/SE0418.pdf

History

June 1, 2019	New policy, approved
September 1, 2020	Policy reviewed, and approved with no changes
March 1, 2023	Policy reviewed, and approved with no changes

Observation Status for Facility and Provider

Last Reviewed Date: September 1, 2022

Policy

MVP does not require a preauthorization for observation services. However, any observation services that are converted to an inpatient stay will require an authorization. Any observation greater than 48 hours may have medical records requested to perform a medical necessity review to verify if there is clinical justification for additional hours to be billed.

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.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

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 to ensure compliance with medical necessity criteria/regulatory as well as Administrative and Medical policies.

MVP does not reimburse observation services for the following:

- Preparation for, or recover from, diagnostic tests
- The routine recovery period following an ambulatory surgical procedure or an outpatient procedure

- Services routinely performed in the emergency department or outpatient department; observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the service
- Observation services submitted with routine pregnancy diagnosis
- Retaining a member for socioeconomic factors
- Custodial care

References

Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

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

History

March 1, 2019	Policy approved
June 1, 2021	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with no changes

Occupational Therapy (OT)

Last Reviewed Date: June 1, 2022

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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

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

CPT Code	Description
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

CPT Code	Description
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, not to treat a specific medical condition; therefore, they are not covered. However, work-hardening therapies that improve mobility and function would be medically necessary. In those instances, work-hardening therapy would be reimbursable.

Medicare Therapy Cap

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

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

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

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

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

History

March 1, 2021 Policy approved
March 1, 2021 Policy reviewed and approved with no changes
June 1, 2022 Policy reviewed and approved with no changes

Personal Care/ Consumer Directed Personal Assistance Services - Service Units Billing

Last Reviewed Date – September 1, 2022

Policy

MVP requires Providers billing claims for reimbursement of Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS) units of service for a date of service on a single line. Units of service provided for each date of service should not be split to separate lines on claim submissions.

This policy applies to Medicaid and HARP Members.

Definitions

Activities of Daily Living (ADL) include bathing, dressing, grooming, eating, transferring, ambulating, and toileting.

Consumer Directed Personal Assistance Service (CDPAS) is the New York State Medicaid program for chronically ill or disabled individuals who have a medical need for help with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or skilled nursing services provided by a personal care aide (home attendant), home health aide, or nurse under the supervision of the consumer.

Consumer is the medical assistance recipient who a social services district has determined eligible to participate in the consumer directed personal assistance program.

Instrumental Activities of Daily Living (IADL) include housekeeping, laundry, meal planning and preparation, use of a telephone, managing finances, and shopping or errands.

Personal Care Assistance (PCA) assist an individual with day-to-day activities in their home and community. PCA's assist with ADLs, health-related procedures and tasks, observation and redirection of behaviors, and IADLs.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required, and the *Benefit Interpretation Manual* for MVP's clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Billing with the appropriate procedure and diagnosis codes expedites processing for payment of services. It is important to code to the highest specificity based on the diagnoses of the Member. MVP will deny claims if a non-specific diagnosis code is utilized as outlined below.

Non-Specific Diagnosis Codes:

Diagnosis Code	Description
R69	Illness, unspecified
R5381	Other malaise
R6889	Other general symptoms and signs
R52	Pain, unspecified
I6990	Unspecified sequelae of unspecified cerebrovascular disease
R5383	Other fatigue
R54	Age related physical debility
Q8789	Other specified congenital malformation syndromes, not elsewhere classified

Sign In to your MVP Provider online account to review the Personal Care & Consumer Directed Services for MVP Medicaid Managed Care Medical Policy.

Service Type	Procedure Code	Unit of Measurement	Billing Instructions	Code Description
PCS – Level I	S5130	1 unit per 15 minutes	Use Modifier U1	Homemaker service, NOS; per 15
Nursing Supervision	T1001	Per visit	n/a	Nursing Assessment Evaluation
PCS – Level II Basic	T1019	1 unit per 15 minutes	Use Modifier U1	PCS, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code cannot be used to identify services provided by home health aide or certified nurse assistant).
CDPAS Basic	T1019	1 unit per 15 minutes	Use Modifier U6	PCS, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code cannot be used to identify services provided by home health aide or certified nurse assistant).
PCS Level II Live In	T1020	Per Diem (13 Hours)	n/a	PCS, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code cannot be used to identify services provided by home health aide or certified nurse assistant.)
CDPAS Live In	T1020	Per Diem (13 Hours)	Use Modifier U6	PCS, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code cannot be used to identify services provided by home health aide or certified nurse assistant.)

Service Type	Procedure Code	Unit of Measurement	Billing Instructions	Code Description
UAS Assessment	T2024	Per Visit	n/a	Service Assessment/plan of care development
UAS Reassessment	T2024	Per Visit	n/a	Service Assessment/plan or care development

References

NYS Department of Health: https://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap.htm

https://www.health.ny.gov/health_care/medicaid/program/longterm/pcs.htm

History

December 1, 202 Policy approved
September 1, 2021 Policy reviewed and approved with changes
September 1, 2022 Policy reviewed and approved with changes

Physical Therapy (PT)

Last Reviewed Date: September 1, 2022

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 Member'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 Member contact by the provider, or modalities may require constant attendance by a healthcare professional. Examples of supervised modalities may include application of hot or cold packs, vasopneumatic devices, whirlpool, diathermy, and infrared. Modalities that require constant attendance include ultrasound, electrical stimulation, and iontophoresis.

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

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

The following CPT codes are covered for Physical Therapy providers:

CPT Code	Description
95992	Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day
97161	Physical therapy evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity

CPT Code	Description
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
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

CPT Code	Description
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 Members 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 Member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

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

- Traction has not been proven effective
- Ultrasound, massage, ice, heat, diathermy, lasers, electrical stimulation to relieve symptoms of low back pain have not been proven effective
- TENS units
- Biofeedback has not been proven effective for acute low back pain
- Acupuncture is not recommended for acute back pain
- Back (lumbar) corsets to treat acute low back pain have not been proven effective
- "Back School," a type of educational program for low back pain, has not been proven to be more effective than other treatments, and is not reimbursable

Medicare Therapy Cap

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

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

The Provider should use the KX modifier to the therapy procedure code that is subject to the cap limits only when a Member 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 Provider agreement for specific reimbursement guidelines.

References

MVP Utilization Management Policy, Provider Resource Manual

History

March 1, 2019	Policy approved
March 1, 2021	Policy reviewed and approved with no changes
June 1, 2022	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with changes

Preoperative Lab Testing

Last Reviewed Date: September 1, 2022

Policy

Routine preoperative testing is not reimbursable for up to 30 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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

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):

ICD-10 Code	Description
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.

History

June 1, 2017	Policy approved
June 1, 2020	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes

Preventive Health Care

Last Reviewed Date: March 1, 2023

Policy

MVP covers the full cost of Preventive Services outlined below with no co-pays, deductibles, or co-insurance 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 co-pay/co-insurance/cost share should be taken at the time of service. Claims will still be subject to clinical edits and bundling. Some products (including but not limited to MVP Medicare) may have exclusions or variations to the Federal Healthcare Reform; providers should check the Member's benefits to determine if preventive services apply to their plan.

Payment of preventive services by MVP is dependent on correct claim submission using diagnosis and procedure codes which identify the services as preventive. All standard coding practices should be observed. When billing the primary reason for the visit, the diagnosis codes identified should be billed on the claim line level in the principal diagnosis position. The following pages provide guidance related to designated preventive services and the associated ICD-10, CPT, and HCPCS codes.

Definitions

Adolescents and Children

Affordable Care Act (ACA)-covered preventive services are provided to Members from birth through attainment of age 19.

Adults

ACA covered preventive services are provided to Members 19 and older.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

General Guidelines

No co-payment, deductible, or co-insurance will be applied when billed in accordance with standard code billing practices.

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

Preventive medicine-Individual Counseling-Risk factor reduction for persons without specific illness (E&M Codes)

CPT codes **99401–99404** are used to report services that promote health and prevent illness or injury in persons without a specific illness for which the counseling might otherwise be used as part of treatment.

Face to Face preventive counseling and risk factor reduction interventions will vary with age.

These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illness, use the appropriate office, hospital, consultation or other evaluation and management (E&M) codes.

These codes will be referred to as: **Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness** throughout this policy

CPT Codes	Description
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes

New Patient comprehensive preventive medicine evaluation and management

CPT codes **99381-99387**–Preventive initial E&M (new patient):

These preventive evaluation and management (E&M) services are represented by distinct CPT codes from those that represent problem-oriented evaluation and management (E&M) services. They are inherently Preventive and, therefore, modifier 33 would not be used with them.

Note that codes 99381–99387 are age-delimited and include counseling, anticipatory guidance, and risk factor reduction interventions that are provided at the time of the **initial** preventive medicine examination.

These codes will be referred to as: **New Patient comprehensive preventive medicine evaluation and management** throughout this policy.

CPT Codes	Description
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)

CPT Codes	Description
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older

Established Patient comprehensive preventive medicine evaluation and management

CPT codes **99391-99397**:

These preventive evaluation and management (E&M) services are represented by distinct CPT codes from those that represent problem-oriented evaluation and management (E&M) services. They are inherently Preventive and, therefore, modifier 33 would not be used with them.

- Preventive periodic E&M (established patient)(CPT codes 99391–99397)

Note that codes 99391–99397 are age delimited and include counseling, anticipatory guidance, and risk factor reduction interventions that are provided at the time of the **periodic** comprehensive preventive medicine examination.

These codes will be referred to as: **Established Patient comprehensive preventive medicine evaluation and management** throughout this policy.

CPT Codes	Description
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older

The following table indicates how preventive services should be billed for the MVP's claims system to recognize that a co-pay, co-insurance, or deductible should not be taken. Typically, the procedure code that is billed needs to have an appropriate diagnosis or modifier on the claim to alert MVP the service is preventable. There are some procedures codes that do not apply co-payment, co-insurance, or deductible regardless of the diagnosis or modifier billed. This billing rules may also apply to state regulation that vary from US Preventive Services Task Force guidelines. For example, a 55-year-old man has a colonoscopy for colorectal cancer screening. The procedure for colonoscopy is billed using CPT procedure code 45378. The claim will not take a co-pay if either a modifier 33 is appended to the procedure or one of the diagnosis codes in the table, such as z12.10 (Encounter for screening for malignant neoplasm of the intestinal tract, unspecified), is put in the first position on the claim. Associated services such as anesthesia will not be subject to co-pay, co-insurance, or deductible if a diagnosis code such as z12.10 is the first diagnosis on the claim. For another example, a 40-year-old woman has her first mammogram for breast cancer screening. The procedure for bilateral screening mammography is billed using CPT procedure code 77067. There are no other billing requirements. The claim will not take a co-pay for screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.

United States Preventive Service Task Force Recommendations

Abdominal Aortic Aneurysm Screening: Men

(June 2014) Rating B

"Task Force" Recommendation

Medical – The USPSTF recommends one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 years who have ever smoked.

Facility – No cost share for one (1)-time screening in men aged 65 to 75 who have ever smoked when billed with appropriate code and one of the following revenue codes: 0320-0329, 0400,0402, 0409.

Code	Billing Instruction	Code Description
76706		Ultrasound B-scan and/or real-time with image documentation; for abdominal aortic aneurysm (AAA) screening

Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions

(November 2018) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant persons, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

Code	Billing Instruction	Code Description
G0442		Annual alcohol misuse screening, 15 minutes
G0443		Brief face-to-face behavioral
99408		Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services
99409		Brief interventions greater than 30 minutes

Unhealthy Drug Use: Screening

(July 2020) Rating B

"Task Force" Recommendation

The USPSTF recommends screening by asking questions about the unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment and appropriate care can be offered or referred.

(Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)

Code	Billing Instruction	Code Description
99408		Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409		Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

Bacteriuria Screening: Pregnant Persons

(July 2008) Rating A

"Task Force" Recommendation

The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant persons at 12 to16 weeks' gestation or at the first prenatal visit, if later.

Code	Billing Instruction	Code Description
87086	Bill with pregnancy related diagnosis code. See Pregnancy related diagnosis code set at the end of Policy	Culture, bacterial; quantitative colony count, urine
87088	Bill with pregnancy related diagnosis code. See Pregnancy related diagnosis code set at the end of policy	Culture, bacterial; with isolation and presumptive identification of each isolate, urine

BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing

(August 2019) Rating B

"Task Force" Recommendation

Medical – The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA 1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.

Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

Facility – No cost share for women to discuss positive BRCA testing when billed with appropriate code Modifier 33 must be appended to the code (96040, S0265) to consider it preventative. These services must also be billed with the following revenue codes: 0500, 0510.

Code	Billing Instruction	Code Description
99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness

Code	Billing Instruction	Code Description
96040	Bill with Modifier 33	Covers genetic counseling (GC) visits provided by counselors only
S0265	Bill with Modifier 33	Genetic counseling, under physician supervision, each 15 minutes
81163 **81164**		BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian
81165		BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81166		BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
81167		BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
81212		BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants
81215		BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant
81216		BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81217		BRCA2 (breast cancer 2) (e.g.,hereditary breast and ovarian cancer) gene analysis; known familial variant
81162		BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary)

Breast Cancer: Medication Used to Reduce Risk

(Sept 2019) Rating B

"Task Force" Recommendation

The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.

Code	Billing Instruction	Code Description
99385–99397		Established Patient comprehensive preventive medicine evaluation and management

Breast Cancer Screening

(January 2016) Rating B

"Task Force" Recommendation

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.

Code	Billing Instruction	Code Description
99401-99404	Medical &Facility codes	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.
99386-99387		New Patient comprehensive preventive medicine evaluation and management
99396-99397		Established Patient comprehensive preventive medicine evaluation and management
77063	Add on code, only use in conjunction with 77067	Screening digital breast Tomosynthesis, bilateral
77067		Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
G0202		Screening mammography, producing direct digital image, bilateral, all views

Breastfeeding Interventions

(2016) Rating B

"Task Force" Recommendation

The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.

Code	Billing Instruction	Code Description
99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness

Cervical Cancer Screening

(August 2018) Rating A

"Task Force" Recommendation

The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women ages 21 to 29 years. For women ages 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing).

