2021 Payment Policies

MVP Health Care® policy and procedure guidelines.

Updated March 1, 2021

MVP Payment Policies

Table of Contents

Click on a policy name to view.

After-Hours

Last Reviewed Date: 12/1/2020

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 as 8:00 am – 6:00 pm. In accordance with Centers for Medicare and Medicaid Services (CMS) guidelines, MVP considers the following after-hours codes inclusive with the Evaluation and Management code that is billed.

Reimbursement Guidelines

Code	Description	Reimbursement Guidelines
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. This reimbursement rule will only apply to MVPs Commercial and Medicare Products.
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

10/15/2018 – policy approved
12/1/2020 – policy reviewed and approved with no changes

Allergy Testing and Serum Preparation Claims

Last Reviewed Date: 12/1/2020

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 doses must be specified on the claim • First Year: Reimbursement is limited to 40 units per claim and 150 units per calendar year • Subsequent Years: Reimbursement is limited to 30 units per claim and 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
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

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. 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

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

History

12/1/2020	Policy Approved
9/1/2019	Annual Review
7/21/2020	Annual Review, added references, added clarification for ‘per calendar year’
12/1/2020	Reviewed with no changes

Anesthesia

Last Reviewed Date: March 1, 2021

Policy

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

Definitions

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

Notification/Prior Authorization Requests

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

Medical Direction and Temporary Relief

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

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

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

Personally Performed

The following criterion applies to anesthesia services personally performed:

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

Medical Direction

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

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

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

Concurrent Medically Directed Procedures

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

A physician who is concurrently directing the administration of anesthesia to not more than four (4) surgical patients cannot ordinarily be involved in rendering additional services to other patients. However, addressing an emergency of

short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous monitoring of an obstetrical patient, does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to the surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

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

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

Medically Supervised

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

Reimbursement Guidelines

Payment at Personally Performed Rate

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

Payment at Medically Directed Rate

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

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

Payment at Non-Medically Directed Rate

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

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

Payment at Medically Supervised Rate

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

Payment Rules

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

Participating Physician not Medically Directing (Modifier AA)	(Base Units + Time Units) x Participating Conversion Factor = Allowance
Non-Participating Physician not Medically Directing (Modifier AA)	(Base Units + Time Units) x Non-Participating Conversion Factor = Allowance
Participating Physician Medically Directing (Modifier QY, QK)	(Base Units + Time Units) x Participating Conversion Factor = Allowance x 50%
Non-Participating Physician Medically Directing (Modifier QY, QK)	(Base Units + Time Units) x Non-Participating Conversion Factor = Allowance x 50%
Non-Medically Directed CRNA (Modifier QZ)	(Base Units + Time Units) x Participating Conversion Factor = Allowance
CRNA Medically Directed (Modifier QX)	(Base Units + Time Units) x Participating Conversion Factor = Allowance x 50%

Base Units

Each anesthesia code (procedure codes 00100-01999) is assigned a base unit value by the American Society of Anesthesiologists (ASA) and used for the purpose of establishing fee schedule allowances. Anesthesia services are paid on the basis of a relative value system, which include both base and actual time units. Base units take into account the complexity, risk, and skill required to perform the service.

For the most current list of base unit values for each anesthesia procedure code can be found on the Anesthesiologist Center page on the CMS website at cms.gov.

Time Units

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

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

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

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

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

Epidural Reimbursement — Effective 5/1/20

MV) shall limit reimbursement for epidural CPT codes to 37 units (5 base units plus 32 units for every 15 minutes) equating to a 480-minute limit. The codes in question are listed below and apply to all MVP health plans:

CPT Code 01967 Neuraxial Labor Analgesia/Anesthesia for Planned Vaginal Delivery

CPT Code 01968 Cesarean Delivery Following Neuraxial Labor Analgesia/Anesthesia

CPT Code 01969 Cesarean Hysterectomy Following Neuraxial Labor Analgesia/Anesthesia

Please note that no changes have been made to how these services should be billed.

Multiple Anesthesia Procedures

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

Modifiers

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

AA	Anesthesia services personally performed by the anesthesiologist
AD	Medical supervision by a physician; more than four concurrent anesthesia services
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure (an informational modifi-er, does not affect reimbursement)
G9	MAC for a patient who has history of severe cardiopulmonary condition (an informational modifier, does not affect reimbursement)
QK	Medical direction of two, three or four con-current anesthesia procedures involving qual-ified individuals

QS	Monitored anesthesia care (an informational modifier, does not affect reimbursement)
QX	CRNA service with medical direction by a physician
QY	Medical direction of one CRNA by a physician
QZ	CRNA service without medical direction by a physician

History

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

Arthroscopic, Endoscopic, and other Non Gastro Intestinal Scope Procedures

Last Reviewed Date: 12/1/2020

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

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 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

6/13/2018 – policy approved
6/1/2020 – policy reviewed, no changes, approved
12/1/2020 – policy reviewed and approved with changes

Article 28 Split Billing

Last Reviewed Date: 6/1/2020

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

6/1/2017 – policy approved

03/01/2020 - policy approved with no changes

06/01/2020 - policy approved with no changes

Audiology Services

Last Reviewed Date: 12/1/2020

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	Policy approved
December 1, 2020	Annual Review approved with no changes

Behavioral Health and Substance Use Disorder

December 1, 2019
Related Policies–MVP Behavioral Health Policy
MVP Claims Section

Policy

This policy applies to the Medicaid (including Health and Recovery Plans ("HARP")), Essential Health Plans, Commercial (including CHP) and Medicare Advantage lines of business. 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 and Provider Agreement. In addition to the guidelines in this policy, MVP Health Care use 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 service, please refer to the Table in Appendix X as well as to the relevant State and Federal guidance documents referenced in each section below.

Definitions

Mental Health Parity

In accordance with applicable state and federal Mental Health Parity requirements, MVP manages Mental Health and Substance Use Disorder benefits in the same manner as medical and surgical benefits, without additional limitations.

Non-Medical Transportation

Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are available for individuals to access authorized behavioral health home and community-based services and destinations that are related to a goal included on the individual's plan of care.

Examples where this service may be requested include transportation to: HCBS that an individual was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, etc.

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, or outlined below. Medicaid reimbursement follows all relevant State-specific guidance and requirements and can be found below.

Psychotherapy

MVP will reimburse behavioral health providers according to terms of their agreements with MVP. We expect claims to be submitted with the appropriate CPT code selected from the Psychiatry codes.

Electroconvulsive Therapy

MVP will reimburse psychiatrists for electroconvulsive therapy.

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.

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 physicians, including psychiatrists, as well as clinical psychologists, social workers, psychiatric nurse specialists, nurse practitioners, licensed professional counselor physicians' assistants are covered.

Medicare Variation:

Services from professional Licensed Mental Health Counselors (LMHC)are not covered.

Medicaid Variation:

The New York State Department of Health (NYSDOH) has expanded Mental Health (MH) and Substance Use Disorder (SUD) services, transitioning management to Medicaid Managed Care Organizations and Health and Recovery Plans (HARPs). This expansion was intended to better assist adults and children living with Serious Mental Illnesses (SMI), Serious Emotional Disturbance (SED) and Substance Use Disorders (SUDs) in their recovery. Effective, January 1, 2020, eligible adults enrolled in the MVP's Health and Recovery Plan will be solely managed by MVP. All our Members receive the full coverage provided under the standard Medicaid plan, with the ability to access enhanced benefits. These benefits include Behavioral Health Home and Community Based Services (BH-HCBS). All claims for both children's and adult mainstream Medicaid and Home and Community Based Services will be submitted directly to MVP for enrolled Members.

All billing for Behavioral Health Services must follow NYS DOH Behavioral Health Billing and Coding Manual for Medicaid and HARP. Billing requirements are specific to service and facility type. Billing guidelines include, but are not limited to:

Ambulatory Behavioral Health Services.
For additional mental health service by service guidance including payment codes, limitations, guidance and restrictions, please reference the New York State Office of Mental Health Medicaid Managed Care Mainstream and Health and Recovery Plan (HARP) billing manual found here.

Ambulatory Behavioral Health Services including Assertive Community Treatment (ACT),OMH licensed and OASAS Certified clinics, Continued Day Treatment, Comprehensive Psychiatric Emergency Program, Intensive Psychiatric Rehabilitation Treatment, Partial Hospitalization and Personalized Recovered Oriented Services, 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.

Comprehensive Psychiatric Emergency Program (CPEP)
All CPEP claims must follow claims must follow OMH billing guidance. CPEP Extended Observation bed (EOB) must bill using rate code 4049.

HARP Home and CBS HCBS Services may only be billed for HARP members. Specific billing and coding requirements are attributable to all HCBS services and must follow DOH Billing guidelines.

Behavioral Health HCBS Staff Transportation MVP shall only reimburse for BH HCBS related to the Member's Covered Services. Costs associated for programs, services and purposes other than BH HCBS do not qualify for reimbursement.

Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS)
Medicaid billing guidance for New York State outpatient behavioral health services can be found by clicking here.

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 DOH Children's Health and Behavioral Health Billing and Coding Manual.

Modifier Codes Used for HARPs and Mainstream BH Carve-in

HCBS Modifiers	Definition
AF	Specialty physician
AH	Clinical psychologist
AJ	Clinical Social Worker (also allowing LMSW)
HE	Mental health program
HF	Substance abuse program
HH	Integrated mental health / substance abuse program
HK	Specialized mental health program for high risk populations
HR	Family with client present
HS	Family without client present
SA	Nurse practitioner
TD	Registered nurse
TG	Complex level of care
U1	Level 1 (state-defined)
U1	Subway round-trip (state-defined, with A0160)
U2	Level 2 (state-defined)
U5	Reduced services (state defined)
UN	Two patients served
UP	Three patients served
UQ	Four patients served
UR	Five patients served
US	Six or more patients served

Claims
Electronic claims 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. This field is already used by Plans to report the weight of a low birth weight baby.

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.

Claims Coding Crosswalks

Below/attached (found in Appendix X, Table Y) are crosswalks for HCBS and all other ambulatory behavioral health services (including 1115 demo services). Also included in the crosswalk is the per diem rate/HCPCS/modifier codes for clinic services delivered in OASAS Part 820 Residential settings. Providers should use these coding combinations to indicate to MVP that the claim is for a behavioral health service provided by a behavioral health program and is to be paid at the government rate.

Service Combinations

Only certain combinations of HCBS and State Plan services are allowed by Medicaid within an individual's current treatment plan. The grid below shows the allowable service combinations.

Allowable Billing Combinations of OMH/OASAS State Plan Services and HCBS Table

HCS/State Plan Services	OMH Clinic/ OLP	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS	OMH IPRT/CDT	OMH Partial Hospital*	OASAS Outpatient Rehab
PSR	Yes	Yes	Yes				Yes	
CPST							Yes	
Habilitation	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Family Support and Training	Yes	Yes	Yes			Yes	Yes	Yes
Education Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Peer Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Employment Services	Yes	Yes	Yes			Yes	Yes	Yes

Telepsychiatry in OMH Clinics
14 NYCRR Part 599.17 (Clinic Treatment Services), allows clinic providers to obtain approval from the New York State Office of Mental Health (OMH) to offer telepsychiatry services in OMH-licensed clinics. In accordance with this section, MVP reimburses for these services at the government Ambulatory Patient Group (APG) rate for telepsychiatry services provided by clinics that have been authorized by OMH to provide this optional service. Detailed information regarding telepsychiatry may be found on the OMH telepsychiatry webpage found here.

OASAS TITLE 14 NYCRR PART 822 Outpatient Clinics, Opioid, and Rehabilitation Programs
MVP reimburses all Substance Use Clinic, Opioid and Rehabilitation Programs in accordance with State Medicaid guidelines for individuals enrolled in Medicaid Managed Care. For a complete description of OASAS Outpatient and Inpatient programs please see the SUD Section of the Mainstream Billing Manual found here.

HARP Home and Community Based Services (HCBS)

Adult HCBS Utilization Thresholds
Adult HCBS services will be subject to utilization caps at the recipient level that apply on a calendar year basis. These limits will fall into three categories:

1. Tier 1 HCBS services will be limited to $8,000 as a group. There will also be a 25% corridor on this threshold that will allow plans to go up to $10,000 without a disallowance.
2. There will also be an overall cap of $16,000 on HCBS services (Tier 1 and Tier 2 combined). There will also be a 25% corridor on this threshold that will allow plans to go up to $20,000 without a disallowance.
3. Both cap 1 and cap 2 are exclusive of crisis respite. The two crises respite services are limited within their own individual caps (7 days per episode, 21 days per year).

If a Plan anticipates they will exceed any limit for clinical reasons they should contact the HARP medical director from either OMH or OASAS and get approval for a specific dollar increase above the $10,000 effective limit.

See the HCBS manual for program/clinical guidance here.

Non-Medical Transportation
This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with Department requirements and as outlined in the participant's plan of care.

There is a $2,000 cost cap per participant per year for Non-Medical Transportation for trips to and from non-HCBS destinations that are related to goals in an individual's Plan of Care. Trips to and from BH HCBS and trips using public transportation are not subject to the $2,000 cap.

Additional Information on Roles Related to a Participant's Access to Non-Medical Transportation can be found here.

Children's Medicaid Behavioral Health Services
In 2019, NYS expanded children's and family Medicaid Managed Care services to include Children's Family Treatment and Support Services (CFTSS) and Behavioral Health Home and Community Based Services (BH-HCBS) Children's SPA Services:

- Other Licensed Practitioner
- Psychosocial Rehabilitation
- Community Psychiatric Treatment and Supports (CPST)
- Family Peer Support Services (FPSS)

As of January 1, 2020, Youth Peer Support and Training and Crisis Intervention will also become available. Please Note: New York State and MVP will monitor and periodically review claim and encounter data to determine if inappropriate BH-HCBS and State Plan service combinations were provided/allowed.

For specific information on billing for these services, please refer to New York State Children's Health and Behavioral Health Services Billing and Coding Manual found 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

Billing Behavioral Health Medicaid Services Under Managed Care

New York State Health and Recovery Plan (HARP)/Mainstream Behavioral Health Billing and Coding Manual

Medicaid billing guidance for New York State outpatient behavioral health services

NYS Telepsychiatry in OMH Clinics

NYS DOH Non-Medical Transportation

New York State Children's Health and Behavioral Health Services Billing and Coding Manual

History

December 1, 2019 New Policy, Approved

Consistency of Denials

Last Reviewed Date: 9/1/2020
Effective: 9/1/2020

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.

Definitions

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

Insert links to references

History

9/01/2020 – New Payment policy approved

Contrast Materials

Last Reviewed Date: 12/1/2016

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

12/1/2016 – policy approved

COVID-19 Lab Testing

Last Reviewed Date – 12/1/2020
Effective – 2/1/2020

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

12/1/2020 – new policy, approved

Default Pricing

Last Reviewed Date: 9/1/2020
Effective Date: 9/1/2020

Policy

When a reimbursement rate has not been assigned by MVP Health Care® (MVP), by the contract, by Medicare, 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 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

Under the Default Pricing, MVP will pay 30% of billed charges unless otherwise provided for in the MVP provider services agreement .

History

9/01/2020 – New Policy approved, effective 10/1/2020.

