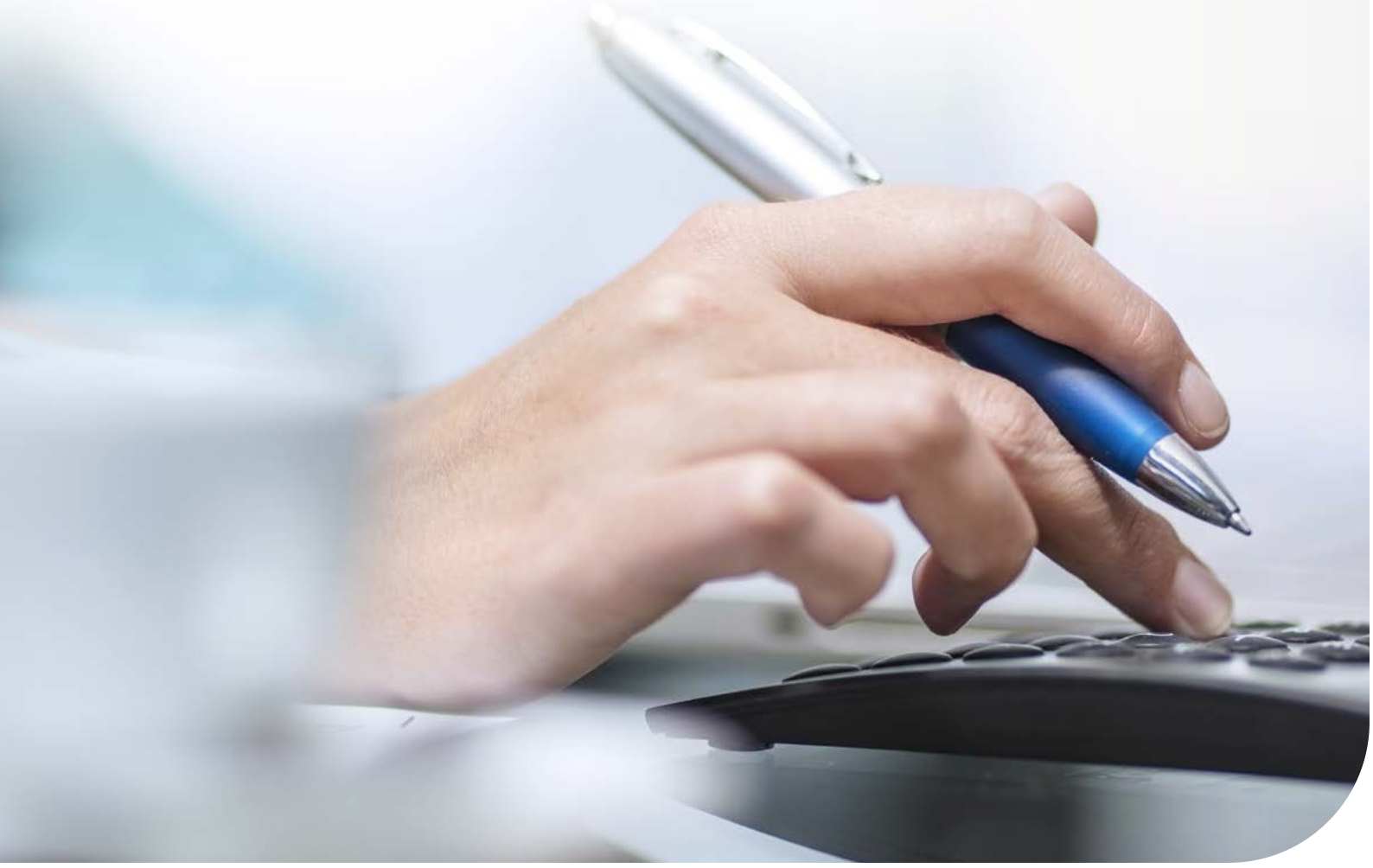
2025 Payment Policies

MVP Health Care® policy and procedure guidelines.

Updated May 1, 2025
Updated policies this quarter effective July 1, 2025



MVP Payment Policies

Table of Contents

MVP Health Care Payment Policy

After-Hours

Last Reviewed Date: February 1, 2025

Policy

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

Reimbursement Guidelines

Code	Description	Reimbursement Guidelines
99050	Service(s) provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service	This code must be billed with an E&M to be reimbursable. This code will not be reimbursable when submitted with preventive visit codes.
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	This code must be billed with an E&M code and is considered inclusive to the E&M. MVP does not reimburse separately for this code for Commercial and Medicare products. For Medicaid/HARP products, MVP will reimburse this code at the Medicaid rate.
99053	Service(s) provided between 10 pm-8 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 policies 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**.

References

Physician Fee Schedule | CMS

History

October 15, 2018	New policy, approved
December 1, 2020	Policy reviewed and approved without changes
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with no changes
March 1, 2024	Policy reviewed and approved with no changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Allergy Testing and Serum Preparation Claims

Last Reviewed Date: February 1, 2025

Policy

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

Billing/Coding Guidelines

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

Notification/Prior Authorization Requests

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

References

1. Noridian Healthcare Solutions, LLC. Local Coverage Determination (LCD): Allergy Testing (L34313). Available: Medicare Coverage Database Search

2. Noridian Healthcare Solutions, LLC. Local Coverage Article: Billing and Coding: Allergy Testing (A57181): Medicare Coverage Database Search

History

December 1, 2018	New Policy approved
September 1, 2019	Policy reviewed and approved with no changes
July 1, 2020	Policy reviewed and approved with changes
December 1, 2020	Policy reviewed and approved with changes
December 1, 2021	Policy reviewed and approved with changes
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with no changes
March 1, 2024	Policy reviewed and approved with no changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Applied Behavior Analysis Services

Last Reviewed Date: May 1, 2025

Policy

Applied Behavior Analysis (ABA) Services are therapy services for Members with a diagnosis of Autism Spectrum Disorder (ASD) as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). This policy applies to the Managed Medicaid, HARP, Essential Health Plans, Child Health Plus, and Commercial lines of business, and provides coding and billing guidelines to assist ABA Providers to ensure codes billed meet regulatory and industry standard requirements (*see* variations applicable to Managed Medicaid and Vermont products below).

Notification/Prior Authorization Requests

Prior Authorization is required for ABA Assessments and Services, and medical necessity criteria must be met. Referrals for ABA Assessments and/or Services must be made by a NY or VT licensed physician, psychologist, psychiatric nurse practitioner, pediatric nurse practitioner, or physician assistant.

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

Referrals

Referrals for ABA Services are valid for a period of two (2) years from the date of referral and should include:

- Age of the patient
- ASD or Rett Syndrome diagnosis
- Date of initial diagnosis
- Co-morbid diagnosis (if applicable)
- Symptom severity level/level of support (if referral is from an ASD-diagnosing provider)
- DSM-5 Diagnostic Checklist for ASD diagnosis
- Referring statement that the Member requires ABA Services as medical necessity

Reimbursement Guidelines

General

ABA Services are reimbursed when a comprehensive evaluation has been completed and services are prescribed by a Participating and MVP credentialed health care professional and appropriately performed by a Licensed Behavior Analyst (LBA), a Certified Behavior Analyst Assistant (CBAA) under the supervision of an LBA, a Registered Behavior Technician (RBT), or other unlicensed professionals acting under the supervision and direction of an LBA under Article 167 of NYS Education Law[1] or under the supervision and direction of a nationally Board-Certified Behavior Analyst (BCBA).

ABA Providers delivering services to eligible Government Program Members (Managed Medicaid, CHP, and HARP)_ must be enrolled in Medicaid FFS and maintain a valid MMIS number.

Authorized ABA Services rendered to Government Program Members (Managed Medicaid, CHP and HARP) will be reimbursed in accordance with the MVP Medicaid Community Fee Schedule provision indicated within the Provider's participation agreement. The MVP Medicaid Community Fee Schedule is the NYS Medicaid Fee Schedule in effect at the time the service was rendered.

Documentation Standards

As a general guideline, MVP expects Providers to follow "Record Keeping Requirements" applicable to NYS providers enrolled in the Medicaid Program[2] and for other state providers, as may be generally accepted by clinical practice and industry standards, when preparing clinical documentation, including but not limited to treatment plans, treatment goals, and session notes.

Prior to the initiation of ABA Services, a comprehensive evaluation of the Member and their physical and behavioral health conditions is required before a full treatment plan is formulated.

ABA Services should be individualized to the specific therapy needs of the Member. Individual services may be provided one-to-one by an appropriate provider in various settings, including but not limited to the Member's home or another community setting; group adaptive behavior treatment(s) may be provided in certain group settings.

A treatment plan should be formulated and maintained by an LBA, who ought to periodically review for clinical appropriateness. Treatment goals and targeted services should be objective and measurable when identified through the assessment process. Only goals documented in the treatment plan as approved during the prior authorization process are reimbursable, unless an LBA updates the treatment plan to reflect mastery and or substitution of goals based on data and relevant changes in psychosocial, family, educational, or medical history.

How to Bill

ABA Services are billed using the LBA as the servicing/rendering provider. Supervising LBAs must be an MVP Participating Provider.

*NY Limited Permit Holders and Graduate Permit Holders: LBAs can bill for services and/or activities provided by non-enrolled LBA Limited Permit Holders and Graduate Permit Holders, as defined by NYSED, under their supervision using the supervising LBA's NPI number for the "Billing," "Supervising" and/or "Rendering" Provider.

ABA Services provided by RBTs or other unlicensed professionals acting under the supervision and direction of the LBA are only covered for CPT codes 97152, 97153, and 97154.

Please refer to your provider fee schedule for specific reimbursement guidelines.

---

[1] Under Article 167 of NYS Education Law, other unlicensed professionals include behavior technicians who must be appropriately supervised by and under the direction of an LBA. Services provided by CBAAs, RBTs, and such other unlicensed professionals shall only be reimbursed when reported under a supervising LBA(s).

[2] "Information to all Providers - General Policy" guidelines include "Record Keeping Requirements" that apply to NYS Medicaid Providers and are helpful as a rule to providers contracted for other health benefit products.

Billing/Coding Guidelines

The following CPT codes are covered for ABA Services providers:

CPT Code	Description
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
0362T	Behavior identification supporting assessment
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes

Other common diagnosis codes[3] for ABA Services include the following:

ICD-10 Code Description

CPT Code	Description
F84.0	Autistic disorder
F84.2	Rett's syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified

[3] Common diagnosis codes referenced in this policy are for informational purposes only and is not an exhaustive list. These codes may be updated to reflect any applicable revisions to the UCD-10 Clinical Modification or CPT code sets adopted by CMS and/or medical necessity criteria.

Non-Reimbursable ABA Services

In compliance with the prohibitions set forth in 14 N.Y.C.R.R § 635.13.4 and applicable CMS Coding and Billing guidelines, MVP does not reimburse for ABA Services provided via audio-only, fax-only, or e-mail-only transmissions for individuals with developmental disabilities.

ABA Services are not considered primary care services and will not be reimbursed in School-Based Health Centers.

ABA Services will not be covered as a substitute for an Early Intervention Program for developmental delays that do not meet the DSM-5 criteria for ASD and/or Rett Syndrome.

Effective July 1, 2025, ABA Services will not be covered in a school setting. . Claims submitted with a place of service of school (POS 3) will be administratively denied for payment. ABA Services that are provided pursuant to an Individualized Educational Plan (IEP) or the Preschool/School Supportive Health Services Program (SSHSP) under the New York State Education Law are not Covered Services.

Temporary Telehealth Waiver: In accordance with CMS' temporary waiver, MVP shall reimburse ABA Services provided via video-enabled telehealth services through March 31, 2025, or until such later date of the expiration of the CMS waiver. After any such expiration or change, MVP may deny ABA Services delivered via telehealth in accordance with applicable state laws or regulations.

Medicaid Variations:

MVP Medicaid Managed Care Plan members have coverage for Applied Behavior Analysis (ABA) therapy, regardless of age, when they have a diagnosis of autism spectrum disorder and/or Rett Syndrome as defined by the American Psychiatric Association in its Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5); and when medically necessary.

The following procedures are excluded from Medicaid Managed Care (MMC) plan coverage:

- Behavior identification supporting assessment (CPT 0362T)
- Adaptive behavior treatment with protocol modification (0373T)

State of Vermont Variation:

The diagnosis and treatment of early childhood developmental disorders is covered in accordance with Vermont state mandate for early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at birth and continuing until the child reaches age 21.

References

Applied Behavior Analysis Policy Manual and Fee Schedule:

eMedNY : Provider Manuals : Applied Behavior Analysts (ABA)

Billing for telebehavioral health | Telehealth.HHS.gov

New York State Medicaid Update February 2019 Special Edition Volume 35 Number 2 (ny.gov)

MVP Applied Behavior Analysis Policy, (MVP Provider Policies)

MVP Telehealth Policy, (MVP Provider Policies)

MVP Utilization Management Policy, (MVP Provider Policies)

New York State Plan Amendment, Attachments 3.1-A and 3.1-B Supplement, SPA #23-0073 (2023). https://www.health.ny.gov/regulations/state_plans/status/non-inst/original/docs/os_2023-09-29_spa_23-73.pdf

Vermont Statutes Title 08 Banking and Insurance Chapter 107 HEALTH INSURANCE §4088i. Available at: https://law.justia.com/codes/vermont/2012/title08/chapter107/section4088i/.

History

June 1, 2023, New policy, approved

September 1, 2023 Policy reviewed and approved with changes
December 1, 2023 Policy reviewed and approved with changes
June 1, 2024 Policy reviewed and approved
November 1, 2024 Policy reviewed and approved with changes
February 1, 2025 Policy reviewed and approved with changes
May 1, 2025 – Policy reviewed and approved with changes

MVP Health Care Payment Policy

Arthroscopic, Endoscopic, and other Non-Gastro Intestinal Scope Procedures

Last Reviewed Date: May 1, 2025

Policy

When multiple Arthroscopic, Endoscopic, and Gastrointestinal 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 procedures 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 policies 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 code families including:

- Biliary Endoscopy
- Anoscopy
- Colonoscopy
- Sigmoidoscopy
- Small Bowel Endoscopy ERCP
- Esophagogastroduodenoscopy
- Esophagoscopy
- Shoulder Arthroscopy
- Elbow Arthroscopy
- Wrist Arthroscopy
- Knee Arthroscopy
- Hip Arthroscopy
- Laryngoscopy w/operating microscope

- Bronchoscope/wash
- Esophagoscopy flexible brush
- Diagnostic laparoscopy
- Cystoscopy
- Cystourethroscopy & or Pyeloscopy
- Hysteroscopy diagnostic separate procedure
- Nasal Endoscopy

History

June 1, 2018	New policy, approved
June 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes
March 1, 2024	Policy reviewed and approved with no changes
June 1, 2024	Policy reviewed and approved with changes
May 1, 2025	Policy reviewed and approved with changes

Article 28 Split Billing

Last Reviewed Date: September 1, 2024

Policy

MVP will reimburse split billing arrangements in accordance with this policy and so long as the billing entity is structured and operates in compliance with the requirements of Article 28 of New York Public Health Law 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 MVP Medicare and/or Government Programs (MMC, CHP, HARP).

Definitions

Split Billing Reimbursement

A billing arrangement 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 Reimbursement

Billable services provided by physician or physician practice, such as provider consultation and physician interpretation of an x-ray, lab, CT Scan, or MRI. Payment is made to the rendering physician or physician practice.

Technical Reimbursement

Billable services provided in a facility setting including but not limited to a laboratory test, x-rays, evaluation and management services, procedures, and any other non-professional (Providers) services. Reimbursement is made to the facility/hospital.

Global Reimbursement

A reimbursement methodology 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 physicians are employed by the facility/hospital.

"Split billing" or "Facility-Based" or "Hospital-Based"

The facility/hospital incurs costs associated with employing the physicians (e.g. rental expense, operating cost) and in turn receives technical component reimbursement for services conducted by the physicians in the facility/hospital setting.
The physicians are paid at the professional fee rate consistent with facility/hospital based RVU's.
The technical component and the professional component associated with each service are 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 Policies 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

General Guidelines

Provider claims would be generated with a facility place of service instead of a non-facility place of service, such as office. For example, a physician claim would be submitted with a place of service 22 for outpatient location instead of place of service 11 for office.
Procedure codes on the MVP In-Office Only list are not reimbursed under a split billing arrangement regardless of product unless an authorization is obtained. If an authorization is obtained, reimbursement may be allowed for Medicare and Medicaid products.