Code	Billing Instruction	Code Description
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

Code	Billing Instruction	Code Description
88143		Cytopathology, cervical, or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
88147		Cytopathology smears, cervical, or vaginal; screening by automated system under physician supervision
88148		Cytopathology smears, cervical, or vaginal; screening by automated system with manual rescreening under physician supervision
88150		Cytopathology, slides, cervical, or vaginal; manual screening under physician supervision
88152		Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
88153		Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88154		Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88155		Cytopathology, slides, cervical or vaginal definitive hormonal evaluation (e.g. maturation index, karyopyknotic index, estrogenic index). List separately in addition to code(s) or other technical and interpretive services
88164		Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165		Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
88166		Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
88167		Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88174		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
G0101		Cervical or vaginal cancer screening; pelvic and clinical breast examination
G0123		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
G0124		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician

Code	Billing Instruction	Code Description
G0141		Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician
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
G0144		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision
G0145		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision
G0147		Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision
G0148		Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening
G0476		Infectious agent detection by nucleic acid (dna or rna); human papillomavirus (hpv), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test
P3000		Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, by technician under physician supervision
P3001		Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, requiring interpretation by physician
Q0091		Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Screening for Chlamydia and Gonorrhea

(Sept 2021) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.

The USPSTF recommends screening for gonorrhea in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.

This recommendation applies to asymptomatic, sexually active adolescents and adults, including pregnant persons.

Code	Billing Instruction	Code Description
87270 87320		Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87490		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
87491		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique

Code	Billing Instruction	Code Description
87492		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
87590		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
87591		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87592		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification
87110		Culture, chlamydia, any source
86631		Antibody: Chlamydia
86632		Antibody; Chlamydia, IgM

Colorectal Cancer Screening

(May 2021) Rating A and Rating B

"Task Force" Recommendation

Rating A - The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

Rating B - The USPSTF recommends screening for colorectal cancer starting at age 45 years and continuing until age 49 years.

ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no co-pay/deductible /co-insurance.

Colorectal Cancer Screening – NY and VT

Code	Billing Instruction	Code Description
Medical and Facility	No cost share for Medical or Facility services when one billed with a modifier PT or 33	
44388	No cost share when billed with Modifier 33 or PT	Colonoscopy Stomal Diagnostic
44390	No cost share when billed with Modifier 33 or PT	Colonoscopy Stomal W Removal of foreign body
44391	No cost share when billed with Modifier 33 or PT	Fiberoptic Colonoscopy; Hemorrhage Control
44402	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
44403	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with endoscopic mucosal resection
44404	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with directed submucosal injection(s), any substance

Code	Billing Instruction	Code Description
44405	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with transendoscopic balloon dilation
44406	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44407	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited
44408	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45300	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45303	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with dilation (e.g., balloon, guide wire, bougie)
45305	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with biopsy, single or multiple
45307	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with removal of foreign body
45309	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique
45315	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45317	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snar technique (e.g., laser)
45327	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)
45330	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45332	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with removal of foreign body
45334	No cost share for Medical or Facility services when billed with a modifier PT or 33	Sigmoidoscopy with Control Hemorrhage
45337	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with decompression (for Pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed

Code	Billing Instruction	Code Description
45341	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342	No cost share for Medical or Facility services when billed with a modifier PT or 33	Under Endoscopy Procedures on the Rectum. Code is active
45347	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
45378	No cost share when billed with a modifier PT or 33.	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	No cost share when billed with a modifier PT or 33	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45381	No cost share when billed with a modifier PT or 33	Colonoscope, submucous injection
45382	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
45386	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with transendoscopic balloon dilation
45389	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)
81528	No modifier or diagnosis code are required to be covered in full	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
G0104	No modifier or diagnosis code is required to be covered in full	Colorectal cancer screening; flexible sigmoidoscopy
82274	No modifier or diagnosis code are required to be covered in full	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
82270	No modifier or diagnosis code are required to be covered in full	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative;
G0105	No modifier or diagnosis code is required to be covered in full	Colorectal cancer screening; colonoscopy on individual at high risk
G0106	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
G0120	No modifier or diagnosis code is required to be covered in full	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0121	No modifier or diagnosis code is required to be covered in full	Colorectal cancer screening; colonoscopy on individual not meeting criteria for
G0122	No modifier or diagnosis code is required to be covered in full	Colorectal cancer screening; barium enema

Code	Billing Instruction	Code Description
G0328	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous determinations
S0285	No modifier or diagnosis code is required to be covered in full Reimbursement will be set to Provider's contracted rate for 99212 **Exception:** Consistent with Medicare guidelines, code S0285 will not be reimbursed separately for Medicare product lines.	Colonoscopy consultation performed prior to a screening colonoscopy procedure

Colorectal Cancer Screening – NY only

Code	Billing Instruction	Code Description
Medical and Facility	No cost share for Medical or Facility services when one billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	
44389	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position	Fiberoptic Colonoscopy; W Biopsy Collect S
44392	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position	Colonoscopy Stomal W Rem Polyp Les
44394	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position	Colonoscopy Through Stoma; W Removal of Tumor/Polyp/Lesions By Snare
44401	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
45305	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position	Proctosigmoidoscopy W Biopsy
45309	No cost share when billed with Modifier 33, PT, or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Proctosigmoidoscop y, Rigid; W Removal Single Tumor/Polyp/Lesion By Snare
45315	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Proctosigmoidoscop y; Multiple Removals

Code	Billing Instruction	Code Description
45331	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with biopsy, single or multiple
45333	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s) polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45338	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45346	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post- dilation and guide wire passage, when performed)
45378	No cost share when billed with Modifier 33, PT, or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45380	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45384	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45388	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
74263	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Computed Tomographic (CT) colonography, screening, including image post processing
88305	No cost share when billed with Modifier 33, PT, or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Surg Pathology; Level 4 Gross & Microscopic examination
99152	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation support. Initial 15 minutes of intraservice time, age 5 and older
99153	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation support, each additional 15 minutes intra service time.

Code	Billing Instruction	Code Description
99156	No cost share when billed with Modifier 33, PT, or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Initial 15 minutes of intraservice time, patient age 5 and older.
99157	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Each additional 15 minutes intraservice time.
00811	Bill with Modifier PT or 33 or with one of the following ICD 10 Codes in the first Position. Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
00812	No cost share when billed with Modifier 33, PT, or ICD-10 code above billed in principal position	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy

Colorectal Cancer Screening–NYS Circular Letter No. 4 (2022) (NY only)

(December 2021)

MVP covers Colorectal Cancer in adults beginning at the age of 45 years.

In addition, MVP covers follow-up Colonoscopies for New York Members when based on the following requirements:

- If an abnormal or positive non-invasive stool-based screening test or direct visualization screening test as recommended by the USPSTF and clarified in federal guidance is obtained, a follow-up Colonoscopy will be covered as Preventive

Covered recommended positive non-invasive stool-based screening tests or direct visualization screening tests:

45330, 45331, 45332, 45333, 45334, 45337, 45338, 45341, 45342, 45346, 45347, 82270, 82274, 81528

If one of the above screening tests results in an abnormal or positive test outcome, bill the follow-up Colonoscopy as outlined below.

Code	Billing Instruction	Code Description
45378	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimens(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45380	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45381	No cost share when billed with Modifier 33 or PT	Colonoscopy, submucous injection
45382	No cost share when billed with a modifier PT or thirty-three	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
45384	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

Code	Billing Instruction	Code Description
45385	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with transendoscopic balloon dilation
45388	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45389	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)

Colorectal Cancer Screening – 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 10 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-pay, deductible, co-insurance, 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.

Code	Billing Instruction	Code Description
Medical & Facility	No cost share for Medical or Facility services when one billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, D50.9, K63.5, Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z12.13, Z13.811, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z85.060, Z85.068, Z86.010, Z86.018, Z87.19.	
44389	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Fiberoptic Colonoscopy; W Biopsy Collect S

Code	Billing Instruction	Code Description
44392	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Colonoscopy Stomal W Rem Polyp Les
44394	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Colonoscopy Through Stoma; W Removal of Tumor/Polyp/Lesions By Snare
44401	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45305	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Proctosigmoidoscopy W Biopsy
45309	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Proctosigmoidoscopy, Rigid; W Removal Single Tumor/ Polyp/Lesion By Snare
45315	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Proctosigmoidoscopy; Multiple Removals
45331	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Sigmoidoscopy, flexible; with biopsy, single or multiple
45333	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s by hot biopsy forceps or bipolar cautery
45338	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45346	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45378	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, D50.9, K63.5, Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z12.13, Z13.811, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z85.060, Z85.068, Z86.010, Z86.018, Z87.19.	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45380	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45384	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

Code	Billing Instruction	Code Description
45388	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post- dilation and guide wire passage, when performed)
74263	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Computed Tomographic (CT) colonography, screening, including image post processing
88305	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Surg Pathology; Level 4 Gross & Microscopic examination
99152	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation support. Initial 15 minutes of intraservice time, age 5 and older
99153	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, each additional 15 minutes intraservice time.
99156	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Initial 15 minutes of intraservice time, patient age 5 and older.
99157	No cost share when billed with Modifier 33, PT, or ICD 10 code above	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Each additional 15 minutes intraservice time.
00811	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
00812	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy

Dental Caries prevention - Screening and Interventions to Prevent Dental Caries in Children Younger Than 5 Years

(December 2021) Rating B

"Task Force" Recommendation

The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.

The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

Code	Billing Instruction	Code Description
99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness
99188		Application of topical fluoride varnish by a physician or other qualified health care professional

*Codes D1206 and D1208 are not reimbursable under the medical benefit.

Depression Screening – Adolescents

(Feb 2016) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for major depressive disorder (MDD) in adolescents ages 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up).

Code	Billing Instruction	Code Description
96160	**Medical & Facility** Applies to children and adolescents – 2 years of age and older	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.
96161	**Medical & Facility** Applies to children and adolescents – 2 years of age and older	Administration of caregiver- focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.

Depression Screening – Adults, including Pregnant and Postpartum Women

(Jan 2016) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (when staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up).

Code	Billing Instruction	Code Description
99401-99404	Medical & Facility	Medical & Facility Annual wellness Visit Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness

Code	Billing Instruction	Code Description
96127	Medical & Facility	Brief emotional/behavioral assessment (e.g., depression inventory, attention- deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
96160	Medical & Facility	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument
96161		Administration of caregiver- focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.
G0439		Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
G0444		Annual Depression Screening 15 minutes
G0447		Face-to-face behavioral counseling for obesity, 15 minutes
G0473		Face-to-face behavioral counseling for obesity, group (2- 10), 30 minutes

Screening for Prediabetes and Type 2 Diabetes

(August 2021) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who are have who have overweight or obeseity. Clinicians should offer, or refer patients with prediabetes to effective preventive interventions. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. See Women's Preventive Health section on *Screening for Gestational Diabetes Mellitus and Screening for Diabetes Mellitus after Pregnancy*.

Code	Billing Instruction	Code Description
	• Bill with one of the following ICD 10 Codes: Z00.00, Z00.01, Z13.1, Z86.32 • And at least one of the following Additional Diagnosis Codes as follows: **OVERWEIGHT:** ICD-10: E66.3, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29	Medical & Facility Annual wellness Visit Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness
82947	**OBESITY:** ICD-10: E66.01, E66.09, E66.1, E66.8, E66.9, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45 **BODY MASS INDEX 25.0 – 29.9:** ICD-10: Z68.25, Z68.26, Z68.27, Z68.28, Z68.29 **BODY MASS INDEX 30.0 – 39.9:** ICD-10: Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39 **BODY MASS INDEX 40.0 AND OVER:** ICD-10: Z68.41, Z68.42, Z68.43, Z68.44, Z68.45	Glucose; quantitative, blood (except reagent strip).
82950	Bill with one of the ICD – 10 codes listed above.	Glucose; post-glucose dose (includes glucose)

Code	Billing Instruction	Code Description
82951	Bill with one of the ICD – 10 codes listed above.	Glucose: tolerance test (GTT), 3 specimens (includes glucose)
82952	Bill with one of the ICD – 10 codes listed above.	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)
82948	Bill with one of the ICD – 10 codes listed above.	Glucose; blood, reagent strip
83036	Bill with one of the ICD – 10 codes listed above.	Hemoglobin; glycosylated (A1c)

Falls Prevention in Older Adults

(April 2018) Rating B

"Task Force" Recommendation

The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.

Folic Acid: Supplementation

(Feb 2016) Rating B

"Task Force" Recommendation

The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.

Code	Billing Instruction	Code Description
99401-99404	Medical & Facility	**Medical & Facility** – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness

Screening for Gestational Diabetes

(August 2021) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at or after 24 weeks of gestation. For additional diabetes screening benefits, see the Women's Preventive Health section for Screening for Gestational Diabetes Mellitus and Screening for Diabetes Mellitus after Pregnancy.

Code	Billing Instruction	Code Description
82947	Bill with appropriate code and appropriate Pregnancy related ICD 10 diagnosis code billed in the principal diagnosis position	Glucose; quantitative, blood (except reagent strip).
82950	Bill with appropriate code and appropriate Pregnancy related ICD 10 diagnosis code billed in the principal diagnosis position	Glucose; post-glucose dose (includes glucose)

Code	Billing Instruction	Code Description
82951	Bill with appropriate code and appropriate Pregnancy related ICD 10 diagnosis code billed in the principal diagnosis position	Glucose: tolerance test (GTT),3 specimens (includes glucose)
82952	Bill with appropriate code and appropriate Pregnancy related ICD 10 diagnosis code billed in the principal diagnosis position	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)
82948	Bill with appropriate code and appropriate Pregnancy related ICD 10 diagnosis code billed in the principal diagnosis position	Glucose; blood, reagent strip
83036	Bill with appropriate code and appropriate Pregnancy related ICD 10 diagnosis code billed in the principal diagnosis position	Hemoglobin; glycosylated (A1c)

Healthy Weight and Weight Gain During Pregnancy: Behavioral Counseling Interventions

(May 2021) Rating B

"Task Force" Recommendation

The USPSTF recommends that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.

Code	Billing Instruction	Code Description
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	No cost share when billed for healthy weight and weight gain during pregnancy
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	No cost share when billed for healthy weight and weight gain during pregnancy
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	No cost share when billed for healthy weight and weight gain during pregnancy
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	No cost share when billed for healthy weight and weight gain during pregnancy

Code	Billing Instruction	Code Description
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	No cost share for women when billed with appropriate pregnancy related ICD 10 Diagnosis code
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	No cost share for women when billed with appropriate pregnancy related ICD 10 Diagnosis code
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes	No cost share for women when billed with appropriate pregnancy related ICD 10 Diagnosis code
S9470	Nutritional counseling, dietitian visit	No cost share for women when billed with appropriate pregnancy related ICD 10 Diagnosis code

Preventive Medications Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum

(Jan 2019) Rating A

"Task Force" Recommendation

The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmic neonatorum.

Code	Billing Instruction	Code Description
Medical & Facility	Global to infant nursery care inpatient admission	Would be included in Hospital bill or well-baby codes.