Diabetic Management and Nutritional Counseling

Last Reviewed Date: 6/1/2020

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

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

ICD-10 CM	ICD-10 DX Description
E08.9	Diabetes mellitus due to underlying condition without complications
E09.9	Drug or chemical induced diabetes mellitus without complications
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma

E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma
E09.00	Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma
E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma
E08.641	Diabetes mellitus due to underlying condition with hypoglycemia with coma
E09.11	Drug or chemical induced diabetes mellitus with ketoacidosis with coma
E09.641	Drug or chemical induced diabetes mellitus with hypoglycemia with coma
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma
E09.11	Drug or chemical induced diabetes mellitus with ketoacidosis with coma
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease
E09.29	Drug or chemical induced diabetes mellitus with other diabetic kidney complication
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema
E08.321	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema

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

E08.39	Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication
E08.610	Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy
E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
E09.44	Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy
E09.49	Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication
E09.610	Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
E08.59	Diabetes mellitus due to underlying condition with other circulatory complications
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene
E09.52	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
E09.59	Drug or chemical induced diabetes mellitus with other circulatory complications

E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.618	Diabetes mellitus due to underlying condition with other diabetic arthropathy
E08.620	Diabetes mellitus due to underlying condition with diabetic dermatitis
E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer
E08.628	Diabetes mellitus due to underlying condition with other skin complications
E08.630	Diabetes mellitus due to underlying condition with periodontal disease
E08.638	Diabetes mellitus due to underlying condition with other oral complications
E08.649	Diabetes mellitus due to underlying condition with hypoglycemia without coma
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.69	Diabetes mellitus due to underlying condition with other specified complication
E09.618	Drug or chemical induced diabetes mellitus with other diabetic arthropathy
E09.620	Drug or chemical induced diabetes mellitus with diabetic dermatitis
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer
E09.628	Drug or chemical induced diabetes mellitus with other skin complications
E09.630	Drug or chemical induced diabetes mellitus with periodontal disease
E09.638	Drug or chemical induced diabetes mellitus with other oral complications
E09.649	Drug or chemical induced diabetes mellitus with hypoglycemia without coma
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia
E09.69	Drug or chemical induced diabetes mellitus with other specified complication
E08.69	Diabetes mellitus due to underlying condition with other specified complication
E09.69	Drug or chemical induced diabetes mellitus with other specified complication
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.8	Diabetes mellitus due to underlying condition with unspecified complications
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications

E08.8	Diabetes mellitus due to underlying condition with unspecified complications
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E11.9	Type 2 diabetes mellitus without complications
E13.9	Other specified diabetes mellitus without complications
E10.9	Type 1 diabetes mellitus without complications
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.65	Type 1 diabetes mellitus with hyperglycemia
E13.10	Other specified diabetes mellitus with ketoacidosis without coma
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with hyperglycemia
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma
E13.00	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E13.01	Other specified diabetes mellitus with hyperosmolarity with coma
E10.69	Type 1 diabetes mellitus with other specified complication
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E11.641	Type 2 diabetes mellitus with hypoglycemia with coma
E13.11	Other specified diabetes mellitus with ketoacidosis with coma
E13.641	Other specified diabetes mellitus with hypoglycemia with coma
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma
E10.641	Type 1 diabetes mellitus with hypoglycemia with coma

E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
E13.21	Other specified diabetes mellitus with diabetic nephropathy
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease
E13.29	Other specified diabetes mellitus with other diabetic kidney complication
E10.21	Type 1 diabetes mellitus with diabetic nephropathy
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.21	Type 1 diabetes mellitus with diabetic nephropathy
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E11.321	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E11.351	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
E11.359	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema

E11.36	Type 2 diabetes mellitus with diabetic cataract
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication
E13.311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema
E13.319	Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema
E13.321	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E13.329	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E13.331	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E13.339	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E13.341	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E13.349	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E13.351	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema
E13.359	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema
E13.36	Other specified diabetes mellitus with diabetic cataract
E13.39	Other specified diabetes mellitus with other diabetic ophthalmic complication
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E10.321	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E10.329	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E10.331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E10.339	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E10.341	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E10.349	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E10.351	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema

E10.359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema
E10.36	Type 1 diabetes mellitus with diabetic cataract
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E11.36	Type 2 diabetes mellitus with diabetic cataract
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E10.36	Type 1 diabetes mellitus with diabetic cataract
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E13.40	Other specified diabetes mellitus with diabetic neuropathy, unspecified
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy
E13.44	Other specified diabetes mellitus with diabetic amyotrophy
E13.49	Other specified diabetes mellitus with other diabetic neurological complication
E13.610	Other specified diabetes mellitus with diabetic neuropathic arthropathy
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy

E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11.59	Type 2 diabetes mellitus with other circulatory complications
E13.51	Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene
E13.52	Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene
E13.59	Other specified diabetes mellitus with other circulatory complications
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.59	Type 1 diabetes mellitus with other circulatory complications
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy
E11.620	Type 2 diabetes mellitus with diabetic dermatitis
E11.621	Type 2 diabetes mellitus with foot ulcer
E11.622	Type 2 diabetes mellitus with other skin ulcer
E11.628	Type 2 diabetes mellitus with other skin complications
E11.630	Type 2 diabetes mellitus with periodontal disease
E11.638	Type 2 diabetes mellitus with other oral complications

E11.649	Type 2 diabetes mellitus with hypoglycemia without coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with other specified complication
E13.618	Other specified diabetes mellitus with other diabetic arthropathy
E13.620	Other specified diabetes mellitus with diabetic dermatitis
E13.621	Other specified diabetes mellitus with foot ulcer
E13.622	Other specified diabetes mellitus with other skin ulcer
E13.628	Other specified diabetes mellitus with other skin complications
E13.630	Other specified diabetes mellitus with periodontal disease
E13.638	Other specified diabetes mellitus with other oral complications
E13.649	Other specified diabetes mellitus with hypoglycemia without coma
E13.65	Other specified diabetes mellitus with hyperglycemia
E13.69	Other specified diabetes mellitus with other specified complication
E10.618	Type 1 diabetes mellitus with other diabetic arthropathy
E10.620	Type 1 diabetes mellitus with diabetic dermatitis
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E10.628	Type 1 diabetes mellitus with other skin complications
E10.630	Type 1 diabetes mellitus with periodontal disease
E10.638	Type 1 diabetes mellitus with other oral complications
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E11.69	Type 2 diabetes mellitus with other specified complication
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.8	Type 2 diabetes mellitus with unspecified complications
E13.8	Other specified diabetes mellitus with unspecified complications

E10.8	Type 1 diabetes mellitus with unspecified complications
E11.8	Type 2 diabetes mellitus with unspecified complications
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.8	Type 1 diabetes mellitus with unspecified complications
E10.65	Type 1 diabetes mellitus with hyperglycemia
I12.9	Hypertensive chronic kidney disease with state 1-4 chronic kidney disease, or unspecified chronic kidney disease
I12.9	Hypertensive chronic kidney disease with state 1-4 chronic kidney disease, or unspecified chronic kidney disease
I12.9	Hypertensive chronic kidney disease with state 1-4 chronic kidney disease, or unspecified chronic kidney disease
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.3	Chronic kidney disease, stage 3 (moderate)
N18.9	Chronic kidney disease, unspecified
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.420	Gestational diabetes mellitus in childbirth, diet controlled
O24.424	Gestational diabetes mellitus in childbirth, insulin controlled
O24.429	Gestational diabetes mellitus in childbirth, unspecified control
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control
Z48.22	Encounter for aftercare following kidney transplant
Z68.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age

Nutritional Counseling is not reimbursed for the following services:

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

Diabetic Management

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

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

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

ICD-10 CM	ICD-10 DX Description
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema
E08.321	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema
E08.329	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema
E08.331	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema

E08.339	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema
E08.341	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema
E08.349	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema
E08.351	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema
E08.359	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract
E08.39	Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
E08.59	Diabetes mellitus due to underlying condition with other circulatory complications
E08.610	Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy
E08.618	Diabetes mellitus due to underlying condition with other diabetic arthropathy
E08.620	Diabetes mellitus due to underlying condition with diabetic dermatitis
E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer
E08.628	Diabetes mellitus due to underlying condition with other skin complications
E08.630	Diabetes mellitus due to underlying condition with periodontal disease
E08.638	Diabetes mellitus due to underlying condition with other oral complications
E08.649	Diabetes mellitus due to underlying condition with hypoglycemia without coma
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia

E08.69	Diabetes mellitus due to underlying condition with other specified complication
E08.8	Diabetes mellitus due to underlying condition with unspecified complications
E08.9	Diabetes mellitus due to underlying condition without complications
E09.00	Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease
E09.29	Drug or chemical induced diabetes mellitus with other diabetic kidney complication
E09.311	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema
E09.319	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy without macular edema
E09.321	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E09.329	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E09.331	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E09.339	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E09.341	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E09.349	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E09.351	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema
E09.359	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract
E09.39	Drug or chemical induced diabetes mellitus with other diabetic ophthalmic complication
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy

E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
E09.44	Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy
E09.49	Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene
E09.52	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
E09.59	Drug or chemical induced diabetes mellitus with other circulatory complications
E09.610	Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy
E09.618	Drug or chemical induced diabetes mellitus with other diabetic arthropathy
E09.620	Drug or chemical induced diabetes mellitus with diabetic dermatitis
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer
E09.628	Drug or chemical induced diabetes mellitus with other skin complications
E09.630	Drug or chemical induced diabetes mellitus with periodontal disease
E09.638	Drug or chemical induced diabetes mellitus with other oral complications
E09.649	Drug or chemical induced diabetes mellitus with hypoglycemia without coma
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia
E09.69	Drug or chemical induced diabetes mellitus with other specified complication
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications
E09.9	Drug or chemical induced diabetes mellitus without complications
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E10.21	Type 1 diabetes mellitus with diabetic nephropathy
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E10.321	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema

E10.329	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E10.331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E10.339	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E10.341	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E10.349	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E10.351	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema
E10.359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema
E10.36	Type 1 diabetes mellitus with diabetic cataract
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.59	Type 1 diabetes mellitus with other circulatory complications
E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy
E10.618	Type 1 diabetes mellitus with other diabetic arthropathy
E10.620	Type 1 diabetes mellitus with diabetic dermatitis
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E10.628	Type 1 diabetes mellitus with other skin complications
E10.630	Type 1 diabetes mellitus with periodontal disease
E10.638	Type 1 diabetes mellitus with other oral complications
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma

E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E10.8	Type 1 diabetes mellitus with unspecified complications
E10.9	Type 1 diabetes mellitus without complications
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E11.321	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E11.351	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
E11.359	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema
E11.36	Type 2 diabetes mellitus with diabetic cataract
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene

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

E13.341	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E13.349	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E13.351	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema
E13.359	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema
E13.36	Other specified diabetes mellitus with diabetic cataract
E13.39	Other specified diabetes mellitus with other diabetic ophthalmic complication
E13.40	Other specified diabetes mellitus with diabetic neuropathy, unspecified
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy
E13.44	Other specified diabetes mellitus with diabetic amyotrophy
E13.49	Other specified diabetes mellitus with other diabetic neurological complication
E13.51	Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene
E13.52	Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene
E13.59	Other specified diabetes mellitus with other circulatory complications
E13.610	Other specified diabetes mellitus with diabetic neuropathic arthropathy
E13.618	Other specified diabetes mellitus with other diabetic arthropathy
E13.620	Other specified diabetes mellitus with diabetic dermatitis
E13.621	Other specified diabetes mellitus with foot ulcer
E13.622	Other specified diabetes mellitus with other skin ulcer
E13.628	Other specified diabetes mellitus with other skin complications
E13.630	Other specified diabetes mellitus with periodontal disease
E13.638	Other specified diabetes mellitus with other oral complications
E13.649	Other specified diabetes mellitus with hypoglycemia without coma
E13.65	Other specified diabetes mellitus with hyperglycemia
E13.69	Other specified diabetes mellitus with other specified complication
E13.8	Other specified diabetes mellitus with unspecified complications
E13.9	Other specified diabetes mellitus without complications

E83.110	Hereditary hemochromatosis
E83.39	Other disorders of phosphorus metabolism
O24.011	Pre-existing diabetes mellitus, type 1, in pregnancy, first trimester
O24.012	Pre-existing diabetes mellitus, type 1, in pregnancy, second trimester
O24.013	Pre-existing diabetes mellitus, type 1, in pregnancy, third trimester
O24.019	Pre-existing diabetes mellitus, type 1, in pregnancy, unspecified trimester
O24.03	Pre-existing diabetes mellitus, type 1, in the puerperium
O24.111	Pre-existing diabetes mellitus, type 2, in pregnancy, first trimester
O24.112	Pre-existing diabetes mellitus, type 2, in pregnancy, second trimester
O24.113	Pre-existing diabetes mellitus, type 2, in pregnancy, third trimester
O24.119	Pre-existing diabetes mellitus, type 2, in pregnancy, unspecified trimester
O24.13	Pre-existing diabetes mellitus, type 2, in the puerperium
O24.311	Unspecified pre-existing diabetes mellitus in pregnancy, first trimester
O24.312	Unspecified pre-existing diabetes mellitus in pregnancy, second trimester
O24.313	Unspecified pre-existing diabetes mellitus in pregnancy, third trimester
O24.319	Unspecified pre-existing diabetes mellitus in pregnancy, unspecified trimester
O24.33	Unspecified pre-existing diabetes mellitus in the puerperium
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.420	Gestational diabetes mellitus in childbirth, diet controlled
O24.424	Gestational diabetes mellitus in childbirth, insulin controlled
O24.429	Gestational diabetes mellitus in childbirth, unspecified control
O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control
O24.811	Other pre-existing diabetes mellitus in pregnancy, first trimester
O24.812	Other pre-existing diabetes mellitus in pregnancy, second trimester
O24.813	Other pre-existing diabetes mellitus in pregnancy, third trimester

O24.819	Other pre-existing diabetes mellitus in pregnancy, unspecified trimester
O24.83	Other pre-existing diabetes mellitus in the puerperium
O24.911	Unspecified diabetes mellitus in pregnancy, first trimester
O24.912	Unspecified diabetes mellitus in pregnancy, second trimester
O24.913	Unspecified diabetes mellitus in pregnancy, third trimester
O24.919	Unspecified diabetes mellitus in pregnancy, unspecified trimester
O24.93	Unspecified diabetes mellitus in the puerperium
P70.0	Syndrome of infant of mother with gestational diabetes
P70.1	Syndrome of infant of a diabetic mother
P70.2	Neonatal diabetes mellitus
R73.09	Other abnormal glucose
Z71.3	Dietary counseling and surveillance
Z86.32	Personal history of gestational diabetes

Reimbursement Guidelines

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

References

MVP Credentialing and Recredentialing of Practitioners

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

History

6/1/2017 – policy approved

6/1/2020 - policy reviewed, no changes & approved

Diagnosis Matching Edits

Last Reviewed Date: 10/01/2020

Policy

MVP Health Care follows the diagnosis matching edits in accordance with Medicare Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) for the procedures listed in the policy. This policy applies to all Lines of Business and all claims including, but not limited to, physicians, hospitals, and ambulatory surgery centers. For more information on Medicare Local Coverage Determinations please visit the Center for Medicare & Medicaid services website at 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 #L33577 – 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 Type 1 and type 2

To access the appropriate diagnoses to be used with these procedure codes, use choosingwisely.org American Academy of Family Physicians

Code	Description	Rule
86695	Herpes Simplex, type 1	MVP requires the correct diagnosis be submitted with the claim in accordance with the source choosingwisley.org American Academy of Family Physicians or the claim will be denied due to Medical Necessity
86696	Herpies Simplex, type 2	

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	

Sedimentation Rate RBC Automated

To access the appropriate diagnoses to be used with this procedure code, use choosingwisely.org American Society for Clinical Pathology

Code	Description	Rule
85652	Sedimentation rate; erythrocyte; automated	MVP requires the correct diagnosis be submitted with the claim in accordance with the source choosingwisley.org 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 this procedure code, use choosingwisely.org American Academy of Allergy, Asthma & Immunology

Code	Description	Rule
82785	Assay of Gammaglobulin IGE	MVP requires the correct diagnosis be submitted with the claim in accordance with the source choosingwisley.org American Academy of Allergy, Asthma & Immunology or the claim will be denied due to Medical Necessity
86003	Allergen Specific IGE ; quantitative or semiquantitative, crude allergen extract, each	
86008	Allergen Specific IGE quantitative or semiquantitative, recombinant/purified component, (each)	

Folic Acid

To access the appropriate diagnoses to be used with this procedure code, use choosingwisely.org American Society for Clinical Pathology

Code	Description	Rule
82746	Assay of Folic Acid Serum	MVP requires the correct diagnosis be submitted with the claim in accordance with the source choosingwisley.org American Society for Clinical Pathology or the claim

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 this procedure code, use choosingwisely.org American Society for Reproductive Medicine.

Code	Description	Rule
83001	Gonadotropin Follicle Stimulating	MVP requires the correct diagnosis be submitted with the claim in accordance with the source **choosingwisely.org** 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 these procedure codes, use choosingwisely.org American Society for Clinical Pathology & the Endocrine Society.

Code	Description	Rule
84480	Assay of Triiodothyronine T3; Total TT3	MVP requires the correct diagnosis be submitted with the claim in accordance with the source choosingwisley.org or the claim will be denied due to Medical Necessity
84481	Assay of Triiodothyronine Free	

References

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

History

03/01/2020	Changed LCD to Articles per CMS and added CPT codes
12/01/19	Policy Review no changes
10/01/2020	Additional lab process codes added to policy

Durable Medical Equipment

Last Reviewed Date: March 1, 2021
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 vendors only. Physicians, podiatrists, physical therapists, and occupational therapists must refer to the utilization management section of the Provider Resource Manual for DMEPOS information and guidelines.

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

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

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

Repairs to DME

Repairs are covered for medically necessary equipment regardless of who is performing the repair. The repair does not have to be completed by the original provider.

Repair claims must include narrative information itemizing:

- The nature for which the repair was required;
- The actual / anticipated time each repair will take;
- Date of purchase (month/year);
- Product name;

- Make/model;
- Manufacturer's suggested retail price (MSRP) is kept on file and you would bill according to your contract with MVP; and
- For common repairs, MVP 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 claims for DME must include the following:

- Tthe description of the owned equipment that is being replaced;
- The HCPCS code of the original piece of equipment;
- The date of purchase of the original piece of equipment;
- Reason for replacement, and;
- New order from physician.