History

June 1, 2017	Policy approved
March 1, 2020	Policy reviewed and approved with no changes
June 1, 2020	Policy reviewed and approved with no changes
September 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes
September 1, 2023	Policy reviewed and approved with no changes
September 1, 2024	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Audiology Services

Last Reviewed Date : February 1, 2025

AUDIOLOGY SERVICES

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 policies 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

MVP reimburses in accordance with CMS 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 Provider is needed to remove impacted cerumen on the same day as a diagnostic test, the Provider 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

Audiologists can furnish certain diagnostic audiology tests without a physician or non-physician practitioner (NPP) order using the AB modifier:

- Covered once per patient per 12-month period
- Limited to non-acute hearing conditions
- Excludes services related to:

o Disequilibrium
    - Hearing aids
    - Exams for prescribing, fitting, or changing hearing aids

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).
- 92622 - Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
- 92623 - Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)

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

Audiology Services | CMS

MM13055 - Allowing Audiologists to Provide Certain Diagnostic Tests Without a Physician Order (cms.gov)

History

December1, 2018	New policy, approved
December 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes
June 1, 2023	Policy reviewed and approved with changes
March 1, 2024	Policy reviewed and approved with no changes
June 1, 2024	Policy reviewed and approved with changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Behavioral Health Non-Licensed Provider (Vermont-Only)

Last Reviewed Date – May 1, 2025

Policy

In Vermont, reimbursement for services provided by a Qualified Non-Licensed Psychotherapist can be billed and reimbursed when under the direct supervision of a Qualified Licensed Psychotherapist.

Definitions

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

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

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

Notifications/Prior Authorization Requests

MVP Payment policies 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

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

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

One of the following modifiers must be appended to the billed CPT code(s):

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

Reimbursement Guidelines

Non-Reimbursable Services

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

References

https://sos.vermont.gov/media/0jyhuiuj/amh-rules-adopted-final-sos-jan-2015.pdf
https://legislature.vermont.gov/statutes/fullchapter/26/078
9.103-supervised-billing-adopted-rule.pdf (vermont.gov)

History

July 1, 2021 New Policy, Approved
June 1, 2023 Policy reviewed and approved with changes
June 1, 2024 Policy reviewed and approved with no changes
May 1 2025 Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Consistency of Denials

Last Reviewed Date: February 1, 2025

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 MVP Radiology Payment Policy

Notification/Prior Authorization Requests

MVP Payment policies 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.**

History

September 1, 2022	New policy, approved
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes
September 1, 2024	Policy reviewed and approved with no changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Contrast Materials

Last Reviewed Date: September 1, 2024

Policy

The cost of ionic contrast is included in the fee paid for Computed Tomography (commonly referred to as "CT scan") and other contrast enhanced exams. No additional charges for contrast materials will be reimbursed. MVP will deny claims for contrast materials for Commercial, Exchange, and Medicaid products.

Notification/Prior Authorization Requests

MVP Payment policies 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

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

HCPCS Code: Gadolinium

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

HCPCS Code: Non-Ionic, Low Osmolar Contrast

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

HCPCS Code: Non-Ionic, Low Osmolar Contrast

Q9958	High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9959	High osmolar contrast material, 150-199 mg/ml iodine concentration, per ml

Q9960	High osmolar contrast material, 200-249 mg/ml iodine concentration, per ml
Q9961	High osmolar contrast material, 250-299 mg/ml iodine concentration, per ml
Q9962	High osmolar contrast material, 300-349 mg/ml iodine concentration, per ml
Q9963	High osmolar contrast material, 350-399 mg/ml iodine concentration, per ml
Q9964	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

History

December 1, 2016	Policy approved
December 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes
September 1, 2023	Policy reviewed and approved with no changes
September 1, 2024	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Default Pricing

Last Reviewed Date: February 1, 2025

Policy

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

Notification/Prior Authorization Requests

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

Reimbursement Guidelines

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

History

September 1, 2022	New policy, approved
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with no changes
March 1, 2024	Policy reviewed and approved with no changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Diabetic Management and Nutritional Counseling

Last Reviewed Date: November 1, 2024

Policy

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 health care professional (e.g., registered dietician, registered nurse, or other health professional) who is a certified diabetes educator (CDE).

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.

Definitions

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

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.

Notification/Prior Authorization Requests

MVP Payment policies 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.

Diabetic Management

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

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

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

ICD-10 CM	CMS reserves the right to add or remove codes associated with its NCDs to implement those NCDs in the most efficient manner within the confines of the policy.
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye
E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3291	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye
E08.3292	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye
E08.3293	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular

	edema, right eye
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3391	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E08.3392	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E08.3393	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3491	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye
E08.3492	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye
E08.3493	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral
E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract
E08.37X1	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, right eye
E08.37X2	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, left eye
E08.37X3	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, bilateral
E08.39	Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication

E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
E08.59	Diabetes mellitus due to underlying condition with other circulatory complications
E08.610	Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy
E08.618	Diabetes mellitus due to underlying condition with other diabetic arthropathy
E08.620	Diabetes mellitus due to underlying condition with diabetic dermatitis
E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer
E08.628	Diabetes mellitus due to underlying condition with other skin complications
E08.630	Diabetes mellitus due to underlying condition with periodontal disease
E08.638	Diabetes mellitus due to underlying condition with other oral complications
E08.649	Diabetes mellitus due to underlying condition with hypoglycemia without coma
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.69	Diabetes mellitus due to underlying condition with other specified complication
E08.8	Diabetes mellitus due to underlying condition with unspecified complications
E08.9	Diabetes mellitus due to underlying condition without complications
E09.00	Drug or chemical induced Diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E09.21	Drug or chemical induced Diabetes mellitus with diabetic nephropathy
E09.22	Drug or chemical induced Diabetes mellitus with diabetic chronic kidney disease
E09.29	Drug or chemical induced Diabetes mellitus with other diabetic kidney complication
E09.311	Drug or chemical induced Diabetes mellitus with unspecified diabetic retinopathy with macular edema
E09.319	Drug or chemical induced Diabetes mellitus with unspecified diabetic retinopathy without macular edema
E09.3211	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E09.3212	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E09.3213	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3291	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E09.3292	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E09.3293	Drug or chemical induced Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3311	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E09.3312	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E09.3313	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3391	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E09.3392	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E09.3393	Drug or chemical induced Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3411	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema,

	right eye
E09.3412	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E09.3413	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3491	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E09.3492	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E09.3493	Drug or chemical induced Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3511	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E09.3512	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E09.3513	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E09.3521	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E09.3522	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E09.3523	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E09.3531	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E09.3532	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E09.3533	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E09.3541	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E09.3542	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E09.3543	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E09.3551	Drug or chemical induced Diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E09.3552	Drug or chemical induced Diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E09.3553	Drug or chemical induced Diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E09.3591	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E09.3592	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E09.3593	Drug or chemical induced Diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E09.36	Drug or chemical induced Diabetes mellitus with diabetic cataract
E09.37X1	Drug or chemical induced Diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E09.37X2	Drug or chemical induced Diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E09.37X3	Drug or chemical induced Diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E09.39	Drug or chemical induced Diabetes mellitus with other diabetic ophthalmic complication
E09.40	Drug or chemical induced Diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E09.41	Drug or chemical induced Diabetes mellitus with neurological complications with diabetic mononeuropathy
E09.42	Drug or chemical induced Diabetes mellitus with neurological complications with diabetic polyneuropathy
E09.43	Drug or chemical induced Diabetes mellitus with neurological complications with diabetic autonomic (poly) neuropathy
E09.44	Drug or chemical induced Diabetes mellitus with neurological complications with diabetic amyotrophy
E09.49	Drug or chemical induced Diabetes mellitus with neurological complications with other diabetic neurological complication
E09.51	Drug or chemical induced Diabetes mellitus with diabetic peripheral angiopathy without gangrene
E09.52	Drug or chemical induced Diabetes mellitus with diabetic peripheral angiopathy with gangrene
E09.59	Drug or chemical induced Diabetes mellitus with other circulatory complications

E09.610	Drug or chemical induced Diabetes mellitus with diabetic neuropathic arthropathy
E09.618	Drug or chemical induced Diabetes mellitus with other diabetic arthropathy
E09.620	Drug or chemical induced Diabetes mellitus with diabetic dermatitis
E09.621	Drug or chemical induced Diabetes mellitus with foot ulcer
E09.622	Drug or chemical induced Diabetes mellitus with other skin ulcer
E09.628	Drug or chemical induced Diabetes mellitus with other skin complications
E09.630	Drug or chemical induced Diabetes mellitus with periodontal disease
E09.638	Drug or chemical induced Diabetes mellitus with other oral complications
E09.649	Drug or chemical induced Diabetes mellitus with hypoglycemia without coma
E09.65	Drug or chemical induced Diabetes mellitus with hyperglycemia
E09.69	Drug or chemical induced Diabetes mellitus with other specified complication
E09.8	Drug or chemical induced Diabetes mellitus with unspecified complications
E09.9	Drug or chemical induced Diabetes mellitus without complications
E10.21	Type 1 Diabetes mellitus with diabetic nephropathy
E10.22	Type 1 Diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 Diabetes mellitus with other diabetic kidney complication
E10.311	Type 1 Diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.319	Type 1 Diabetes mellitus with unspecified diabetic retinopathy without macular edema
E10.3211	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E10.3212	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E10.3213	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3291	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E10.3292	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E10.3293	Type 1 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3311	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E10.3312	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E10.3313	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3391	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E10.3392	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E10.3393	Type 1 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3411	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E10.3412	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E10.3413	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3491	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E10.3492	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E10.3493	Type 1 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3511	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E10.3512	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E10.3513	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E10.3521	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E10.3522	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E10.3523	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E10.3531	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E10.3532	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E10.3533	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E10.3541	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and

	rhegmatogenous retinal detachment, right eye
E10.3542	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E10.3543	Type 1 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E10.3551	Type 1 Diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E10.3552	Type 1 Diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E10.3553	Type 1 Diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E10.3591	Type 1 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E10.3592	Type 1 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E10.3593	Type 1 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E10.36	Type 1 Diabetes mellitus with diabetic cataract
E10.37X1	Type 1 Diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E10.37X2	Type 1 Diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E10.37X3	Type 1 Diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E10.39	Type 1 Diabetes mellitus with other diabetic ophthalmic complication
E10.40	Type 1 Diabetes mellitus with diabetic neuropathy, unspecified
E10.41	Type 1 Diabetes mellitus with diabetic mononeuropathy
E10.42	Type 1 Diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 Diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.44	Type 1 Diabetes mellitus with diabetic amyotrophy
E10.49	Type 1 Diabetes mellitus with other diabetic neurological complication
E10.51	Type 1 Diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.52	Type 1 Diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.59	Type 1 Diabetes mellitus with other circulatory complications
E10.610	Type 1 Diabetes mellitus with diabetic neuropathic arthropathy
E10.618	Type 1 Diabetes mellitus with other diabetic arthropathy
E10.620	Type 1 Diabetes mellitus with diabetic dermatitis
E10.621	Type 1 Diabetes mellitus with foot ulcer
E10.622	Type 1 Diabetes mellitus with other skin ulcer
E10.628	Type 1 Diabetes mellitus with other skin complications
E10.630	Type 1 Diabetes mellitus with periodontal disease
E10.638	Type 1 Diabetes mellitus with other oral complications
E10.649	Type 1 Diabetes mellitus with hypoglycemia without coma
E10.65	Type 1 Diabetes mellitus with hyperglycemia
E10.69	Type 1 Diabetes mellitus with other specified complication
E10.8	Type 1 Diabetes mellitus with unspecified complications
E10.9	Type 1 Diabetes mellitus without complications
E11.00	Type 2 Diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.21	Type 2 Diabetes mellitus with diabetic nephropathy
E11.22	Type 2 Diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 Diabetes mellitus with other diabetic kidney complication
E11.311	Type 2 Diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.319	Type 2 Diabetes mellitus with unspecified diabetic retinopathy without macular edema
E11.3211	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E11.3212	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E11.3213	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3291	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E11.3292	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E11.3293	Type 2 Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3311	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye

E11.3312	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E11.3313	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3391	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E11.3392	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E11.3393	Type 2 Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3411	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E11.3412	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E11.3413	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3491	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E11.3492	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E11.3493	Type 2 Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3511	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E11.3512	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E11.3513	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E11.3521	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E11.3522	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E11.3523	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E11.3531	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E11.3532	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E11.3533	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E11.3541	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E11.3542	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E11.3543	Type 2 Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E11.3551	Type 2 Diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E11.3552	Type 2 Diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E11.3553	Type 2 Diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E11.3591	Type 2 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E11.3592	Type 2 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E11.3593	Type 2 Diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E11.36	Type 2 Diabetes mellitus with diabetic cataract
E11.37X1	Type 2 Diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E11.37X2	Type 2 Diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E11.37X3	Type 2 Diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E11.39	Type 2 Diabetes mellitus with other diabetic ophthalmic complication
E11.40	Type 2 Diabetes mellitus with diabetic neuropathy, unspecified
E11.41	Type 2 Diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 Diabetes mellitus with diabetic polyneuropathy
E11.43	Type 2 Diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.44	Type 2 Diabetes mellitus with diabetic amyotrophy
E11.49	Type 2 Diabetes mellitus with other diabetic neurological complication
E11.51	Type 2 Diabetes mellitus with diabetic peripheral angiopathy without gangrene
E11.52	Type 2 Diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11.59	Type 2 Diabetes mellitus with other circulatory complications
E11.610	Type 2 Diabetes mellitus with diabetic neuropathic arthropathy

E11.618	Type 2 Diabetes mellitus with other diabetic arthropathy
E11.620	Type 2 Diabetes mellitus with diabetic dermatitis
E11.621	Type 2 Diabetes mellitus with foot ulcer
E11.622	Type 2 Diabetes mellitus with other skin ulcer
E11.628	Type 2 Diabetes mellitus with other skin complications
E11.630	Type 2 Diabetes mellitus with periodontal disease
E11.638	Type 2 Diabetes mellitus with other oral complications
E11.649	Type 2 Diabetes mellitus with hypoglycemia without coma
E11.65	Type 2 Diabetes mellitus with hyperglycemia
E11.69	Type 2 Diabetes mellitus with other specified complication
E11.8	Type 2 Diabetes mellitus with unspecified complications
E11.9	Type 2 Diabetes mellitus without complications
E13.00	Other specified Diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E13.21	Other specified Diabetes mellitus with diabetic nephropathy
E13.22	Other specified Diabetes mellitus with diabetic chronic kidney disease
E13.29	Other specified Diabetes mellitus with other diabetic kidney complication
E13.311	Other specified Diabetes mellitus with unspecified diabetic retinopathy with macular edema
E13.319	Other specified Diabetes mellitus with unspecified diabetic retinopathy without macular edema
E13.3211	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E13.3212	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E13.3213	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3291	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E13.3292	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E13.3293	Other specified Diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3311	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E13.3312	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E13.3313	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3391	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E13.3392	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E13.3393	Other specified Diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3411	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E13.3412	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E13.3413	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3491	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E13.3492	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E13.3493	Other specified Diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3511	Other specified Diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E13.3512	Other specified Diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E13.3513	Other specified Diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E13.3521	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E13.3522	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E13.3523	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E13.3531	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E13.3532	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye

E13.3533	Other specified Diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E13.3541	Other specified Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E13.3542	Other specified Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E13.3543	Other specified Diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E13.3551	Other specified Diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E13.3552	Other specified Diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E13.3553	Other specified Diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E13.3591	Other specified Diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E13.3592	Other specified Diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E13.3593	Other specified Diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E13.36	Other specified Diabetes mellitus with diabetic cataract
E13.37X1	Other specified Diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E13.37X2	Other specified Diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E13.37X3	Other specified Diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E13.39	Other specified Diabetes mellitus with other diabetic ophthalmic complication
E13.40	Other specified Diabetes mellitus with diabetic neuropathy, unspecified
E13.41	Other specified Diabetes mellitus with diabetic mononeuropathy
E13.42	Other specified Diabetes mellitus with diabetic polyneuropathy
E13.43	Other specified Diabetes mellitus with diabetic autonomic (poly)neuropathy
E13.44	Other specified Diabetes mellitus with diabetic amyotrophy
E13.49	Other specified Diabetes mellitus with other diabetic neurological complication
E13.51	Other specified Diabetes mellitus with diabetic peripheral angiopathy without gangrene
E13.52	Other specified Diabetes mellitus with diabetic peripheral angiopathy with gangrene
E13.59	Other specified Diabetes mellitus with other circulatory complications
E13.610	Other specified Diabetes mellitus with diabetic neuropathic arthropathy
E13.618	Other specified Diabetes mellitus with other diabetic arthropathy
E13.620	Other specified Diabetes mellitus with diabetic dermatitis
E13.621	Other specified Diabetes mellitus with foot ulcer
E13.622	Other specified Diabetes mellitus with other skin ulcer
E13.628	Other specified Diabetes mellitus with other skin complications
E13.630	Other specified Diabetes mellitus with periodontal disease
E13.638	Other specified Diabetes mellitus with other oral complications
E13.649	Other specified Diabetes mellitus with hypoglycemia without coma
E13.65	Other specified Diabetes mellitus with hyperglycemia
E13.69	Other specified Diabetes mellitus with other specified complication
E13.8	Other specified Diabetes mellitus with unspecified complications
E13.9	Other specified Diabetes mellitus without complications
O24.011	Pre-existing type 1 Diabetes mellitus, in pregnancy, first trimester
O24.012	Pre-existing type 1 Diabetes mellitus, in pregnancy, second trimester
O24.013	Pre-existing type 1 Diabetes mellitus, in pregnancy, third trimester
O24.03	Pre-existing type 1 Diabetes mellitus, in the puerperium
O24.111	Pre-existing type 2 Diabetes mellitus, in pregnancy, first trimester
O24.112	Pre-existing type 2 Diabetes mellitus, in pregnancy, second trimester
O24.113	Pre-existing type 2 Diabetes mellitus, in pregnancy, third trimester
O24.13	Pre-existing type 2 Diabetes mellitus, in the puerperium
O24.410	Gestational Diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational Diabetes mellitus in pregnancy, insulin controlled
O24.415	Gestational Diabetes mellitus in pregnancy, controlled by oral hypoglycemic drugs