Healthy Diet, Physical Activity and Behavioral Health Counseling Interventions for Adults with Cardiovascular Risk Factors.

(November 2020) Rating B

"Task Force" Recommendation

The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.

"Task Force" Recommendation

The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.

Code	Billing Instruction	Code Description
Medical & Facility 99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness
G0446		Intensive behavioral counseling for cardiovascular disease for 15 minutes.

Hearing Loss Screening: Newborns

(July 2008) Rating B

"Task Force" Recommendation

Medical – The USPSTF recommends screening for hearing loss in all newborn infants. When billed with appropriate code (left) along with ICD 10 codes billed in the principal diagnosis position

Facility – No co-pay for screening hearing loss in newborns when billed with appropriate code.

Code	Billing Instruction	Code Description
Medical & Facility 92551	Diagnosis Code set for Hearing loss screening in newborns Z00.110, Z00.111, Z00.121, Z00.129. No diagnosis code required for Facility.	Definition needed- No results Screening test, pure tone, air only.
92560	Bill with one of the ICD – 10 diagnosis codes listed above	Bekesy audiometry; screening
92552	Bill with one of the ICD – 10 diagnosis codes listed above	Pure tone audiometry (threshold); air only
92585	Bill with one of the ICD – 10 diagnosis codes listed above	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	Diagnosis Code set for Hearing loss screening in newborns Z00.110, Z00.111, Z00.121, Z00.129. No diagnosis code required for Facility.	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587	Bill with one of the ICD – 10 diagnosis codes listed above	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
92588	Bill with one of the ICD – 10 diagnosis codes listed above	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report
V5008	Bill with one of the ICD – 10 diagnosis codes listed above	Hearing screening

Hemoglobinopathies Screening: Newborns

(Sept 2017) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for sickle cell disease in newborns. No co-pay for screening of sickle cell disease in newborns under 2 months old when submitted with appropriate code (below).

Code	Billing Instruction	Code Description
85660		Sickle Cell Disease screening

Hepatitis B Screening: Virus Infection in Adolescents and Adults at increased risk

(December 2020) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection. See the Practice Considerations section for a description of adolescents and adults at increased risk for infection.

Code	Billing Instruction	Code Description
G0499	Bill with one of the ICD-10 screening diagnosis codes Z00.00, Z00.01, Z11.59, Z57.8, Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Hepatitis B screening in nonpregnant, high-risk individual
86704	Bill with one of the ICD-10 screening diagnosis codes Z00.00, Z00.01, Z11.59, Z57.8, Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Hepatitis B core antibody (HBcAb); total
86705	Bill with one of the ICD-10 screening diagnosis codes Z00.00, Z00.01, Z11.59, Z57.8, Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Bill with one of the ICD-10 screening diagnosis codes Z00.00, Z00.01, Z11.59, Z57.8, Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Hepatitis B surface antibody (HBsAb)
87340	Bill with one of the ICD-10 screening diagnosis codes Z00.00, Z00.01, Z11.59, Z57.8, Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Infectious agent antigen detection by immunoassay technique

Hepatitis B Virus Infection Screening: Pregnant Persons

(June 2019) Rating A

"Task Force" Recommendation

The USPSTF recommends screening for hepatitis B virus infection in pregnant persons at their first prenatal visit.

Code	Billing Instruction	Code Description
87340	Medical & Facility	Hepatitis B surface antigen (HbsAg)
86704	Bill with a pregnancy diagnosis code	Hepatitis B core antibody (HBcAb); total

Code	Billing Instruction	Code Description
86705	Bill with a pregnancy diagnosis code	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Bill with a pregnancy diagnosis code	Hepatitis B surface antibody (HBsAb)
87340	Bill with a pregnancy diagnosis code	Infectious agent antigen detection by immunoassay technique

Hepatitis C Virus Infection Screening: Adults

(March 2020) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18–79 years.

Code	Billing Instruction	Code Description
86803		Hepatitis C antibody; confirmatory test (e.g., immunoblot)
86804		Hepatitis C antibody; confirmatory test (e.g., immunoblot)
G0472		Hepatitis C antibody screening for individual at high risk and other covered indication(s)
87390		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple-step method; HIV-1
G0432		Infectious agent antibody detection by enzyme immunoassay (eia) technique, hiv-1 and/or hiv-2, screening
G0433		Infectious agent antibody detection by enzyme-linked immunosorbent assay (elisa) technique, hiv-1 and/or hiv-2, screening
G0435		Infectious agent antibody detection by rapid antibody test, hiv-1 and/or hiv-2, screening or just "Oral hiv-1/hiv-2 screen"
G0475		HIV antigen/antibody, combination assay, screening
S3645		Hiv-1 antibody testing of oral mucosal transudate mucosal transudate

Screening for Hypertension in Adults

(April 2021) Rating A

"Task Force" Recommendation

The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

Code	Billing Instruction	Code Description
99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness

Human Immunodeficiency Virus (HIV) Infections: Screening for Pregnant Persons, Adolescents, and Adults 15–65)

(June 2019) Rating A

"Task Force" Recommendation

The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.

Medical & Facility – No cost share for screening HIV infection in pregnant women, including those who present in labor who are untested and whose HIV status is unknown. Submit bill with appropriate code.

Code	Billing Instruction	Code Description
G0432		Infectious agent antibody detection by enzyme immunoassay (eia) technique, hiv-1 and/or hiv-2, screening
G0433		Infectious agent antibody detection by enzyme immunoassay (elisa) technique, hiv-1 and/or hiv-2, screening
G0435		Infectious agent antibody detection by rapid antibody test, hiv-1 and/or hiv-2, screening or just "Oral hiv-1/hiv-2 screen"
G0475		HIV antigen/antibody, combination assay, screening
86701		Antibody; HIV-1
86702		Antibody; HIV-2
86703		Antibody; HIV-1 and HIV-2, single assay
87390		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple-step method; HIV-1
S3645		Hiv-1 antibody testing of oral mucosal transudate
87389		Microbiology procedures

Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis

(June 2019) Rating A

"Task Force" Recommendation

The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

Note: This benefit also includes the following services:

- Kidney function testing (creatinine),
- Serologic testing for Hepatitis B and C virus,
- Testing for other STIs,
- Pregnancy testing (when appropriate), and
- Ongoing follow-up and monitoring including HIV testing every 3 months

*Refer to the plan's pharmacy benefit for details on prescription medications available under plans preventive benefit.

Code	Billing Instruction	Code Description
82565	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Creatinine; Blood
82570	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Creatinine; Urine
81025	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Urine pregnancy test, by visual color comparison methods
84702, 84703	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Gonadotropin, Chorionic; Quantitative; Gonadotropin, Chorionic; Qualitative
99202-99205*	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Office or other outpatient visit for the evaluation and management of a new patient
99212-99215	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Established Outpatient Office Visit
99417	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Prolonged Codes Specific to 99205 and 99215
G0463	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Hospital outpatient clinic visit for assessment and management of a patient
96372	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Therapeutic, Prophylactic, or Diagnostic Injection (Specify Substance or Drug); Subcutaneous or Intramuscular
J0739	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Injection, cabotegravir, 1 mg
87147	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Under Microbiology Culture and Typing Procedures
36415, 36416	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Collection of venous blood by venipuncture
86689	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Antibody Htlv/Hiv Antibody Confirm
87391	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Infectious agent antigen detection
87806	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies
87801	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Nucleic Acid Detection, Multiple Organisms; Amplified Probe(s) Techniq
87810	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	Immunoassay With Direct Optical Observation; Chlamydia Trachomatis
87850	Bill with the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53	87850 - Immunoassay With Direct Optical Observation; Neisseria Gonorrhoeae

*Also see codes in the wellness section

Please refer to supporting policies:

- Sexually Transmitted Infections Counseling
- Screening for Chlamydia and Gonorrhea
- Hepatitis B Screening: Virus Infection in Adolescents and Adults at increased risk
- Hepatitis B Virus Infection Screening: Pregnant Women
- Hepatitis C Virus Infection Screening: Adults
- Syphilis Infection in Nonpregnant Adults and Adolescents: Screening
- Syphilis Screening: Pregnant Persons
- Human Immunodeficiency Virus (HIV) Infection: Screening for Pregnant Persons, Adolescents, and Adults 15–65

Hypothyroidism Screening (Newborns)

(March 2008) Rating A

"Task Force" Recommendation

The USPSTF recommends screening for congenital hypothyroidism in newborns.

No cost share for congenital hypothyroidism screening in newborns when billed with appropriate CPT code.

Code	Billing Instruction	Code Description
84437		Hypothyroidism screening in newborns

Intimate Partner Violence Screening: Women of Childbearing Age

(Jan 2013) Rating B

"Task Force" Recommendation

The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.

Code	Billing Instruction	Code Description
99385-99387	Medical & Facility	New Patient comprehensive preventive medicine evaluation and management
99395-99397		Established Patient comprehensive preventive medicine evaluation and management
99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.

Lung Cancer Screening

(March 2021) Rating B

"Task Force" Recommendation

The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adult's ages 50 to 80 years old who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Counseling to discuss lung cancer screening should be discussed.

Code	Billing Instruction	Code Description
71271	Prior authorization is required for 71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material is intended to be the replacement code.
G0296		Counseling visit to discuss need for lung cancer screening (ldct) using low dose CT scan (service is for eligibility determination and shared decision making)

Maternal Depression Screening

New York State Department of Financial Services to Title 11 NYCRR 52, Amendment 52 (Insurance Regulation 62) Sections: 52.1(r), 52.17(a)(39), and 52.18(a)(14)

Description/ Recommendation	Code	Description	Business Rule
Coverage will be provided for screening and referral for maternal depression.	**Medical Screening Services** **99401-99404** **96127** **96160** **96161** **G0444**	Depression Screening	Medical Services No cost share for depression screening when performed by a provider of obstetrical, gynecologic, or pediatric services. In the event the mother is covered under a different policy than the infant and the screening and referral are performed by a provider of pediatric services, coverage for the screening and referral shall also be provided under the policy in which the infant is covered. The provider should bill the maternal screening services on the infants claim.

Obesity, Screening and Counseling: Adults

(September 2018) Rating B

"Task Force" Recommendation

The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.

Code	Billing Instruction	Code Description
99381-99387		New Patient comprehensive preventive medicine evaluation and management
99395-99397		Established Patient comprehensive preventive medicine evaluation and management
99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.
G0447		Face-to-face behavioral counseling for obesity, 15 minutes

Obesity Screening and Counseling: Children

(Jan 2010) Rating B

"Task Force" Recommendation

The USPSTF recommends that clinicians screen children ages 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.

Code	Billing Instruction	Code Description
Medical & Facility 99381-99387		New Patient comprehensive preventive medicine evaluation & management
99395-99397		Established Patient comprehensive preventive medicine evaluation and management
99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.
G0447		Face-to-face behavioral counseling for obesity, 15 minutes

Osteoporosis Screening: Women

(June 2018) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for osteoporosis with bone measurement testing: To prevent osteoporotic fractures in women 65 years and older. In postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.

Code	Billing Instruction	Code Description
Medical & Facility 77080		Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, & spine)
77081		Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

Preeclampsia Screening

(April 2017) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for preeclampsia in pregnant persons with blood pressure measurements throughout pregnancy.

Code	Billing Instruction	Code Description
99394 99395 99396	Medical & Facility Use codes to the left	Established Patient comprehensive preventive medicine evaluation and management.

Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication

(September 2021) Rating B

"Task Force" Recommendation

The USPSTF recommends the use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia. A written prescription for aspirin is required: Age limit >/= 12 (women) QL of 100 units/fill Generics only Single ingredient OTC dosages 325mg or less.

Perinatal Depression, Preventive Interventions

(Feb 2019) Rating B

"Task Force" Recommendation

The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling intervention.

Code	Billing Instruction	Code Description
96127		Brief emotional/behavioral assessment (for example, depression inventory, ADHD scale), with scoring and documentation, per standardized instrument.
G0444		Annual depression screening, 15 minutes

Rh Incompatibility Screening: 24- 28 Weeks Gestation

(Feb 2004) Rating A

"Task Force" Recommendation

The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)- negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)- negative.

Code	Billing Instruction	Code Description
86901	Medical & Facility and appropriate Pregnancy related ICD 10 diagnosis code at end of Policy.	Blood typing; Rh (D)antibody testing

Rh Incompatibility Screening: First Pregnancy Visit

(Feb 2004) Rating B

"Task Force" Recommendation

Medical & Facility – No cost share for Rh incompatibility screening for all pregnant persons during their first visit for pregnancy-related care when billed with appropriate code and appropriate Pregnancy related ICD 10 diagnosis code set billed in the principal diagnosis position

Code	Billing Instruction	Code Description
Medical & Facility		**Medical & Facility** – Blood typing; Rh (D)antibody testing

Sexually Transmitted Infections Counseling

(August 2020) Rating B

"Task Force" Recommendation

The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections. No co-pay in females with Cervical Dysplasia Sexually Active Females.

Code	Billing Instruction	Code Description
99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.
G0445	**Limited to 2x a year**	Semi-annual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior.

Skin Cancer Behavioral Counseling

March 2018 (May 2012) Rating B

"Task Force" Recommendation

The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons ages 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

Code	Billing Instruction	Code Description
99381-99385		New Patient comprehensive preventive medicine evaluation and management
99391-99395		Established Patient comprehensive preventive medicine evaluation and management
99401-99404		Preventive medicine Counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.

Statin Preventive Medication

adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater

"Task Force" Recommendation (1 of 2)

No cost share for adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10- year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.

Code	Billing Instruction	Code Description
80061	Procedure codes 82465, 83718,84478 will not be reimbursed if billed with 80061 (lipid panel).	Lipid panel. This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)
82465		Cholesterol, serum or whole blood, total

Code	Billing Instruction	Code Description
83718		Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
84478		Triglycerides

"Task Force" Recommendation (2 0f 2)

Pharmacy Guidelines for men and women – ages 40 through 75 years old:

- No quantity limit
- No prior authorization
- Low to moderate dose statins, generics only (no high dose or brand statins are included)
  - Atorvastatin 10 mg, 20 mg
  - Fluvastatin 20 mg, 40 mg
  - Fluvastatin ER 80 mg o Lovastatin 10 mg, 20 mg, 40 mg
  - Pravastatin 10 mg, 20 mg, 40 mg, 80 mg
  - Rosuvastatin 5 mg, 10 mg
  - Simvastatin 5 mg, 10 mg, 20 mg, 40 mg

As with other ACA- mandated preventive services coverage for non-grandfathered plans, coverage will be provided at zero Member cost share. For statin prescriptions outside of these age ranges and/or strengths, the standard plan benefits will apply.