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

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

This policy relates to the payment of DME items and equipment only; please refer to MVP 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 beneficiary's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (such as assisted living facility, or an intermediate care facility for the mentally 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

Referral/Notification/Prior Authorizations Requests

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

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

The list is updated periodically and is located on the MVP website in the Provider section, under 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 faxed to fax number **1-888-452-5947** unless otherwise noted below.
- Be sure to fax all appropriate and pertinent medical documentation (e.g., office notes, lab and radiology reports) with the completed PARF.
- Phone requests will only be taken for urgent care determinations and hospital discharges. Call **1-800-452-6966**.

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

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

Delivery Charges

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

Retrospective Audits

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

Billing/Coding Guidelines

CPAP and BiPAP

Code	Description	Rule
E0601 **E0562**	CPAP machine Heated humidifier Includes Auto PAP machines	• The initial CPAP rental is for up to three months. DME providers must contact Members and confirm compliance via objective reporting from the device and submit to Utilization Management prior to the end of the third month of use. Adherence to PAP therapy is defined as use of PAP >4 hours per night on 70% of the nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. • We do not back date authorizations if the compliance is not received during the first three months of initial usage. The provider will only be paid for what months remain on the 13-month rental from the date they submit compliance. Please refer to MVP's Medical Policy to determine medical necessity and rules regarding CPAP machine compliance. • All CPAP machines are a 13-month rental. • All heated humidifiers are a 10-month rental.
E0470 **E0471** **E0562**	Respiratory Assist device BiPAP machine Heated humidifier Includes Auto BiPAP machines.	• The initial BiPAP rental is for up to three months. • DME providers must contact Members and confirm compliance via objective reporting from the device and submit to Utilization Management prior to the end of the third month of use. • Please refer to MVP's Medical Policy to determine medical necessity and rules regarding BiPAP machines compliance. • All BiPAP machines are a 13-month rental. • All heated humidifiers are a 10-month rental.
A4604	Tubing with integrated heating element	• 1 per three months
A7027	Combo oral/nasal mask	• 1 per three months
A7028	Oral cushion for combo oral nasal mask	• 2 per one month
A7029	Nasal pillows	• 2 per one month
A7030	Full Face Masks	• 1 per three months
A7031	Face mask interface	• 1 per month
A7032	Replacement Cushions	• 2 per one month
A7033	Replacement Pillows	• 2 per one month
A7034	CPAP Masks	• 1 per three months

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

DME Equipment

Code	Description	Rule
E0935	Continuous Passive Motion Device	• One unit equals one day of rental. • Coverage is limited to 21 days follow-ing 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. A5500KX- RT x 1; A5500KX-LT x1 for one pair. • Medicaid Managed Care Plans: allow one pair per year when medical policy criteria are met.
A5512-A5513	Diabetic Shoe Inserts	• MVP will not reimburse for diabetic shoe inserts/modifications when billed more than 6 units (3 pair) within a calendar year. • If bilateral items are provided on the same date of service, bill for both items on separate claim lines using the RT and LT modifiers i.e. A5513KX- RT x 3; A5513KX-LT x3 for three pair. • Medicaid Managed Care Plans: allowed one pair per year when medical policy criteria are met.
A5508 & A5510	Diabetic Shoes	• MVP does not cover these codes.

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

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

Oxygen and Oxygen Equipment

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

Transcutaneous Electrical Nerve Stimulation (TENS)

Code	Description	Rule
E0720, E0730	Transcutaneous electrical nerve stimulation (TENS) Device.	• MVP allows the purchase or rental of TENS units. • These cannot be prescribed by Chiropractors or therapists; they must be prescribed by a physician. • Medicaid Managed Care Plans are not covered for E0720. • Supplies are not covered as a DME product. MVP does cover these items if the Member has the disposable coverage for commercial and ASO products. Please refer to the Member's benefits to determine if these are covered. • Medicaid Managed Care Plans are covered if supplies are medically necessary

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

Medical Supplies

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

HCPCS Modifiers

MVP requires the use of the following Medicare modifiers:

Code	Description	Rule
NU	Purchased/new equipment	• Submit with HCPCS DME code to indicate a purchase
RR	Rental use	• Submit with HCPCS DME code to indicate a rental
RT	Right Side	• Submit with HCPCS DME procedure code to indicate item ordered for right side.
LT	Left Side	• Submit with HCPCS DME procedure code to indicate item ordered for left side.
UE	Used Equipment	• MVP does not generally reimburse for used equipment, this may require specific prior approval according to the Prior Authorization List.
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply	• Submit with HCPCS DME procedure codes
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic	• Submit with HCPCS DME procedure codes

Code	Description	Rule
AW	Item furnished in conjunction with a surgical dressing	• Submit with HCPCS DME procedure codes
RA	Replacement of a DME, orthotic or prosthetic item	• Use when an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged.
RB	Replacement of a part of DME furnished as part of a repair	• Use to denote the replacement of a part of a DMEPOS item furnished as part of the service of repairing the item.

Nebulizers

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

External Infusion Supplies

Code	Description	Rule
E0784	Insulin Pump	• MVP covers the purchase of this item according to the provider's contract. • Providers should check the Member's benefits to determine how these are covered under their individual plan. • Refer to MVP's Medical Policies for additional information.
A9274	External Ambulatory Delivery System (Disposable Insulin Pump)	• MVP covers the purchase of this item according to the provider's contract. • Providers should check the Member's benefits to determine how these are covered under their individual plan. • Allowed up to 30 per month; up to 90 units once every 90 days. • There is a 5 day grace period allowed for shipping/billing on the 85th day. • Refer to MVP's Medical Policies for additional information. • This item is not covered for MVP Medicare plans.
A4230	Infusion Set – Cannula Type	• Covered as diabetic 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.
A4231	Infusion Set – Needle Type	
A4232	Syringe/reservoirs	

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

Blood Glucose Monitoring

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

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

Code	Description	Rule
A9277	Transmitter; for use with Continuous Glucose Monitoring System	• Only one (1) transmitter allowed at one time; no duplicates or back-up allowed • Replacement frequency based on manufacturers recommendations • Managed Medicaid Plans: 1 unit/frequency based on manufacturers recommendations • Covered under the Member diabetic benefit and can be billed to MVP through the medical benefit. Refer to MVP Medical Policy for coverage information. • Non-covered for MVP Medicare plans
A9278	Receiver (monitor) for use with Continuous Glucose Monitoring System	• Only one (1) Receiver allowed at one time; no duplicates or back-up allowed • Managed Medicaid Plans: 1 unit/once 3 years • Covered under the Member diabetic benefit and can be billed to MVP through the medical benefit. Refer to MVP Medical Policy for coverage information • Non-covered for MVP Medicare plans
K0553	Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories	• 3 month supply = 3 unit of service • Covered benefit for Commercial, ASO products, Medicaid and Medicare plans
K0554	Receiver (monitor) for use with therapeutic continuous glucose monitor system	• Only one (1) Receiver allowed at one time; no duplicates or back-up allowed • Covered benefit for Commercial, ASO Products, Medicaid and Medicare plans • Must meet FDA approval as Therapeutic CGMS. See MVP Medical Policy for details • Managed Medicaid Plans: 1 unit/once every 3 years

Tracheostomy Care Supplies

Code	Description	Rule
A7520-A7522	Tracheostomy/ Laryngectomy Tube	• MVP does cover this code under the Member's DME benefit
L8501	Tracheostomy Speaking Valve	• MVP does cover this code under the Member's DME benefit
A4625 and A4629	Tracheostomy Care Kit	• MVP does cover this code if the Member's contract covers disposable medical supplies
A4623	Tracheostomy disposable inner cannula	• MVP does cover this item if the Member's contract covers disposable medical supplies
A4626	Tracheostomy cleaning brush	• MVP does cover this item if the Member's contract covers disposable medical supplies
A4649	Tracheostomy Foam Holder/ Tie	• MVP does cover this item if the Member's contract covers disposable medical supplies
A4217	Sterile water/ saline for Irrigation 5 ml	• MVP does cover this item if the Member's contract covers disposable medical supplies
A7525	Tracheostomy Mask	• MVP does cover this item if the Member's contract covers disposable medical supplies

Code	Description	Rule
A4625	Tracheal Suction Catheter (not closed)	• MVP does cover this item if the Member's contract covers disposable medical supplies
A7523	Tracheostomy Shower Protector	• MVP does cover this item if the Member's contract covers disposable medical supplies
A7524	Tracheostomy Plug/ Button	• MVP does cover this item if the Member's contract covers disposable medical supplies

Ostomy Supplies

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

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

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

Managed Medicaid Incontinence Supply Management Program

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

History

April 1, 2019 Policy approved

March 1, 2021 Policy reviewed and approved with changes

Elective Delivery for Providers and Facilities

Last Reviewed Date: March 1, 2021

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

Emergency Department - Physician

Last Reviewed Date: 6/1/2020

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 30.6.12.H.

History

6/1/2019 – policy approved

6/1/2020 – changes reviewed, approved

Evaluation and Management

Last Reviewed Date: 12/1/2020

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 another provider of the same 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

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.

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.

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.

Code	Description	Rule
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.

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

Osteopathic Manipulation

Code	Description	Rule
98925, 98926, 98927, 98928, 98929	Osteopathic Manipulation	• MVP will **not** reimburse for these 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.
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.

Code	Description	Rule
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.
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.**

Code	Description	Rule
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.
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.

Code	Description	Rule
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

12/1/2020 – policy changes, reviewed and approved

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: March 1, 2021

EYE WEAR COVERAGE

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

Home Infusion

Last Reviewed Date: 6/1/2020
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

6/1/2019 – policy approved

06/01/2020 – policy approved with no changes

Incident to Guidelines

Last Reviewed Date: 12/1/2019

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 1, 2018	Policy approved
December 1, 2019	Policy review no changes

Infusion Policy

Last Reviewed Date: 3/1/2019

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

References

Remicade (infliximab) Injection. Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; October 2011.

Avastin (bevacizumab) Injection. Prescribing Information. South San Francisco, CA: Genentech, Inc.; 21 December 2011.

Neulasta (pegfilgrastim) Injection. Prescribing Information. Thousand Oaks, California: Amgen Manufacturing, Limited; 2/2010.

Rituxan (rituximab) Injection. Prescribing Information. South San Francisco, Ca: Genentech Inc.; February 2012.

HERCEPTIN® [trastuzumab] Injection. Prescribing Information. South San Francisco, Ca: Genentech Inc.; October 2010.

Zometa® (zoledronic acid) Injection. Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation 2011.

ALOXI® (palonosetron hydrochloride) Injection. Prescribing Information. Albuquerque, NM: OSO Biopharmaceuticals, LLC; 06/09.

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

Tysabri (natalizumab) for Injection. Prescribing Information. Cambridge, MA: Biogen Idec Inc. 9/2011.

Sandostatin LAR® Depot (octreotide acetate) Injection. East Hanover, NJ: Novartis Pharmaceuticals Corporation 2011.

Luent is (ranibizumab) Injection. Prescribing Information. South San Francisco, CA: Genentech, Inc.; June 2010.

Orencia (abatacept) Injection. Prescribing Information. Princeton, NJ: Bristol-Myers Squibb; December 2011.

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

3/1/2019 – policy approved

Interpreter Services

Medicaid Products

Last Reviewed Date: December 1, 2019

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	Policy approved
December 1, 2019	annual review, approved, no changes

JW Modifier

Last Reviewed Date: 9/1/2020

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 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

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

This modifier must be billed on a separate line and will provide payment for the amount of the discarded drug or biological. Drug wastage must be documented in the patient's medical record with the date, time, amount wasted, and reason for wastage. Upon review, any discrepancy between amount administered to the patient and amount billed may be denied as non-rendered unless the wastage is clearly and accurately documented. The amount billed as "wasted" must not be administered to another patient or billed to either MVP or another carrier. Drug wastage cannot be billed if none of the drug was administered (e.g. missed appointment).

Single Use Vials

Example of when JW Modifier IS required:

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

Example of when JW Modifier IS NOT required:

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

Multi-Use Vials – short shelf life/multiple patients

Example of when JW Modifier IS required:

> An office schedules three patients to receive a drug from a multi-use vial on the same day. The vial is 100 mg and is billed per individual unit. Patient A receives 30 mg and the claim would be billed at 30 units. Patient B receives 20 mg and the claim would indicate 20 units. Patient C receives 40 mg of the drug, which means 10 mg of the drug was not used and should be accounted for as wa stage. Patient C's claim should indicate 40 units of the drug that was used and a second line item indicating the wastage (JW modifier) of 10 units of the drug.

Per Medicare's billing guidelines, only Patient C's claim would indicate the wastage with JW Modifier since this was the last patient of the day receiving the drug.

Multi-Use Vials – long shelf life/multiple patients

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

References

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

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

History

9/1/2018 – policy approved

9/1/2020 – policy reviewed, no changes, approved

Laboratory Services

Last Reviewed Date: 10/15/2020

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	Policy approved
December 1, 2019	Annual review updates to documentation guidelines and non-contracted labs.
October 1, 2020	Annual review, approved with changes.

Locum Tenens

Last Reviewed Date: March 1, 2021

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

Mid-Level Payment Policy

Last Reviewed Date: 6/1/2020
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

12/1/2018	Policy approved
12/1/2019	Annual review, approved no changes
06/01/2020	policy approved with no changes

Modifier Policy for Physician

Last Reviewed Date: 12/1/2020

MODIFIER POLICY FOR PHYSICIAN

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

.

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

Unless otherwise designated this modifier may be appended to procedures and services listed in 20100-69999 code series. Modifier 63 should not be appended to any CPT code listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory or Medicine sections.

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 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. 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

6/1/2019 - Policy Approved
3/1/2020 – Policy Approved with changes
6/1/2020 – Reviewed with no changes
12/1/2020 – Policy approved with changes

Multiple Surgery – VT Facilities Only

Last Reviewed Date: 9/1/2020

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

9/1/2018 – policy approved

9/1/2020 – policy reviewed with no changes, approved

NDC Policy

Last Reviewed Date: 6/1/2020

Policy

When submitting NDC codes, the NDC number must be valid. MVP requires the valid NDC and quantity be included on all claims where a medication is administered for outpatient or professional setting with a procedure code beginning with J or which has an O1E or O1D BETOS designation. The BETOS designation can be referenced here.

The only exceptions to this required NDC rule are for claims billed at the inpatient hospital location or for drugs purchased from the 340B program when billed with the UD modifier for New York State Medicaid. If an NDC is submitted on any claim, for any procedure, that NDC will be verified for accuracy and the unit quantity will be reviewed to ensure it is not zero.

Definitions

NDC – National Drug Code

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

Instructions for filling out CMS 1500 form

All NDC should be entered in the shaded area of fields 24A – 24G for the corresponding procedure code.

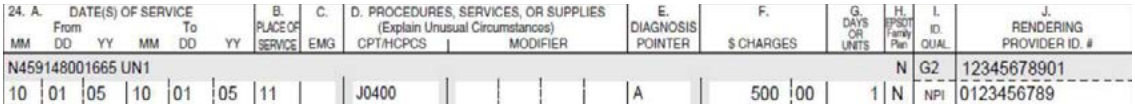
The following should be included in order:

- Report the N4 qualifier (left justified)
- Followed immediately by 11 digit NDC (no hyphens)
- One space
- Followed immediately by Unit of measurement qualifier:

  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 Code



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

Instructions for filling out UB 04 form

NDC should be entered into field 43.

The following should be included in order:

- Report the N4 qualifier (left justified) followed immediately by:
- 11 digit NDC (no hyphens) followed immediately by:
- Unit of measurement qualifier:

  F2 – International Unit 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 National Drug Code 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 dashes.

However, you will usually not see just 11 numbers when you look at an NDC on a medication package. This is because the 11 digits of an NDC are broken out into 3 sections.

- The first 5 digits identify the drug manufacturer.
- The next 4 digits identify the specific drug and its strength.
- The last 2 digits 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 will simply have to remove the dashes, and submit the 11 numbers.

But in most cases, you will see other formats as many manufacturers omit leading zeros in one or more of the three NDC sections.

For a claim to be paid, the leading zeros must be added back into the appropriate place within the NDC to create an 11 digit NDC number that matches the Medispan and/or First Data Bank databases.

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

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

Choosing the Applicable NDC

If a drug has two NDCs, one on the package and one on the vial, submit the NDC on the package rather than the vial.

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

References

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

History

2/1/2018 – policy approved

6/1/2020 – policy reviewed, no changes, approved

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

Last Reviewed Date: 9/1/2020

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

6/1/2019 – policy approved

9/1/2020 – Policy reviewed, no changes

Observation Status for Facility and Provider

Last Reviewed Date: 3/1/2019

Policy

MVP does not require a preauthorization for observation services. However, any observation services that are converted to an inpatient stay will require an authorization. Observation services are limited to 48 hours. Any observation services over 48 hours will be denied at Observation stays greater than 48 hours not covered.