O24.419	Gestational Diabetes mellitus in pregnancy, unspecified control
O24.420	Gestational Diabetes mellitus in childbirth, diet controlled
O24.424	Gestational Diabetes mellitus in childbirth, insulin controlled
O24.425	Gestational Diabetes mellitus in childbirth, controlled by oral hypoglycemic drugs
O24.429	Gestational Diabetes mellitus in childbirth, unspecified control
O24.430	Gestational Diabetes mellitus in the puerperium, diet controlled
O24.434	Gestational Diabetes mellitus in the puerperium, insulin controlled
O24.435	Gestational Diabetes mellitus in puerperium, controlled by oral hypoglycemic drugs
O24.439	Gestational Diabetes mellitus in the puerperium, unspecified control
O24.811	Other pre-existing Diabetes mellitus in pregnancy, first trimester
O24.812	Other pre-existing Diabetes mellitus in pregnancy, second trimester
O24.813	Other pre-existing Diabetes mellitus in pregnancy, third trimester
O24.83	Other pre-existing Diabetes mellitus in the puerperium

Nutritional Counseling

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

97802	Medical nutritional therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Group (2 or more individuals(s)), each 30 minutes
G0270	Medical nutritional therapy; re-assessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutritional therapy; re-assessment and subsequent interventions(s) following second referral in the same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group, (2 or more individuals), each 30 minutes

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

ICD-10 CM	CMS reserves the right to add or remove diagnosis codes associated with its NCDs to implement those NCDs in the most efficient manner within the confines of the policy.
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye
E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3291	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye
E08.3292	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye
E08.3293	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular

	edema, right eye
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3391	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E08.3392	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E08.3393	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3491	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye
E08.3492	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye
E08.3493	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral
E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral
E08.37X1	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, right eye
E08.37X2	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, left eye
E08.37X3	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, bilateral
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy

E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
E08.59	Diabetes mellitus due to underlying condition with other circulatory complications
E08.610	Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy
E08.618	Diabetes mellitus due to underlying condition with other diabetic arthropathy
E08.620	Diabetes mellitus due to underlying condition with diabetic dermatitis
E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer
E08.628	Diabetes mellitus due to underlying condition with other skin complications
E08.630	Diabetes mellitus due to underlying condition with periodontal disease
E08.638	Diabetes mellitus due to underlying condition with other oral complications
E08.641	Diabetes mellitus due to underlying condition with hypoglycemia with coma
E08.649	Diabetes mellitus due to underlying condition with hypoglycemia without coma
E08.69	Diabetes mellitus due to underlying condition with other specified complication
E08.8	Diabetes mellitus due to underlying condition with unspecified complications
E08.9	Diabetes mellitus due to underlying condition without complications
E09.00	Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma
E09.11	Drug or chemical induced diabetes mellitus with ketoacidosis with coma
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease
E09.29	Drug or chemical induced diabetes mellitus with other diabetic kidney complication
E09.321	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E09.3211	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E09.3212	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E09.3213	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E09.329	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E09.3291	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E09.3292	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E09.3293	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E09.331	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E09.3311	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E09.3312	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E09.3313	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E09.339	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E09.3391	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E09.3392	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye

E09.3393	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E09.341	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E09.3411	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E09.3412	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E09.3413	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E09.349	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E09.3491	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E09.3492	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E09.3493	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E09.351	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema
E09.3511	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E09.3512	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E09.3513	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3521	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E09.3522	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E09.3523	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E09.3531	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E09.3532	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E09.3533	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E09.3541	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E09.3542	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E09.3543	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E09.3551	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E09.3552	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E09.3553	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E09.359	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema
E09.3591	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E09.3592	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E09.3593	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E09.37X1	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E09.37X2	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E09.37X3	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy
E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
E09.44	Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy
E09.49	Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological

	complication
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene
E09.52	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
E09.59	Drug or chemical induced diabetes mellitus with other circulatory complications
E09.610	Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy
E09.618	Drug or chemical induced diabetes mellitus with other diabetic arthropathy
E09.620	Drug or chemical induced diabetes mellitus with diabetic dermatitis
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer
E09.628	Drug or chemical induced diabetes mellitus with other skin complications
E09.630	Drug or chemical induced diabetes mellitus with periodontal disease
E09.638	Drug or chemical induced diabetes mellitus with other oral complications
E09.641	Drug or chemical induced diabetes mellitus with hypoglycemia with coma
E09.649	Drug or chemical induced diabetes mellitus with hypoglycemia without coma
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia
E09.69	Drug or chemical induced diabetes mellitus with other specified complication
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications
E09.9	Drug or chemical induced diabetes mellitus without complications
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma
E10.21	Type 1 diabetes mellitus with diabetic nephropathy
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3291	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E10.3292	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E10.3293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E10.3392	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E10.3393	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E10.3493	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye

E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E10.37X1	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E10.37X2	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E10.37X3	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.59	Type 1 diabetes mellitus with other circulatory complications
E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy
E10.618	Type 1 diabetes mellitus with other diabetic arthropathy
E10.620	Type 1 diabetes mellitus with diabetic dermatitis
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E10.628	Type 1 diabetes mellitus with other skin complications
E10.630	Type 1 diabetes mellitus with periodontal disease
E10.638	Type 1 diabetes mellitus with other oral complications
E10.641	Type 1 diabetes mellitus with hypoglycemia with coma
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E10.8	Type 1 diabetes mellitus with unspecified complications
E10.9	Type 1 diabetes mellitus without complications
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E11.3291	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye

E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E11.3293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E11.3392	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E11.3393	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E11.3491	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E11.3492	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E11.3493	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E11.37X1	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E11.37X2	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E11.37X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy

E11.49	Type 2 diabetes mellitus with other diabetic neurological complication
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11.59	Type 2 diabetes mellitus with other circulatory complications
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy
E11.620	Type 2 diabetes mellitus with diabetic dermatitis
E11.621	Type 2 diabetes mellitus with foot ulcer
E11.622	Type 2 diabetes mellitus with other skin ulcer
E11.628	Type 2 diabetes mellitus with other skin complications
E11.630	Type 2 diabetes mellitus with periodontal disease
E11.638	Type 2 diabetes mellitus with other oral complications
E11.641	Type 2 diabetes mellitus with hypoglycemia with coma
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with other specified complication
E11.8	Type 2 diabetes mellitus with unspecified complications
E11.9	Type 2 diabetes mellitus without complications
E13.00	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E13.01	Other specified diabetes mellitus with hyperosmolarity with coma
E13.10	Other specified diabetes mellitus with ketoacidosis without coma
E13.11	Other specified diabetes mellitus with ketoacidosis with coma
E13.21	Other specified diabetes mellitus with diabetic nephropathy
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease
E13.29	Other specified diabetes mellitus with other diabetic kidney complication
E13.3211	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E13.3212	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E13.3213	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3291	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E13.3292	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E13.3293	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3311	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E13.3312	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E13.3313	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3391	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E13.3392	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E13.3393	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3411	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E13.3412	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E13.3413	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3491	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E13.3492	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E13.3493	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3511	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E13.3512	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E13.3513	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E13.3521	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E13.3522	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye

E13.3523	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E13.3531	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E13.3532	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E13.3533	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E13.3541	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E13.3542	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E13.3543	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E13.3551	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E13.3552	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E13.3553	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E13.3591	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E13.3592	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E13.3593	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E13.37X1	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E13.37X2	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E13.37X3	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E13.40	Other specified diabetes mellitus with diabetic neuropathy, unspecified
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy
E13.44	Other specified diabetes mellitus with diabetic amyotrophy
E13.49	Other specified diabetes mellitus with other diabetic neurological complication
E13.51	Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene
E13.52	Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene
E13.59	Other specified diabetes mellitus with other circulatory complications
E13.610	Other specified diabetes mellitus with diabetic neuropathic arthropathy
E13.618	Other specified diabetes mellitus with other diabetic arthropathy
E13.620	Other specified diabetes mellitus with diabetic dermatitis
E13.621	Other specified diabetes mellitus with foot ulcer
E13.622	Other specified diabetes mellitus with other skin ulcer
E13.628	Other specified diabetes mellitus with other skin complications
E13.630	Other specified diabetes mellitus with periodontal disease
E13.638	Other specified diabetes mellitus with other oral complications
E13.641	Other specified diabetes mellitus with hypoglycemia with coma
E13.649	Other specified diabetes mellitus with hypoglycemia without coma
E13.65	Other specified diabetes mellitus with hyperglycemia
E13.69	Other specified diabetes mellitus with other specified complication
E13.8	Other specified diabetes mellitus with unspecified complications
E13.9	Other specified diabetes mellitus without complications
I12.9	Hypertensive chronic kidney disease with state 1-4 chronic kidney disease, or unspecified chronic kidney disease
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.31	Chronic kidney disease, stage 3a (CMS: only for a GFR <51)
N18.32	Chronic kidney disease, stage 3b
N18.4	Chronic kidney disease, stage 4 (severe)

N18.5	Chronic kidney disease, stage 5 (severe)
O24.011	Pre-existing type 1 diabetes mellitus, in pregnancy, first trimester
O24.012	Pre-existing type 1 diabetes mellitus, in pregnancy, second trimester
O24.013	Pre-existing type 1 diabetes mellitus, in pregnancy, third trimester
O24.03	Pre-existing type 1 diabetes mellitus, in the puerperium
O24.111	Pre-existing type 2 diabetes mellitus, in pregnancy, first trimester
O24.112	Pre-existing type 2 diabetes mellitus, in pregnancy, second trimester
O24.113	Pre-existing type 2 diabetes mellitus, in pregnancy, third trimester
O24.13	Pre-existing type 2 diabetes mellitus, in the puerperium
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.415	Gestational diabetes mellitus in pregnancy, controlled by oral hypoglycemic drugs
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.420	Gestational diabetes mellitus in childbirth, diet controlled
O24.424	Gestational diabetes mellitus in childbirth, insulin controlled
O24.425	Gestational diabetes mellitus in childbirth, controlled by oral hypoglycemic drugs
O24.429	Gestational diabetes mellitus in childbirth, unspecified control
O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
O24.435	Gestational diabetes mellitus in puerperium, controlled by oral hypoglycemic drugs
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control
O24.811	Other pre-existing diabetes mellitus in pregnancy, first trimester
O24.812	Other pre-existing diabetes mellitus in pregnancy, second trimester
O24.813	Other pre-existing diabetes mellitus in pregnancy, third trimester
O24.83	Other pre-existing diabetes mellitus in the puerperium
Z48.22	Encounter for aftercare following kidney transplant

Nutritional Counseling is not reimbursed for the following services:

- Commercial diet plans, weight management programs, or any foods or services related to such plans or programs
- Gym membership programs
- Holistic therapy
- Nutritional counseling when offered by health resorts, recreational programs, camps, wilderness programs, or outdoor programs
- Skill programs, or 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

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:
    - https://www.cms.gov/medicare/coverage/determination-process/local

History

June 1, 2017	Policy approved
June 1, 2020	Policy reviewed and approved with no changes
September 1, 2021	Policy reviewed and approved with changes
December 1, 2022	Policy reviewed and approved with no changes
December 1, 2023	Policy reviewed and approved with no changes
November 1, 2024	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Diagnosis Matching Edits

Last Reviewed Date: June 1, 2024

Policy

MVP follows the diagnosis matching edits in accordance with Medicare Local Coverage Determinations (LCD) or National Coverage Determinations (NCD), in addition to guidelines established by Physician Medical Societies for the procedures listed in the policy. This policy applies to all lines of business and all claims including, but not limited to, physicians, hospitals, and ambulatory surgery centers. For more information on Medicare coverage determinations, please visit the Center for Medicare & Medicaid services (CMS) website at **cms.gov**.

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 Policies 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 (BIM) for MVP's clinical guidelines. These resources can be accessed by signing into your account at **mvphealthcare.com/providers**.

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 LCD or the claim will be denied due to medical necessity • The Upstate New York LCD 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 LCD or the claim will be denied due to medical necessity • The Upstate New York LCD 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 LCD or the claim will be denied due to medical necessity • The Upstate New York LCD 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 LCD or the claim will be denied due to medical necessity • The Upstate New York LCD for these codes • Pediatric Cardiology Specialty is excluded from this edit

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

To access the appropriate diagnoses to be used with these Procedure codes, use Document ID #L35936 – Contract # 13282 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 LCD or the claim will be denied due to medical necessity • The Upstate New York LCD 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 LCD or the claim will be denied due to medical necessity • The Upstate New York LCD 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 LCD or the claim will be denied due to medical necessity • The Upstate New York LCD for these codes
95937	Neuromuscular Junction Testing Group 2	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare LCD or the claim will be denied due to medical necessity • The Upstate New York LCD for these codes

Corneal Pachymetry

To access the appropriate diagnoses to be used with these Procedure codes, use Document ID # L33630 corneal pachymetry – Contract # 13282 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 LCD or the claim will be denied due to medical necessity • The Upstate New York LCD 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 LCD or the claim will be denied due to medical necessity • The Upstate New York LCD for these codes

Gonadotropin Follicle Stimulating Hormone

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

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

References

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

History

March 1, 2020 Policy reviewed and approved with changes
December 1, 2020 Policy reviewed and approved with no changes
June 1, 2021 Policy reviewed and approved with changes
September 1, 2021 Policy reviewed and approved with changes
September 1, 2022 Policy reviewed and approved with changes
December 1, 2022 Policy reviewed and approved with changes
September 1, 2023 Policy reviewed and approved with changes
June 1, 2024 Policy reviewed and approved with changes

MVP Health Care Payment Policy

Durable Medical Equipment

Last Reviewed Date: February 1, 2025

Related Policies: Home Infusion Policy

Policy

The Durable Medical Equipment (DME) and Orthotics & Prosthetics Coverage and Purchasing Guidelines apply to all MVP participating DME, Orthotics, prosthetics, and specialty Providers only. Physicians, podiatrists, physical therapists, and occupational therapists must refer to the utilization management section of the MVP Provider Policies for Durable Medical Equipment Prosthetic Orthotic Services (DMEPOS) information and guidelines.

DME Rental vs. Purchase

MVP reimburses Providers for DME for a limited time when all required medical necessity guidelines are met. Claims for DME rental must be for the time the equipment is used by the Member, but not to exceed the maximum allowed rental period for the equipment. For authorized items that have a rental price, MVP will calculate the purchase price on either 10- or 13-months rental according to Medicare payment categories. Monthly rentals cannot exceed capped rental period of 10- or 13-months of continuous use. At that time (end of 10- or 13-month rental) ownership of the equipment passes to the Member.

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

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

MVP will only pay for the remainder of the capped consecutive rental period when the rental started under a previous insurer or previous plan and the item is medically necessary. If prior authorization is required for the item, then the DME Provider would need to indicate the start date and how many months were rented under the previous insurer or previous plan.

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

Providers may NOT require 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. If MVP has implemented exceptions from Medicare they are indicated in this payment policy.

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

Note: Providers looking for MVP's payment policy on Enteral Nutrition Therapy should refer to MVP's Home Infusion Policy.

Definitions

DME is defined as:

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

Home

For purposes of rental and purchase of DME, a Member's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (such as assisted living facility, or an intermediate care facility for the mentally disabled).

However, an institution may not be considered a Member's home if it:

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

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

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

Code	Description	Rules
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	• Submit with HCPCS DME procedure codes

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

Referral/Notification/Prior Authorization Requests

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

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

The list is updated periodically and is located on the MVP website in the Provider section, under Reference Library.

Important information for Items and/or services requiring prior authorization:

- Complete the Prior Authorization Request Form for DME/O&P Items and Services (PARF) located at: https://www.mvphealthcare.com/providers/forms
- Can be submitted online, faxed to **1-888-452-5947** or emailed to authorizationrequest@mvphealthcare.com unless otherwise noted below.
- Be sure to include all appropriate and pertinent medical documentation (e.g., office notes, lab, and radiology reports) with the completed PARF.
- Phone requests will only be taken for urgent care determinations and hospital discharges. Call **1-800-684-9286**
- If MVP is the secondary plan, all medical necessity rules still apply to DME items/services for all MVP products.
- If prior authorization is not obtained for the required medically necessary items/services, the Member may not be billed by the Provider. MVP does not "backdate" authorizations for items where prior authorization was not obtained.

Repairs to DME

- Repairs are covered for medically necessary equipment regardless of who is performing the repair. The repair does not have to be completed by the original Provider
- Repair claims must include narrative information itemizing:
    - The nature for which the repair was required

- The actual / anticipated time each repair will take
- Date of purchase (month/year)
- Product name
- Make/model
- Manufacturer's suggested retail price (MSRP) is kept on file, and you would bill according to your contract with MVP
- 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.

Code E1399 may be used for any replacement part(s) without a specific HCPCS code.