Code	Billing Instruction	Code Description
82465		Cholesterol, serum or whole blood, total
83718		Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
84478		Triglycerides
80061	Procedure codes 82465, 83718,84478 will not be reimbursed if billed with 80061 (lipid panel).	Lipid panel. This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)

Syphilis Infection in Nonpregnant Adults and Adolescents: Screening

(June 2016) Rating A

"Task Force" Recommendation

The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.

Code	Billing Instruction	Code Description
86592		Syphilis test, non- Treponema antibody; qualitative (e.g., VDRL, RPR, ART)
86593		Syphilis test, non- treponemal antibody; quantitative
86780		Antibody; Treponema pallidum

Syphilis Screening: Pregnant Persons

(May 2009) Rating A

"Task Force" Recommendation

The USPSTF recommends early screening for syphilis infection in all pregnant persons.

Code	Billing Instruction	Code Description
86592		Syphilis test, non- Treponema antibody; qualitative (e.g., VDRL, RPR, ART)
86593		Syphilis test, non- treponemal antibody; quantitative
86780		Antibody; Treponema pallidum

Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons

(January 2021) Rating A

"Task Force" Recommendation

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 nonpregnant adults who use tobacco.

The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.

Reimbursement restricted to the following specialties:

- Primary Care Physicians: Family Practice, Internal Medicine, General Practitioners
- Specialists: OB/GYN, Pediatricians Services (included in Preventative E&M codes)

Note: MVP considers Smoking, Tobacco, Vaping/ E-cigarettes included under this recommendation

Code	Billing Instruction	Code Description
99406	**Medical and Facility** Bill with CPT code to left	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	**Medical and Facility** Bill with CPT code to left	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Tobacco Use Interventions: Children and Adolescents

(Aug 2020) Rating B

"Task Force" Recommendation

The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-age children and adolescents.

Note: MVP considers Smoking, Tobacco, Vaping/E-cigarettes included under this recommendation

Code	Billing Instruction	Code Description
99406	**Medical and Facility** Bill with CPT code to left	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	**Medical and Facility** Bill with CPT code to left	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Tuberculosis Screening: Adults

(Sept 2016) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.

Code	Billing Instruction	Code Description
CPT codes 86480, 86481 86580 **ICD-10 codes Z11.1 Z20.1**	**Medical & Facility** Use the appropriate CPT code along with the appropriate ICD-10 code to the left.	• **86480** Tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon • **86481** Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T- cells in cell suspension • **86580** Skin test; tuberculosis, intradermal • **Z11.1** Screening for respiratory tuberculosis • **Z20.1** Contact with or suspected exposure to tuberculosis

Visual Acuity Screening in Children

(Jan 2011) Rating B

"Task Force" Recommendation

Medical & Facility – 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.

Code	Billing Instruction	Code Description
99173		**Medical & Facility** – Visual acuity screening in children

Non-USPSTF Preventative Services Coverage

Women's Preventive Health Policies (HRSA)

Women's Preventive Health-Contraception methods and counseling.
No cost share when billed with the appropriate code.

Code	Description	Business Rule
Contraceptive Care		• No cost share when billed with appropriate codes. • HRSA Requirement (Jan. 2023): WPSI recommends that adolescent and adult women have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve birth outcomes. Contraceptive care includes screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period). Contraceptive care also includes follow-up care (e.g., management, evaluation and changes, including the removal, continuation, and discontinuation of contraceptives). • WPSI recommends that the full range of U.S. Food and Drug Administration (FDA)- approved, -granted, or -cleared contraceptives, effective family planning practices, and sterilization procedures be available as part of contraceptive care. • The full range of contraceptives includes those currently listed in the FDA's Birth Control Guide****: (1) sterilization surgery for women, (2) implantable rods, (3) copper intrauterine devices, (4) intrauterine devices with progestin (all durations and doses), (5) injectable contraceptives, (6) oral contraceptives (combined pill), 7) oral contraceptives (progestin only), (8) oral contraceptives (extended or continuous use), (9) the contraceptive patch, (10) vaginal contraceptive rings, (11) diaphragms, (12) contraceptive sponges, (13) cervical caps, (14) condoms, (15) spermicides, (16) emergency contraception (levonorgestrel), and (17) emergency contraception (ulipristal acetate), and any additional contraceptives approved, granted, or cleared by the FDA.
99401 - 99404	No cost share for contraceptive methods and counseling in females when billed with appropriate CPT codes	
99202, 99203, 99204, 99205	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position	
99211, 99212, 99213, 99214, 99215	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position	
Please see Policy: Contraceptive Use and Counseling		
Please see Policy: Sterilization Surgery		

Contraceptive Use and Counseling

Code	Description	Business Rule
11976	Removal Only Implanted Contraceptive Cap	No cost share for contraceptive use and counseling for women when billed with appropriate CPT codes
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
11981	Insertion, non-biodegradable drug delivery implant	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
11982	Removal, non-biodegradable drug delivery implant	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position

Code	Description	Business Rule
11983	Removal with reinsertion, non-biodegradable drug delivery implant	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
S4993	Contraceptive pills for birth control	No cost share for contraceptive use and counseling for women when billed with appropriate code (left)
57170	Diaphragm or cervical cap fitting with instructions	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
58300	Insertion of intrauterine device (IUD)	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
58301	Removal of intrauterine device (IUD)	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
A4267	Mail Condom (obtained thru Pharmacy with prescription	
S4981	Insertion of levonorgestrel- releasing intrauterine system	No cost share for contraceptive use and counseling for women when billed with appropriate code
S4989	Contraceptive intrauterine device (e.g., progestacert iud), including implants and supplies	No cost share for contraceptive use and counseling for women when billed with appropriate code
S4993	Contraceptive pills for birth control	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4261	Cervical cap for contraceptive use	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4266	Diaphragm for contraceptive use	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4268	Contraceptive supply, condom, female, each	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each	No cost share for contraceptive use and counseling for women when billed with appropriate code
J1050	Injection, medroxyprogesterone acetate, 1 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code

Code	Description	Business Rule
J7297	Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7298	Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7300	Intrauterine copper contraceptive	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7301	Levonorgestrel releasing intrauterine contraceptive system, 13.5 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7304	Contraceptive supply, hormone containing patch, each	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
00851	Anes, Intraperitoneal Procedures in Lower Abdomen Including Laparoscopy; Tubal Ligation/ Transection.	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
00840	Anesthesia intraperitoneal lower abd w/laps nos	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
00940	Anesthesia vaginal procedure w/biopsy nos	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position.
00952	Anes hysteroscopy&/hysterosalpingography w/bx	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
81025	Urine pregnancy test, by visual color comparison methods	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
74018	Radiologic exam abdomen 1 view	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
76857	Ultrasound pelvic nonobstetric image DCMTN limited/f/u	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position

Code	Description	Business Rule
76830	Ultrasound transvaginal	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
76998	Ultrasonic guidance intraoperative	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position

Contraceptive-related ICD 10 diagnosis code set billed in the principal diagnosis position:
T8331XA, T8331XD, T8331XS, T83.32XA, T83.32XD, T83.32XS , T83.39XA, T8339XD, T8339XS, Z30.011, Z30.012, Z30.013, Z30.014, Z30.015, Z30.016, Z30.017, Z30.018, Z30.019, Z30.02, Z30.09, Z30.2, Z30.40, Z30.41, Z30.42, Z30.430, Z30.431, Z30.432, Z30.433, Z30.44, Z30.45, Z30.46, Z30.49, Z30.8, Z30.9, Z97.5, Z98.51

Women's Preventive Health-Well-woman Preventive Visits

Code	Description	Business Rule
99202-99215	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. * No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position	• No cost share when billed with appropriate code. • HRSA Requirement (Jan. 2023): WPSI recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure the provision of all recommended preventive services, including preconception and many services necessary for prenatal and interconception care, are obtained. • The primary purpose of these visits should be the delivery and coordination of recommended preventive services as determined by age and risk factors. These services may be completed at a single or as part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors. • Well-women visits also include pre-pregnancy, prenatal, postpartum and interpregnancy visits. • See Policies: Pediatric and Adult Preventive Exams
99401-99404	E&M Codes Preventive medicine counseling and/ or risk factor reduction intervention(s) provided to an individual without specific illness.	
99381-99387	New Patient comprehensive preventive medicine evaluation and management	
99391-99397	Established Patient comprehensive preventive medicine evaluation and management	
S0610	Annual Gynecological Examination	
S0612	Annual Gynecological Examination	
S0613	Annual breast exam	
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visi	
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	

Pediatric and Adult Preventive Exams

Code	Description	Business Rule
99381-99387	New Patient comprehensive preventive medicine evaluation and management	No cost share for a routine preventative exam when billed with the appropriate CPT code.
99391-99397	Established Patient comprehensive preventive medicine evaluation and management	No cost share for a routine preventative exam when billed with the appropriate CPT code (left).
99401-99404	E&M Codes Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	No co-pay for a routine preventative exam.
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	No co-pay for a routine preventative exam when billed with the appropriate CPT code
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	No co-pay for a routine preventative exam when billed with the appropriate CPT code
S0610	Annual Gynecological Examination	No cost share for a routine preventative exam when billed with the appropriate CPT code
S0612	Annual Gynecological Examination	No cost share for a routine preventative exam when billed with the appropriate CPT code
S0613	Annual breast exam	No cost share for a routine preventative exam when billed with the appropriate CPT code

Immunizations for Adults and Children

The immunizations below were identified using ACIP guidelines.

Business Rule: No co-pay when immunization is provided based on ACIP guidelines.

Code	Description
90587	Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use
90611	Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous use
90622	Vaccinia (smallpox) virus vaccine, live, lyophilized, 0.3 mL dosage, for percutaneous use
90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use Ages 16 – 23 years
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use Ages 16–23 years
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use Ages 2-71 months
90632	Hepatitis A vaccine, adult dosage, for intramuscular use Age 12 months and older
90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use Age 12 months and older

Code	Description
90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use Age 12 months and older
90636	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use Age 18 years and older
90644	Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenzae type b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 6 weeks-18 months of age, for intramuscular use
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use Age 0 and older
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use Age 0 and older
90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use, ages
90650	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use Male/female ages
90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 3 dose schedule, for intramuscular use Female age 9 – 45 years
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use Age 65 years and older
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use Age 18 – 64 years
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use All NDCs inactive 7/9/15
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use Age 3 years and older.
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use Afluria age 9 years and older
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use Age 3 years and older.
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
90661	Influenza virus vaccine (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use Age 4 years and older
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use Age 65 years and older
90664	Influenza virus vaccine, live (LAIV), pandemic formulation, for intranasal use. Benefit limit:
90666	Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use
90667	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use
90668	Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use.
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use.
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use. Benefit limit: Ages 6-35 months old

Code	Description
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use.
90689	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use
90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 ml dosage, for intramuscluar use
90696	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use Ages 4 – 6 years.
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use.
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
90702	Diphtheria and tetanus toxoids adsorbed (DT) when administered to individuals younger than 7 years, for intramuscular use
90707	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use Ages 0 and older
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use Ages 12 months -12 years
90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use Ages 7 years and older.
90715	Tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use Ages 12 months and older
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use Ages 6 weeks – 6 years
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use Ages 2 years and older
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W- 135 (tetravalent), for intramuscular use ages 9 months- 55 years 9 - 23 months 2 doses, 2 -55 years 1 dose
90736	Zoster (shingles) vaccine, live, for subcutaneous injection Ages 50 years and older
90739	Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use.
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use Ages 18 years and older
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use Ages 7 – 18 years
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use Ages 0-18 years

Code	Description
90746	Hepatitis B vaccine, adult dosage, for intramuscular use Ages 10 years and older
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use Ages 0 and older
90748	Hepatitis B andHemophilus influenza b vaccine (HepB-Hib), for intramuscular use Ages 6 weeks – 15 months
90750	Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular useShingrix® age 50 years & older, Zostavax® age 60 years & older
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use
90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use
J3530	Nasal vaccine inhalation ACIP recommendation - do not use product
Q2034	Influenza virus vaccine, split virus, for intramuscular use (Agriflu) Ages 6 months and older. All NDCs Inactive 6/13/12
Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA) Ages 5 years and older
Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL) age 6 months or older for Flulaval Quadrivalent.>>>All NDCs Inactive as of 6/4/15
Q2037	Influenza virus vaccine, split virus, when administered to individuals 4 years of age and older, for intramuscular use (FLUVIRIN) age 4 years & older for Fluvirin
Q2038	Influenza virus vaccine, split virus, for intramuscular use (Fluzone) FDA approved age 6 months of age or older for Fluzone. FDA approved 65 years of age or older for Fluzone High Dose. FDA approved age 18- 64 for Fluzone Intradermal.
Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified) Ages 3 years and older)

Immunization Administration

Code	Description	Business Rule
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	No cost share when submitted with an appropriate CPT code (left) and immunization code (above).
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered. (List separately in addition to code for primary procedure)	No cost share when submitted with the appropriate CPT code (left) and immunization code (above).
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	No cost share when submitted with an appropriate immunization code (above).
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/ toxoid). (List separately in addition to code for primary procedure)	No cost share when submitted with an appropriate immunization code (above).

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

Hemoglobin/Hematocrit Testing

Code	Description	Business Rule
86762	Antibody; rubella	No cost share for rubella antibody testing as follows: when performed on children under the age of 13 months as a preventative visit when billed with the appropriate CPT code (left). Children are covered for one (1) test and immunization between 11 and 17 years of age as a preventative visit when billed with the appropriate CPT code (left). Adults are covered for one (1) test and immunization between 18 and 49 years of age as a preventative visit when billed with the appropriate CPT code (left).

Women's Preventative Health

Code	Description	Business Rule
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician	No co-pay
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	No co-pay
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 co-pay
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision	No co-pay
88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision	No co-pay
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision	No co-pay when modifier attached to code.