Definitions

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

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

3/1/2019 – policy approved

Occupational Therapy (OT)

Last Reviewed Date: March 1, 2021

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

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

Last Reviewed Date – 12/1/2020

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

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
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.)

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

12/1/2020 – new policy, approved

Physical Therapy (PT)

Last Reviewed Date: March 1, 2021

Policy

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

Definitions

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

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

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

Notification/Prior Authorization Requests

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

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

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

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

Medicare Therapy Cap

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

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

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

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

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

Reimbursement Guidelines

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

References

MVP Utilization Management Policy, Provider Resource Manual

History

March 1, 2019 Policy approved

March 1, 2021 Policy reviewed and approved with no changes

Preoperative Lab Testing

Last Reviewed Date: 6/1/2020

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

6/1/2017 – policy approved

6/1/2020 – policy reviewed, no changes & approved

Preventive Health Care

Last Reviewed Date: March 1, 2021

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 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 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)

CPT Codes	Description
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older

Established Patient comprehensive preventive medicine evaluation and management

CPT codes **99391-99397**:

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

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

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

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

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

CPT Codes	Description
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 women, 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

Code	Billing Instruction	Code Description
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 refereed.

(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 Women

(July 2008) Rating A

"Task Force" Recommendation

The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women 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

Blood Pressure in Adults: Screening

(Dec 2013) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. They also recommend obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

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

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. Also, must 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
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) (eg, hereditary breast and ovarian
81165		BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81166		BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
81167		BRCA2 (BRCA2, DNA repair associated) (eg, 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

Code	Billing Instruction	Code Description
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

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

Chlamydia Screening Women

(Sept 2014) Rating B

"Task Force" Recommendation

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

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
87492		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification

Code	Billing Instruction	Code Description
87590	Bill with Modifier 33	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

Colorectal Cancer Screening

(June 2016) Rating A

"Task Force" Recommendation

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

ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no 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
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

Code	Billing Instruction	Code Description
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	Proctosigmoidoscop y, 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
45337	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with decompression (for Pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45341	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45347	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
45355	No cost share when billed with Modifier 33 or PT	Colonoscopy, rigid or flexible, transabdominal via colostomy, single or multiple
45378	No cost share when billed with a modifier PT or 33.	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	No cost share when billed with a modifier PT or 33	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body

Code	Billing Instruction	Code Description
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
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
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)

Code	Billing Instruction	Code Description
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.
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.

Code	Billing Instruction	Code Description
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 – 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 are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, 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.	

Code	Billing Instruction	Code Description
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 for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Proctosigmoidoscopy, Rigid; W Removal Single Tumor/ Polyp/Lesion By Snare
45315	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Proctosigmoidoscopy; Multiple Removals
45331	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with biopsy, single or multiple
45333	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s by hot biopsy forceps or bipolar cautery
45338	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45346	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

Code	Billing Instruction	Code Description
45378	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, 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 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 for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Surg Pathology; Level 4 Gross & Microscopic examination
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 supports, each additional 15 minutes intraservice time.

Code	Billing Instruction	Code Description
99156	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Initial 15 minutes of intraservice time, patient age 5 and older.
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	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
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

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
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

Diabetes Screening

(Oct 2015) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults ages 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. See Women's Preventive Health section for *Screening for Gestational Diabetes Mellitus and Screening for Diabetes Mellitus after Pregnancy*.

Code	Billing Instruction	Code Description
82947	• 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 **OBESITY:** ICD-10: E66.01, E66.09, E66.1, E66.8, E66.9, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45 **BODY MASS INDEX 30.0 – 39.9:** ICD-10: Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39 **BODY MASS INDEX 40.0 AND OVER:** ICD-10: Z68.41, Z68.42, Z68.43, Z68.44, Z68.45 **ESSENTIAL:** Glucose; quantitative, blood (except reagent strip).	Medical & Facility Annual wellness Visit Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness
82950	Bill with one of the ICD – 10 codes listed above.	Glucose; post-glucose dose (includes glucose)
82951	Bill with one of the ICD – 10 codes listed above.	Glucose: tolerance test (GTT), 3 specimens (includes glucose)
82952	Bill with one of the ICD – 10 codes listed above.	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for 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

Gestational Diabetes Mellitus Screening

(Jan 2014) Rating B

"Task Force" Recommendation

The USPSTF recommends screening for gestational diabetes Mellitus in asymptomatic pregnant women after 24 weeks gestation. For additional diabetes screening benefits, see the Women's Preventive Health section for Screening for Gestational Diabetes Mellitus and Screening for Diabetes Mellitus after Pregnancy.

Code	Billing Instruction	Code Description
82977	Bill with ICD- 10 Z13.1	Glutamyltransferase, gamma (GGT)s

Gonorrhea Screening Sexually Active Women

(Sept 2014) Rating B

"Task Force" Recommendation

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

Code	Billing Instruction	Code Description
87590	Bill with Modifier33	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, gonnorrhoeae, quantification

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	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	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	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	Hepatitis B surface antibody (HBsAb)
87340	Bill with one of the ICD-10 screening diagnosis codes Z00.00, Z00.01, Z11.59, Z57.8	Infectious agent antigen detection by immunoassay technique

Hepatitis B Virus Infection Screening: Pregnant Women

(June 2019) Rating A

"Task Force" Recommendation

The USPSTF recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.

Code	Billing Instruction	Code Description
87340	Medical & Facility	Hepatitis B surface antigen (HbsAg)

Code	Billing Instruction	Code Description
86704	Bill with a pregnancy diagnosis code	Hepatitis B core antibody (HBcAb); total
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)

High Blood Pressure in Adults: Screening

(October 2015) Rating A

"Task Force" Recommendation

The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

Code	Billing Instruction	Code Description
99410-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness

HIV Screening: Adolescents and adults aged 15 to 65 years.

(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.

Code	Billing Instruction	Code Description
86701		Antibody; HIV-1
86702		Antibody; HIV-2

Code	Billing Instruction	Code Description
86703		Antibody; HIV-1 and HIV-2 single assay
87389		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies

HIV Screening (Pregnant Women, Adolescents, and Adults 15–65)

(April 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

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

(Dec 2013) Rating B

"Task Force" Recommendation

The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adult's ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Counseling to discuss lung cancer screening.

Code	Billing Instruction	Code Description
G0297	Prior authorization is required for G0297	Low dose CT scan (LDCT) for lung cancer screening
G0296		Counseling visit to discuss need for lung cancer screening (ldct) using low dose CT scan (service is for eligibility determination and shared decision making)
71271		Computed tomography, thorax, low dose for lung cancer screening, without contrast material is intended to be the replacement code.

Maternal Depression Screening

New York State Department of Financial Services 52 Amendment to Title 11 NYCRR 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

Code	Billing Instruction	Code Description
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 A

"Task Force" Recommendation

The USPSTF recommends screening for preeclampsia in pregnant women 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.

Preeclampsia Prevention: Aspirin

"Task Force" Recommendation

The USPSTF recommends the use of low dose aspirin (81mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia. A written prescription for aspirin is required: Age limit >/= 12 (women) QL of 100 units/fill Generics only Single ingredient OTC dosages 325mg or less.

Code	Billing Instruction	Code Description
Medical & Facility		**Medical & Facility** – Preventive medicine counseling and/or risk factor reduction interventions

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 women during their first visit for pregnancy-related care when billed with appropriate code and appropriate Pregnancy related ICD 10 diagnosis code set billed in the principal diagnosis position

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.

Code	Billing Instruction	Code Description
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
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 Women

(May 2009) Rating A

"Task Force" Recommendation

The USPSTF recommends early screening for syphilis infection in all pregnant women.

Code	Billing Instruction	Code Description
86592		Syphilis test, non- Treponema antibody; qualitative (e.g., VDRL, RPR, ART)

Code	Billing Instruction	Code Description
86593		Syphilis test, non- treponemal antibody; quantitative
86780		Antibody; Treponema pallidum

Tobacco Use Counseling and Interventions: Non-pregnant Adults

(Sept 2015) 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 adults who use tobacco. The USPSTF recommends that clinicians as all Pregnant Women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women 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 and/or Vaping 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

Contraceptive Use and Counseling

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

Code	Description	Business Rule
57170	Diaphragm or cervical cap fitting with instructions	No cost share for contraceptive use and counseling for women when billed with appropriate code
58300	Insertion of intrauterine device (IUD)	No cost share for contraceptive use and counseling for women when billed with appropriate code
58301	Removal of intrauterine device (IUD)	No cost share for contraceptive use and counseling for women when billed with appropriate code
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	No cost share for contraceptive use and counseling for women when billed with appropriate code
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 contraceptive use and counseling for women when billed with appropriate code
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 code
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	No cost share for contraceptive use and counseling for women when billed with appropriate code
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
A4266	Diaphragm for contraceptive use	No cost share for contraceptive use and counseling for women when billed with appropriate code
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
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
J7303	Contraceptive supply, hormone containing vaginal ring, each	No cost share for contraceptive use and counseling for women when billed with appropriate code

Code	Description	Business Rule
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 code

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

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
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
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

Code	Description
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
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

Code	Description
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
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

Code	Description
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
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).
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).

Code	Description	Business Rule
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
82977	Glutamyltransferase, gamma (GGT) s	No cost share for screening for gestational diabetes in females when billed with diagnosis code billed in the principal diagnosis position; Z13.1
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician	No 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

Code	Description	Business Rule
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	No co-pay
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 on Sexually Transmitted infections

Code	Description	Business Rule
99401 99402 99403 99404	Preventive medicine counseling and/or risk factor reduction interventions	No cost share for counseling on sexually transmitted infections for females when billed with appropriate CPT code

Women's Preventative Health – Counseling and Screening for HIV Infection

Code	Description	Business Rule
86701 86702 86703	Antibody; HIV-1 Antibody; HIV-2 Antibody; HIV-1 and HIV-2, single result	No cost share for counseling and screening for HIV infection in females when billed with appropriate CPT codes

Women's Preventative Health – Contraceptive Methods and Counseling

Code	Description	Business Rule
99401 99402 99403 99404	Preventive medicine counseling and/or risk factor reduction interventions	No cost share for contraceptive methods and counseling in females when billed with appropriate CPT codes

Women's Preventative Health – Sterilization Surgery

Code	Description	Business Rule
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	
58661	Removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	Covered in full with no cost share for female sterilization surgery for females when billed with diagnosis code Z30.2
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	

Women's Preventative Health – Counseling to Detect and Prevent Interpersonal and Domestic Violence

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 – For Lactation Counseling and Equipment

Code	Description	Business Rule
E0602 **E0603** **E0604**	Breast pump, manual, any type Breast pump, electric (AC and/or DC), any type breast pump, hospital grade, electric (AC and/or DC), any type	No cost share for lactation counseling and equipment for females when billed with the appropriate CPT code. Members are allowed reimbursement for 1 breast pump per live birth. Members can complete the Child Care Form to be reimbursed for the purchase of a breast pump
A4281	Tubing for breast pump, replacement	MVP will cover this replacement part at no cost to the Member for the first year of the child's life.
A4282	Adapter for breast pump, replacement	MVP will cover this replacement part at no cost to the Member for the first year of the child's life.
A4283	Cap for breast pump bottle, replacement	MVP will cover this replacement part at no cost to the Member for the first year of the child's life.
A4284	Breast shield and splash protector for use with breast pump, replacement	MVP will cover this replacement part at no cost to the Member for the first year of the child's life.
A4285	Polycarbonate bottle for use with breast pump, replacement	MVP will cover this replacement part at no cost to the Member for the first year of the child's life.
A4286	Locking ring for breast pump, replacement	MVP will cover this replacement part at no cost to the Member for the first year of the child's life.

Women's Preventative Health

Code	Description	Business Rule
S9443	Non-physician doing a lactation class	No co-pay

Women's Preventative Health – Supervisor of Lactation

Code	Description	Business Rule
99211 **99212** **99213** **99214** **99215**	Nurse visit usually under 5 minutes Office or other outpatient visit for the evaluation and management of an established patient	No cost share for supervision of lactation when billed by a physician with the appropriate E&M code and the following diagnosis codes billed in the principal diagnosis position; Z39.1

Women's Preventative Health – Screening for Urinary Incontinence

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 – Screening for Diabetes Mellitus after Pregnancy

Code	Description	Business Rule
83036	Hemoglobin: Glycosylated (A1C)	• No cost share for women when billed with diagnosis code Z39.2. • The Women's Preventive Services Initiative recommends women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus should be screened for diabetes mellitus. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum. • Women with a negative initial postpartum screening test result should be rescreened at least every 3 years for a minimum of 10 years after pregnancy • Also See Diabetes Screening and Gestational Diabetes Screening in the Preventive Healthcare Payment Policy.

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

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	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 **77058 and 77059 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. **77049 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.

Code	Description	Business Rule
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:

A34., E07.81, O00.00, O00.01, O00.101, O00.102, O00.109, O00.111, O00.112, O00.119, O00.201, O00.202, O00.209, O00.211, O00.212, O00.219, O00.80, O00.81, O00.90, O00.91, O02.0, O02.1, O02.81, O02.89, O02.9, O03.0, O03.1, O03.2, O03.30, O03.31, O03.32, O03.33, O03.34, O03.35, O03.36, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.89, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O08.9, O09.00, O09.01, O09.02, O09.03, O09.10, O09.11, O09.12, O09.13, O09.211, O09.212, O09.213, O09.219, O09.291, O09.292, O09.293, O09.299, O09.30, O09.31, O09.32, O09.33, O09.40, O09.41, O09.42, O09.43, O09.511, O09.512, O09.513, O09.519, O09.521, O09.522, O09.523, O09.529, O09.611, O09.612, O09.613, O09.619, O09.621, O09.622, O09.623, O09.629, O09.70, O09.71, O09.72, O09.73, O09.811, O09.812, O09.813, O09.819, O09.821, O09.822, O09.823, O09.829, O09.891, O09.892, O09.893, O09.899, O09.90, O09.91, O09.92, O09.93, O09.A0, O09.A1, O09.A2, O09.A3, O10.011, O10.012, O10.013, O10.019, O10.02, O10.03, O10.111, O10.112, O10.113, O10.119, O10.12, O10.13, O10.211, O10.212, O10.213, O10.219, O10.22, O10.23, O10.311, O10.312, O10.313, O10.319, O10.32, O10.33, O10.411, O10.412, O10.413, O10.419, O10.42, O10.43, O10.911, O10.912, O10.913, O10.919, O10.92, O10.93, O11.1, O11.2, O11.3, O11.4, O11.5, O11.9, O12.00, O12.01, O12.02, O12.03, O12.04, O12.05, O12.10, O12.11, O12.12, O12.13, O12.14, O12.15, O12.20, O12.21, O12.22, O12.23, O12.24, O12.25, O13.1, O13.2, O13.3, O13.4, O13.5, O13.9, O14.00, O14.02, O14.03, O14.04, O14.05, O14.10, O14.12, O14.13, O14.14, O14.15, O14.20, O14.22, O14.23, O14.24, O14.25, O14.90, O14.92, O14.93, O14.94, O14.95, O15.00, O15.02, O15.03, O15.1, O15.2, O15.9, O16.1, O16.2, O16.3, O16.4, O16.5,