Replacement DME

Replacement requests and claims for DME must include the following:

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

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

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

Delivery Charges

Delivery charges, including shipping and handling, are considered part of the purchase or rental costs. Providers may not bill MVP or the Member for these charges. Providers 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

Code	Description	Rules
E0601 E0562	CPAP machine heated humidifier Includes Auto PAP machines	No prior authorization is required. The initial CPAP rental is for up to three months. To continue rental, DME Providers must contact Members and confirm compliance via objective reporting from the device and maintain copies of Member compliance records per CMS's document retention requirements. Adherence to PAP therapy is defined as use of PAP >4 hours per night on 70% of the nights during a consecutive 30-day period anytime during the first three months of initial usage. Member compliance and DME Provider record retention may be subject to retrospective review. Please refer to MVP's Medical Policy to determine medical necessity and rules regarding CPAP machine compliance. • All CPAP machines are a 13-month rental • All heated humidifiers are a 10-month rental
E0470 E0471	Respiratory Assist device	No prior authorization is required. The initial BiPAP rental is for up to three months. To continue rental, DME Providers must contact Members and confirm

Code	Description	Rules
E0562	BiPAP machine heated humidifier Includes Auto BiPAP machines	compliance via objective reporting from the device and maintain copies of Member compliance records per CMS's document retention requirements. Adherence to PAP therapy is defined as use of PAP >4 hours per night on 70% of the nights during a consecutive 30-day period anytime during the first three months of initial usage. Member compliance and DME Provider record retention may be subject to retrospective review. Please refer to MVP's Medical Policy to determine medical necessity and rules regarding BiPAP machine compliance. • All BiPAP machines are a 13-month rental • All heated humidifiers are a 10-month rental
A4604	Tubing with integrated heating element	• 1 per three months
A7027	Combo oral/nasal mask	• 1 per three months
A7028	Oral cushion for combo oral nasal mask	• 2 per one month
A7029	Nasal pillows	• 2 per one month
A7030	Full face masks	• 1 per three months
A7031	Face mask interface	• 1 per month
A7032	Replacement cushions	• 2 per one month
A7033	Replacement pillows	• 2 per one month
A7034	CPAP masks	• 1 per three months
A7035	CPAP headgears	• 1 per six months
A7036	CPAP chin straps	• 1 per six months
A7037	CPAP tubing	• 1 per three months
A7038	CPAP filters	• 2 per one month
A7039	CPAP non-disposable filters	• 1 per six months
A7046	Water chamber	• 1 per six months
A7047	Oral interface used with respiratory suction pump	• Not covered for Commercial, ASO, and Medicaid Plans

DME Equipment

Code	Description	Rules
E0935	Continuous Passive Motion Device	• One unit equals one day of rental • Coverage is limited to 21 days following surgery for Medicare members only. • Please refer to MVP Medical Policy for additional information
A5500–A5501	Diabetic Shoes	• Coverage is limited to one of the following within one calendar year: • one pair of depth shoes (A5500) and three (3) pairs of inserts (A5512, A5513 or A5514); or • one pair of custom molded shoes, which includes inserts (A5501) and two (2) additional pairs of inserts (A5512, A5513 or A5514). • If bilateral items are provided on the same date of service, bill for both items on separate claim lines using the RT and LT modifiers i.e. A5500-RT x 1; A5500-LT x1 for one pair • Medicaid Managed Care Plans: allow one pair per year when medical policy criteria are met
A5512-A5513	Diabetic Shoe Inserts	• MVP will not reimburse for diabetic shoe inserts/modifications when billed more than six units (three pair) within a calendar year • If bilateral items are provided on the same date of service, bill for both items on separate claim lines using the RT and LT modifiers i.e. A5513-RT x 3; A5513-LT x3 for three pair • Medicaid Managed Care Plans: allowed one pair per year when medical policy criteria are met
A5508 & A5510	Diabetic Shoes	• MVP does not cover these codes
L3000-L3214 L3224, L3649	Foot Orthotics	• Foot orthotics are not covered unless the contract specifically states they are covered. Refer to the specific plan benefit for foot orthotics coverage

Code	Description	Rules
		• If bilateral items are provided on the same date of service, bill for both items on separate claim lines using the RT and LT modifiers i.e., L3000RT x 1; L3000LT x 1 for one pair • Medicaid Managed Care Plans: Follows the New York State Medicaid Program DME, Prosthetics, Orthotics and Supplies Procedures Codes and Coverage Guidelines • Foot orthotics are not covered for Medicare Advantage plans

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

Oxygen and Respiratory Equipment

Code	Description	Rules
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 • MVP allows up to 13 months rental if medically necessary according to the MVP Medical Policy for Oxygen and Oxygen Equipment. • Probes are inclusive during the rental period
A4606	Oximeter Replacement Probe	• Commercial Plans: Covered if contract allows disposable medical supplies and oximeter is owned by Member • Medicaid Managed Care Plans: Included in rental of oximeter device
E0465, E0466, E0467	Ventilators for home use	• The monthly rental payment for items in this pricing category is all-inclusive meaning there is no separate payment by MVP for any options, accessories, or supplies used with a ventilator o All necessary maintenance, servicing, repairs, and replacement are also included in the monthly rental o Backup equipment must be distinguished from multiple medically necessary items which are defined as identical or similar devices, each of which meets a different medical need for the beneficiary. Although MVP does not pay separately for backup equipment, MVP will make a separate payment for a second piece of equipment if it is required to serve a different medical purpose that is determined by the beneficiary's medical needs

Transcutaneous Electrical Nerve Stimulation (TENS)

Code	Description	Rules
E0720, E0730	Transcutaneous electrical nerve stimulation (TENS) Device	• MVP allows for the purchase of TENS units • These cannot be prescribed by Chiropractors or therapists; they must be prescribed by a physician • Medicaid Managed Care Plans are not covered for E0720 For Medicare the following codes (A4557, A4556, A4630, E0720, E0730, E0731) are **not** covered when these diagnoses are present (primary or secondary dx): M54.50, M54.51, M54.59, R51.9, M26.60 per CMS Coverage Criteria. For Medicaid and HARP, the following codes (A4557, A4556, A4630, E0720, E0730, E0731) are only covered with the following diagnoses: M17.0, M17.11, M17.12, M17.2, M17.31, M17.32, M17.4 and M17.5 per New York State Medicaid Coverage guidelines.
A4556,A4557, A4595 and A4630	Transcutaneous electrical nerve stimulations (TENS) Supplies	• Supplies are not covered as a DME benefit. MVP does cover these items if the Member has the disposable coverage for commercial and ASO products. Please refer to the Member's benefits to determine if these are covered

Medical Supplies

Medicaid Managed Care and HARP plans

As of April 1, 2023, Providers are no longer able to bill MVP Medicaid Managed Care Plan or HARP Members for pharmacy and pharmacy related DME and supplies. This includes certain DME, enteral and parenteral nutrition, family planning supplies, medical/surgical supplies, miscellaneous supplies, and hearing aid batteries as designated by the New York State Department of Health in the New York State Medicaid Program Medical Supply Procedure Codes & Coverage Guidelines manual. The full list of codes that must be billed to Medicaid Fee-For-Service is located at: emedny.org/ProviderManuals/DME/PDFS/MedicalSupply_Procedure_Codes.pdf

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

Commercial, Medicare and ASO plans

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

Code	Description	Rules
Various HCPCS codes	Disposable Supplies; Medical and Surgical Supplies	• Commercial Products: MVP will not reimburse for these supplies unless the contract allows disposable medical supplies coverage • Providers should check the Member's benefits to determine if this is covered under their plan • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service • To determine if an item is considered disposable medical and surgical supplies, please call the MVP Customer Care Center

Nebulizers

Code	Description	Rules
E0570-E0572, E0574-E0575, E0580, and E0585	Nebulizers	• MVP allows purchase or rental of a Nebulizer • One will be covered (either one standard or one 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 two per year (one every six months) • Nebulizer solutions, when used in conjunction with a covered nebulizer must be billed through the pharmacy benefits manager

External Infusion Supplies

Code	Description	Rules
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)	• Per the manufacturer, the product with this code has been discontinued as of December 31,2023. All other Omnipod products go through MVP Pharmacy.
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

Code	Description	Rules
A4231	Infusion Set – Needle Type	• Allowed up to 20 per month; up to 60 units once every 90 days • There is a five-day grace period allowed for shipping/billing on the 85th day • Vermont Exchange (on and off) Products: Diabetic Supplies are covered under the Member pharmacy benefit and must be submitted through an MVP pharmacy carrier • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service
A4232	Syringe/reservoirs	
A4224, A4225	Supplies for insulin pump	• Covered as diabetic management supplies but all-inclusive and includes cannula and all supplies for insulin pump • MMC and HARP: Not covered.
K0552, A4221, A4222	Supplies for external infusion pump	• Invalid for submission for all MVP plans • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service

Blood Glucose Monitoring

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

Code	Description	Rules
E0607	Blood glucose monitor	• MVP will not reimburse DME Providers for Blood Glucose Monitoring machines • Blood Glucose Monitors must be obtained from an MVP participating pharmacy or through one of the preferred monitor free access program
A4259 and A4253	Blood glucose testing supplies.	• Blood Glucose Supplies must be obtained from an MVP participating pharmacy for all lines of business • Prior authorization is required for non-preferred test strips
A4238	Supply allowance for adjunctive, nonimplanted continuous glucose monitor (CGM), includes all supplies and accessories	• 1 unit = 1 month supply • Providers can bill for 3-month supply = 3 unit of service • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service • Covered benefit for Commercial, ASO Products, and Medicare plans
E2102	Receiver (monitor) for use with adjunctive Continuous Glucose Monitoring System	• Only one Receiver allowed at one time and must be billed with the corresponding E0784 pump; no duplicates or back-up allowed • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service • Commercial, Medicare, ASO covered under the Member diabetic benefit and can be billed to MVP through the medical benefit. Refer to MVP Medical Policy for coverage information
A4239	Supply allowance for non-adjunctive glucose monitor (CGM), nonimplanted CGM, includes all supplies and accessories	• 1 unit = 1 month supply • Providers can bill for 3-month supply = 3 unit of service • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service • Covered benefit for Commercial, ASO Products, and Medicare plans Uses Durable Medical Equipment benefit and can be obtained through DME providers or eligible pharmacies that can bill through CVS.
E2103	Receiver (monitor) for use with non-adjunctive continuous glucose monitor system	• Only one Receiver allowed at one time; no duplicates or back-up allowed • Commercial, Medicare, ASO covered under the Member diabetic benefit and can be billed to MVP through the medical benefit. Refer to MVP Medical Policy for coverage information • Must meet FDA approval as Therapeutic CGMS. See MVP Medical Policy for details Uses Durable Medical Equipment benefit and can be obtained through DME providers or eligible pharmacies that can bill through CVS. • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service
A9276, A9277 and A9278	A9276 - Sensor; invasive (e.g., subcutaneous), disposable A9277 – Transmitter; external A9278 - Receiver (monitor)	• MVP will not reimburse for these codes for any line of business. See A4238 and E2102 above.

Tracheostomy Care Supplies

Medicare Tracheostomy Care Supplies LCD:

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33832

Code	Description	Rules
A7520-A7522	Tracheostomy/ Laryngectomy Tube	• MVP does cover this code under the Member's DME benefit
L8501	Tracheostomy Speaking Valve	• MVP does cover this code under the Member's DME benefit
A4625 and A4629	Tracheostomy Care Kit	• MVP does cover this code if the Member's contract covers disposable medical supplies
A4623	Tracheostomy disposable inner cannula	• MVP does cover this item if the Member's contract covers disposable medical supplies • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service
A4626	Tracheostomy cleaning brush	• MVP does cover this item if the Member's contract covers disposable medical supplies; cannot be billed at the same time as A4625 and A4629.
A4625	Tracheal Suction Catheter (not closed)	• MVP does cover this item if the Member's contract covers disposable medical supplies • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service
A7523	Tracheostomy Shower Protector	• MVP does not cover this item as it is a convenience item. • MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service
A7524	Tracheostomy Plug/ Button	• MVP does cover this item if the Member's contract covers disposable medical supplies

Ostomy Supplies

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

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

Medicare Ostomy LCD link: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33828

Incontinence Supplies

- MMC and HARP: Providers must bill New York State Medicaid Fee-for-Service
- The following Incontinence supplies are not reimbursed/not covered for Commercial, ASO and Medicare plans: A4335, A4554, T4521, T4522, T4523, T4524, T4529, T4530, T4533, T4535, T4537, T4539, T4540, T4543

Orthotics and Prosthetics

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

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

- Additional fabrication time of an orthosis/prosthetic
- Consult and evaluation

- Digital scanning and casting
- Fabricating an orthosis/prosthetic
- Fitting of orthosis/prosthetic
- Follow up appointments
- Model modification
- Use of CAD-CAM technology
- X-Ray evaluation

Prosthetics

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

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

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

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

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

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

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

Orthotic and Scoliosis Bracing

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

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

There is one HCPCS code available that fully describes the following scoliosis braces: The Rigo Cheneau (WCR) (NYRC) brace, the custom Boston scoliosis brace, the Charleston brace, and the Providence brace are properly described by HCPCS code L1300.

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

History

April 1, 2019	New policy, approved
March 1, 2021	Policy reviewed and approved with changes
June 1, 2022	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with changes
September 1, 2023	Policy reviewed and approved with changes
March 1, 2024	Policy reviewed and approved with changes
September 1, 2024	Policy reviewed and approved with changes
February 1, 2025	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Elective Delivery for Providers and Facilities

Last Reviewed Date – September 1, 2024

Related Policies – Preoperative Lab Testing

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% of allowed amount 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 policies 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

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	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
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.

ICD –10 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
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:
https://www.emedny.org/ProviderManuals/communications/OBSTETRICAL_DELIVERIES_PRIOR_TO_39_WEEKS_GESTATION.pdf

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

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

History

December 1, 2018	Policy approved
December 1, 2019	Policy approved with no changes
March 1, 2021	Policy reviewed and approved with no changes
June 1, 2022	Policy reviewed and approved with no changes
September 1, 2024	Policy reviewed and approved with changes

Electronic Visit Verification (EVV)

Last Reviewed Date: February 1, 2025

Policy

In compliance with the federal requirements set forth in the 21st Century Cures Act[1], New York (NY) and Vermont (VT) require Electronic Visit Verification (EVV) for certain Medicaid-funded Personal Care Assistants (PCA 1& II), and Consumer Directed Personal Assistants (CDPA), Home Health Care Services, and Home and Community Based Services (HCBS) for children. EVV applicable services for Children's HCBS include Community Habilitation, Planned and Crisis Respite. Providers delivering these services should refer to their state requirements for EVV-applicable procedure/rate codes for services provided in a Member's home, unless an exception applies. EVV data must be submitted directly by NY Providers to eMedNY and/or using Time4Care (applicable to PCA and CDPA only) or by VT providers using EVV Mobile Connect or Touch-Tone Telephone. Although EVV data is not submitted to MVP directly, MVP will require Providers to submit an EVV attestation to demonstrate regulatory compliance and monitor quality of care and payment integrity. This policy applies to Managed Medicaid, CHP, and HARP.

Definitions

Electronic Visit Verification (EVV) is a telephone and computer-based system that verifies when health care services are provided to an eligible Medicaid member by collecting information regarding the person receiving and providing the service, the date and location of the service, the type of service rendered, and the start and end times for the service.

Fiscal Intermediary (FI) is an entity that provides fiscal intermediary services for the Consumer Directed Personal Assistance Program (CDPAP).

Office of the Medicaid Inspector General (OMIG) is the NYS agency responsible for the auditing and reviewing EVV data against claims data and ensuring through review that providers and FIs subject to EVV are in compliance with the 21st Century Cures Act and NYS requirements.

Notification/Prior Authorization Requests

MVP Payment Policies 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**.

Services Subject to EVV Requirements

MVP follows EVV program guidelines and requirements for managed care as currently published by the New York State Department of Health and the Agency of Human Services, Department of Vermont Health Access (see References). For complete guidelines, EVV applicable services/codes and any updates, please refer to the state publications. New York State guidance is available at:
https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/app_billing_codes.htm
And select:

- Personal Care Services (PCS) Managed Care (MC) EVV Appliable Procedure Codes
- -Home Health Care Services (HHCS) Managed Care (MC) EVV Appliable Procedure Codes

Vermont guidance is available at **https://dvha.vermont.gov/initiatives/electronic-visit-verification.**

Non-compliance with state EVV program requirements may result in a claim(s) denial.

Reimbursement Guidelines

For EVV applicable services, MVP will reimburse according to the Provider's contract when the CPT/HCPCS codes are reported with an appropriate EVV.
MVP will not reimburse when the required EVV was not utilized unless the Provider has specified a valid exception in the medical record. Exceptions may vary, so please review NYS and VT guidance, accordingly. It is expected that system issues can occur, however it is essential that once these issues are identified, corrective actions are implemented swiftly and documented thoroughly to ensure compliance and facilitate future reimbursements.
If a Provider agency or FI has a high rate of paper time sheets or other non-compliant methods and has not shown an improvement of compliance over time, MVP reserves the right to conduct a compliance review which may lead to the discovery of overpayments. Providers are required to maintain all documentation associated with paper timesheets or other non-compliant entries for audit review.
If non-compliance with state EVV program requirements is determined through audit, MVP has the right to recover payment from the Provider.