Code	Description	Business Rule
88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision	No co-pay
88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision	No co-pay
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	No co-pay
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index). (List separately in addition to code[s] for other technical and interpretation services)	No co-pay
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	No co-pay
88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision	No co-pay
88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision	No co-pay
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 co-pay
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	No co-pay
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 co-pay
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	No co-pay
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	No co-pay
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	No co-pay
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	No co-pay

Code	Description	Business Rule
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 co-pay
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 co-pay
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	No co-pay
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	No co-pay
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	No co-pay
P3000	Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, by technician under physician supervision	No co-pay
P3001	Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, requiring interpretation by physician	No co-pay
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	No co-pay

Women's Preventative Health – HPV Testing

Code	Description	Business Rule
87623	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (e.g., 6, 11, 42, 43, 44)	No cost share for HPV testing in females over age 30 when billed with appropriate CPT code
87624	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	No cost share for HPV testing in females over age 30 when billed with appropriate CPT code
87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	No cost share for HPV testing in females over age 30 when billed with appropriate CPT code
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	No cost share for HPV testing in females over age 30 when billed with appropriate CPT code

Women's Preventative Health – Counseling and screening for human immune-deficiency virus

Code	Description	Business Rule
86701	Antibody; HIV-1	No cost share when billed with appropriate code. HRSA Requirement (Jan. 2023): WPSI recommends all adolescent and adult women, ages 15 and older, receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk, and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. WPSI recommends risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk. A screening test for HIV is recommended for all pregnant persons upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant persons who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission.
86702	Antibody; HIV-2	
86703	Antibody; HIV-1 and HIV-2, single result	
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot	
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening	
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening	
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening	
G0475	HIV antigen/antibody, combination assay, screening	
S3645	HIV-1 antibody testing of oral mucosal transudate	

Women's Preventative Health – Sexually Transmitted Infection Counseling

Code	Description	Business Rule
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	• No cost share when billed with appropriate code. • HRSA Requirement (Jan. 2023): WPSI recommends directed behavioral counseling by a health care clinician or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for STIs. • WPSI recommends that clinicians review a woman's sexual history and risk factors to help identify those at an increased risk of STIs. Risk factors include, but are not limited to, age younger than 25, a recent history of an STI, a new sex partner, multiple partners, a partner with concurrent partners, a partner with an STI, and a lack of or inconsistent condom use. For adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgment.
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	
G0445	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior	
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes	

Women's Preventative Health – Obesity Prevention in Midlife Women

Code	Description	Business Rule
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	• No cost share when billed with appropriate code. • HRSA Requirement (Jan. 2023): WPSI recommends counseling midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5-29.9 kg/m2) to maintain weight or limit • Bill with appropriate BMI code: Z68.1 = BMI 19.9 or less Z68.2 = BMI 20 – 29
G0473	Face-to-face behavioral counseling for obesity, group (2- 10), 30 minutes	
99401 – 99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness	
99385 – 99387	New Patient comprehensive preventive medicine evaluation and management	
99395 - 99397	Established Patient comprehensive preventive medicine evaluation and management	

Women's Preventative Health – Contraceptive Methods and Counseling

Vermont Only

8 V.S.A. § 4099c. Reproductive health equity in health insurance coverage

Code	Description	Business Rule
99202	Office/outpatient new sf MDM 15-29 minutes	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position
99203	Office/outpatient new low MDM 30-44 minutes	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position
99204	Office/outpatient new moderate MDM 45-59 minutes	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position
99205	Office/outpatient new high MDM 60-74 minutes	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position
99211	Office/outpatient established minimal problem(s)	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position
99212	Office/outpatient established sf MDM 10-19 min	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position

Code	Description	Business Rule
99213	Office/outpatient established low MDM 20-29 min	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position
99214	Office/outpatient established mod MDM 30-39 min	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position
99215	Office/outpatient established high MDM 40-54 min	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position

Women's Preventative Health – Sterilization Surgery

Code	Description	Business Rule
58565	Hysteroscopy, surgical	No cost share for contraceptive use and counseling for women when billed with appropriate CPT codes
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58661	Removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	No cost share for female sterilization surgery when billed with the appropriate CPT codes (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	No cost share for contraceptive use and counseling for women when billed with appropriate CPT codes
58555	Hysteroscopy diagnostic separate procedure	No cost share for female sterilization surgery when billed with the appropriate CPT codes (left) and appropriate contraceptive related ICD10 diagnosis code set billed in the principal diagnosis position
58562	Hysteroscopy removal impacted foreign body	No cost share for female sterilization surgery when billed with the appropriate CPT codes (left) and appropriate contraceptive related ICD10 diagnosis code set billed in the principal diagnosis position

Code	Description	Business Rule
58340	Saline or contrast material / cath & saline/contrast sonohyster/hysterosalpi	No cost share for female sterilization surgery when billed with the appropriate CPT codes (left) and appropriate contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
74740	Hysterosalpingography	No cost share for female sterilization surgery when billed with the appropriate cpt codes (left) and appropriate contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position
88302	Level II Surgical Pathology Gross & Microscope Exam	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position

Women's Preventative Health – Counseling to Detect and Prevent Interpersonal and Domestic Violence

Code	Description	Business Rule
99401 **99402** **99403** **99404**	Preventive medicine counseling and/or risk factor reduction interventions	No co-pay screening and counseling to detect and prevent interpersonal and domestic violence for females when billed with the appropriate CPT codes

Women's Preventative Health – Breastfeeding Services and Supplies (Breastfeeding support, supplies, and counseling)

Code	Description	Business Rule
E0602 **E0603** **E0604**	Breast pump, manual, any type of Breast pump, electric (AC and/or DC), any type Breast pump, hospital grade, electric (AC and/or DC), any type	• No cost share when billed with appropriate code. • HRSA Requirement (Jan. 2023): Comprehensive lactation support services (including consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to optimize the successful initiation and maintenance of breastfeeding. • Breastfeeding equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric pumps should be a priority to optimize breastfeeding and should not be predicated on prior failure of a manual pump. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services. • 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 • Members must use current vendor
A4281	Tubing for breast pump, replacement	
A4282	Adapter for breast pump, replacement	
A4283	Cap for breast pump bottle, replacement	
A4284	Breast shield and splash protector for use with breast pump, replacement	
A4285	Polycarbonate bottle for use with breast pump, replacement	
A4286	Locking ring for breast pump, replacement	
K1005	Disposable collection and storage bag for breast milk, any size, any type, each	
S9443	Non-physician conducting a lactation class	

Code	Description	Business Rule
99501	Home visit for postnatal assessment and follow-up care	No cost share for supervision of lactation when billed by a physician with the appropriate E&M code and the following diagnosis codes billed in the principal diagnosis position; Z39.1
99502	Home visit for newborn care and assessment	
99211 **99212** **99213** **99214** **99215**	Nurse visit usually under 5 minutes Office or other outpatient visit for the evaluation and management of an established patient	

Women's Preventative Health – Screening for Gestational Diabetes Mellitus

Code	Description	Business Rule
82947	Glucose; quantitative, blood (except reagent strip).	• No cost share for women when billed with appropriate Pregnancy related ICD 10 Diagnosis code. • HRSA Requirement (Dec. 2016): Recommends screening pregnant persons for gestational diabetes mellitus after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) in order to prevent adverse birth outcomes. Screening with a 50-g oral glucose challenge test (followed by a 3-hour 100-g oral glucose tolerance test if results on the initial oral glucose challenge test are abnormal) is preferred because of its high sensitivity and specificity. This recommendation also suggests that women with risk factors for diabetes mellitus be screened for preexisting diabetes before 24 weeks of gestation—ideally at the first prenatal visit, based on current clinical best practices. • Also see Pre-Diabetes Screening and Gestational Diabetes Screening in the Preventive Healthcare Payment Policy.
82950	Glucose; post-glucose dose	
82951	Glucose: tolerance test (GTT),3 specimens (includes glucose)	
82952	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)	
82948	Glucose; blood, reagent strip	
83036	Hemoglobin; glycosylated (A1c)	

Women's Preventative Health – Screening Diabetes Mellitus after Pregnancy

Code	Description	Business Rule
82947	Glucose; quantitative, blood (except reagent strip).	• No cost share for women when billed with a Pregnancy diagnosis Z86.32 (personal history of gestational diabetes) or Z39.2 (routine postpartum) • HRSA Requirement (Dec. 2017): The Women's Preventive Services Initiative recommends women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus should be screened for diabetes mellitus. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum. • Women with a negative initial postpartum screening test result should be rescreened at least every 3 years for a minimum of 10 years after pregnancy • Also see Pre-Diabetes Screening and Gestational Diabetes Screening in the Preventive Healthcare Payment Policy.
82950	Glucose; post-glucose dose	
(includes glucose)	Glucose: tolerance test (GTT),3 specimens (includes glucose)	
82951	Glucose; tolerance test (GTT),3 specimens (includes glucose)	
82952	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)	
82948	Glucose; blood, reagent strip	
83036	Hemoglobin; glycosylated (A1c)	

Women's Preventative Health – Screening for Urinary Incontinence

Code	Description	Business Rule
99381-99387	New Patient comprehensive preventive medicine evaluation and management	No cost share for screening women for urinary incontinence annually.
99395-99397	Established Patient comprehensive preventive medicine evaluation and management	No cost share for screening women for urinary incontinence annually.
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	No cost share for screening women for urinary incontinence annually.

Women's Preventative Health – Breast Cancer Screening

Business Rule: Call-back mammograms and ultrasounds for patients whose screening mammograms were inconclusive or who have dense breast tissue, or both, will be covered in full when billed with diagnosis code R92.2, R92.8

Code	Description
76641-76642	Diagnostic Ultrasound Procedures of the Chest
77061- 77063	Under Breast, Mammography
77065-77067	Under Breast, Mammography
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral
99401-99404	Preventive medicine counseling and/or risk factor reduction interventions
99386, 99387,	Initial comprehensive preventive medicine evaluation and management code set

Code	Description
99396, 99397	Established patient comprehensive preventive medicine evaluation and management

USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.

Men's Preventive Health—Contraception Consultation and Voluntary Sterilization

(Vermont Only)

8 V.S.A. § 4099c. Reproductive health equity in health insurance coverage

A health insurance plan shall provide coverage for voluntary sterilization procedures for men and women without any deductible, coinsurance, co-payment, or other cost-sharing requirement, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

This includes consultation services associated with providing the procedures covered under this section.

Code	Description	Business Rule
99202	Office/outpatient new sf MDM 15-29 minutes	**Non-HDHP Plans:** No cost share for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.
99203	Office/outpatient new low MDM 30-44 minutes	**Non-HDHP Plans:** No cost share for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.
99204	Office/outpatient new moderate MDM 45-59 minutes	**Non-HDHP Plans:** No cost share for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.
99205	Office/outpatient new high MDM 60-74 minutes	**Non-HDHP Plans:** No cost share for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.
99211	Office/outpatient established minimal problem(s)	**Non-HDHP Plans:** No cost share for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.

Code	Description	Business Rule
99212	Office/outpatient established sf MDM 10-19 min	**Non-HDHP Plans:** No cost share for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.
99213	Office/outpatient established low MDM 20-29 min	**Non-HDHP Plans:** No cost share for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.
99214	Office/outpatient established mod MDM 30-39 min	**Non-HDHP Plans:** No cost share for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.
99215	Office/outpatient established high MDM 40-54 min	**Non-HDHP Plans:** No cost share for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for male counseling when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.

Men's Preventive Health—Elective Sterilization Vasectomy Surgery

(Vermont Only)

8 V.S.A. § 4099c. Reproductive Health Equity in Health Insurance Coverage

A health insurance plan shall provide coverage for voluntary sterilization procedures for men and women without any deductible, coinsurance, co-payment, or other cost-sharing requirement, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. sec 223.

Code	Description	Business Rule
55250	Vasectomy	**Non-HDHP Plans:** No cost share for male sterilization surgery when billed with the appropriate CPT codes **Qualified HDHP Plans:** No cost share after Deductible for male sterilization surgery when billed with the appropriate CPT codes
00921	Anesthesia Vasectomy	**Non-HDHP Plans:** No cost share for male sterilization surgery when billed with the appropriate CPT codes **Qualified HDHP Plans:** No cost share after Deductible for male sterilization surgery when billed with the appropriate CPT codes

Code	Description	Business Rule
88302	Level II Surgical Pathology Gross & Microscopic Exam	**Non-HDHP Plans:** No cost share for lab when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position **Qualified HDHP Plans:** No cost share after Deductible for lab when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.

Post-Surgical Lab work

Code	Description	Business Rule
89321	Semen analysis sperm presence &/motility sperm	**Non-HDHP Plans:** No cost share for lab when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for lab when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.
89320	Semen analysis volume count motility different	**Non-HDHP Plans:** No cost share for lab when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position. **Qualified HDHP Plans:** No cost share after Deductible for lab when billed with appropriate code (left) and appropriate Contraceptive related ICD 10 diagnosis code set billed in the principal diagnosis position.

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 Medical Services

New York State Insurance Law Chapter 74 of the Laws of 2016 Insurance Law requires no cost share for diagnostic imaging, ultrasounds, and MRI of the breast.

Code	Description	Business Rule
Medical Services 76641*, 76642*, 77053, 77046, 77047**, 77048**, 77049**, 77054, 77061*, 77062*, 77063, 77065*, 77066*, 77067, G0279*, S8080, C8903, C8905, C8906, C8908**	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	**Medical Services** No cost share for diagnostic imaging, ultrasounds, and MRI of the breast when billed with the appropriate CPT code. *Codes are covered in full only when billed with diagnosis codes R92.2 and R92.8 **Require prior authorization via eviCore

VT Diagnostic MRI with Screening (Vermont Diagnostic Mammogram Medical Services)

Code	Description	Business Rule
Medical Services 77046, 77047**, 77048**, 77049****	MRI of the breast	No cost share for MRI of the breast when billed with the appropriate CPT code. **Require prior authorization via eviCore

Medicaid Product Variation

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

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

Code	Description	Business Rule
J7300	Intrauterine copper contraceptive	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code.
J7301	**Levonorgestrel** releasing intrauterine contraceptive system, 13.5 mg	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.
J7306	**Levonorgestrel** (contraceptive) implant system, including implants and supplies	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code.
J7307	**Etonogestrel** (contraceptive) implant system, including implant and supplies	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.
J7297	**Levonorgestrel** releasing intrauterine contraceptive system, 52 mg, 3 year duration	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code.
J7307	**Levonorgestrel** releasing intrauterine contraceptive system,52 mg, 5 year duration	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.

Modifier PT and Modifier 33

Modifier PT

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

Modifier 33

*Each preventive care service will identify the specific billing rules as to when to apply Modifier 33 or when Modifier is not needed to be billed.

Code	Description	Business Rule
Preventive Services	When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.	The Member's co-pay/co-insurance/cost share for this service will be waived as appropriate.

Code Sets

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

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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, 77046*, 77047*, 77048*, 77049*, 77053, 77054, 77061, 77062, 77063, 77065, 77066, 77067, G0279

Preventive medicine counseling and/or risk factor reduction interventions service code set:

99401, 99402, 99403, 99404

*Mammography codes requiring prior authorization via eviCore.