O16.9, O20.0, O20.8, O20.9, O21.0, O21.1, O21.2, O21.8, O21.9, O22.00, O22.01, O22.02, O22.03, O22.10, O22.11, O22.12, O22.13, O22.20, O22.21, O22.22, O22.23, O22.30, O22.31, O22.32, O22.33, O22.40, O22.41, O22.42, O22.43, O22.50, O22.51, O22.52, O22.53, O22.8X1, O22.8X2, O22.8X3, O22.8X9, O22.90, O22.91, O22.92, O22.93, O23.00, O23.01, O23.02, O23.03, O23.10, O23.11, O23.12, O23.13, O23.20, O23.21, O23.22, O23.23, O23.30, O23.31, O23.32, O23.33, O23.40, O23.41, O23.42, O23.43, O23.511, O23.512, O23.513, O23.519, O23.521, O23.522, O23.523, O23.529, O23.591, O23.592, O23.593, O23.599, O23.90, O23.91, O23.92, O23.93, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13, O24.311, O24.312, O24.313, O24.319, O24.32, O24.33, O24.410, O24.414, O24.415, O24.419, O24.420, O24.424, O24.425, O24.429, O24.430, O24.434, O24.435, O24.439, O24.811, O24.812, O24.813, O24.819, O24.82, O24.83, O24.911, O24.912, O24.913, O24.919, O24.92, O24.93, O25.10, O25.11, O25.12, O25.13, O25.2, O25.3, O26.00, O26.01, O26.02, O26.03, O26.10, O26.11, O26.12, O26.13, O26.20, O26.21, O26.22, O26.23, O26.30, O26.31, O26.32, O26.33, O26.40, O26.41, O26.42, O26.43, O26.50, O26.51, O26.52, O26.53, O26.611, O26.612, O26.613, O26.619, O26.62, O26.63, O26.711, O26.712, O26.713, O26.719, O26.72, O26.73, O26.811, O26.812, O26.813, O26.819, O26.821, O26.822, O26.823, O26.829, O26.831, O26.832, O26.833, O26.839, O26.841, O26.842, O26.843, O26.849, O26.851, O26.852, O26.853, O26.859, O26.86, O26.872, O26.873, O26.879, O26.891, O26.892, O26.893, O26.899, O26.90, O26.91, O26.92, O26.93, O29.011, O29.012, O29.013, O29.019, O29.021, O29.022, O29.023, O29.029, O29.091, O29.092, O29.093, O29.099, O29.111, O29.112, O29.113, O29.119, O29.121, O29.122, O29.123, O29.129, O29.191, O29.192, O29.193, O29.199, O29.211, O29.212, O29.213, O29.219, O29.291, O29.292, O29.293, O29.299, O29.3X1, O29.3X2, O29.3X3, O29.3X9, O29.40, O29.41, O29.42, O29.43, O29.5X1, O29.5X2, O29.5X3, O29.5X9, O29.60, O29.61, O29.62, O29.63, O29.8X1, O29.8X2, O29.8X3, O29.8X9, O29.90, O29.91, O29.92, O29.93, O30.001, O30.002, O30.003, O30.009, O30.011, O30.012, O30.013, O30.019, O30.021, O30.022, O30.023, O30.029, O30.031, O30.032, O30.033, O30.039, O30.041, O30.042, O30.043, O30.049, O30.091, O30.092, O30.093, O30.099, O30.101, O30.102, O30.103, O30.109, O30.111, O30.112, O30.113, O30.119, O30.121, O30.122, O30.123, O30.129, O30.131, O30.132, O30.133, O30.139, O30.191, O30.192, O30.193, O30.199, O30.201, O30.202, O30.203, O30.209, O30.211, O30.212, O30.213, O30.219, O30.221, O30.222, O30.223, O30.229, O30.231, O30.232, O30.233, O30.239, O30.291, O30.292, O30.293, O30.299, O30.801, O30.802, O30.803, O30.809, O30.811, O30.812, O30.813, O30.819, O30.821, O30.822, O30.823, O30.829, O30.831, O30.832, O30.833, O30.839, O30.891, O30.892, O30.893, O30.899, O30.90, O30.91, O30.92, O30.93, O31.00X0, O31.00X1, O31.00X2, O31.00X3, O31.00X4, O31.00X5, O31.00X9, O31.01X0, O31.01X1, O31.01X2, O31.01X3, O31.01X4, O31.01X5, O31.01X9, O31.02X0, O31.02X1, O31.02X2, O31.02X3, O31.02X4, O31.02X5, O31.02X9, O31.03X0, O31.03X1, O31.03X2, O31.03X3, O31.03X4, O31.03X5, O31.03X9, O31.10X0, O31.10X1, O31.10X2, O31.10X3, O31.10X4, O31.10X5, O31.10X9, O31.11X0, O31.11X1, O31.11X2, O31.11X3, O31.11X4, O31.11X5, O31.11X9, O31.12X0, O31.12X1, O31.12X2, O31.12X3, O31.12X4, O31.12X5, O31.12X9, O31.13X0, O31.13X1, O31.13X2, O31.13X3, O31.13X4, O31.13X5, O31.13X9, O31.20X0, O31.20X1, O31.20X2, O31.20X3, O31.20X4, O31.20X5, O31.20X9, O31.21X0, O31.21X1, O31.21X2, O31.21X3, O31.21X4, O31.21X5, O31.21X9, O31.22X0, O31.22X1, O31.22X2, O31.22X3, O31.22X4, O31.22X5, O31.22X9, O31.23X0, O31.23X1, O31.23X2, O31.23X3, O31.23X4, O31.23X5, O31.23X9, O31.30X0, O31.30X1, O31.30X2, O31.30X3, O31.30X4, O31.30X5, O31.30X9, O31.31X0, O31.31X1, O31.31X2, O31.31X3, O31.31X4, O31.31X5, O31.31X9, O31.32X0, O31.32X1, O31.32X2, O31.32X3, O31.32X4, O31.32X5, O31.32X9, O31.33X0, O31.33X1, O31.33X2, O31.33X3, O31.33X4, O31.33X5, O31.33X9, O31.8X10, O31.8X11, O31.8X12, O31.8X13, O31.8X14, O31.8X15, O31.8X19, O31.8X20, O31.8X21, O31.8X22, O31.8X23, O31.8X24, O31.8X25, O31.8X29, O31.8X30, O31.8X31, O31.8X32, O31.8X33, O31.8X34, O31.8X35, O31.8X39, O31.8X90, O31.8X91, O31.8X92, O31.8X93, O31.8X94, O31.8X95, O31.8X99, O32.0XX0, O32.0XX1, O32.0XX2, O32.0XX3, O32.0XX4, O32.0XX5, O32.0XX9, O32.1XX0, O32.1XX1, O32.1XX2, O32.1XX3, O32.1XX4, O32.1XX5, O32.1XX9, O32.2XX0, O32.2XX1, O32.2XX2, O32.2XX3, O32.2XX4, O32.2XX5, O32.2XX9, O32.3XX0, O32.3XX1, O32.3XX2, O32.3XX3, O32.3XX4, O32.3XX5, O32.3XX9, O32.4XX0, O32.4XX1, O32.4XX2, O32.4XX3, O32.4XX4, O32.4XX5, O32.4XX9, O32.6XX0, O32.6XX1, O32.6XX2, O32.6XX3, O32.6XX4, O32.6XX5, O32.6XX9, O32.8XX0, O32.8XX1, O32.8XX2, O32.8XX3, O32.8XX4, O32.8XX5, O32.8XX9, O32.9XX0, O32.9XX1, O32.9XX2, O32.9XX3, O32.9XX4, O32.9XX5, O32.9XX9, O33.0, O33.1, O33.2, O33.3XX0, O33.3XX1, O33.3XX2, O33.3XX3, O33.3XX4, O33.3XX5, O33.3XX9, O33.4XX0, O33.4XX1, O33.4XX2, O33.4XX3, O33.4XX4, O33.4XX5, O33.4XX9, O33.5XX0, O33.5XX1, O33.5XX2, O33.5XX3, O33.5XX4, O33.5XX5, O33.5XX9, O33.6XX0, O33.6XX1, O33.6XX2, O33.6XX3, O33.6XX4, O33.6XX5, O33.6XX9, O33.7XX0, O33.7XX1, O33.7XX2, O33.7XX3, O33.7XX4, O33.7XX5, O33.7XX9, O33.8, O33.9, O34.00, O34.01, O34.02, O34.03, O34.10, O34.11, O34.12, O34.13, O34.211, O34.212, O34.218, O34.219, O34.22, O34.29, O34.30, O34.31, O34.32, O34.33, O34.40, O34.41, O34.42, O34.43, O34.511, O34.512, O34.513, O34.519, O34.521, O34.522, O34.523, O34.529, O34.531, O34.532, O34.533, O34.539, O34.591, O34.592, O34.593, O34.599, O34.60, O34.61, O34.62, O34.63, O34.70, O34.71, O34.72, O34.73, O34.80, O34.81, O34.82, O34.83, O34.90, O34.91, O34.92, O34.93, O35.0XX0, O35.0XX1, O35.0XX2, O35.0XX3, O35.0XX4, O35.0XX5, O35.0XX9, O35.1XX0, O35.1XX1, O35.1XX2, O35.1XX3, O35.1XX4, O35.1XX5, O35.1XX9, O35.2XX0, O35.2XX1, O35.2XX2, O35.2XX3, O35.2XX4, O35.2XX5, O35.2XX9, O35.3XX0, O35.3XX1, O35.3XX2, O35.3XX3, O35.3XX4, O35.3XX5, O35.3XX9, O35.4XX0, O35.4XX1, O35.4XX2, O35.4XX3, O35.4XX4, O35.4XX5, O35.4XX9, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, O35.6XX0, O35.6XX1, O35.6XX2, O35.6XX3, O35.6XX4, O35.6XX5, O35.6XX9, O35.7XX0, O35.7XX1, O35.7XX2, O35.7XX3, O35.7XX4, O35.7XX5, O35.7XX9, O35.8XX0, O35.8XX1, O35.8XX2, O35.8XX3, O35.8XX4, O35.8XX5, O35.8XX9, O35.9XX0, O35.9XX1, O35.9XX2, O35.9XX3, O35.9XX4, O35.9XX5, O35.9XX9, O36.0110, O36.0111, O36.0112, O36.0113, O36.0114, O36.0115, O36.0119, O36.0120, O36.0121, O36.0122, O36.0123, O36.0124, O36.0125, O36.0129, O36.0130, O36.0131, O36.0132, O36.0133, O36.0134, O36.0135, O36.0139, O36.0190, O36.0191, O36.0192, O36.0193, O36.0194, O36.0195, O36.0199, O36.0910, O36.0911, O36.0912, O36.0913, O36.0914, O36.0915, O36.0919, O36.0920, O36.0921, O36.0922, O36.0923,

O36.0924, O36.0925, O36.0929, O36.0930, O36.0931, O36.0932, O36.0933, O36.0934, O36.0935, O36.0939, O36.0990, O36.0991, O36.0992, O36.0993, O36.0994, O36.0995, O36.0999, O36.1110, O36.1111, O36.1112, O36.1113, O36.1114, O36.1115, O36.1119, O36.1120, O36.1121, O36.1122, O36.1123, O36.1124, O36.1125, O36.1129, O36.1130, O36.1131, O36.1132, O36.1133, O36.1134, O36.1135, O36.1139, O36.1190, O36.1191, O36.1192, O36.1193, O36.1194, O36.1195, O36.1199, O36.1910, O36.1911, O36.1912, O36.1913, O36.1914, O36.1915, O36.1919, O36.1920, O36.1921, O36.1922, O36.1923, O36.1924, O36.1925, O36.1929, O36.1930, O36.1931, O36.1932, O36.1933, O36.1934, O36.1935, O36.1939, O36.1990, O36.1991, O36.1992, O36.1993, O36.1994, O36.1995, O36.1999, O36.20X0, O36.20X1, O36.20X2, O36.20X3, O36.20X4, O36.20X5, O36.20X9, O36.21X0, O36.21X1, O36.21X2, O36.21X3, O36.21X4, O36.21X5, O36.21X9, O36.22X0, O36.22X1, O36.22X2, O36.22X3, O36.22X4, O36.22X5, O36.22X9, O36.23X0, O36.23X1, O36.23X2, O36.23X3, O36.23X4, O36.23X5, O36.23X9, O36.4XX0, O36.4XX1, O36.4XX2, O36.4XX3, O36.4XX4, O36.4XX5, O36.4XX9, O36.5110, O36.5111, O36.5112, O36.5113, O36.5114, O36.5115, O36.5119, O36.5120, O36.5121, O36.5122, O36.5123, O36.5124, O36.5125, O36.5129, O36.5130, O36.5131, O36.5132, O36.5133, O36.5134, O36.5135, O36.5139, O36.5190, O36.5191, O36.5192, O36.5193, O36.5194, O36.5195, O36.5199, O36.5910, O36.5911, O36.5912, O36.5913, O36.5914, O36.5915, O36.5919, O36.5920, O36.5921, O36.5922, O36.5923, O36.5924, O36.5925, O36.5929, O36.5930, O36.5931, O36.5932, O36.5933, O36.5934, O36.5935, O36.5939, O36.5990, O36.5991, O36.5992, O36.5993, O36.5994, O36.5995, O36.5999, O36.60X0, O36.60X1, O36.60X2, O36.60X3, O36.60X4, O36.60X5, O36.60X9, O36.61X0, O36.61X1, O36.61X2, O36.61X3, O36.61X4, O36.61X5, O36.61X9, O36.62X0, O36.62X1, O36.62X2, O36.62X3, O36.62X4, O36.62X5, O36.62X9, O36.63X0, O36.63X1, O36.63X2, O36.63X3, O36.63X4, O36.63X5, O36.63X9, O36.70X0, O36.70X1, O36.70X2, O36.70X3, O36.70X4, O36.70X5, O36.70X9, O36.71X0, O36.71X1, O36.71X2, O36.71X3, O36.71X4, O36.71X5, O36.71X9, O36.72X0, O36.72X1, O36.72X2, O36.72X3, O36.72X4, O36.72X5, O36.72X9, O36.73X0, O36.73X1, O36.73X2, O36.73X3, O36.73X4, O36.73X5, O36.73X9, O36.80X0, O36.80X1, O36.80X2, O36.80X3, O36.80X4, O36.80X5, O36.80X9, O36.8120, O36.8121, O36.8122, O36.8123, O36.8124, O36.8125, O36.8129, O36.8130, O36.8131, O36.8132, O36.8133, O36.8134, O36.8135, O36.8139, O36.8190, O36.8191, O36.8192, O36.8193, O36.8194, O36.8195, O36.8199, O36.8210, O36.8211, O36.8212, O36.8213, O36.8214, O36.8215, O36.8219, O36.8220, O36.8221, O36.8222, O36.8223, O36.8224, O36.8225, O36.8229, O36.8230, O36.8231, O36.8232, O36.8233, O36.8234, O36.8235, O36.8239, O36.8290, O36.8291, O36.8292, O36.8293, O36.8294, O36.8295, O36.8299, O36.8310, O36.8311, O36.8312, O36.8313, O36.8314, O36.8315, O36.8319, O36.8320, O36.8321, O36.8322, O36.8323, O36.8324, O36.8325, O36.8329, O36.8330, O36.8331, O36.8332, O36.8333, O36.8334, O36.8335, O36.8339, O36.8390, O36.8391, O36.8392, O36.8393, O36.8394, O36.8395, O36.8399, O36.8910, O36.8911, O36.8912, O36.8913, O36.8914, O36.8915, O36.8919, O36.8920, O36.8921, O36.8922, O36.8923, O36.8924, O36.8925, O36.8929, O36.8930, O36.8931, O36.8932, O36.8933, O36.8934, O36.8935, O36.8939, O36.8990, O36.8991, O36.8992, O36.8993, O36.8994, O36.8995, O36.8999, O36.90X0, O36.90X1, O36.90X2, O36.90X3, O36.90X4, O36.90X5, O36.90X9, O36.91X0, O36.91X1, O36.91X2, O36.91X3, O36.91X4, O36.91X5, O36.91X9, O36.92X0, O36.92X1, O36.92X2, O36.92X3, O36.92X4, O36.92X5, O36.92X9, O36.93X0, O36.93X1, O36.93X2, O36.93X3, O36.93X4, O36.93X5, O36.93X9, O40.1XX0, O40.1XX1, O40.1XX2, O40.1XX3, O40.1XX4, O40.1XX5, O40.1XX9, O40.2XX0, O40.2XX1, O40.2XX2, O40.2XX3, O40.2XX4, O40.2XX5, O40.2XX9, O40.3XX0, O40.3XX1, O40.3XX2, O40.3XX3, O40.3XX4, O40.3XX5, O40.3XX9, O40.9XX0, O40.9XX1, O40.9XX2, O40.9XX3, O40.9XX4, O40.9XX5, O40.9XX9, O41.00X0, O41.00X1, O41.00X2, O41.00X3, O41.00X4, O41.00X5, O41.00X9, O41.01X0, O41.01X1, O41.01X2, O41.01X3, O41.01X4, O41.01X5, O41.01X9, O41.02X0, O41.02X1, O41.02X2, O41.02X3, O41.02X4, O41.02X5, O41.02X9, O41.03X0, O41.03X1, O41.03X2, O41.03X3, O41.03X4, O41.03X5, O41.03X9, O41.1010, O41.1011, O41.1012, O41.1013, O41.1014, O41.1015, O41.1019, O41.1020, O41.1021, O41.1022, O41.1023, O41.1024, O41.1025, O41.1029, O41.1030, O41.1031, O41.1032, O41.1033, O41.1034, O41.1035, O41.1039, O41.1090, O41.1091, O41.1092, O41.1093, O41.1094, O41.1095, O41.1099, O41.1210, O41.1211, O41.1212, O41.1213, O41.1214, O41.1215, O41.1219, O41.1220, O41.1221, O41.1222, O41.1223, O41.1224, O41.1225, O41.1229, O41.1230, O41.1231, O41.1232, O41.1233, O41.1234, O41.1235, O41.1239, O41.1290, O41.1291, O41.1292, O41.1293, O41.1294, O41.1295, O41.1299, O41.1410, O41.1411, O41.1412, O41.1413, O41.1414, O41.1415, O41.1419, O41.1420, O41.1421, O41.1422, O41.1423, O41.1424, O41.1425, O41.1429, O41.1430, O41.1431, O41.1432, O41.1433, O41.1434, O41.1435, O41.1439, O41.1490, O41.1491, O41.1492, O41.1493, O41.1494, O41.1495, O41.1499, O41.8X10, O41.8X11, O41.8X12, O41.8X13, O41.8X14, O41.8X15, O41.8X19, O41.8X20, O41.8X21, O41.8X22, O41.8X23, O41.8X24, O41.8X25, O41.8X29, O41.8X30, O41.8X31, O41.8X32, O41.8X33, O41.8X34, O41.8X35, O41.8X39, O41.8X90, O41.8X91, O41.8X92, O41.8X93, O41.8X94, O41.8X95, O41.8X99, O41.90X0, O41.90X1, O41.90X2, O41.90X3, O41.90X4, O41.90X5, O41.90X9, O41.91X0, O41.91X1, O41.91X2, O41.91X3, O41.91X4, O41.91X5, O41.91X9, O41.92X0, O41.92X1, O41.92X2, O41.92X3, O41.92X4, O41.92X5, O41.92X9, O41.93X0, O41.93X1, O41.93X2, O41.93X3, O41.93X4, O41.93X5, O41.93X9, O42.00, O42.011, O42.012, O42.013, O42.019, O42.02, O42.10, O42.111, O42.112, O42.113, O42.119, O42.12, O42.90, O42.911, O42.912, O42.913, O42.919, O42.92, O43.011, O43.012, O43.013, O43.019, O43.021, O43.022, O43.023, O43.029, O43.101, O43.102, O43.103, O43.109, O43.111, O43.112, O43.113, O43.119, O43.121, O43.122, O43.123, O43.129, O43.191, O43.192, O43.193, O43.199, O43.211, O43.212, O43.213, O43.219, O43.221, O43.222, O43.223, O43.229, O43.231, O43.232, O43.233, O43.239, O43.811, O43.812, O43.813, O43.819, O43.891, O43.892, O43.893, O43.899, O43.90, O43.91, O43.92, O43.93, O44.00, O44.01, O44.02, O44.03, O44.10, O44.11, O44.12, O44.13, O44.20, O44.21, O44.22, O44.23, O44.30, O44.31, O44.32, O44.33, O44.40, O44.41, O44.42, O44.43, O44.50, O44.51, O44.52, O44.53, O45.001, O45.002, O45.003, O45.009, O45.011, O45.012, O45.013, O45.019, O45.021, O45.022, O45.023, O45.029, O45.091, O45.092, O45.093, O45.099, O45.8X1, O45.8X2, O45.8X3, O45.8X9, O45.90, O45.91, O45.92, O45.93, O46.001, O46.002, O46.003, O46.009, O46.011, O46.012, O46.013, O46.019, O46.021, O46.022, O46.023, O46.029,