Attestation

As a requirement of the NYS EVV Program, Providers and FIs must sign an EVV attestation which details Provider and FI responsibilities annually. The form can be accessed by visiting **www.emedny.org/evv**.
Non-compliance with state EVV program requirements may result in a claim(s) denial or recovery.

References

H.R. 34 –114th Congress (2015-2016): An Act to Accelerate the Discovery, Development, and Delivery of 21st Century Cures, and for Other Purposes (21st Century Cures Act), 42 USC 201, H.R. 34 (2016)
https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf

Children's Waiver Requirements for Electronic Visit Verification (EVV). New York State Department of Health. (Oct. 2020).
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/childrens_waiver_evv_guidance.htm
CMCS Informational Bulletin—Additional EVV Guidance. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Aug. 8, 2019. **https://www.medicaid.gov/federal-policy-guidance/downloads/cib080819-2.pdf**

Electronic Visit Verification—A Guide to Understanding Electronic Visit Verification (EVV) in Vermont. Agency of Human Services, Department of Vermont Health Access. (undated) Last accessed [insert month], 1, 2025 (insert

updated publication date for this policy) **https://dvha.vermont.gov/sites/dvha/files/documents/initiatives/evv-faq.pdf**

Electronic Visit Verification—EVV Program Guidelines and Requirements. New York State Department of Health. Apr. 14, 2022.
https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/evv_prog_guidelines.pdf

NY Medicaid Electronic Visit Verification Program (EVV)
https://www.health.ny.gov/health_care/medicaid/redesign/evv/
Department of Health Electronic Visit Verification (EVV) Applicable Billing Codes
https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/app_billing_codes.htm.
Vermont guidance is available at https://dvha.vermont.gov/initiatives/electronic-visit-verification.

History

November 1, 2024	New policy, approved
February 1, 2025	Approved with changes

MVP Health Care Payment Policy

Emergency Department – Physician

Last Reviewed Date: November 1, 2024

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 ED. The following billing guidelines are used as a guide for physicians seeing MVP members in the ED. These guidelines do not apply to the ED facility charges or to physicians who are employed by the ED. MVP requires all professional charges be submitted on a CMS1500 claims form.

Definitions

In New York State, 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 policies 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/providers**.

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.

Infusion/Injection Services

Code	Description	Rule
96360	Hydration Injections	MVP does not reimburse for these services when administered in the ED. 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 ED. This code will deny as global to the emergency room E&M code.

EKGs

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

Resources

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

History

June 1, 2019 Policy approved
June 1, 2020 Policy reviewed and approved with no changes
September 1, 2021 Policy reviewed and approved with changes
December 1, 2023 Policy reviewed and approved with changes
November 1, 2024 Policy reviewed with no changes

MVP Health Care Payment Policy

Evaluation and Management

Last Reviewed Date: May 1, 2025

Policy

MVP will reimburse for "Medically Necessary" Evaluation / Management (E&M) services. MVP recognizes AMA's definition of CPT codes and follows the CMS 1995/1997 documentation guidelines for E&M services. In addition, MVP will follow the CMS 2021 E&M Coding Guidelines "Office and Other Outpatient Services." Medical records may be periodically requested to ensure appropriate documentation and accuracy of services billed. Member eligibility and benefit specifics should be verified prior to providing services.

Definitions

Medical Necessity

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

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

MVP's Definition: "Medically Necessary" or "Medical Necessity" means health care services that are: (a) necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap; and (b) recommended by the Member's treating Provider; and (c) determined by MVP's or its designee to meet the following criteria, which may be subject to external review:

1. The services are appropriate and consistent with the diagnosis and treatment of the Member's medical condition;
2. The services are not primarily for the convenience of the Member, the Member's family, or the Provider;
3. The services are required for the direct care and treatment of that condition;

4. The services are provided in accordance with general standards of good medical practice, as evidenced by reports in peer reviewed medical literature; reports and guidelines as published by nationally recognized health care organizations that include supporting scientific data; and, any other relevant information brought to MVP's attention; and
5. The services are provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and severity of symptoms.

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

New Patient

MVP follows the American Medical Association's definition of a new patient as one who has not received any professional services from the same Provider, or other qualified health care professional of the exact same specialty and sub-specialty, who belongs to the same group Participating Provider Group (same tax ID), within the past three years.

Significant E&M Service

A significant service at minimum warrants the need for an expanded problem focused examination.

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

Notification/Prior Authorization Requests

MVP Payment policies 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**.

E&M Codes and Preventive Services/Medicine

If the claim indicates the primary reason for the visit was for preventive services, then the claim will be reimbursed in accordance with state and federal regulations.

There should be no co-pays/co-insurance/cost share taken at the time of the service unless the specific product is excluded from Federal Health Care Reform. For the full policy regarding billing and reimbursement of preventive services, please refer to MVP Payment Policy identified as Preventive Health Care Policy.

Payment of Evaluation and Management for Preventive and Sick Visits

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

E&M Codes and Sexual Assault Forensic Exam

If the claim indicates the primary reason for the exam is a diagnosis related to sexual assault or sexual abuse, the claim will be reimbursed in accordance with the New York State Office of Victims Services mandated regulations for victims of sexual assault and the forensic exam. This mandate, which is applicable to the New York Fully Insured and

select ASO groups, should be billed with applicable CPT codes as outlined in the mandate located at: Forensic Rape Examination (FRE) Direct Reimbursement Program | Office of Victim Services (ny.gov) and Claim No: (ny.gov). 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, and99174. See Member benefits to determine if these codes are reimbursable.
99391-99397	Preventative Medicine Evaluation and Management of an individual	MVP will reimburse for a preventive medicine visit; however, will not reimburse for an office visit procedure including the following codes when performed on the same day as the preventive visits: 99202-99215, 92015, 92081, 92551, 92552, 92553, 92555, 92556, 92557, 92567, 99172, 99173, 95930, and 99174. See Member benefits to determine if these codes are reimbursable.

Routine Screening Services Billed with E&M

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

Smoking Cessation Billed with E&M

Code	Description	Rule
99406, 99407,	Smoking Cessation	MVP will not reimburse for these procedure codes.

G0376, G0375, S9453, S9075	Counseling	Exception: Please check the Member benefits to determine if this is a covered benefit

E&M Billed During a Global Period

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

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

MVP will not separately reimburse for 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 Telehealth Policy.

Diabetes Education

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

Osteopathic Manipulation

Code	Description	Rule
98925, 98926, 98927, 98928, 98929	Osteopathic Manipulation	Osteopathic manipulation codes are only reimbursable to MDs and DOs. 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 guidelines on 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.
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.
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	These are timed and component-based codes. They must meet the components and time requirements set forth by the CPT code guidelines.

	Admission and Discharge are done on the same day	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	Time spent performing this procedure does NOT count toward critical care time

	information data stored in computers (e.g., ECGs, blood pressures, hematologic data)	and cannot be billed separately by a physician providing the critical care services.
43752 & 43753	Gastric intubation	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
92953	Transcutaneous pacing	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by physician providing the critical care services.
94002-94004, 94660, 94662	Ventilator management	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
36000, 36410, 36415, 36591	Vascular access procedures	Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
92950	CPR	MVP will reimburse for this procedure separately from critical care services.
31500	Endotracheal intubation	MVP will reimburse for this procedure separately from critical care services.
36555, 36556	Central line placement	MVP will reimburse for this procedure separately from critical care services.
36680	Intraosseous placement	MVP will reimburse for this procedure separately from critical care services.
32551	Tube thoracostomy	MVP will reimburse for this procedure separately from critical care services.
33210	Temporary transvenous pacemaker	MVP will reimburse for this procedure separately from critical care services.
93010	Electrocardiogram - routine ECG with at least 12 leads; interpretation and report only	MVP will reimburse for this procedure separately from critical care services.
99291 & 99292	Critical Care, Evaluation & Management of the critically ill or critically injured Member	• MVP will not reimburse for this code if the time spent with the Member is less than 30 minutes. • 30-74 minutes code 99291 once. • 75 – 104 minutes code 99291 once and 99292 x 1. • 105-134 minutes code 99291 once and 99292 x 2. • 135-164 minutes code 99291 once and 99292 x 3. • 165-194 minutes code 99291 once and 99292 x 4. • These codes should be used when transporting a critically ill patient

History

December 1, 2022 Policy approved
September 1, 2022 Policy reviewed and approved with changes
March 1, 2023 Policy reviewed and approved with changes
March 1, 2024 Policy reviewed and approved with no changes
May 1, 2025 Policy reviewed and approved with changes

MVP Health Care Payment Policy

Eye Wear Coverage

Last Reviewed Date: September 1, 2024

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

Policy

MVP provides coverage for lenses, frames, and contact lenses for Members when it is deemed medically necessary by an ophthalmologist or optometrist and have the eye wear benefit. Participating opticians/dispensers have a variety of quality eye wear 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. Providers must check the Member's specific benefits as it relates to eye wear before dispensing any pairs of lenses, frames, or contact lenses.

(Note: Lenses, frames, and contact lenses may be covered under the medical benefit for specific medical circumstances. See "Lenses for Medical Conditions" in related Eye Medical Policy).

Benefits

Eye wear coverage will be reimbursed based on the Member's benefits. Member benefits vary based on the type of product and may change from year to year. All Member benefits can be found by signing into their secure MVP Provider Online Account at **mvphealthcare.com/providers**. Once Providers have signed in, they may access the benefit detail under the Member eligibility section.

Notification/Prior Authorization Requests

MVP Payment Policies 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

Eyeglasses do not require changing more frequently than once every 24 months for individuals over the age of 19 and every 12 months for individuals aged 19 and under unless medically indicated, such as a change in correction greater than half 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, Providers may review the Member subscriber contract to confirm what is covered.

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

History

March 1, 2019	Policy approved
March 1, 2020	Policy reviewed and approved with no changes
March 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes
September 1, 2023	Policy reviewed and approved with changes
September 1, 2024	Policy reviewed and approved with changes

MVP Health Care Payment Policy

EyeMed Payment Policy

Last Reviewed Date: November 1, 2024

Policy

Eye and vision services billed under a Member's medical benefit will be reimbursed in accordance with their health benefit plan. For eligible MVP members with supplemental vision benefits through EyeMed, additional coverage for routine eye is available through the EyeMed network of participating providers. To determine what is covered by EyeMed or MVP, please review the below CPT codes and diagnosis codes that will be billed to each. If a Member's plan utilizes the EyeMed network for routine vision care, their Member's ID card will bear the EyeMed emblem. Or, sign in to your MVP Provider Online Account to confirm the Member's benefits on the MVP online benefits display.

Notification/Prior Authorization Requests

MVP Payment Policies 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 MVP's Medical Policies within the Provider Reference Library for MVP's clinical guidelines. These resources can be accessed by signing into your account at **mvphealthcare.com**.

Billing/Coding Guidelines

Routine Only Eye Care

When the following Vision CPT/HCPCS codes are billed, claims should be sent to **EyeMed**:

Vision CPT/HCPCS Codes	Description
92002	Intermediate Exam
92004	Comprehensive Exam
92012	Intermediate Exam
92014	Comprehensive Exam
92015	Refraction
92071	Fitting Of Contact Lens For Treatment Of Ocular Surface Disease
92072	Keratoconus
92310	Fitting of contact lenses
92311	Fitting of corneal contact lenses for aphakia, one eye
92312	Fitting of corneal contact lens for aphakia, both eyes
92313	Prescription/Fitting Contact Lens, Premium
92314	Prescription/Fitting Contact Lens, Standard
92315	Prescription/Fitting Contact Lens, Premium
92316	Prescription/Fitting Contact Lens, Premium
92317	Prescription/Fitting Contact Lens, Premium
99199	Dialation
92072AD	Advanced Keratoconus
92250-52	Retinal Imaging

92310-21	Established Comprehensive fitting of contact lenses
92310-22	Fitting of contact lenses
92310-25	Premium/Specialty Daily Wear Fit
92310AN	Anisometropia
92310HA	High Ametropia
92310VI	Vision Improvement
S0500	Disposable Contact Lenses
S05000A	ACUVUE OASYS TRANSITIONS (25 lens pack)
S05000B	Contact Lens, Disposable
S05000C	Contact Lens, Disposable
S05000D	Contact Lens, Disposable
S05000E	ACUVUE OASYS MAX 1-DAY (90 lens pack)
S05001A	ACUVUE VITA (6-lens pack)
S05001B	ACUVUE VITA (12- lens pack)
S05001C	ACUVUE OASYS 1-DAY (90)
S05001D	ACUVUE OASYS 1-DAY with HydraLuxe for ASTIGMATISM (30-lens pack)
S05001E	ACUVUE OASYS 2-Week (12-lens pack)
S05001F	ACUVUE OASYS 2-Week Annual Supply Pack (24-lens pack)
S05001G	ACUVUE OASYS 2-Week for ASTIGMATISM (6-lens pack)
S05001H	ACUVUE OASYS 2-Week for PRESBYOPIA (6-lens pack)
S05001I	ACUVUE OASYS FOR 1-WEEK OVERNIGHT USE (54)
S05001J	1-DAY ACUVUE MOIST (30 lens pack)
S05001K	1-DAY ACUVUE MOIST (90 lens pack)
S05001L	1-DAY ACUVUE MOIST FOR ASTIGMATISM (30 lens pack)
S05001M	1-DAY ACUVUE MOIST FOR ASTIGMATISM (90 lens pack)
S05001N	1-DAY ACUVUE MOIST MULTIFOCAL (30 lens pack)
S05001O	1-DAY ACUVUE MOIST MULTIFOCAL (90 lens pack)
S05001P	1-DAY ACUVUE DEFINE (30 lens pack)
S05001Q	1-DAY ACUVUE DEFINE (90 lens pack)
S05001R	1-DAY ACUVUE TruEye (30 lens pack)
S05001S	1-DAY ACUVUE TruEye (90 lens pack)
S05001T	ACUVUE 2 (6 lens pack)
S05001U	1-DAY ACUVUE (30)***
S05001V	ACUVUE OASYS 1-DAY with HydraLuxe (90-lens pack)
S05001W	ACUVUE VITA for ASTIGMATISM (6-lens pack)
S05001X	ACUVUE OASYS 2-WEEK TRANSITIONS (6 lens pack)
S05001Y	ACUVUE OASYS 1-DAY with HydraLuxe for ASTIGMATISM (90-lens pack)
S05001Z	ACUVUE OASYS 2-Week Multifocal
S050022	Contact Lens, Disposable
S050025	J&J Disposable Contact Lenses
S050026	Contact Lens, Disposable
S0512	Contact Lens, Daily Wear
S0620	Routine Exam
S0621	Routine Exam
V2020	Frame
V2025	Deluxe Frame
V2100 – V2118	Single Vision Lens
V2121, V2221, V2321	Lenticular

V2199	Single Vision Lens, Not Classified
V2200 – V2220, V2299	Bifocal Lens
V2300 – V2320, V2399	Trifocal Lens
V2410, V241022	Single Vision Ashperic
V2430, V243022	Bifocal Ashperic
V2499	Variable Asphericity Lens
V249922	Variable Asphericity Lens
V249925	Variable Asphericity Lens
V2499TF	Variable Asphericity Lens
V2499TG	Variable Asphericity Lens
V2500 –V2503	PMMA
V2524	Contact lens, hydrophilic, spherical, photochromic additive, per lens
V2510 – V2513	Gas Permeable
V2520 – V2523	Hydrophilic
V2530 – V2531	Scleral
V2599	Other Contact Lenses
V2599-22	J&J Conventional Contact Lenses
V2599-25	J&J Disposable Contact Lenses
V2700	Balance Lens, Glass or Plastic
V2702	Edge Treatment (Polish or Roll)
V2702U9	Edge treatment
V2702UA	Edge treatment
V2702UB	Edge treatment
V2702UC	Edge treatment
V2702UD	Edge treatment
V2702-TG	Faceting
V2710	Slab-Off Prism
V2715	Prism
V2718	Fresnell Prism
V2730	Special Base Curve
V2740	Rose Tint Plastic
V2741	Non-Rose Tint Plastic
V2742	Rose Tint Glass
V2743	Non-Rose Tint Glass
V2744, V2744U1, V2744U2	Photochromic plastic (Transitions®)
V2744U5, V2744U6, V2744U7, V2744U8	Photochromic
V2744TF	Photo Plastic
V2744TG	Photo Plastic
V2745, V2745UA, V2745UB	Tint, Solid or Gradient
V2745TF	Addition to lens, tint, any color, solid, gradient or equal, excludes photocroatic
V2745TG	Addition to lens, tint, any color, solid, gradient or equal, excludes photocroatic
V2750	Standard A/R
V2750-21	A/R Tier 3
V2750-22	A/R Tier 1
V2750-25	A/R Tier 2
V2750-TG	Premium A/R
V2750TF	Standard A/R