History

June 1, 2019	New Policy approved
October 1, 2019	Policy reviewed and approved with changes
January 1, 2020	Policy reviewed and approved with changes
March 1, 2020	Policy reviewed and approved with changes
June 1, 2020	Policy reviewed and approved with changes
September 1, 2020	Policy reviewed and approved with changes
December 1, 2020	Policy reviewed and approved with changes
March 1, 2021	Policy reviewed and approved with changes
September 1, 2021	Policy reviewed and approved with changes
December 1, 2021	Policy reviewed and approved with changes
March 1, 2022	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with changes
December 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with changes

Radiology

Last Reviewed Date: March 1, 2023

Policy

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

MVP requires an overread by a Radiologist or a Specialist Physician within the scope of their specialty when diagnostic images are performed and read by a Primary Care Physicians, Physician Assistants and Nurse Practitioners. Physician specialists are required to have the image overread by a Radiologist if the imaging is outside the scope of their practice.

Prior Authorization Requests

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

Billing/Coding Guidelines

Diagnostic Radiology Reading

MVP reimburses for only one reading of a diagnostic radiology test. Duplicate readings are not eligible for reimbursement.

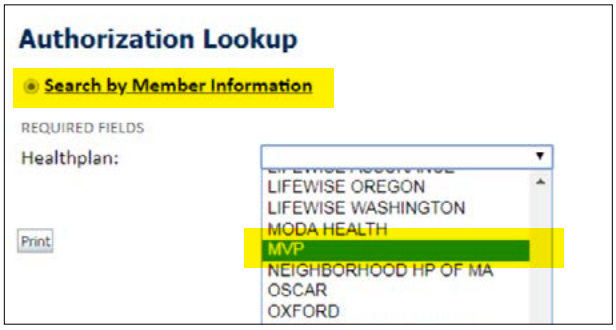
Diagnostic Radiology Prior Authorization

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

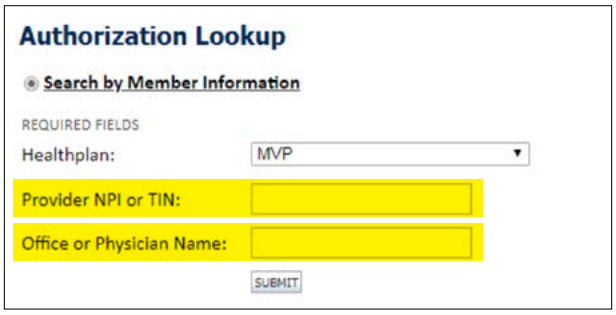
- Services provided when an authorization is required but there is not a valid authorization for the services obtained
- Radiology claims that require prior authorization that are submitted with a Modifier 26 for the professional reading will not be reimbursed without a valid authorization

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

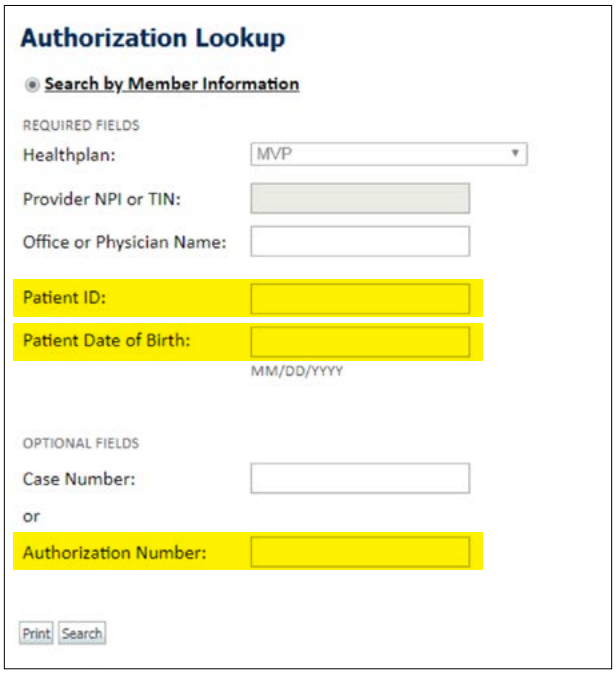
1. Go to evicore.com
2. Click on *Check Status of Existing Prior Authorization*
3. Choose *Search by Member Information* and then choose *MVP* for Healthplan



4. Enter the Provider's Name and NPI and click *Submit*.



5. Enter the Members information, the MVP Member ID and DOB (MM/DD/YYYY) or the Authorization number if you have it. Click *Search*.



Results will be returned for all authorization requests and approvals will be displayed for the Member. The Authorization number, the status (pended, approved, or denied), the approval date, the expiration date of the authorization and the authorized procedures will be displayed. If records are not returned the Member does not have an authorization for the service.

History

September 1, 2018	New policy, approved
September 1, 2020	Policy reviewed and approved with no changes
December 1, 2021	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with no changes

Radiopharmaceuticals

Last Reviewed Date: September 1, 2022

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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

For Commercial, Exchange, and Medicaid Claims. Codes will be paid up to $100 without an invoice

A9541	Technetium tc-99m sulfur colloid, diagnostic, per study dose, up to 20 millicuries
A9560	Technetium tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries

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

A9500	Technetium te-99m sestamibi, diagnostic, per study dose

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

A9502	Technetium tc-99m tetrofosmin, diagnostic, per study dose
A9505	Thallium tl-201 thallous chloride, diagnostic, per millicurie
A9538	Technetium tc-99m pyrophosphate, diagnostic, per study dose, up to 25 millicuries

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

A9562	Technetium tc-99m mertiatide, diagnostic, per study dose, up to 15 millicuries
A9556	Gallium ga-67 citrate, diagnostic, per millicurie

The following Radiopharmaceutical codes will not be reimbursed as they are considered inclusive of the procedure:

A9552	Fluorodeoxyglucose f-18 fdg, diagnostic, per study dose, up to 45 millicuries

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.

History

December 1, 2020	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with no changes

Robotic and Computer Assisted Surgery

Last Reviewed Date: September 1, 2021

Policy

Robotic and Computer Assisted Surgery refers to the use of surgical robots, and computer-assisted devices to facilitate manipulation, positioning, and control of instrumentation during a variety of surgical procedures. These devices are used at the discretion of a surgeon.

Definitions

Computer-assisted navigation devices may be image-based or non-image-based. Imaged-based devices use preoperative computed tomography scans, and operative fluoroscopy to direct implant positioning. Newer non-image-based devices use information obtained in the operating room, typically with infrared probes.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

CPT Codes	Guidelines
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less
S2900	Surgical techniques requiring use of robotic surgical system
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation
61781	Stereotactic computer-assisted (navigational) procedure; cranial, intradural
61872	Stereotactic computer-assisted (navigational) procedure; cranial, extradural
61783	Stereotactic computer-assisted (navigational) procedure; spinal

Reimbursement Guidelines

MVP provides coverage for surgical procedures that are medically necessary and meet the criteria in MVP Medical Policies. The use of specific surgical techniques, instrumentation, and surgical approaches is left to the discretion of the surgeon. MVP does not provide additional professional or technical reimbursement for use of robotic, or computer assisted instrumentation utilizing CPT codes 0054T, 0055T, 20985, 31627, 61781, 61782, 61783 and S2900 because payment is included in the reimbursement for the primary procedure. CPT-4 or HCPC Level II Codes indicating robotic surgical system(s) or computer-assisted navigation will be denied as inclusive or global as they are not eligible for separate payment. This policy applies to both professional and facility providers.

Use of Modifier 22 (increased procedural services) appended to the primary surgical procedure is not appropriate if used exclusively for the purpose of reporting the use of robotic assistance. Modifier 22 may only be used when substantial additional work is performed, (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, and physical and mental effort required) that is unrelated to robotic assistance.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

References

1. Functional outcomes following total knee arthroplasty: A randomized trial comparing computer-assisted surgery with conventional techniques. Knee. Hoppe S, Mainzer JD, Frauchiger L. March 2014
2. More accurate component alignment in navigated total knee arthroplasty has no clinical benefit at 5-year follow-up. Acta Orthop. Hoppe S, Mainzer JD, Frauchiger L. December 2012
3. Computer-assisted surgical navigation does not improve the alignment and orientation of the components in total knee arthroplasty. J Bone Joint Surg Am. Kim YH, Kim JS, Choi Y. January 2009
4. Computer-navigated versus conventional total knee arthroplasty a prospective randomized trial. J Bone Joint Surg Am. Kim YH, Park JW, Kim JS. November 2012
5. Robotic surgery. A current perspective. Annals of Surgery. Lanfranco, AR, Castellanos, AE, Desai, JP, Meyers, WC. January 2004
6. No difference between computer-assisted and conventional total knee arthroplasty: five-year results of a prospective randomized study. Knee Surg Sports Traumatol Arthrosc. Lutzner J, Dexel J, Kirschner S. October 2013
7. Practice Management. So, you think you want a robot: Analyzing cost and implementation. The Female Patient. Swisher E, MD; Weiss PM, MD; Scribner Jr. July 2011.
8. Advantages and limits of robot-assisted laparoscopic surgery: preliminary experience. Surg Endosc. Corcione F, Esposito C, Cuccurullo D, et al. January 2005

History

June 1, 2021	Policy approved
September 1, 2022	Policy reviewed and approved with changes

Services Not Separately Reimbursed

Last Reviewed Date: December 1, 2022

Policy

MVP follows Claims EXT edits for services that are not reimbursed distinctly and separately. In addition, MVP does not reimburse separately for the services that fall under the categories listed below; these services are inclusive in other payments made by MVP.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Reimbursement Guidelines

Services and CPT codes that are considered inclusive and are not separately reimbursed include but are not limited to:

Category	CPT Codes
Care Management Services (including care planning, care plan oversight, assessment, care management home visits, and medication therapy management) Note: Facilities that have been identified by MVP as a Health Home Health Home will be reimbursed separately for these services as outlined by New York State Guidelines.	**99366, 99367, 99368, G0076, G0077, G0078, G0079, G0080, G0081, G0082, G0083, G0084, G0085, G0086, G0087, G0088, G0089, G0090, G2215, G2216, 99339, 99340, 99379, 99380, S0315, S0316, S0317, S0320, S0280, S0281, 99605, 99606, 99607, G0506, G9001, G9005, T2022**
Chronic Care Management Note: Chronic Care Management will be reimbursed separately for Medicare plans.	**99424, 99425, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491**
Bundled Payments for Care Improvement Advanced	**G9978, G9979, G9980, G9981, G9982, G9983, G9984, G9985, G9986, G9987**
Results/Data Collection & Review	**99090, 93793, G0452**
Informational Codes	**0001F – 9999F, G2173 – G2211, M1146 – M1149**
Review of Medical Records	**99358, 99359, S9981, S9982**
Miscellaneous Special Services Procedures and Reports	**P9603, P9604, H0048, S3600, S3601, 99000, 99001, 99002, 99024, 99070, 99080, S8415, 99091, 99098, 98969, 98961, 98962, S2900, Q0511, Q0512, Q0513, S5000, S5001**
On Call & Standby Service	**99026, 99027, 99360**

History

September 1, 2019	Policy approved
June 1, 2020	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with changes
December 1, 2022	Policy reviewed and approved with changes

Speech Therapy (ST)

Last Reviewed Date: June 1, 2022

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. They should be provided one-to-one by a speech-language pathologist educated in the assessment of speech and language development and 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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

The following CPT codes are covered for Speech Therapy providers:

CPT Code	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)

CPT Code	Description
92522	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)
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
92609	Therapeutic services for the use of speech-generating device, including programming and modification
92610	Evaluation of oral and pharyngeal swallowing function
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording
92612	Flexible endoscopic evaluation of swallowing by cine or video recording;
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes
92630	Auditory rehabilitation; prelingual hearing loss
92633	Auditory rehabilitation; post lingual hearing loss
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
S9128	Speech therapy, in the home, per diem
S9152	Speech therapy, re-evaluation

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

Non-Reimbursable Speech Therapy 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
- Laryngoscopy, flexible or rigid telescopic, with stroboscopy (CPT 31579) is a diagnostic procedure to be performed by a physician. It may not be performed by a speech-language pathologist.

Medicare Therapy Cap

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

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

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

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

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

Reimbursement Guidelines

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

References

MVP Utilization Management Policy, Provider Resource Manual

History

March 1, 2019	Policy approved
March 1, 2021	Policy reviewed and approved with no changes
June 1, 2022	Policy reviewed and approved with changes

Surgical Supplies

Last Reviewed Date: September 1, 2022

Policy

MVP follows CMS guidelines and does not reimburse for surgical supplies (except Splinting and Casting) separate from the Evaluation and Management and/or Procedure codes when billed at the professional level. These supplies are bundled into the practice expense RVU and will not be reimbursed when billed with the E&M/procedure code or as a stand-alone service.

Definitions

The Practice Expense (PE) RVU reflects the costs of maintaining a practice. PE RVU includes but is not limited to:

- Medical and/or Surgical Supplies (i.e. surgical trays, syringes, saline irrigation or flush supplies, dressings, and gloves)
- Staff Costs
- Renting office space and expenses incurred to run the office (i.e. furniture, utilities, office supplies)
- Purchasing and maintaining equipment

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Code	Description	Rule
A4550	Surgical Trays	• Surgical Trays are not reimbursable when billed at the professional level. • Surgical trays are considered part of the practice expense RVU for E&M and procedure codes.
A4263	Permanent, long-term, non-dissolvable lacrimal duct implant	• Lacrimal duct implants are not reimbursable when billed at the professional level. • Surgical trays are considered part of the practice expense RVU for E&M and procedure codes..

References

CMS Regulations and Guidance:
cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

CMS Medicare Physician Fee Schedule Fact Sheet:
cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medcrephysfeeschedfctsht.pdf

AMA – Medicare Physician Payment Schedules:
ama-assn.org/practice-management/medicare-physician-payment-schedules

History

September 1, 2019	Policy approved
June 1, 2020	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Telehealth

Last Reviewed Date: May 11, 2023

Related Policies:
Modifier Payment Policy
Provider Responsibilities
Virtual Check-in Payment Policy

Policy

MVP will reimburse for Telehealth Services, which are live audio-only or audio-visual services provided through electronic information and communication devices to patients at a site (originating site) that is not the same as the Provider (distant site), and for Telemedicine Services through MyVisitNow® or Gia Urgent Care. This policy serves as a guide to assist you in accurate telehealth claims submissions for Medicare, Medicaid, Health, and Recovery Plan ("HARP"), Essential Health Plans, Child Health Plus and Commercial plans, and is not meant to be an exhaustive list for every payment scenario. Guidance from federal and state authorities may be updated from time to time, but links are provided below to assist in maintaining the most updated guidance. Definitions related to Telehealth can be found in the applicable statute, regulation and/or guidance. Reimbursement guidance for Virtual Check-ins can be found in the MVP Virtual Check-in Payment Policy.