O46.091, O46.092, O46.093, O46.099, O46.8X1, O46.8X2, O46.8X3, O46.8X9, O46.90, O46.91, O46.92, O46.93, O47.00, O47.02, O47.03, O47.1, O47.9, O48.0, O48.1, O60.00, O60.02, O60.03, O60.10X0, O60.10X1, O60.10X2, O60.10X3, O60.10X4, O60.10X5, O60.10X9, O60.12X0, O60.12X1, O60.12X2, O60.12X3, O60.12X4, O60.12X5, O60.12X9, O60.13X0, O60.13X1, O60.13X2, O60.13X3, O60.13X4, O60.13X5, O60.13X9, O60.14X0, O60.14X1, O60.14X2, O60.14X3, O60.14X4, O60.14X5, O60.14X9, O60.20X0, O60.20X1, O60.20X2, O60.20X3, O60.20X4, O60.20X5, O60.20X9, O60.22X0, O60.22X1, O60.22X2, O60.22X3, O60.22X4, O60.22X5, O60.22X9, O60.23X0, O60.23X1, O60.23X2, O60.23X3, O60.23X4, O60.23X5, O60.23X9, O61.0, O61.1, O61.8, O61.9, O62.0, O62.1, O62.2, O62.3, O62.4, O62.8, O62.9, O63.0, O63.1, O63.2, O63.9, O64.0XX0, O64.0XX1, O64.0XX2, O64.0XX3, O64.0XX4, O64.0XX5, O64.0XX9, O64.1XX0, O64.1XX1, O64.1XX2, O64.1XX3, O64.1XX4, O64.1XX5, O64.1XX9, O64.2XX0, O64.2XX1, O64.2XX2, O64.2XX3, O64.2XX4, O64.2XX5, O64.2XX9, O64.3XX0, O64.3XX1, O64.3XX2, O64.3XX3, O64.3XX4, O64.3XX5, O64.3XX9, O64.4XX0, O64.4XX1, O64.4XX2, O64.4XX3, O64.4XX4, O64.4XX5, O64.4XX9, O64.5XX0, O64.5XX1, O64.5XX2, O64.5XX3, O64.5XX4, O64.5XX5, O64.5XX9, O64.8XX0, O64.8XX1, O64.8XX2, O64.8XX3, O64.8XX4, O64.8XX5, O64.8XX9, O64.9XX0, O64.9XX1, O64.9XX2, O64.9XX3, O64.9XX4, O64.9XX5, O64.9XX9, O65.0, O65.1, O65.2, O65.3, O65.4, O65.5, O65.8, O65.9, O66.0, O66.1, O66.2, O66.3, O66.40, O66.41, O66.5, O66.6, O66.8, O66.9, O67.0, O67.8, O67.9, O68., O69.0XX0, O69.0XX1, O69.0XX2, O69.0XX3, O69.0XX4, O69.0XX5, O69.0XX9, O69.1XX0, O69.1XX1, O69.1XX2, O69.1XX3, O69.1XX4, O69.1XX5, O69.1XX9, O69.2XX0, O69.2XX1, O69.2XX2, O69.2XX3, O69.2XX4, O69.2XX5, O69.2XX9, O69.3XX0, O69.3XX1, O69.3XX2, O69.3XX3, O69.3XX4, O69.3XX5, O69.3XX9, O69.4XX0, O69.4XX1, O69.4XX2, O69.4XX3, O69.4XX4, O69.4XX5, O69.4XX9, O69.5XX0, O69.5XX1, O69.5XX2, O69.5XX3, O69.5XX4, O69.5XX5, O69.5XX9, O69.81X0, O69.81X1, O69.81X2, O69.81X3, O69.81X4, O69.81X5, O69.81X9, O69.82X0, O69.82X1, O69.82X2, O69.82X3, O69.82X4, O69.82X5, O69.82X9, O69.89X0, O69.89X1, O69.89X2, O69.89X3, O69.89X4, O69.89X5, O69.89X9, O69.9XX0, O69.9XX1, O69.9XX2, O69.9XX3, O69.9XX4, O69.9XX5, O69.9XX9, O70.0, O70.1, O70.20, O70.21, O70.22, O70.23, O70.3, O70.4, O70.9, O71.00, O71.02, O71.03, O71.1, O71.2, O71.3, O71.4, O71.5, O71.6, O71.7, O71.81, O71.82, O71.89, O71.9, O72.0, O72.1, O72.2, O72.3, O73.0, O73.1, O74.0, O74.1, O74.2, O74.3, O74.4, O74.5, O74.6, O74.7, O74.8, O74.9, O75.0, O75.1, O75.2, O75.3, O75.4, O75.5, O75.81, O75.82, O75.89, O75.9, O76., O77.0, O77.1, O77.8, O77.9, O82., O85., O86.00, O86.01, O86.02, O86.03, O86.04, O86.09, O86.11, O86.12, O86.13, O86.19, O86.20, O86.21, O86.22, O86.29, O86.4, O86.81, O86.89, O87.0, O87.1, O87.2, O87.3, O87.4, O87.8, O87.9, O88.011, O88.012, O88.013, O88.019, O88.02, O88.03, O88.111, O88.112, O88.113, O88.119, O88.12, O88.13, O88.211, O88.212, O88.213, O88.219, O88.22, O88.23, O88.311, O88.312, O88.313, O88.319, O88.32, O88.33, O88.811, O88.812, O88.813, O88.819, O88.82, O88.83, O89.01, O89.09, O89.1, O89.2, O89.3, O89.4, O89.5, O89.6, O89.8, O89.9, O90.0, O90.1, O90.2, O90.3, O90.4, O90.5, O90.6, O90.81, O90.89, O90.9, O91.011, O91.012, O91.013, O91.019, O91.02, O91.03, O91.111, O91.112, O91.113, O91.119, O91.12, O91.13, O91.211, O91.212, O91.213, O91.219, O91.22, O91.23, O92.011, O92.012, O92.013, O92.019, O92.02, O92.03, O92.111, O92.112, O92.113, O92.119, O92.12, O92.13, O92.20, O92.29, O92.3, O92.4, O92.5, O92.6, O92.70, O92.79, O98.011, O98.012, O98.013, O98.019, O98.02, O98.03, O98.111, O98.112, O98.113, O98.119, O98.12, O98.13, O98.211, O98.212, O98.213, O98.219, O98.22, O98.23, O98.311, O98.312, O98.313, O98.319, O98.32, O98.33, O98.411, O98.412, O98.413, O98.419, O98.42, O98.43, O98.511, O98.512, O98.513, O98.519, O98.52, O98.53, O98.611, O98.612, O98.613, O98.619, O98.62, O98.63, O98.711, O98.712, O98.713, O98.719, O98.72, O98.73, O98.811, O98.812, O98.813, O98.819, O98.82, O98.83, O98.911, O98.912, O98.913, O98.919, O98.92, O98.93, O99.011, O99.012, O99.013, O99.019, O99.02, O99.03, O99.111, O99.112, O99.113, O99.119, O99.12, O99.13, O99.210, O99.211, O99.212, O99.213, O99.214, O99.215, O99.280, O99.281, O99.282, O99.283, O99.284, O99.285, O99.310, O99.311, O99.312, O99.313, O99.314, O99.315, O99.320, O99.321, O99.322, O99.323, O99.324, O99.325, O99.330, O99.331, O99.332, O99.333, O99.334, O99.335, O99.340, O99.341, O99.342, O99.343, O99.344, O99.345, O99.350, O99.351, O99.352, O99.353, O99.354, O99.355, O99.411, O99.412, O99.413, O99.419, O99.42, O99.43, O99.511, O99.512, O99.513, O99.519, O99.52, O99.53, O99.611, O99.612, O99.613, O99.619, O99.62, O99.63, O99.711, O99.712, O99.713, O99.719, O99.72, O99.73, O99.810, O99.814, O99.815, O99.820, O99.824, O99.825, O99.830, O99.834, O99.835, O99.840, O99.841, O99.842, O99.843, O99.844, O99.845, O99.891, O99.892, O99.893, O9A.111, O9A.112, O9A.113, O9A.119, O9A.12, O9A.13, O9A.211, O9A.212, O9A.213, O9A.219, O9A.22, O9A.23, O9A.311, O9A.312, O9A.313, O9A.319, O9A.32, O9A.33, O9A.411, O9A.412, O9A.413, O9A.419, O9A.42, O9A.43, O9A.511, O9A.512, O9A.513, O9A.519, O9A.52, O9A.53, Q86.0, Q86.1, Q86.2, Q86.8, Z03.79, Z33.1, Z33.3, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, Z36.0, Z36.1, Z36.2, Z36.3, Z36.4, Z36.5, Z36.81, Z36.82, Z36.83, Z36.84, Z36.85, Z36.86, Z36.87, Z36.88, Z36.89, Z36.8A, Z36.9, Z37.0, Z37.1, Z37.2, Z37.3, Z37.4, Z37.50, Z37.51, Z37.52, Z37.53, Z37.54, Z37.59, Z37.60, Z37.61, Z37.62, Z37.63, Z37.64, Z37.69, Z37.7, Z37.9, Z39.0, Z39.1, Z39.2, Z3A.00, Z3A.01, Z3A.08, Z3A.09, Z3A.10, Z3A.11, Z3A.12, Z3A.13, Z3A.14, Z3A.15, Z3A.16, Z3A.17, Z3A.18, Z3A.19, Z3A.20, Z3A.21, Z3A.22, Z3A.23, Z3A.24, Z3A.25, Z3A.26, Z3A.27, Z3A.28, Z3A.29, Z3A.30, Z3A.31, Z3A.32, Z3A.33, Z3A.34, Z3A.35, Z3A.36, Z3A.37, Z3A.38, Z3A.39, Z3A.40, Z3A.41, Z3A.42, Z3A.49

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

77049 require prior authorization via eviCore.

History

June 1, 2019 – 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

Radiology

Last Reviewed Date: 9/1/2020

Policy

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

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.

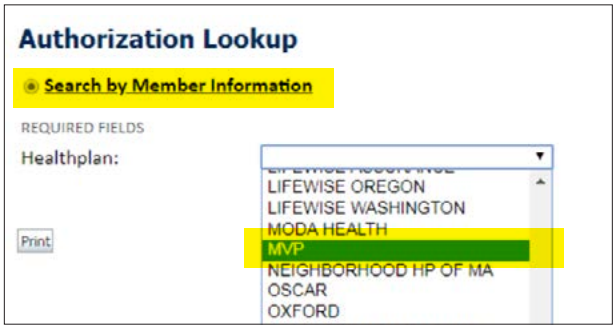
Diagnostic Radiology Prior Authorization

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:

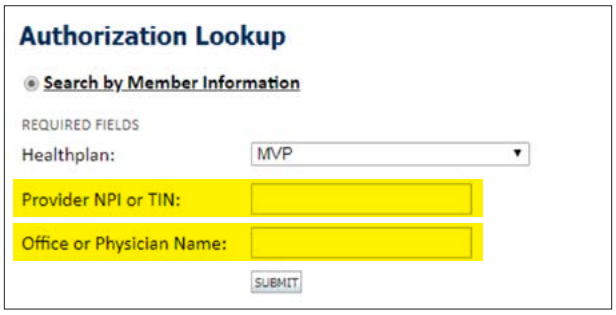
- Services provided when an authorization is required but there is not a valid authorization for the services obtained
- Radiology claims that require prior authorization that are submitted with a Modifier 26 for the professional reading will not be reimbursed without a valid authorization

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

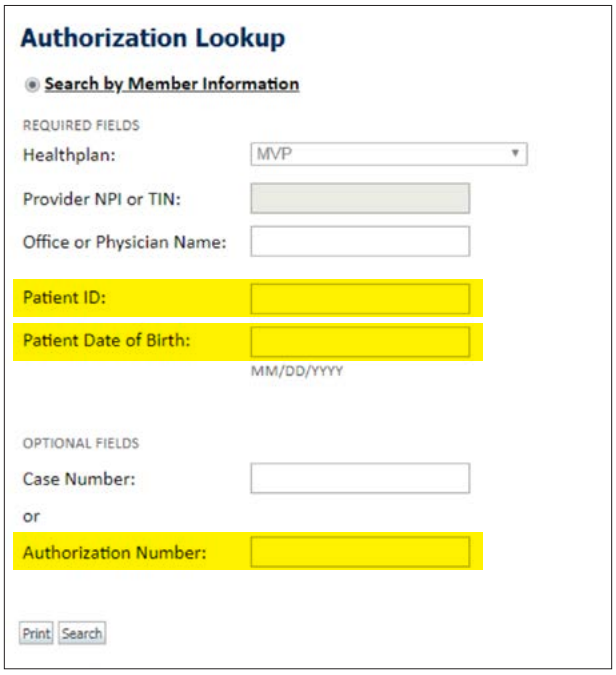
1. Go to evicore.com
2. Click on *Check Status of Existing Prior Authorization*
3. Choose *Search by Member Information* and then choose *MVP* for Healthplan



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 no records are returned the Member does not have an authorization for the service.

History

9/1/2018 – policy approved

9/1/2020 – policy reviewed with no changes, approved

Radiopharmaceuticals

Last Reviewed Date: 12/1/2020

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

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 a flat rate of $45

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
A9552	Fluorodeoxyglucose f-18 fdg, diagnostic, per study dose, up to 45 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

12/20/2020 – policy reviewed and approved with changes

Robotic and Computer Assisted Surgery

Last Reviewed Date: New Policy, effective June 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

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, and S2900. These services are considered global to the primary procedure.