V2755	UV Lens
V2755TG	Uv Lens/Es
V2760, V2760-TG	Scratch-Resistant Coating
V276022	Scratch Resistant Coating
V2760TF	Scratch Resistant Coating
V2761	Mirror Coating
V2762	Polarization
V2770	Occluder Lens
V2780	Oversize Lens
V2781	Plans without Fixed Pricing by Tier - Standard Progressive
V2781-22	Progressive Tier 2
V2781-25	Progressive Tier 3
V2781-26	Progressive Tier 4
V2781-TG	Progressive Tier 1
V2781PL	Progressive Lens, Standard
V2781TF	Progressive Lens, Standard
V2782	Mid-Index (1.56)
V2782TF	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2782TG	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2782UA	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2783, V2783U1, V2783U3, V2783U4	Hi-Index (1.60+)
V2783UA	High Index
V2784	Polycarbonate Standard
V2784-22	Premium Polycarbonate
V2786	Specialty occupational multifocal lens, per lens
V2797	Vision supply, accessory and/or service component of another HCPCS vision code
V2799	Not Otherwise Classified
V2799PS	Miscellaneous Vision Service
V2799TG	Miscellaneous Vision Service
V2799UA	Miscellaneous Vision Service
V2799UB	Miscellaneous Vision Service
S1002	Customized item (list in addition to code for basic item)
S0518	Frame, Sunglass
S0590	Integral lens service, miscellaneous services reported separately
S0592	Comprehensive contact lens evaluation
Low Vision Codes	
V2600	Hand held low vision aids and other nonspectacle mounted aids
V2610	Single lens spectacle mounted low vision aids
V2615	Telescopic and other compound lens system, including distance
V2620	Prosthetic eye, glass, stock
V2621	Prosthetic eye, plastic, stock
V2622	Prosthetic eye, glass, custom
V2623	Prosthetic eye, plastic, custom
S0506	Bifocal Lenses, Prescription - Safety, Athletic or Sunglass
S0508	Trifocal Lenses, Prescription - Safety, Athletic or Sunglass
S0510	Non-prescription lens (safety, athletic, or sunglass), per lens
S0516	Frame, Safety

Medical Only Eye Care

When the following Vision CPT/HCPCS codes are billed, claims should be sent to MVP:

Vision CPT/HCPCS Codes	Description
92018	Eye exam/evaluation, under general anesthesia; complete
92019	Eye exam/evaluation, under general anesthesia; limited
92020	Gonioscopy w/medical dx evaluation
92025	Corneal topography
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive, or paretic muscle with diplopia) with interpretation and report (separate procedure)
92065	Orthoptic and/or preoptic training
92071	Fitting of contact lens for treatment of ocular surface disease
92081	Visual field/medical exam; limited; unilateral or bilateral
92082	Exam visual field intermediate
92083	Visual field/medical exam; extended
92100	Serial tonometry/medical exam; Multiple measurements
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with unilateral, or bilateral, with interpretation and report
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with unilateral, or bilateral, with interpretation and report
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with unilateral, or bilateral, with interpretation and report
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report
92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation
92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with unilateral, or bilateral, with interpretation and report lateral
92227	Imaging of retina for detection or monitoring of disease
92228	Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review
92230	Ophthalmoscopy; fluorescein angioscopy
92235	Ophthalmoscopy, with DX eval; with multiframe procedures
92240	Indocyanine-green angiography with interpretation and report
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report
92250	Ophthalmoscopy; with fundus photography
92260	Ophthalmoscpy; with ophthalmodynamometer
92265	Electromyography used to guide injections for chemonervation for strabismus
92270	Electroretinography (ERG) with DX evaluation
92273	Electroretinography (ERG), with interpretation and report; full field -i.e., fferg, flash erg, ganzfeld erg
92274	Electroretinography (ERG) with interpretation and report; multifocal -mferg
92283	Color vision exam, extended
92284	Dark adaptation exam w/medical DX evaluation
92285	External Ocular photography, with DX evaluation
92286	Anterior seg. Photography; with DX evaluation; spec. Endo
92287	Anterior seg. Photography; fluorscn angio
92313	Prescribe/fit contact lens; corneoscleral

92314	Prescribe/fit contact lens, tech; cor, 2 eyes
92315	Prescribe/fit con. lens, tech; aphak,1eye
92316	Prescribe/fit con. lens, tech; corneal-apha
92317	Prescribe/fit contact lens, tech; corneoscl
92325	Modification of contact lens
92358	Prosth.service for aphakia, temporary
92371	Repr/refit spect; prosth. for aphakia
92499	Unlisted ophthalmological service or pro
C1841	Retinal prosthesis, includes all internal and external components
V2623	Plastic eye prosth custom
V2624	Polishing artificial eye
V2625	Enlargement of eye prosthesis
V2626	Reduction of eye prosthesis
V2627	Scleral cover shell
V2628	Fabrication & fitting
V2629	Prosthetic eye other type
V2785	Corneal tissue processing
V2787	Astigmatism correcting function of intraocular lens
V2788	Presbyopia correcting function of intraocular lens
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral, or bilateral, with interpretation and report
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated Data transmitted to a remote surveillance center
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (dm)
2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: without evidence of retinopathy (dm)
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: without evidence of retinopathy (DM)

Routine and Medical Care with Diagnosis Specific Requirements

Bill to EyeMed

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

Vision CPT/HCPCS Codes	Claim
H5200	Hypermetropia, unspecified eye
H5201	Hypermetropia, right eye
H5202	Hypermetropia, left eye
H5203	Hypermetropia, bilateral
H5210	Myopia, unspecified eye
H5211	Myopia, right eye
H5212	Myopia, left eye
H5213	Myopia, bilateral

H52201	Unspecified Astigmatism, right eye
H52202	Unspecified Astigmatism, left eye
H52203	Unspecified Astigmatism, bilateral
H52209	Unspecified Astigmatism, unspecified eye
H52211	Irregular Astigmatism, right eye
H52212	Irregular Astigmatism, left eye
H52213	Irregular Astigmatism, bilateral
H52219	Irregular Astigmatism, unspecified eye
H52221	Regular Astigmatism, right eye
H52222	Regular Astigmatism, left eye
H52223	Regular Astigmatism, bilateral
H52229	Regular Astigmatism, unspecified eye
H5231	Anisometropia
H5232	Aniseikonia
H524	Presbyopia
H52511	Internal ophthalmoplegia (complete) (total), right eye
H52512	Internal ophthalmoplegia (complete) (total), left eye
H52513	Internal ophthalmoplegia (complete) (total), bilateral
H52519	Internal ophthalmoplegia (complete) (total), unspecified eye
H52521	Paresis of accommodation, right eye
H52522	Paresis of accommodation, left eye
H52523	Paresis of accommodation, bilateral
H52529	Paresis of accommodation, unspecified eye
H52531	Spasm of accommodation, right eye
H52532	Spasm of accommodation, left eye
H52533	Spasm of accommodation, bilateral
H52539	Spasm of accommodation, unspecified eye
H526	Other disorders of refraction
H527	Unspecified disorder of refraction
H53001	Unspecified Amblyopia, right eye
H53002	Unspecified Amblyopia, left eye
H53003	Unspecified Amblyopia, bilateral
H53009	Unspecified Amblyopia, unspecified eye
H53011	Deprivation Amblyopia, right eye
H53012	Deprivation Amblyopia, left eye
H53013	Deprivation Amblyopia, bilateral
H53019	Deprivation Amblyopia, unspecified eye
H53021	Refractive Amblyopia, right eye
H53022	Refractive Amblyopia, left eye
H53023	Refractive Amblyopia, bilateral
H53029	Refractive Amblyopia, unspecified eye
H53031	Strabismic Amblyopia, right eye
H53032	Strabismic Amblyopia, left eye
H53033	Strabismic Amblyopia, bilateral
H53039	Strabismic Amblyopia, unspecified eye
H53041	Amblyopia Suspect, right eye
H53042	Amblyopia Suspect, left eye
H53043	Amblyopia Suspect, bilateral

H53049	Amblyopia Suspect, unspecified eye
H5310	Unspecified subjective visual disturbances
Z0100	Encounter for examination of eyes and vision without abnormal findings
Z0101	Encounter for examination of eyes and vision with abnormal findings
H53141	Visual Discomfort, right eye
H53142	Visual Discomfort, left eye
H53143	Visual Discomfort, bilateral
H53149	Visual Discomfort, unspecified eye
Z460	Encounter for fitting and adjustment of spectacles and contact lenses
Z135	Encounter for screening for eye and ear disorders
Z01020	Encounter for examination of eyes and vision following failed vision screening without abnormal findings
Z01021	Encounter for examination of eyes and vision following failed vision screening with abnormal findings
Z961	Presence of intraocular lens

Bill to MVP

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

Vision CPT/HCPCS Codes	Description
92002	Ophthalmologic. Serv; intermediate
92004	Eye exam, comprehansive,1or more session
92012	Eye exam; intermediate, estab. Pt
92014	Comprehensive, established patient
92015	Determination of refractive state
92072	Fitting of contact lens for management of keratoconus, initial fitting
92311	Prescribe/fit contact lens, aphakia,1 eye
92312	Prescribe/fit contact lens, aphakia,2 eyes
92326	Replacement of contact lens
92340	Fit spectacle, not aphakia; monofocal
92341	Fit spectacles, not aphakia; bifocal
92342	Fit spectacles, not aphakia; multifocal
92370	Repair/refit spectacles; except aphakia
S0590	Integral lens service, miscellaneous services reported separately
S0592	Comprehensive contact lens evaluation
S0620	Routine ophthalmological exam
S0621	Routine ophthalmological exam
V2020	Vision svcs frames purchases
V2100	Lens spherocylindrical single plano 4.00
V2101	Single vision spherocylindrical 4.12-7.00
V2102	Single vision spherocylindrical 7.12-20.00
V2103	Spherocylindrical 4.00d/12-2.00d
V2104	Spherocylinder4.00d/2.12-4d
V2105	Spherocylindrical 4.00d/4.25-6d
V2106	Spherocylindrical 4.00d/>6.00d
V2107	Spherocylindrical 4.25d/12-2d
V2108	Spherocylindrical 4.25d/2.12-4d
V2109	Spherocylindrical 4.25d/4.25-6d
V2110	Spherocylindrical 4.25d/over 6d

V2111	Spherocylinder7.25d/.25-2.25
V2112	Spherocylinder7.25d/2.25-4d
V2113	Spherocylinder7.25d/4.25-6d
V2114	spherocylindrical over 12.00d
V2115	Lens lenticular bifocal
V2118	Lens aniseikonia single
V2121	Lenticular Lens, per Lens, single
V2199	Lens single vision
V2200	Lens spherocylindrical bifocal plano 4.00d
V2201	Lens spherocylindrical bifocal 4.12-7.0
V2202	Lens spherocylindrical bifocal 7.12-20.
V2203	Lens spherocylindrical bifocal 4.00d/.1
V2204	Lens spherocylindrical c 4.00d/2.1
V2205	Lens spherocylindrical bifocal 4.00d/4.2
V2206	Lens spherocylindrical bifocal 4.00d/Ove
V2207	Lens spherocylindrical bifocal 4.25-7d/.
V2208	Lens spherocylindrical bifocal 4.25-7/2.
V2209	Lens spherocylindrical bifocal 4.25-7/4.
V2210	Lens spherocylindrical bifocal 4.25-7/ova
V2211	Lens spherocylindrical bifocal 7.25-12/.25-
V2212	Lens spherocylindrical bifocal 7.25-12/2.2
V2213	Lens spherocylindrical bifocal 7.25-12/4.2
V2214	Lens spherocylindrical bifocal over 12.
V2215	Lens lenticular bifocal Cal
V2218	Lens aniseikonia bifocal
V2219	Lens bifocal Cal seg width over
V2220	Lens bifocal Cals add over 3.25d
V2221	Lenticular lens, per lens, bifocal Cal
V2299	Lens bifocal Cal specialty
V2300	Lens spherocylindrical trifocal 4.00d
V2301	Lens supercollider trifocal 4.12-7.
V2302	Lens spherocylindrical trifocal 7.12-20
V2303	Lens supercollider trifocal 4.0/.12-
V2304	Lens spherocylindrical trifocal 4.0/2.25
V2305	Lens supercollider trifocal 4.0/4.25
V2306	Lens spherocylindrical trifocal 4.00/>6
V2307	Lens spherocylindrical trifocal 4.25-7/.
V2308	Lens spherocylindrical trifocal 4.25-7/2.
V2309	Lens spherocylindrical trifocal 4.25-7/4.
V2310	Lens spherocylindrical trifocal 4.25-7/>6
V2311	Lens spherocylindrical trifocal 7.25-12/.25-
V2312	Lens spherocylindrical trifocal 7.25-12/2.25
V2313	Lens spherocylindrical trifocal 7.25-12/4.25
V2314	Lens spherocylindrical trifocal over 12
V2315	Lens lenticular trifocal
V2318	Lens aniseikonia trifocal
V2319	Lens trifocal seg width > 28
V2320	Lens trifocals add over 3.25d

V2321	Lenticular lens, per lens, trifocal
V2399	Lens trifocal specialty
V2410	Lens variable a sphericity sing
V2430	Lens variable sphericity bi
V2499	Variable a sphericity lens
V2500	Contact lens pmma spherical
V2501	Contact lens pmma-toric/prism
V2502	Contact lens pmma bifocal
V2503	Contact lens pmma color vision
V2510	Contact gas permeable spherical
V2511	Contact toric prism ballast
V2512	Contact lens gas perm bifocal
V2513	Contact lens extended wear
V2520	Contact lens hydrophilic
V2521	Contact lens hydrophilic toric
V2522	Contact lens hydrophile bifocal call
V2523	Contact lens hydrophile extend
V2530	Contact lens gas impermeable
V2531	Contact lens gas permeable
V2599	Contact lens/es other type
V2700	Balance lens
V2745	Addition to lens, tint, any color, solid, gradient, or equal, excludes photochromatic, any lens material, per lens
V2750	Anti-reflective coating
V2755	UV lens/es
V2762	Polarization, any lens material, per lens
V2780	Oversize lens/es
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2783	Lens, index greater than/equal to 1.66 plastic or greater than/equal to 1.80, excludes polycarbonate, per lens
V2784	Lens, polycarbonate or equal, qny index, per lens
V2744	Tint photochromatic lens/es
V2744U1	Tint photochromatic lens/es
V2744U2	Tint photochromatic lens/es
V2744U5	Tint photochromatic lens/es
V2744U6	Tint photochromatic lens/es
V2744U7	Tint photochromatic lens/es
V2744U8	Tint photochromatic lens/es

History

December 1, 2021 New policy, approved
December 1, 2022 Policy reviewed and approved with no changes
December 1, 2023 Policy reviewed and approved with changes
November 1, 2024 Policy reviewed and approved with changes

MVP Health Care Payment Policy

Home Infusion

Last Reviewed Date: May 1, 2025

Related Policies –
MVP Enteral Therapy
NDC Payment Policy
Benefit Interpretation Manual

Policy

MVP reimburses a network home infusion therapy provider for the following infusion services when safely administered in the home, only on the days Member receives IV therapy services:

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

Home infusion Providers will not be reimbursed separately if the administration of the medication or refill of medication is performed by the Member's primary care physician or other health care professional in an office or facility setting (e.g. not in the Member's home).

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.

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

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.

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 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.

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, 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.

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.

Medicaid variation: All Medicaid Members enrolled in MVP Medicaid Managed Care will receive their prescription drugs through NYRx, the Medicaid Pharmacy Program, including enteral therapy.

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

		home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles, and feeding bags, associated with enteral formulas. See MVP Enteral Therapy Benefit Interpretations for additional information.
S9342	Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	• See above definition for per diem definition. Including or not limited to the HCPCS Code. • Enteral supplies (including but not limited to enteral feeding kits, pumps, and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles, and feeding bags, associated with enteral formulas. See MVP Enteral Therapy Benefit Interpretations for additional information.
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit* *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.
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.
B4105	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.
B4149	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.
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.
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.
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.
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.
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	• 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

	combination, administered through an enteral feeding tube, 100 calories = 1 unit	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.

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.
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.
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; 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	
S9375	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	
S9376	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	
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	
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	
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	
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	
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	
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
S5498	Home infusion therapy, catheter care/ maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem
S5501	Home infusion therapy, catheter care/ maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S5502	Home infusion therapy, catheter care/ maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use)

Home Nursing

Code	Description
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 MVPNDC 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 part of the per diem and should not be billed independently.

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

References

Department Of Health & Human Services

History

June 1, 2019	New policy, approved
June 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
June 1, 2023	Policy reviewed and approved with changes
November 1, 2024	Policy reviewed and approved with changes
May 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Implantable Devices

Last Reviewed Date: September 1, 2024

Policy

Applies to: Hospitals and Ambulatory Surgery Centers in Vermont, New Hampshire, and Massachusetts
Applicable Plans: All Commercial and Individual Products.

MVP requires an invoice of the implantable device for reimbursement and reserves the right to request additional supporting documentation if necessary. The invoice submitted should clearly identify the applicable line item(s) corresponding to the implantable device billed.

When revenue codes 0274, 0275, 0276, or 0278 are billed, a HCPCS code that meets the definition of an Implant must be reported on the claim. If a HCPCS code is not submitted and/or an invoice is not submitted, the claim line(s) will be denied.

Definitions

"Implantable Devices" or "Implants" is defined by the United States Food and Drug Administration (FDA) as "a device that is placed into a surgically or naturally formed cavity of the human body and is intended to remain there for a period of 30 days or more."