Billable Codes and Descriptions

Professionals

The following Place of Service Codes should be used when billing for Telehealth Services on Professional Claims:

Place of Service Code	Description
02	Telehealth is provided at in a setting other than the home of the patient
10	Telehealth is provided in the home of the patient (including residence, shelter or temporary housing)

Modifiers

The following Modifiers should be used when billing for Telehealth Services to the extent applicable:

Modifier	Description
93	Synchronous Telehealth services rendered via telephone or other real-time interactive audio-only telecommunications systems (i.e., audio-only). NOTE: Modifier 93 is to be used for all audio-only services, including mental health services furnished via audio-only. For RHCs, FQHCs and OTPs, modifier 93 must be used, but modifier FQ should be used as well when services are furnished in such settings.
95	Synchronous Telehealth services rendered via real-time interactive audio and video telecommunications systems (i.e., audio-video)
FQ	Telehealth service was furnished using real-time audio-only communication technology. For RHCs, FQHCs and OTPs, this modifier must be used in conjunction with modifier 93
FR	A supervising practitioner was present through a real-time two-way, audio/video communication technology
GQ	Telehealth services provided via asynchronous telecommunication system (store and forward technology)
GT	Telehealth services provided via interactive audio and video telecommunication systems.
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day as a procedure or other services. For example, the Member has a psychiatric consultation via

	telemedicine on the same day as a primary care E&M visit at the originating site. The E&M service should be appended with the 25 modifier.
HD	Used with maternal remote patient monitoring; denotes pregnant/postpartum services

Medicare, Essential Health Plans, and Commercial Plans

MVP will reimburse for covered Telehealth Services and in compliance with the CMS List of Telehealth Services for each calendar year, including audio-only services. However, audio-video services are highly encouraged over audio-only services for quality of care. MVP also encourages the Provider to notate the reason for the services to be audio-only and any Member preference for providing audio-only services.

Medicaid, HARP, and Child Health Plus

MVP pays for Telehealth Services for Medicaid, HARP and Child Health Plus Members in accordance with guidance provided by NY Department of Health, Office of Mental Health (OMH), Office of Persons With Developmental Disabilities (OPWDD), and Office of Alcohol and Substance Abuse Services (OASAS). Telehealth Services include audio-visual services, store and forward technology, remote patient monitoring, after-hours services, virtual check-ins, virtual patient education, and in for certain Providers, virtual eTriage. Telehealth Services provided through audio-only should only be used in rare occasions to meet the personalized needs of each Member and in compliance with the most current guidelines developed by the NY Department of Health, which can be found on their website or viewed here: *New York State Medicaid Update - February 2023 Volume 39 - Number 2 (ny.gov)*

For Medicaid products, licensed physicians or Nurse Practitioners may bill for Telehealth Services provided in an Article 28 Facility setting; however, the APG payment for all other Telehealth providers providing Telehealth services in an Article 28 Facility setting are included in MVP's APG payment to the Article 28 Facility.

Additional Billable Codes and Descriptions

In addition to the CMS allowable Place of Service Codes and Modifiers above, the NY Department of Health separately provides the following Billable Codes and Descriptions applicable to Medicaid, HARP, and Child Health Plus programs.

Services	Codes	Description	Notes
Tele-dentistry	D9995	Synchronous tele-dentistry services using audio-visual technology; can include urgent visits, follow-up visits, and new patient screening	Modifier cannot be used.
Tele-dentistry	D9996	Asynchronous transmission of recorded health information (store and forward technology)	Modifier cannot be used.
Telehealth Facility (including Teledentistry)	Q3014	Originating Site Facility Fee	For facilities only; Only facilities should use this code and the Member must be physically present in the originating facility to receive reimbursement.
Remote Patient Monitoring	99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring)	Can only be billed one time per Member per month.
Remote Patient Monitoring (Pregnancy/Post-partum)	99453 + HD modifier	Remote monitoring of physiologic parameters (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) initial; set-up and patient education on use of equipment.	One-time billing of service.

Remote Patient Monitoring (Pregnancy/Post-partum)	99454+HD	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. Every 30 days when a minimum of 16 days of data is collected within the 30-day period.	This is a once per 30-day fee regardless of the number of devices used to monitor the pregnant/post-partum individual. NOTE: 99454 and 99091 cannot be billed on the same day. FQHCs that have opted out of APGs are unable to bill for RPM services
After-Hours	99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.	Bill with modifiers 93, 95, GT or FQ as appropriate. Please review the MVP After-Hours Payment Policy for additional information on this service.
After-Hours	99051		Bill with modifiers 93, 95, GT or FQ as appropriate. Please review the MVP After-Hours Payment Policy for additional information on this service.
Virtual Check-In	G2012	Brief communication technology-based service by a physician or other qualified health care professional who can report E&M services, not originating from a related E&M service provided within the previous seven days nor leading to a E&M service or procedure within the next 24 hours or soonest available appointment; *5 to 10 minutes of medical discussion.*	Bill with modifiers 93, 95, FQ, GT and GQ as appropriate.
Virtual Check-In	G2252	Brief communication technology-based service by a physician or other qualified health care professional who can report E&M services, not originating from a related E&M service provided within the previous seven days nor leading to a E&M service or procedure within the next 24 hours or soonest available appointment; *11 to 20 minutes of medical discussion.*	Bill with modifiers 93, 95, FQ, GT and GQ as appropriate
Virtual Patient Education	0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day	Bill with modifiers 95 and GT as appropriate
Virtual Patient Education	0488T	Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days.	Coaches must be able to track participant progress through online modules. To bill, the patient must complete a minimum of three sessions per month and adhere to the CDC guidelines regarding coaching support (no less than once per week first six months and no less than once per month next six months); No applicable modifiers
Virtual Patient Education	D1320	Tobacco counseling for the control and prevention of oral disease. Billable only as an individual session, greater than 3 minutes.	Bill with modifiers 95 and GT as appropriate

Virtual Emergency eTriage	Base rate procedure code + A0425 (milage code) + modifier	This permits ambulance companies responding to 911 calls to provide treatment in place or transport patients to destinations other than the emergency room. Providers must be approved to participate in both the CMS ET3 model AND the NYS DOH parallel model in order to bill for this service.	Use the following destination modifier as appropriate: C – Community Mental Health Ctr (including substance use disorder Ctr) F – FQHC O – Physician's office U – Urgent care W – Treatment in place by a licensed healthcare practitioner either in person or via telehealth (no mileage permitted with this modifier)
All Other Services, including audio-only and additional patient education codes		See *List of Telehealth Services | CMS*	

Allowable Telehealth Platforms

Authorized Providers who deliver Telehealth Services must use non-public facing communication technologies and/or platforms that comply with the HIPAA rules.

Remote Patient Monitoring (RPM)

Remote Patient Monitoring (RPM) may be utilized as Telehealth Services when medically necessary to monitor Members with certain health conditions and must be discontinued when their condition is determined to have stabilized. RPM must be ordered by a New York licensed physician, nurse practitioner or midwife who has examined the Member and with whom the Member has an established, documented, and ongoing relationship. Member health information or data may be received at the Distant Site by a New York licensed registered nurse. While ordering RPM, the Provider must see the Member in-person, as needed, for follow-up care.

Certified Home Health Agencies ("CHHA") are ineligible to provide RPM Telehealth Services to a Member if they are receiving home health care services through the CHHA.

OMH Specific Requirements

Providers licensed by the Office of Mental Health (OMH) or listed as a designated Provider, must follow current OMH guidelines for Telehealth Services, including but not limited to obtaining approval to use telehealth. Additional criteria and information specific to OMH Providers are listed in the OMH guidelines referenced above.

Billing for services by an OMH licensed or designated provider follows the NY Department of Health Guidelines and the billing instructions listed above for Medicaid, HARP and Child Health Plus.

DEA Specific Extension of COVID-19 Flexibilities

In response to the expiration of the COVID-19 Public Health Emergency, the Drug Enforcement Agency (DEA) with the U.S. Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration have issued a temporary extension of COVID-19 flexibilities for prescription of certain controlled medications. Through November 11, 2023, or until further regulatory notice, authorized Providers may use Telehealth Services to prescribe controlled medications, including but not limited to buprenorphine for the treatment of opioid use disorder, without the requirement of an in-person evaluation.

For Provider-patient relationships that have been established and using Telehealth Services before the extension deadline of November 11, 2023, the DEA will further allow the COVID-19 flexibilities for an additional twelve (12) months (or, November 11, 2024).
After any such extension date(s), Providers must again comply with the Ryan Haight Online Pharmacy Consumer Protection Act of 2008.

Vermont Specific Requirements for Audio-Only Services

For billing requirements specific to audio-only services in Vermont, please refer to the MVP Audio-Only (Vermont Only)" Payment Policy.

Additional information:

Tele-dentistry: *New York State Medicaid Update February 2019 Special Edition Volume 35 Number 2 (ny.gov); New York State Medicaid Update January 2020 Volume 36 Number 1 (ny.gov)*
Maternal Remote Patient Monitoring: *New York State Medicaid Update September 2022 Volume 38 Number 10 (ny.gov)*
Emergency Virtual eTriage: *New York State Medicaid Update November 2021 Volume 37 Number 13 (ny.gov)*
More information on physician fee schedules can be found at the following CMS sites:
Physician Fee Schedule | CMS
Medicare payment policies during COVID-19 | Telehealth.HHS.gov
List of Telehealth Services | CMS

Exclusions

The following services are excluded from services:

- eConsults, which are interprofessional consultations between a treating/requesting Provider with a consulting Provider, without a member present, are currently not reimbursable
- The acquisition, installation and maintenance of telecommunication devices or systems is not reimbursable
- Electronic mail messages, text messages or facsimiles are not reimbursable telehealth services
- Telehealth services during which all or part of the service was undeliverable due to a failure of transmission or other technical difficulty
- Services where the originating site and the distant site are the same location
- Facility fees when neither the originating site or the distant site is a clinic or facility
- Individual Practitioner Services for Individuals with Developmental Disabilities (IPSIDD)

References

Physician Fee Schedule | CMS
Medicare payment policies during COVID-19 | Telehealth.HHS.gov
List of Telehealth Services | CMS
New York State Medicaid Update - February 2023 Volume 39 - Number 2 (ny.gov)
Telehealth Services Guidance for OMH Providers - April 2023 (ny.gov)
Vermont Telemedicine Requirements

42 USC §1395m(m)
42 CFR §410.78
42 CFR §422.135
New York Insurance Law §§ 3217-h, 4306-g;
New York Public Health Law §§ 2999-cc; 2999-dd;
14 N.Y.C.R.R. Parts 538 (Medicaid reimbursement); 596 (OMH); Parts 679, 635 (OPWDD); Part 830 (OASAS); and 585.28 (CDPAS)

History

September 1, 2018	New Policy, approved
December 1, 2019	Reviewed, approved with changes
July 1, 2022	Reviewed, approved with changes
September 1, 2022	Reviewed, approved with changes
May 11, 2023	Reviewed, approved with changes

Transitional Care Management

Medicare Advantage Products Only

Last Reviewed Date: March 1, 2023

Policy

Transitional Care Management (TCM) services are for a patient whose medical and/or psychosocial problems require moderate- or high-complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital, inpatient psychiatric hospital), partial hospital, observation status in a hospital, or skilled nursing facility (SNF)/nursing facility to the patient's community setting (e.g., home, domiciliary, nursing facility or assisted living facility). TCM services begin on the date of patient discharge and continues for the next 29 days.

TCM services are reimbursable only for the MVP Medicare Advantage products. All other products do not include TCM services as a Covered Benefit.

Definitions

TCM services includes 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. Members may receive the following TCM services via telehealth as per Medicare guidelines.

Below are the two CPT TCM codes and their related requirements:

99495	Transitional Care Management Services (**Moderate** Complexity): • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two (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 two (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

MVP Payment Polices are not a guarantee of payment. Providers must confirm Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into the Provider's account at mvphealthcare.com.

Billing/Coding Guidelines

TCM services are only reimbursable only for a MVP Medicare Advantage products.

The CPT TCM codes can be billed only once per patient within 30 days after the original patient 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 patient 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.

Non-physicians who may bill TCM codes are Nurse Practitioner's (NP), Physician Assistant's (PA), Clinical Nurse Specialist's (CNS), and Certified Nurse Midwives (CNM), unless they are otherwise limited by their scope of practice as defined by the state in which they are licensed and/or certified.

There is a distinction between the discharge day management and TCM services. MVP seeks 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 TCM services that must be conducted within seven (7) or 14 calendar days of discharge.

The physician billing discharge day management could also be the physician who is regularly responsible for the patient's primary care (this may be especially the case in rural communities). However, MVP will not allow both discharge and TCM services to be billed on the same day.

The CPT TCM codes may not be billed when patients are discharged to an SNF. For patients in SNFs there are separate E&M codes for initial, subsequent, and discharge care, and the visit for the annual facility assessment, Initial nursing home visits are coded with 99304-99306. Subsequent nursing home visits are coded 99307–99310.

TCM services provided during a post-surgery period for a service with a global period will not be reimbursed because such services shall be included in the payment for the underlying procedure.

Practitioners can bill for TCM services only once in the 30 days after discharge, even if the patient may be readmitted and subsequently discharged two (2) or more times within the 30-day period.

When billing for TCM services, the following cannot also be billed during the TCM period:

- Care Plan Oversight services (CPT codes 99374-99380)
- Chronic Care Management Services (CCM and TCM service periods cannot overlap)

Reimbursement Guidelines

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

References

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

MLN908628 August 2022 Available: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf

American Academy of Family Physicians Transitional Care Management ©2023 Available: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/transitional-care-management.html

History

September 1, 2018	New policy, approved
March 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with changes

Unlisted CPT Code

Last Reviewed Date: September 1, 2022

Policy

MVP requires all claims submitted with non-contracted unlisted CPT code(s) to be submitted with medical records that support the use of the unlisted code. For claims submitted with an unlisted code without medical records, the claim or claim line(s) will deny and it will be the provider's responsibility to submit medical records to substantiate the unlisted code.

Definitions

An unlisted CPT code is used for a service or procedure that is rarely provided, unusual, variable, or is a new service or procedure that does not have a more specified CPT code.