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

Services Not Separately Reimbursed

Last Reviewed Date: 9/1/2019

Policy

MVP is consistent with following Medicare guidelines and 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 that are considered inclusive and are not separately reimbursed include but are not limited to:

- Care Management Services (including care planning, care plan oversight, assessment, care management home visits, chronic or complex care management services, & medication therapy management). **Note:** Facilities that have been identified by MVP as a Health Home will be reimbursed separately for these services as outlined by New York State Guidelines.
- Bundled Payments for Care Improvement Advance
- Results/Data Collection & Review
- Informational Codes
- Review of Medical Records
- Miscellaneous Special Services Procedures and Reports
- On Call & Standby Service

History

9/1/2019 – policy approved

Shared Split-Visit Guidelines

Last Reviewed Date: 7/1/2020

Policy

An E&M (Evaluation and Management) service performed in a hospital inpatient, outpatient, or emergency department which is shared between a physician and Non-Physician Practitioner (NPP) from the same Participating Provider group practice. A shared service may not be performed in a critical care setting. Physician and NPP each personally perform a portion of the E&M service. Services must be for the same patient and the same DOS and there is no supervision requirement. Services may only be provided by an NP, PA, CNS, or CNMW. Service must be within the scope of their practice as defined by law.

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

Both Participating Providers must follow documentation guidelines for E&M services. Each physician/NPP personally documents each portion of the E&M performed. The physician must clearly indicate his or her face-to-face involvement. The combined service should support the level of services billed. The documentation must contain legible signatures and credentials of both providers.

Examples of Inappropriate Documentation

- "Agree with above"
- "Discussed with NPP. Agree"
- "Seen and agree"
- "Patient seen and evaluated"

Example of Appropriate Shared Visit

A PA makes morning rounds and sees a patient who is hospitalized for deep vein thrombosis. The PA does an interim history and performs an exam. A physician from the same Participating Provider Group practice comes to the hospital after office hours, has a face to face visit with the patient, reviews the PA's note, does a brief exam, writes orders for labs, and makes medication changes. Both appropriately document and sign their notes.

Example of Inappropriate Shared Visit

The NP makes a visit to the hospital in the morning to see a patient who has been in a cardiac step-down unit for unstable angina, evaluating him for possible discharge the next day. The physician is performing procedures in the catheterization lab but stops in the unit in the afternoon to review the chart. He does not have face to face visits with the patient on this date of service.

Reimbursement Guidelines

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

References

Medicare Claims Processing Manual Chapter 12:
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

History

9/1/2018 – policy approved

9/1/2020 – policy approved

Speech Therapy (ST)

Last Reviewed Date: March 1, 2021

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)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92610	Evaluation of oral and pharyngeal swallowing function
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording
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
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 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

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

Surgical Supplies

Last Reviewed Date: 6/1/2020

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

9/1/2019 – policy approved
6/1/2020 – policy reviewed, no changes & approved

Telehealth

Last Reviewed Date: June 1, 2020
Related Policies:
Modifier Payment Policy
Provider Responsibilities
Virtual Check-in Payment Policy

Policy

This policy applies to the Medicaid, Health and Recovery Plans ("HARP"), Essential Health Plans, Commercial, Child Health Plus, and Medicare Advantage lines of business.

MVP provides reimbursement for a limited number of TeleHealth Services furnished by a TeleHealth Provider to an eligible member via (1) TeleMedicine, (2) Store and Forward Technology; (3) Remote Image Monitoring; and/or (4) through MVP's MyVisitNow® (each as defined below) as a substitution for an in-person visit (if those services would have been covered if delivered in person).

MVP shall not reimburse any individual or entity for services that are provided (i) via audio-only, fax-only, or email-only transmissions or (ii) for the purpose of providing individual practitioner services for individuals with developmental disabilities, as set forth in 14 N.Y.C.R.R. § 635.13.4.

Reimbursement for TeleHealth Services is subject to the delivery of such services in accordance with applicable state and federal law, regulation, and agency guidance, which may include, but is not limited to New York Public Health Law §§ 2999-cc; 2999-dd; New York Social Services Law § 367-u; New York Insurance Law §§ 3217-h, 4306-6; 14 N.Y.C.R.R. §§ 596; 679; 635; 830; and 42 C.F.R. § 135.

Reimbursement for Telepsychiatry and other Telemental Health Services provided by Office of Mental Health licensed providers under NYS Mental Hygiene Law is addressed in MVP's Telemental Health Payment Policy.

Definitions

Different health care services may fall under different governing law, even within the State of New York. In the event that the definition of any specific term defined herein and the definition of the same term in any applicable state or federal statute, regulation or agency guidance (a "Legal Definition"), the Legal Definition shall control.

Distant Site

The location at which a Telehealth Provider is located while delivering health care services by means of telehealth.

MyVisitNow®

MVP's mobile application which uses electronic information and communication technologies to deliver health care services to Members at a distance including but not limited to Telehealth consultation, and communication with MVP's Participating Providers, Online Care Network ("OCN").

Originating Site

A site at which a Member is located at the time health care services are delivered to him or her by means of Telehealth Originating Sites shall be limited to: (1) facilities licensed under NYS PHL Articles 28 and 40; (2) facilities as defined in Subdivision Six of Section 1.03 of the Mental Health Hygiene Law; (3) certified and non-certified day and residential

programs funded or operated by the Office for People with Developmental Disabilities (OPDD); (4)private physician's, or dentist's offices located within the State of New York; (5) any type of adult care facility licensed under Title 2 of Article 7 of the Social Services law; (6) public, private, and charter elementary and secondary schools, school age children's programs, and child day care centers within the State of New York; and (7) the Member's place of residence located within the state of New York or other temporary location located within or outside the state of New York.[1]

Remote Patient Monitoring

The use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a Member at an Originating Site; this information is transmitted to a provider at a Distant Site for use in the treatment and management of medical conditions that require frequent monitoring. Such technologies may include additional interaction triggered by previous transmissions, such as interactive queries conducted through communication technologies or by telephone. Such conditions shall include, but not be limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Remote patient monitoring shall be ordered by a physician licensed pursuant to Article 130 of the New York Education Law, a nurse practitioner licensed pursuant to Article 139 of the New York Education Law, or a midwife licensed pursuant to Article 141 of the New York Education Law with which the patient has a substantial and ongoing relationship.

Store and Forward Technology

The asynchronous, secure electronic transmission of a Member's health information in the form of Member-specific digital images and/or pre-recorded videos from a TeleHealth Provider at an Originating Site to a TeleHealth Provider at a Distant Site.

TeleHealth or TeleHealth Services

Use of electronic information and telecommunications by Telehealth Providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of a Member. TeleHealth includes Telemedicine, Store and Forward Technology, Remote Patient Monitoring and services provided through MVP's MyVisitNow®. Services or communications by audio-only (e.g. telephone, fax, skype, etc.) do not qualify as a TeleHealth Services when used alone and not in support of Telemedicine, Store and Forward, Remote Patient Monitoring or MVP's MyVisitNow®.[2]

TeleHealth Provider

Includes the following, so long as such individuals are duly licensed in accordance with New York State Education Law: (i) physician; (ii) physician's assistant; (iii) dentist; (iv) nurse practitioner (v)registered professional nurse (vi) podiatrist; (vii) optometrist (viii) psychologist (ix) licensed social worker; (x) speech language pathologist, (xi) audiologist; (xii) licensed midwife; (xiii)physical therapist; (xiv)occupational therapist. TeleHealth Providers shall also include the following individuals: (i) person certified as a diabetes educator by the National Certification Board or affiliated with a program certified by the American Diabetes Association the American Association of Diabetes Educators, the Indian Health Services, or any other national accreditation organization approved by the federal Centers for Medicare and Medicaid Services ("CMS") ; (ii) a person who is a certified asthma educator by the National Asthma Educator Certification Board or successor national certification board; (iii) a person who is a certified genetic counselor by the American Board of Geriatric Counseling, or a successor national certification board (iv) alcoholism and substance abuse counselors credentialed by the New York State Office of Alcoholism and Substance Abuse Services ("OASAS") or by a credentialing

[1] Authorized Originating Sites for Medicare Advantage may differ. See Medicare Variation for Authorized Originating Site and Distant Site TeleHealth Providers:

[2] Pursuant to 42 C.F.R. § 135, TeleHealth Services for the Medicare Advantage Product shall include (i) those services included under the traditional Medicare telehealth benefit and (ii) subject to certain conditions set forth herein, any service available under Medicare Part B, but not payable under the original Medicare telehealth benefit

entity approved by OASAS pursuant to applicable law, and (v) providers authorized to provide services and service coordination under the early intervention program set forth in Article 25 of the New York Public Health Law . Telehealth Providers shall also include the following entities: (i) a "hospital" as that term is defined in Article 28 of the New York Public Health Law, including residential health care facilities serving special populations; (ii)a "home care agency" as that term is defined in Article 36 of the New York Public Health Law; (iii) a "hospice" as that term is defined in Article 40 of the New York Public Health Law, ; (iv) clinics licensed or certified under Article 16 of the New York Mental Hygiene Law; and (v) certified and non-certified residential programs funded by the Office for People With Developmental Disabilities ("OPWDD"). A TeleHealth Provider shall also include any other provider as determined by the New York State Department of Health ("DOH"), the New York State Office of Mental Health, OASAS, or OPWDD who provides TeleHealth Services in compliance with all applicable state and federal laws and in accordance with MVP Protocols.

Telemedicine

The use of synchronous, two-way electronic audiovisual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a Member while the Member is at an Originating Site and the Telehealth Provider is at a distant site.

Billing/Coding Reimbursement Guidelines

Generally.

Providers must submit claims for TeleHealth Services using the appropriate CPT or HCPCS code for the applicable professional service.

TeleHealth Services must be billed with Place of Service ("POS") 02, identifying the location where health services and health-related services are provided or received.

If all or part of a TeleHealth Service is undeliverable due to a failure of transmission or other technical difficulty, MVP will not provide reimbursement for the TeleHealth Service.

Billing For Professional Services Provided Via Telemedicine

Providers should submit claims for Telemedicine using the appropriate CPT or HCPCS code for the professional service and append Telemedicine Modifier 95, via interactive audio and video telecommunications systems (for example: 99201 95).

Modifier GT, Telehealth Services rendered via interactive audio and video telecommunications system must be used when Modifier 95 does not apply. All other modifiers must be attached as appropriate, please see MVP's Modifier Payment Policy.

For Medicaid Products, licensed physicians 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.

There is no separate payment for TeleHealth Services provided by individual TeleHealth Providers in Diagnostic and Treatment Centers. MVP's APG payment to the Diagnostic and Treatment Center is all-inclusive.

For New York Commercial and Medicare Advantage Products MVP follows CMS guidelines and will only reimburse for CPT and HCPCS codes outlined by CMS.

Telehealth Services

You must use an interactive audio and video telecommunications system that permits real-time communication between you at the distant site, and the beneficiary at the originating site.

Transmitting medical information to a physician or practitioner who reviews it later is permitted only in Alaska or Hawaii Federal telemedicine demonstration programs.

CY 2019 Medicare Telehealth Services

Service	HCPCS/CPT Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420–G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training	G0108–G0109
Individual and group health and behavior assessment and intervention	96150–96154
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791–90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90964
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	90966
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	90967
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2–11 years of age	90968
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12–19 years of age	90969

Service	HCPCS/CPT Code
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	90970
Individual and group medical nutrition therapy	G0270, 97802–97804
Neurobehavioral status examination	96116
Smoking cessation services	G0436, G0437, 99406, 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396, G0397
Annual alcohol misuse screening, 15 minutes	G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Annual depression screening, 15 minutes	G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	G0446
Face-to-face behavioral counseling for obesity, 15 minutes	G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	99496
Advance Care Planning, 30 minutes	99497
Advance Care Planning, additional 30 minutes	99498
Psychoanalysis	90845
Family psychotherapy (without the patient present)	90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	99356

Service	HCPCS/CPT Code
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	G0438
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	G0439
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making	G0296
Interactive Complexity Psychiatry Services and Procedures	90785
Health Risk Assessment	96160, 96161
Comprehensive assessment of and care planning for patients requiring chronic care management	G0506
Psychotherapy for crisis	90839, 90840
Prolonged preventive services	G0513, G0514

A physician, NP, PA, or CNS must furnish at least one ESRD-related "hands on visit" (not telehealth) each month to examine the beneficiary's vascular access site.

Billing for the Originating and Distant Site

An Originating Site and Distant Site operating under the same Tax Identification Number ("TIN") or within the same provider network will be reimbursed for the Distant Site only. In such cases, the Distant Site is responsible for reimbursing the Originating Site.

Medicaid Requirements for Authorized Originating Site and Distant Site

Article 28 Originating Site may bill for TeleHealth Services under APGs using the appropriate CPT code for the visit only when a qualified TeleHealth Provider is present with the Member and has provided billable face-to-face services (e.g., "facetime" encounter) with the Distant Site.

When TeleHealth Services are provided at an Article 28 Originating Site and a qualified TeleHealth Provider is not present with the Member at the time of the encounter, the Originating Site should bill Q3014 for the audio-visual connection only. The Distant site should bill using APGs for TeleHealth Services using the appropriate CPT code for the service provided, appended with the "GT" modifier.

Medicare Variation for Authorized Originating Site and Distant Site TeleHealth Providers

Medicare Telehealth services include office visits, psychotherapy, consultations, and certain specified medical or health services Unless otherwise provided in the Members' benefit plan and MVP Protocols, Medicare limits TeleHealth

Services reimbursement by geographic and Originating Site restrictions. The Originating Site must be in a Health Professional Shortage Area ("HPSA") or a county outside of any Metropolitan Statistical Area ("MSA"). and the authorized Originating Site are limited to:

1. Provider offices.
2. Hospitals
3. Critical Access Hospitals (CAH)
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Hospital based or CAH-based Renal Dialysis Centers (including satellites)
7. Skilled Nursing Facilities
8. Community Mental Health Centers
9. Renal Dialysis Facilities (and home for End State Renal Disease)
10. Homes of Members with End-Stage Renal Disease getting home dialysis
11. Mobile Stroke Units.

NOTE: variations for Substance Use Disorder or co-occurring mental health disorders are addressed in MVP's Telemental Health Payment Policy.

Additional Telehealth Benefits for Medicare Advantage

Medicare Advantage plans may provide "Additional Telehealth Benefits," at locations mutually determined by MVP, the Member, and the Telehealth Provider, including a Member's home. Additional Telehealth Benefits include Covered Services available under Medicare Part B, but not payable under the original Medicare Telehealth benefit and identified by MVP as clinically appropriate to furnish through electronic exchange when the physician or provider providing services is not in the same location as the Member. To check a members eligibility and benefits go to mvphealthcare.com/provider and log in using your online account. Only properly credentialed in-network Medicare providers are eligible to provide and receive reimbursement for "additional telehealth benefits" under Medicare.

Billing And Payment For Store And Forward Technology

Payment for TeleHealth Services provided via Store and Forward Technology shall be made to the consulting physician. The physician must submit claims for the CPT Code for the professional service and attach Modifier GQ (via asynchronous telecommunications system). Modifier GQ may only be submitted with Store and Forward Technology.

If at any time DOH or any other applicable agency limits TeleHealth Services using Store and Forward Technology to limited services or disciplines, only those services or disciplines may be billed.

The Distant Site provider must provide the requesting Originating Site Provider with a written report of the consultation for payment to be made.

Vermont Variation

Teleophthalmology or teledermatology services may be provided by Store and Forward Technology.

Billing For Remote Patient Monitoring (RPM)

RPM must be orders by a New York licensed physician, nurse practitioner or midwife who has examined the Member and with whom the Members 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.

The use of RPM must be determined to be medically necessary and must be discontinued when the Member's condition is determined to be stable/controlled. RPM requires a minimum of 30 minutes per month to be spent collecting and

interpreting the Member's RPM data. In addition to TeleHealth Services, Members must be periodically seen in-person by a health care provider.

Certified Home Health Agencies ("CHHA") are not eligible for RPM TeleHealth Services to a Member if the Members is receiving home health care services through the CHHA.

MVP shall pay a daily fee of note more than $4.00 for each day RPM equipment is used to monitor a Member's health; however, the maximum rate for RPM per Member per month may not exceed $36.00.

CPT Code 99091 must be billed for the collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the Member and/or caregiver to the Provider and must not be submitted more than once per month and must be billed on the last day of the month the services were performed.

Medicare Variation for Remote Patient Monitoring (RPM)

RPM requires the RPM device to be a medical device as defined by the U.S. Food and Drug Administration (FDA), and the service ordered by a physician or other qualified health care professional.

The Member must be documented it in the Member's medical record.

RPM services must be initiated during a face-to-face visit with the provider for new Members or Members not seen by the provider within one year.

CPT Code 99453 is specific to RPM and must be billed for RPM of physiologic parameter(s) (e.g. weight, blood pressure, pulse oximetry, respiratory flow rate), for initial set-up and Member education on use of equipment.

CPT CODE 99454 is specific to RPM and must be billed for RPM of physiologic parameter(s) (e.g. weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.