Implants may include, but are not limited to, metal anchors, artificial joints, pins, plates, radioactive seeds, metal screws, shunts, and stents; and must remain in the patient's body upon discharge from the inpatient stay or outpatient procedure. Implantable Devices or brachytherapy sources eligible for payment by MVP will have a CMS Status Indicator H (pass-through device) or K (brachytherapy sources).

Notification/Prior Authorization Requests

MVP Payment Policies are not a guarantee of payment. Providers must also check Member eligibility and refer t 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/providers**.

Billing and Reimbursement Guidelines

The following condition codes, value codes, and/or modifiers are required to report the respective circumstances they represent:

Condition Codes:

1. Condition Code 49: Product Replacement within Product Lifecycle - Replacement of a product earlier than the anticipated lifecycle due to premature failure, etc.
2. Condition code 50: Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and is being replaced accordingly.
3. Condition code 53: Initial Placement of a Medical Device Provided as Part of a Clinical Trial or Free Sample – Provider has been issued a credit upon initial Implant placement as part of a clinical trial or a free sample.

Value Codes:

1. Value Code FD: Credit Received from the Manufacturer for a Medical Device

Modifiers:

1. Modifier FB: Items without cost to provider, supplier, or practitioner, or full credit received for replaced device (examples include but are not limited to devices covered under warranty, replaced due to defect, or furnished at zero dollars to provider)
2. Modifier FC: Partial credit for replaced device

Examples of HCPCS Codes That Do Not Meet the FDA Definition of an Implant*

HCPCS codes that do not qualify as a medical device and/or implant according to the FDA and are therefore excluded from reimbursement include, but are not limited to, the following:
C1724 C1725 C1726 C1727 C1728 C1729 C1730 C1731 C1732 C1733 C1750 C1751 C1752 C1753 C1754 C1755 C1756 C1757 C1758 C1759 C1764 C1765 C1766 C1769 C1773 C1782 C1819 C1884 C1885 C1886 C1887 C1892 C1893 C1894 C2614 C2615 C2618 C2628 C2629 C2630
*This list is subject to change based on FDA guidance. MVP will use the most current FDA information available when deciding whether a device meets the requirements for payment.

Other Exclusions:

- Materials, liquids, and allografts that are dissolved/absorbed/resorbed/remodeled, such as sealants, hemostats, topical thrombin's, bone morphogenetic protein, bone putty or cement, catheters, staples, and clips; these are generally considered supplies and do not meet the definition of Implants for reimbursement.
- Single use/disposable instruments or supplies do not meet the definition of Implants for reimbursement.
- Provider or vendor administrative storage and delivery costs are not separately reimbursable.
- Cardiac and vascular catheters and guide wires billed separately regardless of the amount billed are not separately reimbursable.

The following circumstances will disqualify any Implant from payment. Providers cannot bill MVP or MVP Members for these items:

1. Implants obtained by the provider at no cost or reduced cost. (See additional information below on use of appropriate condition codes, value codes, and/or modifiers.)
2. Implants that are contaminated or unused and/or were not implanted in the patient. Examples include:
    - Items that were prepared or opened during a surgical case but not used or implanted into the patient
    - Items opened in error
    - Surgeon "change of mind"
    - Technical or equipment failure/difficulties
    - Surgery case cancellation
    - Multi-pack implants when more appropriate unit sizes can be purchased

References

IDE Definitions and Acronyms. U.S. Food and Drug Administration. (2017, December 22).

History

August 1, 2022	New policy, approved
September 1, 2023	Policy reviewed and approved with changes
September 1, 2024	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Incident to Guidelines

Last Reviewed Date: May 1, 2025

Policy

MVP Health Care follows the CMS Incident to guidelines in full for all lines of business. Summarized content is provided in this policy for Provider convenience, and the complete guidelines are publicly accessible for complete review. Please see the references below.

Services provided in a Physician's office:

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 during diagnosis or treatment of an injury or illness.

Supplies usually furnished by the physician in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen, are also covered. Charges for such services and supplies must be included in the physicians' bills. To be covered, supplies, including drugs and biologicals, must represent an expense to the physician or legal entity billing for the services or supplies. For example, where a patient purchases a drug and the physician administers it, the cost of the drug is not covered. However, the administration of the drug, regardless of the source, is a service that represents an expense to the physician. Therefore, administration of the drug is payable if the drug would have been covered if the physician purchased it.

Direct Personal Supervision:

Coverage 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.

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. If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than hospital or SNF), their services are covered incident to a physician's service only if there is direct supervision by the physician.

Services provided by auxiliary personnel in an institution (e.g., nursing, or convalescent home) present a special problem in determining whether direct physician supervision exists. The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision.

Services of Nonphysician Personnel Provided Incident To Physician's Services:

Services performed by nonphysician licensed practitioners (certified nurse midwives, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists) incident to a physician's professional services include not only services ordinarily rendered by a physician's office staff person (e.g., medical services such as taking blood pressures and temperatures, giving injections, and changing dressings) but also services ordinarily performed by the physician such as minor surgery, setting casts or simple fractures, reading xrays, and other activities that involve evaluation or treatment of a patient's condition.

For services of a nonphysician practitioner to be covered as incident to the services of a physician, the services must meet all the requirements for coverage specified in this policy. For example, the services must be an integral, although incidental, part of the physician's personal professional services, and they must be performed under the physician's direct supervision.

Incident To Physician's Services in Clinic:

A physician directed clinic is one where:

1. A physician (or a number of physicians) is present to perform medical (rather than administrative) services at all times the clinic is open;
2. Each patient is under the care of a clinic physician; and
3. The nonphysician services are under medical supervision.

In most clinics, direct physician supervision may be the responsibility of several physicians as opposed to an individual attending physician. In this situation the physician ordering a particular service need not be the physician who is supervising the service.
Supplies provided by the clinic during the course of treatment are also covered. When the auxiliary personnel perform services outside the clinic premises, the services are covered only if performed under the direct supervision of a clinic physician. If the clinic refers a patient for auxiliary services performed by personnel who are not supervised by clinic physicians, such services are not incident to a physician's service.

Incident to Services for Behavioral Health:

MVP Health Care covers the services of CP, CSW, CNS, NP, PA, and CNM and supplies as an incident to professional services of a physician or other specified NPP, the same as an MD or a DO with the same requirements listed in this policy.

Notification/Prior Authorization Requests

MVP Payment policies 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 MVP's Medical Policies within the Provider Reference Library for MVP's clinical guidelines. These resources can be accessed by signing into your account at **mvphealthcare.com**.

References

Manuals | CMS

History

December 2, 2018	Policy approves
December 1, 2019	Policy reviewed and approved with no changes
September 1, 2021	Policy reviewed and approved with no changes
December 1, 2022	Policy reviewed and approved with no changes
December 1, 2023	Policy reviewed and approved with changes
March 1, 2024	Policy reviewed and approved with changes

November 1, 2024	Policy reviewed and approved with changes
May 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Infusion Policy

Last Reviewed Date: June 1, 2023

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)

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)

Notification/Prior Authorization Requests

MVP Payment policies 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.

Medications that can be self-administered will be billed under Member's pharmacy benefit.

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 part of the per diem and should not be billed independently.

Medicaid Variation

For medical benefit drugs, buy and bill is the preferred method of obtaining. If provider is unable to buy and bill, provider can work with MVP's preferred specialty pharmacy CVS Specialty to obtain the drug. CVS Specialty will then bill MVP via a medical claim. If CVS Specialty is unable to provide the medication, such as limited distribution drugs, MVP would consider a single case agreement with an alternative pharmacy.

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

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

MVP Health Care Payment Policy

Interpreter Services

Medicaid Products

Last Reviewed Date: February 1, 2025

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.

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 Policies 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

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 eight 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 two 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: https://www.health.ny.gov/health_care/medicaid/program/update/main.htm

History

December 1, 2018	New policy, approved
December 1, 2019	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes
March 1, 2024	Policy reviewed and approved with no changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

JW and JZ Modifiers

Last Reviewed Date: February 1, 2025

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

Billing/Coding Guidelines

JW modifier must be used to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. The use of this modifier is not appropriate for drugs that are from multiple-dose containers. This modifier provides payment for the amount of drug or biological (hereafter "drug") discarded along with the amount administered up to the amount of the drug or biological indicated on the vial or package label. The smallest vial or package size needed to administer the appropriate dose should be used.

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

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

Example of when JW Modifier IS required:

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

Example of when JW Modifier IS NOT required and JZ Modifier IS required if under Medicare Part B:

A billing unit for a single drug is equal to 10mg. A 7mg dose is administered to a patient and 3mg is discarded. The 7mg dose is billed as 10mg on a single line item because the billing unit for this drug is already established at 10mg regardless of how much was administered. The claim would be processed as a single line item for 10mg, which includes the 7mg administered and the 3mg discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of the drug is not permitted because it has already been accounted for. In this example, the actual dose of the drug or biological being administered is less than the billing unit so the JW modifier would not apply. To attest that there was no waste, a JZ Modifier must be submitted.

References

Medicare Claims Processing Manual: Medicare Claims Processing Manual (cms.gov) Article - Billing and Coding: JW Modifier Billing Guidelines (A53024) (**cms.gov**)

History

September 1, 2018	New policy, approved
September 1, 2020	Policy reviewed and approved with no changes
December 1, 2021	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with changes
March 1, 2024	Policy reviewed and approved with no changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Locum Tenens

Last Reviewed Date: September 1, 2024

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 temporarily out of office for personal time (e.g. vacation) or require an extended leave of absence for reasons such as illness, pregnancy, 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. . 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 MVP's 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). The Locum Tenens provider is required to abide by all MVP Protocols including the Benefits Interpretation Manual, Provider Policies and Payment Policies.

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.

Notification/Prior Authorization Requests

MVP Payment Policies 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 MVP's clinical guidelines. These resources can be accessed by signing into your account at **mvphealthcare.com**.

Billing/Coding Guidelines

All claims for Covered Services should be submitted under the Member's Regular Physician. MVP will report 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 Groups 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

r3774cp.pdf (cms.gov)

History

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
June 1, 2022	Policy reviewed and approved with no changes
June 1, 2023	Policy reviewed and approved with no changes
September 1, 2024	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Mental Health and Substance Use Disorder

Last Reviewed Date: May1, 2025
Related Policies–MVP Behavioral Health Policy
MVP Claims Section

MENTAL HEALTH AND SUBSTANCE USE DISORDER

Policy

This policy summarizes regulatory and administrative requirements needed for behavioral health claims to be reimbursed and applies to all MVP lines of business, with any exceptions noted below. Covered Services and payments are based on the Member's Subscriber Contract and the terms and conditions in the Provider's participation agreement. In addition to this policy, MVP uses claims payment rules supported by the American Medical Association, National Correct Coding Initiative, ClaimsXten, and other MVP administrative guidelines. For specific NYS Medicaid Managed Care CPT codes and rate codes by services, MVP follows the applicable State and Federal guidance.

Mental Health Parity

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

Billing/Coding Guidelines

All Behavioral Health Participating Providers must submit claims using the correct forms and CPT and HCPCS codes and billing guidelines. For those benefits covered by Commercial plans, MVP follows Medicare Advantage payment rules unless otherwise specified in the Provider Contract, or applicable State or Federal law, rule or regulations, or as outlined below. Medicaid, HARP and CHP reimbursement follow all relevant State-specific guidance and requirements and can be found below.

Adult Behavioral Health Home and Community Based Services (BH HCBS)

Services may only be billed for HARP Members meeting eligibility requirements as defined by NYS. Specific billing and coding requirements are attributable to all HCBS services and must follow NYS billing guidelines, including transportation requirements.

Ambulatory Behavioral Health Services

Ambulatory Behavioral Health Services including, but not limited to Assertive Community Treatment (ACT), OMH licensed and OASAS Certified clinics, Continuing Day Treatment (CDT), Comprehensive Psychiatric Emergency Program (CPEP), Intensive Psychiatric Rehabilitation Treatment (IPRT), Partial Hospitalization (PHP) and Personalized Recovered Oriented Services (PROS), shall be reimbursed using APG rate-setting methodology or other government

rates established and published by OMH and/or OASAS. 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.

Article 29-I Health Facility (VFCA) Services

Article 29-I Health Facility services are available to Managed Medicaid under the age of 21 (effective July 1, 2021) and CHP Members (effective January 1, 2023). Specific billing and coding requirements are attributable to 29-I Health facilities. 29-I Health facilities must follow New York States 29-I Health Facility Billing guidelines which can be found under 29-I Health Facility Rates and Billing Guidance at health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm

Assertive Community Treatment (ACT), Young Adult and Youth Assertive Community Treatment

ACT, Young Adult ACT and Youth ACT services must be billed in accordance with NYS Billing guidelines. Effective January 1, 2023, ACT, Youth ACT and Young Adult ACT services are also available to CHP Members and must be billed in accordance with NYS Billing guidelines.

Children's Family Treatment and Support Services (CFTSS)

CFTSS Services may only be billed for Managed Medicaid Members under the age of 21 that meet applicable medical necessity criteria. CFTSS services must follow the specific billing and coding requirements indicated within the NYS Children and Family Treatment and Support Services Provider Manual. Effective January 1, 2023, CFTSS services are also available to CHP Members and must be billed in accordance with the same billing guidance. *See* Children and Family Treatment and Support Services (ny.gov)

In addition, effective for dates of service beginning December 1, 2023, CFTSS services must include the applicable value code and Federal Information Processing Standard (FIPS) or Proxy Locator Code that identifies where the Member received services in order to be reimbursed.

Children's HCBS

Children's HCBS Services may only be billed for Members under the age of 21 that are eligible for waiver services. Effective January 1, 2025, Children's HCBS service were expanded to CHP members that meet eligibility and medical necessity criteria. Specific billing and coding requirements are attributable to all Children's HCBS services and must follow NYS Children's HCBS Provider Manual. Both the billing guidance and Allowable Service combinations can be found in the HCBS Provider Manuals and Rates (ny.gov)

Per NYS guidance, effective for dates of service beginning December 1, 2023, Children's HCBS services must include the applicable value code and Federal Information Processing Standard (FIPS) or Proxy Locator Code that identifies where the Member received services in order to be reimbursed. This requirement is applicable to both Managed Medicaid and CHP members.

Additionally, NYS Department of Health now requires an Electronic Visit Verification (EVV) for certain Children's HCBS services. Please refer to NYS guidance available at https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/app_billing_codes.htm for the applicable billing codes and guidance, as well as any updates that may occur (see also MVP EVV Payment Policy).

Community Health Workers (CHW)

Beginning January 1, 2024, CHW services provided in accordance with NYS CHW program guidance are covered for Medicaid Managed Care and HARP members. CHW services must be billed in accordance with NYS billing guidance to be eligible for reimbursement. Additional information on CHW program and billing guidance can be found at health.ny.gov/health_care/medicaid/program/update/2023/no17_2023-12.htm#CHW

Community Oriented Recovery and Empowerment Services (CORE)

Services may only be billed for HARP Members. Specific billing and coding requirements are attributable to all CORE services and must follow NYS billing guidelines. CORE and BH HCBS Allowable Service Combinations and the CORE and other OASAS/OMH Service Allowable combinations can be found in the NYS CORE Billing guide. *See* https://omh.ny.gov/omhweb/bho/core/

Comprehensive Psychiatric Emergency Program (CPEP)

All CPEP services must be billed in accordance with NYS billing guidance. CPEP programs designated for Mobile Crisis Services may provide and be reimbursed for Mobile Crisis services for adults and children in accordance with the New York State Crisis Intervention State Plan Amendment (#22-0026). CPEP programs must bill with the applicable Mobile Crisis rate codes, procedures, and modifier combinations per NYS guidelines. In addition, effective July 1, 2023, per updated guidance, Rate code 4010 was discontinued and is not reimbursable. Effective July 1, 2024, Rate code 4009 was retired and ineligible for reimbursement.

Crisis Residence

Effective March 1,2024, claims submitted for Crisis Residence Services for both Children and Adults must be billed in accordance with the NYS Crisis Intervention State Plan Amendment. NYS Rate codes 4625-4627 and their associated procedure codes and modifiers will apply for both children and adults. There are no longer different requirements for individuals ages 18-20, effective retroactive to April 1, 2022. Crisis Residence rate code 7943-7945 were retired as of May 1, 2024.

Electroconvulsive Therapy (ECT)

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

Evaluation and Management (E&M) 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.

Gambling Disorder Treatment

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

Inpatient Treatment

Medically necessary inpatient care is covered.

Outpatient Treatment

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

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.

Personalized Recovery Oriented Services (PROS)

PROS may be billed for Managed Medicaid or HARP Members that are 18 or over which meet applicable medical necessity criteria. PROS services must be billed in accordance with NYS billing guidelines to be reimbursable.

Psychological and Neuropsychological Testing

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

Residential Rehabilitation Services for Youth (RRSY)

Effective April 1, 2023, RRSY is a covered service for CHP members. RRSY services must be billed with rate code 4210.

Residential Treatment Centers (RTC)

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

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

Bill Types: 731,762,763,861,086,891
Revenue Codes: 0900.0902.0911.0914.0944.0945.1002

Transcranial Magnetic Stimulation (TMS)

MVP will reimburse psychiatrists for Transcranial Magnetic Stimulation.