Billing/Coding Guidelines

Unlisted CPT codes

Code	Description	Rule
Non-contracted unlisted CPT codes	Claims submitted with unlisted CPT code(s)	Claims submitted with records will be reviewed and, based upon the review, the claim will be processed accordingly: • Correct code: claim will be processed • Correct code but requires medical necessity review: record will be reviewed as such with claim processed upon completion of review. • Incorrect CPT code assigned: The provider will receive an explanation of benefits indicating there is a more specific or more appropriate code available. • Claims submitted without records: The unlisted CPT code will be denied, but provider can submit medical records for review in contracted timeframes.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

History

January 1, 2018	Policy approved
December 1, 2019	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes

Urgent Care

Last Reviewed Date: September 1, 2022

Policy

MVP determines urgent care reimbursement to be based on coding which specifically describes the services provided. Consistent with CPT and CMS, physicians and other healthcare professionals should report the evaluation and management, and/or procedure code(s) that specifically describe the urgent care service(s) performed.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding Guidelines

Code	Description	Rule
E&M Codes		The appropriate Evaluation and Management and/or procedures codes that describe the type of services performed should be billed. POS Bill with Place of Service code 20 (urgent care facility)
S9088	Services provided in an urgent care center (list in addition to code for service)	Informational only as it pertains to the place of service and not the components of the specific service(s) provided MVP does not reimburse for CPT code, whether billed alone or with any other service
S9083	Global fee urgent care centers	Global code which does not provide encounter level specificity MVP does not reimburse for CPT code, whether billed alone or with any other service

History

December 1, 2018 Policy approved
December 1, 2019 Policy reviewed and approved with no changes
Juine 1, 2021 Policy reviewed and approved with no changes
September 1, 2022 Policy reviewed and approved with no changes

Vaccine Administration (Vermont Only)

Last Reviewed Date: June 1, 2022

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 Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's *Utilization Management Guides* to determine if prior authorization is required and the *Benefit Interpretation Manual* for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Billing/Coding 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.

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:

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.

COVID-19 Vaccine and Administrative Billing Guidelines

MVP covers approved COVID-19 vaccines at no cost-share to Members in all plans. MVP will reimburse Participating Providers and out-of-network providers for the administration of the COVID-19 vaccine when the guidance below is followed when submitting for reimbursement for administration of the COVID-19 vaccine.

MVP Commercial Members

In addition to the vaccine administration code, Vermont Providers must also include the vaccine code; billed with a $0.00 or $0.01 charge on the claim. COVID-19 vaccines are not considered state-supplied; therefore, providers should not use the SL modifier.

Administration Code	Short Description	Vaccine Code	Effective Date
0001A	Pfizer vaccine – 1st dose	91300	12/11/2022
0002A	Pfizer vaccine – 2nd dose	91300	12/11/2020
0003A	Pfizer vaccine – 3rd dose	91300	8/12/2021
0004A*	Pfizer vaccine – Booster	91300	9/22/2021
0011A	Moderna vaccine – 1st dose	91301	12/18/2020
0012A	Moderna vaccine – 2nd dose	91301	12/18/2020
0013A	Moderna vaccine – 3rd dose	91301	8/12/2021
0031A	Janssen/Johnson & Johnson vaccine – 1st dose	91303	2/27/2021
0034A*	Janssen/Johnson & Johnson vaccine – Booster	91303	10/20/2021
0051A	Pfizer ready-to-use vaccine – 1st dose	91305	9/22/2021
0052A	Pfizer ready-to-use vaccine – 2nd dose	91305	9/22/2021
0053A	Pfizer ready-to-use vaccine – 3rd dose	91305	9/22/2021
0054A*	Pfizer ready-to-use vaccine – Booster	91305	9/22/2021
0064A*	Moderna lower dose vaccine – Booster	91306	10/20/21
0071A	Pfizer Pediatric vaccine – 1st dose	91307	10/29/2021
0072A	Pfizer Pediatric vaccine – 2nd dose	91307	10/29/2021
0073A	Pfizer Pediatric vaccine – 3rd dose	91307	1/3/2022
0094A*	Moderna vaccine - Booster	91309	3/29/2022

* CDC guidance regarding eligibility for a booster dose is available at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html

The administration code must match the manufacturer code of the vaccine provided at the encounter.

MVP Medicare Advantage Plan Members

As of January 1, 2022, COVID vaccine administration claims for MVP Medicare Advantage members should be submitted to MVP. Providers should not include the vaccine code on the claim for Medicare Advantage members, when COVID-19 vaccine doses are provided by the government at no charge, only bill for the vaccine administration.

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

History

September 1, 2018	Policy approved
December 1, 2019	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with changes
June 1, 2022	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Virtual Check-ins and Interpersonal Telephone/Internet/ Electronic Health Record Consultations

Last Reviewed Date: May 11, 2023

Related Policies– Provider Responsibilities
Telehealth Payment Policy

Policy

MVP will reimburse Virtual Check-ins and Interprofessional Telephone/Interne/Electronic Health Record Consultations to avoid unnecessary office visits. Providers must obtain verbal consent from a Member prior to providing these services and consent must be documented in the Members chart. Providers must inform Members that these services will be subject to all Deductibles, Co-insurance, or Copay's per the Members benefits prior to providing the services. The Virtual Check-in or Interprofessional Telephone/Internet/Electronic Health Record Consultation must be medically necessary and documented in the medical record. This policy applies to MVP Commercial and Medicare products only. These codes are not reimbursable or MVP Medicaid, CHP, or HARP.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's Utilization Management Guides to determine if prior authorization is required and the Benefit Interpretation Manual for MVPs clinical guidelines. These resources can be accessed by signing into your account at **mvphealthcare.com**.

Billing/Coding Guidelines

Virtual Check-ins are reimbursed only:

Code	Description	Reimbursement
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management [E/M] services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	• This code can only be used with established patients of the Provider. Members must have seen the Provider in person within 3-years of the Virtual Check-in by the billing Provider or by a Provider within the Provider's group who has the same specialty, and for Providers eligible to bill for an Evaluation and Management (E/M) services • Patients must not have been seen in the office for 7-days prior to the virtual check in or within 24hours of the virtual check in

G2010	Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.	• This code can only be used with established patients of the Provider. Members must have seen the Provider in person within 3-years of the Virtual Check-in by the billing Provider or by a Provider within the Provider's group who has the same specialty, and for Providers eligible to bill for an Evaluation and Management (E/M) services • Patients must not have been seen in the office for 7-days prior to the virtual check in or within 24 hours of the virtual check in.

Telephone/Internet/Electronic Health Record Consultation:

Code	Description	Reimbursement
99451	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time.	• Consultation does not lead to a transfer of care or other face-to-face services within the next 14-days (or soonest available appointment date after the consultant) • 50% or more of the time must be devoted to medical consultative verbal or internet discussion (and not a review of data) Only one consultation is billed (the service should be reported only once with a single code if more than one contact is needed to complete the consult) • Only one consult can be billed within a 7-day period by the consulting physician
99452	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified healthcare professional, 30 minutes.	
99446	Interprofessional telephone/internet assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 5-10 minutes of medical consultative discussion and review.	
99447	Same as CPT Code 99446, except 11-20 minutes	
99448	Same as CPT Code 99446, except 21–30 minutes	
99449	Same as CPT Code 99446, except 31 or more minutes	

History

December 1, 2019	Policy approved
December 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes
May 11, 2023	Policy reviewed and approved with changes

Viscosupplementation of the Knee: Non-Coverage for Medicaid Managed Care (MMC) Plans

Last Reviewed Date: March 1, 2022

Policy

Effective April 1, 2014, MVP Medicaid Managed Care (MMC) Members will be following New York State (NYS) Medicaid's limit for reimbursement for viscosupplementation of the knee. Specifically, MVP will no longer cover viscosupplementation of the knee for an enrollee with a diagnosis of osteoarthritis of the knee. All other diagnosis associated with viscosupplementation will continue to be reimbursed.

Definitions

Viscosupplementation of the knee is a procedure in which a gel-like fluid called hyaluronic acid is injected into the knee joint. Hyaluronic acid is a natural occurring substance found in the synovial (joint) fluid. Individuals with osteoarthritis ("wear-and-tear" arthritis) of the knee have a lower-than-normal concentration of hyaluronic acid in their joints.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's Utilization Management Guides to determine if prior authorization is required and the Benefit Interpretation Manual for MVPs clinical guidelines. These resources can be accessed by signing into the Providers account at mvphealthcare.com.

Reimbursement Guidelines

Based on the current available evidence, for NYS Medicaid Managed Care (MMC) Plans, MVP will no longer cover viscosupplementation of the knee to a member diagnosed with osteoarthritis of the knee. This coverage decision was based on research presented which included the potential harms attached to viscosupplementation (including joint infection, hematoma, inflammation), and the fact that viscosupplementation is only marginally effective in practice.

Billing/Coding Guidelines

The following ICD-10 diagnosis codes are associated with the non-coverage decision:

- ICD-10: M17 – Osteoarthritis of knee
- ICD-10: M17.0 – Bilateral primary osteoarthritis of knee
- ICD-10: M17.0 – Unilateral primary osteoarthritis of knee
- ICD-10: M17.4 – Other bilateral secondary osteoarthritis of knee
- ICD-10: M17.5 – Other unilateral secondary osteoarthritis of knee
- ICD-10: M17.9 – Osteoarthritis of knee, unspecified
- ICD-10: M17.10 – Unilateral primary osteoarthritis, unspecified knee

- ICD-10: M17.11 – Unilateral primary osteoarthritis, right knee
- ICD-10: M17.12 – Unilateral primary osteoarthritis, left knee

There will be no reimbursement provided by MVP when the following thirteen (13) medication codes are reported with the ICD-10 diagnosis codes listed above:

- J7318 – Hyaluronan or derivative, Durolane, for intra-articular injection, 1 mg
- J7320 - Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
- J7321 - Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose
- J7322 - Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
- J7323 - Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
- J7324 - Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
- J7325 - Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
- J7326 - Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
- J7327 – Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
- J7328 – Hyaluronan or derivative, GELSYN-3, for intra-articular injection, 0.1 mg
- J7329 – Hyaluronan or derivative, Trivisc, for intra-articular injection, 1 mg
- J7331 – Hyaluronan or derivative, SYNOJOYNT, for intra-articular injection, 1 mg
- J7332 - Hyaluronan or derivative, Triluron, for intra-articular injection, 1 mg

Notification/Prior Authorization Requests

MVP Payment Polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's Utilization Management Guides to determine if prior authorization is required and the Benefit Interpretation Manual for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

References

health.ny.gov/health_care/medicaid/program/update/2014/mar14_mu.pdf

History

April 1, 2022 New policy, approved

Implantable Devices

Last Reviewed Date: August 1, 2022

Policy

Applies to: Hospitals and Ambulatory Surgery Centers in Vermont, New Hampshire, and Massachusetts

Applicable **Plans**: All Commercial and Individual Products.

Definitions

For purposes of this policy, the definition of "Implantable Devices" or "Implants" is based on the United States Food and Drug Administration ("FDA") description, which is a device that is placed into a natural or surgically formed cavity of the human body and is intended to remain implanted continuously for a period of 30 days or more. Implants must remain in the patient's body upon discharge from the inpatient stay or outpatient procedure. Implants may include but are not limited to metal anchors artificial joints, pins, plates, radioactive seeds, metal screws, shunts, and stents.

Materials, liquids, and allografts that are dissolved / absorbed / resorbed / remodeled, such as sealants, hemostats, topical thrombins, bone morphogenetic protein, bone putty or cement, catheters, staples, and clips are generally considered supplies and do not meet the definition of Implants for reimbursement. Single use / disposable instruments or supplies also do not meet the definition of Implants for reimbursement. Provider or vendor administrative storage and delivery costs are not separately reimbursable.

Cardiac and vascular catheters and guide wires billed separately regardless of the amount billed are not separately reimbursable.

Implantable Devices or brachytherapy sources eligible for payment by MVP will have a CMS Status

Indicator H (pass-through device) or K (brachytherapy sources).

HCPCS Codes That Do Not Meet the FDA Definition of an Implant*

C1724 C1725 C1726 C1727 C1728 C1750 C1751 C1752 C1764 C1886 C1753 C1754 C1755 C1756
C1757 C1773 C1782 C1819 C1884 C1885 C2615 C2618 C2628 C2629 C2630 C1729 C1730 C1731
C1732 C1733 C1758 C1759 C1765 C1766 C1769 C1887 C1892 C1893 C1894 C2614

* - This list is subject to change based on FDA guidance.MVP will use the most current FDA information available when making a determination of whether or not a device meets the requirements for payment.

Notification/Prior Authorization Requests

MVP Payment polices are not a guarantee of payment. Providers must also check Member eligibility and refer to the Member Benefits Display to determine benefits. Providers must also review MVP's Utilization Management Guides to determine if prior authorization is required and the Benefit Interpretation Manual for MVPs clinical guidelines. These resources can be accessed by signing into your account at mvphealthcare.com.

Additional Exclusions

The following circumstances will disqualify any Implants from payment. Providers can not bill MVP Members for these items:

1. Implants obtained by the provider at no cost or reduced cost. (See additional information below on use of appropriate condition codes, value codes, and / or modifiers.)
2. Implants that are contaminated or unused and / or were not implanted in the patient. Examples include:
   - Items that were prepared or opened during a surgical case but not used or implanted into the patient
   - Items opened in error
   - Surgeon “change of mind”
   - Technical or equipment failure / difficulties
   - Surgery case cancellation
   - Muli-pack implants when more appropriate unit size can be purchased

Reimbursement Guidelines

The following condition / value codes and / or modifiers are required to report the respective circumstances they represent:

Condition Codes:

1. Condition Code 49: Product Replacement within Product Lifecycle - Replacement of a product earlier than the anticipated lifecycle due to premature failure, etc.
2. Condition code 50: Product Replacement for Known Recall of a Product - Manufacturer or FDA

has identified the product for recall and is being replaced accordingly.

3. Condition code 53: Initial Placement of a Medical Device Provided as Part of a Clinical Trial or

Free Sample – Provider has been issued a credit upon initial Implant placement as part of a clinical trial or a free sample.

Value Codes:

1. Value Code FD: Credit Received from the Manufacturer for a Medical Device

Modifiers:

1. Modifier FB: Items without cost to provider, supplier, or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free examples).
2. Modifier FC: Partial credit for replaced device.

MVP reserves the right to request supporting documentation if claims do not adhere to coding and billing which may result in a denial or reduced payment rate. Claims may be reviewed on a case-by-case basis. When revenue codes 0274, 0275, 0276, or 0278 are billed, a HCPCS code which meets definition above of an Implant must be reported on the claim. If a HCPCS code is not submitted or if the HCPCS code submitted does not match the above definition, the claim line will be denied.

References

https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/ Internet Only Manuals 100-04,4,60.4.2 Complete List of Device Pass-through Category Codes

History

August 1, 2022 New policy, approved