CPT Code 99453 is reported once for each episode of care, documents the initial set-up and Member education, specifically on the use of the device. At the same time, CPT Code 99454 is submitted for providing the device and for daily recordings or programmed alert transmissions for a 30-day period. Both codes may only be reported if the RPM is 16 days or more. These codes are not used for the treatment or management of the condition.

CPT Code 99457 for RPM for physiologic treatment management services, requires 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month and interactive communication with the Member/caregiver during the month and is reimbursed monthly.

- CPT Code 99091 must not be billed in the same 30 day period as 99457.

Billing For Telehealth Provided By myVisitNow®

Effective January 1, 2017 TeleHealth will be covered without Distant Site and Originating Site requirements under certain health benefit plans when provided through MVP's MyVisitNow® mobile application. Please check Member benefits to ensure the Member is covered for TeleHealth through MyVisitNow®. Providers who want to provide Telehealth Services through MVP's myVisitNow® may contract with OCN to become an OCN provider.

Reimbursement Guidelines

Reimbursement for the Distant Site provider in New York for Medicare, Child Health Plus, and Commercial Products will be based on the CMS allowed telehealth codes referenced in this Policy and reimbursed at 100% of the applicable contracted fee schedule.

Reimbursement for the Distant Site provider for Medicaid and Essential Plan will follow NYS Medicaid requirements and pay at 100% of the applicable contracted Government Programs fee schedule.

Reimbursement for the Distant Site provider for Vermont for all products will follow Vermont state requirements and pay at 100% of the physicians contracted fee schedule.

Originating Site Facility Fee is reimbursed a flat fee of $25.

Reimbursement Guidelines for MyVisitNow®

Online Care Network Participating Providers please see the Online Care Network Participating Physician Group Agreement.

Exclusions

Remote consultations between Providers, without a Medicaid Member present, including for the purposes of teaching or skill building, are not TeleHealth Services and are not reimbursable under this TeleHealth Payment Policy, please refer to the Virtual Check-in Policy for guidelines.

The acquisition, installation and maintenance of telecommunication devices or systems is not reimbursable.

Virtual Check-ins and Inter-Professional non-face-to-face Consultations are covered under MVP's Virtual Check-in Payment Policy.

Notification/Prior Authorization Requests

Notifications/Prior Authorization Request

References

CMS Telehealth Services

CMS – Physician Fee Schedule

NYS Medicaid Telehealth Update

VT State Telemedicine Requirement

History

September 1, 2018	Policy approved
December 1, 2019	Updated Medicaid Expansion, Medicare Expansion. Medicare Codes.

Telemental Health Services

March 1, 2020
Related Policies:
Telemental Health Payment Policy
Modifier Payment Policy
Provider Responsibilities
Credentialing

Policy

This policy applies to MVP's Medicaid, Health and Recovery Plans (HARP), Essential Health Plans, Commercial, Child Health Plus, and Medicare Advantage Products.

MVP provides reimbursement for certain Telemental Health Services furnished by a Telemental Health Provider (as defined herein) to an eligible Member via the use of two-way real-time, interactive audio and video equipment. Telemental Health Services may only be utilized in Personalized Recovery Oriented Services (PROS) programs, or Assertive Community Treatment (ATC) programs. All other Covered Services via the use of two-way real-time interactive audio and video equipment are subject to MVP's **Telehealth Payment Policy**.

Reimbursement for Telemental Health Services is subject to the delivery of such services in accordance with all applicable state and federal law, regulation, and agency guidance, which may include, but is not limited to New York Public Health Law §§ 2999-cc; 2999-dd; New York Social Services Law § 367-u; New York Insurance Law §§ 3217-h, 4306-6; 14 N.Y.C.R.R. §§ 596; and 42 C.F.R. § 135.

Reimbursement for Telemental Health Services provided by a licensed provider of services pursuant to Article 31 of the Mental Hygiene Law must follow all applicable regulatory and agency guidance including the submission of an Attestation of Compliance attesting to Office of Mental Health authorization to use Telemental Health Services as a means of rendering services licensed or authorized by the Office of Mental Health

MVP will not reimburse any individual or entity for services that are provided (i) via audio-only, fax-only, or email-only transmissions; or (ii) for a consultation between two professionals or clinical staff.

Definitions

Different health care services may fall under different governing laws, even within the State of New York. If the definition of any specific term defined herein differs from the definition of the same term in any applicable state or federal statute, regulation or agency guidance (a "Legal Definition"), the Legal Definition shall control.

Distant Site

The distant location at which a Telemental Health Provider is located while delivering health care services by means of Telemental Health.

Originating Site

A site at which a Member is physically located at the time mental health care services are delivered to the Member by means of Telemental Health Services located within the state of New York or other temporary location located within or outside the state of New York.[1]

[1] Authorized Originating Sites for Medicare Advantage may differ. See Medicare Variation for Authorized Originating Site and Distant Site TeleHealth Providers:

Telemental Health

Use of the use of two-way real-time, interactive audio and video electronic information and telecommunications by Telemental Health Providers to deliver mental health services, which shall include the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of a Member.

Telemental Health Services

Mental health care services delivered via Telemental Health when on-site services are not available or would be delayed due to distance, location, time of day or availability of resources.

Telemental Health Provider or Qualified Mental Health Professional

Includes providers rendering services in Article 31 sites[2] who are qualified by licensing, permitting, credentials and training, and experience to provide direct services related to the treatment of mental illness and, so long as such individuals are duly licensed in accordance with New York State Education Law, and shall include physicians and nurse practitioners in psychiatry as defined by as defined by 14 NYCRR §596.4 as well as: (i) creative arts therapist; (ii) licensed practical nurse; (iii) licensed psychiatrist; (iv) licensed psychoanalyst (v)licensed psychologist (vi) marriage and family therapist(vii) mental health counselor(viii) nurse practitioner (ix) physician assistant; (x) registered professional nurse, (xi) social worker. (Please note that a Telehealth Provider as defined by MVP's Telehealth Payment Policy who provides TeleHealth Services in compliance with all applicable state and federal laws and in accordance with MVP Protocols is not automatically qualified as a Telemental Health Provider unless otherwise determined by the New York State Department of Health, the New York State Office of Mental Health (OMH), the Office of Addiction Services and Supports OASAS), or the Office for People With Developmental Disabilities.

Billing/Coding Reimbursement Guidelines

Generally

Telemental Health Providers must submit claims for Telemental Health Services using the appropriate CPT or HCPCS code for the applicable service.

Telemental Health Services must be billed with Place of Service (POS) 02, identifying the location where health services and health-related services are provided or received.

If all or part of a Telemental Health Service is undeliverable due to a failure of transmission or other technical difficulty, MVP will not provide reimbursement for the Telemental Health Service.

BILLING FOR PROFESSIONAL SERVICES PROVIDED VIA TELEMENTAL HEALTH SERVICES

Telemental Health Providers are authorized to submit a Medicaid claim for Telemental Health Services through the Originating Site if the following requirements are met:

1. The Member is at the Originating Site and the practitioner is at the Distant Site;
2. The Member must be located at an OMH-designated or OASAS Certified program or location;

[2] Under section 31.02 of the Mental Hygiene Law and various sections of 14 NYCRR, a provider of services must be issued an operating certificate in order to operate the following mental health programs:
- Comprehensive psychiatric emergency program (CPEP)
- Outpatient (non-residential) program, including clinic, continuing day treatment, day treatment, partial hospitalization, intensive psychiatric rehabilitation treatment, and personalized recovery-oriented services (PROS)
- Assertive community treatment (ACT) program
- Psychiatric inpatient unit in a general hospital
- Hospital for mentally ill persons (freestanding psychiatric hospital other than a state-operated psychiatric center)
- Residential treatment facility for children and youth
- Residential (housing) facility such as a community residence or apartment program.

3. Documentation of the request, the rationale for the request, the encounter or consultation, the results and the communication of the results must be made in the Member's clinical or case record; and
4. The Provider must be licensed in New York State, practicing within their scope at a Distant Site that is affiliated with the Originating Site facility.

NOTE: For Medicaid Members, the Distant site must also be a Participating Provider in MVP's Network.

Telemental Health Providers should submit claims using the appropriate CPT or HCPCS code for the professional service and append Telemedicine Modifier 95, via interactive audio and video telecommunications systems (for example: 99201 95).

Modifier GT, Telehealth Services rendered via interactive audio and video telecommunications system must be used when Modifier 95 does not apply. All other modifiers must be attached as appropriate, please see MVP's Modifier Payment Policy.

For Medicaid Products, licensed physicians may bill for Telemental Services provided in an Article 28 Facility setting; however, the APG payment for all other Telemental Providers providing Telemental Health Services in an Article 28 Facility setting are included in MVP's APG payment to the Article 28 Facility.

> Medicaid Variation for Personalized Recovery Oriented Services (PROS) programs. Psychiatrists and nurse practitioners in psychiatry may only bill for Telemental Health Services delivered in a PROS program and the Member must be physically located onsite of the PROS program where the Member is enrolled.
>
> Medicaid Variation for Assertive Community Treatment (ACT) teams. Psychiatrists and nurse practitioners in psychiatry may only bill for Telemental Health Services may only be delivered within an ACT Team. When an ACT visit is conducted in the community, ACT staff must be present during the delivery of Telemental Health Services.

For Commercial and Medicare Advantage Products, MVP follows CMS guidelines and will only reimburse for CPT and HCPCS codes outlined by CMS.

BILLING FOR THE ORIGINATING AND DISTANT SITE

An Originating Site and Distant Site operating under the same Tax Identification Number (TIN) or within the same provider network will be reimbursed for the Originating Site only. In such cases, the Originating Site is responsible for reimbursing the Distant Site.

Medicaid Requirements for Authorized Originating Site and Distant Site

Article 28 Originating Site may bill for Telemental Health Services under APGs using the appropriate CPT code for the visit only when a qualified Telemental Health Provider is present with the Member and has provided billable face-to-face services (e.g. "facetime" encounter) with the Distant Site.

When Telemental Health Services are provided at an Article 28 Originating Site and a qualified Telemental Health Provider is not present with the Member at the time of the encounter, the Originating Site should bill Q3014 for the audio-visual connection only. The Distant site should bill using APGs for TeleHealth Services using the appropriate CPT code for the service provided, appended with the "GT" modifier.

An Originating Site and Distant Site operating under the same Tax Identification Number (TIN) or within the same provider network will be reimbursed for the Originating Site only. In such cases, the Originating Site is responsible for reimbursing the Distant Site.

> Medicare Variation for Authorized Originating Site and Distant Site Telemental Health Providers: Medicare Telemental Health Services follow the same requirements and limitations as Telehealth Services and are addressed in MVP's **Telehealth Payment Policy**.

NOTE: variations for Substance Use Disorder or co-occurring mental health disorders are addressed in MVP's Telemental Health Payment Policy.[3]

**NOTE: Starting in 2020, Medicare Advantage plans will be allowed to provide "additional telehealth benefits," including Telemental Health benefits at locations mutually determined by MVP, the Member, and the Telemental Health Provider, including a Member's home. "Additional telehealth benefits" include those health care services available under Medicare Part B, but not payable under the original Medicare telehealth benefit and identified by MVP as clinically appropriate to furnish through electronic exchange when the physician or provider providing services is not in the same location as the Member. MVP has determined that the following benefits qualify as "additional telehealth benefits" are eligible for payment under Medicare [MVP to list applicable Part B benefits]. Only properly credentialed in-network Medicare providers are eligible to provide and receive reimbursement for "additional telehealth benefits" under Medicare.

Reimbursement Guidelines

Reimbursement for the Distant Site provider in New York for Medicare, Child Health Plus, and Commercial Products will be based on the CMS allowed codes referenced in this Policy and reimbursed at 100% of the applicable contracted fee schedule.

Reimbursement for the Distant Site provider for Medicaid and Essential Plan will follow New York State Medicaid requirements and pay at 100% of the applicable contracted Government Programs fee schedule.

Reimbursement for the Distant Site provider for Vermont for all products will follow Vermont state requirements and pay at 100% of the physicians contracted fee schedule.

Originating Site Facility Fee is reimbursed a flat fee of $25.

Exclusions

Remote consultations between Telemental Health Providers, without a Medicaid Member present, including for the purposes of teaching or skill building, are not Telemental Health Services and are not reimbursable under this Telemental Health Payment Policy, please refer Virtual Check-in Policy for guidelines.

The acquisition, installation and maintenance of telecommunication devices or systems is not reimbursable.

Notification/Prior Authorization Requests

Notifications/Prior Authorization Request

References

CMS Telehealth Services

NYS Medicaid Telehealth Update

Office of Mental Health Telemental Health Services

VT State Telemedicine Requirement

History

[3] If applicable, Medicaid or other third-party reimbursement for services delivered via telepractice by OASAS designated providers may be sought only for services the Office has approved as deliverable via telepractice pursuant to Part 830. • Programs should consult the most recent DOH Medicaid Update for information on billing, code modifiers and any allowable additional fees (administration or facility). • Contract or MOU. Providers participating in telepractice via agreement (contract or MOU) with practitioners must submit claims pursuant to the terms of the agreement. • Practitioners must be licensed to practice in New York state and physically located in the USA; practitioners or an entity with which they are affiliated must be enrolled in NY Medicaid to be able to bill Medicaid. • It is the obligation of the distant practitioner and the designated program to make sure that the documents required by regulation are received in a timely manner and entered into the patient's clinical record.

Transitional Care Management

Medicare Advantage Products Only

Last Reviewed Date: 03/01/2020

Policy

Transitional Care Management services are for a patient whose medical and/or psychosocial problems require moderate- or high-complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital, inpatient psychiatric hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home or assisted living). Transitional care management begins on the date of discharge and continues for the next 29 days.

Transitional care management (TCM) is reimbursable only for the MVP Medicare Advantage products. All other products will deny.

Definitions

Transitional care management (TCM) 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 services listed below via telehealth as per Medicare guidelines.

Below are the two CPT TCM codes and their related requirements:

99495	Transitional Care Management Services (**Moderate** Complexity): • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two 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 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 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

Transitional care management is only reimbursable for MVP Medicare Advantage products.

The codes can be billed only once per patient within 30 days after the original discharge for which a TCM code has been billed. These services may be billed by only one individual during the 30-day period after discharge.

The physician billing for TCM services should have an ongoing relationship with the member and the intended use of these codes is for community-based primary care physicians. It is unlikely that most hospitalists will have the post-discharge relationship with a patient necessary to fulfill the required services.

Non-physicians who may bill TCM codes are NPs, PAs, CNSs, and CNMs, unless they are otherwise limited by their state scope of practice.

There is a distinction between the discharge day management and TCM services. MVP has specifically sought to avoid any implication that the E & M services furnished on the day of discharge as part of discharge management services could be considered to meet the requirement for the TCM service that must be conducted within seven or 14 days of discharge.

The physician billing discharge day management could also be the physician who is regularly responsible for the member's primary care (this may be especially the case in rural communities). However, MVP will not allow both discharge and TCM to be billed on the same day.

The TCM codes may not be billed when patients are discharged to an SNF. For patients in SNFs there are E/M codes for initial, subsequent, discharge care, and the visit for the annual facility assessment, specifically CPT codes 99304-99318.

TCM services provided during a post-surgery period for a service with a global period will not be reimbursed since it is understood that these services are already included in the payment for the underlying procedure.

Practitioners can bill for TCM only once in the 30 days after discharge, even if the patient happens to be discharged two or more times within the 30-day period.

If billing for TCM, the following cannot also be billed during the TCM period:

- Care Plan Oversight services (CPT codes 99339, 99340,99374-99380
- Home health or hospice supervision (HCPCs codes G0181 and G0182)
- ESRD services (CPT codes 90951-90970)
- Chronic Care Management Services (CCM and TCM service periods cannot overlap)
- Prolonged E/M services without Direct Patient Contact (CPT codes 99358 and 99359)

Reimbursement Guidelines

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

References

aafp.org/practice-management/payment/coding/medicare-coordination-services/tcm/tcmfaq.html

cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf

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

History

9/1/2018 – policy approved

3/1/2020 - No changes

Unlisted CPT Code

Last Reviewed Date: December 1, 2019

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	Annual review, no changes

Urgent Care

Last Reviewed Date: December 1, 2019

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. 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	Reviewed and approved, no changes

Vaccine Administration (Vermont Only)

Last Reviewed Date: December 1, 2019

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.

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, no changes

Virtual Check-ins and Interpersonal Telephone/Internet/ Electronic Health Record Consultation

POLICY NAME

Definitions

Reimbursement Guidelines

Notifications/Prior Authorization Request

Billing/Coding Guidelines (if applicable)

December 1, 2019

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.

Reimbursement Guidelines

Reimbursement Guidelines

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 healthcare 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 vi 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.

Code	Description	Reimbursement
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 vi 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 healthcare 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	

For clarification purposes, MVP does not reimburse for codes 99441, 99442, and 99443.

History

December 1, 2019 New Policy Approved