Managed Medicaid, CHP, and HARP Variations:

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

Billing requirements are specific to service and facility type.

Claims

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

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

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

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

As of December 1, 2023, CHCBS and CFTSS services must include the applicable value code and Federal Information Processing Standard (FIPS) or Proxy Locator Code that identifies where the Member received services in order to be reimbursed:

When billing electronically, Value code 24 and the rate code for the CHCBS or CFTSS service are to be entered in field 39A; the rate code is input into the amount field. Value code 85 and the FIPS code are to be entered into field 40A; the 5-digit FIPS code is input into the amount field.

When billing paper claims, Value code 24 and the rate code are to be entered into field 39A; the rate code is input into the amount field. Value code 61 and the 3-digit county locator code are to be entered in field 40A.

For additional information on claims, please review the MVP Claims section.

Notification/Prior Authorization Requests

MVP Payment Policies 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**.

References

https://omh.ny.gov/omhweb/bho/billing-services.html
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm
https://omh.ny.gov/omhweb/bho/hcbs.html
https://omh.ny.gov/omhweb/bho/core/
https://omh.ny.gov/omhweb/bho/crisis-intervention.html
HCBS Provider Manuals and Rates (ny.gov)
Children and Family Treatment and Support Services (ny.gov)
Ambulatory Providers | Office of Addiction Services and Supports (ny.gov)
Electronic Visit Verification (EVV) Technical Assistance (ny.gov)

History

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

March 1, 2024	Policy reviewed and approved with changes
September 1, 2024	Policy reviewed and approved with changes
November 1, 2024	Policy reviewed and approved with changes
February 1, 2025	Policy reviewed and approved with changes
May 1 2025	Policy reviewed and approved with changes

Mid-Level Payment Policy

Last Reviewed Date: February 1, 2025

Related Policies:
Incident to Guidelines
NP/PA/CNS Billing in a Skilled Nursing Facility
Anesthesia
Credentialing

Policy

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

Payment Guidelines

General Guidelines

PA, NP, RNFA, CRNA, CNM Payment Policy: Payment for services rendered by these provider types, subject to the Incident. To see policy, please refer to your provider Fee Schedule or IPA contract for specific reimbursement guidelines. Notwithstanding this provision, no payment for RNFA services shall be issued for:

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

History

December 1, 2018	New policy, approved
December 1, 2019	Policy reviewed and approved with no changes
June 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with no changes
March 1, 2024	Policy reviewed and approved with no changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Modifier Policy for Physician

Last Reviewed Date: May 1, 2025

MODIFIER POLICY FOR PHYSICIAN

Policy

MVP reimburses for modifiers when billed in accordance with CMS guidelines for Assistant at Surgery Services. but also applies appropriate clinical edits for certain modifiers listed below. In certain circumstances, MVP will recognize the use of modifiers 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 use of each modifier.

Definitions

A modifier indicates that the service or procedure performed has been altered by some specific circumstance but not changed the underlying definition or code for the service or procedure.

Process for Documentation Submission

Paper claim submission is preferable to electronic submission, as documentation can be submitted along with the paper claim. If a claim is submitted without documentation and denied, a Provider may use a Claim Adjustment Request Form (CARF) to appeal the denial and submit clinical and other supporting documentation .

As all documentation is scanned into MVP's system; it is preferred if the specific portion of included in the documentation that supports the request is underlined, starred, or bracketed rather than highlighted. Highlighting may result in sections being blacked out when they are scanned.

Notification/Prior Authorization Requests

MVP Payment policies 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

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- CI - 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 it 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 ay involve significant increase in complexity for physicians and other health care professionals whose work is commonly associated with these patients **Rule** This circumstance may be reported by adding modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20100-69990 code series and 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93530, 93531, 93532, 93533, 93561, 93562, 93563, 93564, 93568, 93580, 93582, 93590, 93591, 93592, 93615, 93616 from the Medicine/Cardiovascular section. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections (other than those identified above from the Medicine/Cardiovascular section). **Reimbursement** Modifier 63 is reimbursed at 120% of the contracted rate
Modifier 73 **For Facility Use Only**	**Description**
	Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s), or general). **Rule** This code is to be used by the Hospital/Ambulatory Surgery Center when the procedure is discontinued. This modifier is not used to indicate discontinued radiology procedures. This modifier applies in extenuating circumstances and when the well-being of the patient is threatened. The patient must be taken to the room where the procedure is to be performed 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 CMS - 2A318-Assistant at Surgery Services Billed Without Correct Payment Modifiers: Incorrect Coding | CMS. **Reimbursement** Modifier AS is reimbursed at 16 percent of the assistant surgeon's contracted fee schedule. Modifiers 80-82 are reimbursed at 16 percent of the assistant surgeon's contracted fee schedule.
Modifier CG	**Description**
	Policy criteria applies. **Rule** When submitting a venipuncture claim when laboratory work is sent to an external lab, modifier CG is required. **Reimbursement** Claims submitted without the modifier will be denied as global.

Modifier CH-CN	Description
	Functional G-codes and corresponding severity modifiers are used in the required reporting on specified therapy claims. **Rule** At the outset of a therapy episode of care, i.e., on the DOS for the initial therapy service; At least once every 10 treatment days -- which is the same as the newly revised progress reporting period – the functional reporting is required on the claim for services on same DOS that the services related to the progress report are furnished; The same DOS that an evaluative procedure, including a re-evaluative one, is submitted on the claim (see below for applicable HCPCS/CPT codes); At the time of discharge from the therapy episode of care, if data is available; and, On the same DOS the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary. **Reimbursement** Claims submitted without the severity modifiers will be denied.

Modifier CO-CQ	Description
	Therapy modifier indicating a Physical Therapy Assistant or Occupational Therapy assistant performed a service in whole or in part. **Rule** • Services wholly furnished by PTAs and OTAs. • In cases where one final 15-minute unit (of a multi-unit scenario) remains to be billed, the de minimis standard is applied to: • Services where the PTA/OTA furnishes 8 or more minutes of a 15-minute unit of service and the PT/OT furnishes less than 8 minutes – bill with the CQ/CO modifier as the de minimis standard is exceeded. • Services where both the PTA/OTA and the PT/OT each provide less than 8 minutes of a service – bill with the CQ/CO modifier if the minutes furnished by the PTA/OTA exceed the de minimis standard. **Reimbursement** Claims submitted with these modifiers will be reimburses at 85% of charges or contracted rate.

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

Modifier KX	Description
	Therapy modifier indicating that the services over the CMS therapy cap were medically necessary. Please refer to CMS.Gov for annual KX therapy caps. **Rule** The Provider should use the KX modifier to the therapy procedure code (physical/speech and/or occupational) that is subject to CMS cap limits only when a beneficiary qualifies for a therapy cap exception. The KX modifier should not be used prior to the member meeting their therapy cap. Submission of medical records will be required to support the use of modifier KX. By attaching the KX modifier, the Provider is attesting that the services billed: • Qualified for the cap exception; • Are reasonable and necessary services that require the skills of a therapist; and • Are justified by appropriate documentation in the medical record.

Modifier PT	Description
	This modifier should be used when a CRC screening test has been converted to diagnostic test or other procedure. **Rule** MVP will pay the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code, or screening barium enema when the screening test becomes a diagnostic service.

	Reimbursement The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance for Medicare beneficiaries would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.
Modifier Q6	**Description**
	Services furnished by a Locum Tenens physician. **Rule** The patient's regular physician may submit the claim and receive payment for covered-visit services (including emergency visits and related services) of a Locum Tenens physician who is not an employee of the regular physician and whose services for the regular physician's patients are not restricted to the regular physician's office. **Reimbursement** Reimbursement would be made at the regular physician's fee schedule.
Modifier QK, QY, QX	**Description – QK**
	Modifier QK – Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals **Reimbursement – QK** Modifier QK will be reimbursed at the lesser of 50 percent of charges or the contracted rate. **Description – QY** Modifier QY – Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist **Reimbursement – QY** Modifier QY will be reimbursed at the lesser of 50 percent of charges or the contracted rate **Description – QX** Modifier QX – CRNA service: with medical direction by a physician **Reimbursement – QX** Modifier QX will be reimbursed at the lesser of 50 percent of charges or the contracted rate
Modifier U8, U9, UB	**Description – U8**
	Modifier U8 – Delivery prior to 39 weeks gestation **Reimbursement – U8** A 75 percent reduction will apply when modifier U8 is billed and an acceptable diagnosis is not documented **Description – U9** Modifier U9 – Delivery at 39 weeks gestation or later **Reimbursement – U9** Full payment will be made when modifier U9 is submitted **Description – UB** Modifier UB- Spontaneous obstetrical deliveries occurring between 37-39 weeks gestation **Reimbursement – UB** Full payment will be made when modifier UB and U8 are billed
Modifier CT	**Description**
	Modifier CT **Reimbursement** For a global procedure billed with CT, global fee schedule will be reduced by 15% of the amount for TC only code. For codes with both TC and CT, fee schedule amount is decreased by 15 percent
Modifiers GA, GY, GZ	**Description**
	Modifier GA, GY, GZ **Reimbursement** Only applicable with a valid pre-authorization denial. ABN is not applicable. Providers are to use GA, GY, GZ modifiers only if the service is not an MVP benefit; use will result in denial.

References

MVP Payment Policies- Elective Delivery (For Providers and Facilities)
CMS Pub. 100-04, chapter 12, section 40.2-40.5, and chapter 23, section 30.2
CPT 2019 Preventive Medicine Services Section
CPT 2019 Professional Edition, American Medical Association
Grider, Deborah, Coding with Modifiers, 5th Edition. American Medical Association. 2013
Medicare Claims Processing Manual Chapter 12 §§ 30.3.7, 40.2(A)(4)

History

June 1, 2019	Policy Approved
March 1, 2020	Policy reviewed with changes
June 1, 2020	Policy reviewed and approved with changes
December 1, 2020	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with changes
March 1, 2024	Policy reviewed and approved with changes
May 1, 2025	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Multiple Surgery- Vermont Facilities Only

Last Reviewed Date: February 1, 2025

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

Billing/Coding Guidelines

Multiple Surgery Rule

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

History

September 1, 2018 New policy, approved
September 1, 2020 Policy reviewed and approved with no changes
March 1, 2022 Policy reviewed and approved with no changes
March 1, 2023 Policy reviewed and approved with no changes
February 1, 2025 Policy reviewed and approved with no changes

MVP Health Care Payment Policy

NDC Policy

Last Reviewed Date: February 1, 2025

Policy

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

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

Notification/Prior Authorization Requests

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

Billing/Coding Guidelines

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

Vailid NDC numbers should be entered in the respective fields 24A – 24G for the corresponding CPT codes. The following should be included in order:

- Report the N4 qualifier (left justified)
- Followed immediately by 11-digit NDC (no hyphens)
- One space
- Followed immediately by Unit or Basis for Measurement Code: F2 – International Unit

ML – Milliliter
GR – Gram
UN - Unit

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

- Examples: 1234.56 2 9,999,999.999

- Example: N412345678901 UN1234.567

NDC Number

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

Instructions for filling out UB 04 claim form

NDC should be entered into field 43 - Revenue Code Description. The following should be included in order:

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

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

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

Instructions for Electronic Claim Format

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

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

NDC Formatting

A valid NDC is submitted as an 11-digit code without any hyphens. However, you will rarely see 11 digits when referring to an NDC on a medication package. This is because the 11 digits of an NDC are separated into three (3) sections.

- The first 5 digits identify the drug manufacturer
- The next 4 digits identify the specific drug and its strength
- The last 2 digits indicate the package size

In some cases, you may see a 5 digit-4 digit-2-digit code (for example 12345-1234-12). In this situation, you should remove hyphens, and submit the 11-digit 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 MVP to process a claim for reimbursement, the leading zeros must be added back into the appropriate place within the NDC to create an 11-digit NDC number that matches the Medispan and/or First Data Bank databases.

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

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

Choosing the Applicable NDC

If a drug has two (2) NDC numbers - one on the package and one on the vial, submit the NDC on the package rather than the number on the vial.
If the drug is a compound drug and does not have a single Federal NDC, individual components and their respective Federal NDC's numbers must be billed on separate lines with appropriate numbers of units.
If the drug is available in both medical and cosmetic packaging (e.g., Botox and Botox Cosmetic), use the appropriate NDC for the medical packaging. Submission of an NDC associated with the cosmetic product will result in a claim denial regardless of authorization status and diagnosis being treated.

References

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

History

February 1, 2018	New policy, approved
June 1, 2020	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with no changes
March 1, 2023	Policy reviewed and approved with changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

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

Last Reviewed Date: February 1, 2025

Policy

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

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 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 several 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 policies 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

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, 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 cms.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf cms.gov/SNFPPS/05_ConsolidatedBilling.asp
cms.gov/MLNMattersArticles/downloads/SE0418.pdf

History

June 1, 2019	New policy, approved
September 1, 2020	Policy reviewed, and approved with no changes
March 1, 2023	Policy reviewed, and approved with no changes
February 1, 2025	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Observation Status for Facility and Provider

Last Reviewed Date: May 1, 2025

Policy

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

Definitions

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

Notification/Prior Authorization Requests

MVP Payment Policies 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

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 most 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 forty-eight (48) hours, usually in less than twenty-four (24 hours).

When a physician orders that a patient receive observation care, the patient's status is classified as 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 the patient's 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 twenty-four (24)-hour interval.

MVP may retrospectively conduct a review of observation services which may take place either pre-claim payment or post-claim payment to ensure compliance with medical necessity criteria, regulatory requirements and to ensure compliance with MVP's administrative and medical policies.

MVP does not reimburse observation services for the following:

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

References

Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)
cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

History

March 1, 2019	Policy approved
June 1, 2021	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with no changes
September 1, 2023	Policy reviewed and approved with no changes
June 1, 2024	Policy reviewed and approved with no changes
May 1, 2025	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Occupational Therapy (OT)

Last Reviewed Date: February 1, 2025

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 policies 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

The following CPT codes are covered for Occupational Therapy Providers:

CPT Code	CPT Code
97165	Occupation therapy: low complexity
97166	Occupational therapy: moderate complexity
97167	Occupational therapy: high complexity
97168	Re-evaluation of occupational therapy standard plan of care
97010	Application of a modality to one or more areas; hot or cold packs
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy (eg. microwave)
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in
97542	Wheelchair management (e.g., 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
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (List separately in addition to code for primary service)
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers

Non-Reimbursable OT Services

Duplicate therapy–if Members 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 Member with the primary goal of returning an individual to work, not to treat a specific medical condition; therefore, they are not covered.

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
- Are justified by appropriate documentation in the medical record

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

History

March 1, 2021 Policy approved
March 1, 2021 Policy reviewed and approved with no changes
June 1, 2022 Policy reviewed and approved with no changes
June 1, 2023 Policy reviewed and approved with changes
March 1, 2024 Policy reviewed and approved with changes
February 1, 2025 Policy reviewed and approved with no changes

Office Place of Service

Last Reviewed Date – September 1, 2024

Policy

This policy is intended to ensure reimbursement is based on the code(s) that most appropriately describe the place of service in which a service is provided. The in-office procedure list below reflects those procedures that can be safely and more effectively performed in the in-office setting when reported by a physician or other health care professional. This policy applies to services billed on a CMS-1500 form or its equivalent or successor form (e.g. "Professional Claims") by any MVP Participating Provider or non-Participating Provider and applies to all MVP Commercial benefit plans.

Definitions

"Place of Service" (POS) means a two-digit code used on health care Professional Claims to indicate the setting in which a health care service was provided.

"POS 11" indicates the place of service is "Office" setting, which refers to a "location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis."

"POS 22" indicates the place of service is "On Campus-Outpatient Hospital" setting, which refers to a "portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization."

"Professional Claim" or "Professional Claims" means a health care service(s) reported by a physician or other health care professional or group and is billed on a CMS-1500 form or its equivalent or successor form and is entirely separate and distinct from a facility fee.

Notification/Prior Authorization Requests

MVP Payment policies 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

MVP follows The Centers for Medicare and Medicaid Services (CMS) POS Code Set for place of service codes and descriptions, and for purposes of applying industry-standard coding guidelines for place(s) of service for many CPT and HCPCS codes. In this policy, MVP is adopting a list of certain CPT and HCPCS codes that include a POS modifier in their description or applicable coding guidelines.
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.

Reimbursement Guidelines

MVP will reimburse CPT and HCPCS codes when reported with an appropriate POS based on the code's description or available coding guidelines when reported by a physician or other health care professional.
MVP does not classify Provider Based Clinics (PBCs), classified by CMS , as an extension of the hospital.
Professional Claims for certain procedures and services provided in-office should be appropriately billed with POS 11. For these CPT or HCPCS services specified below that are billed with POS modifier other than POS 11 will default to POS 11.
MVP does not reimburse separate facility fees billed in conjunction Professional Claims in an office setting.

Procedure and POS List:

CPT/HCPCS	POS
99202	11

References

American Medical Association, *Current Procedural Terminology* (CPT®) and other associated publications and services
Centers for Medicare and Medicaid Services, *Place of Service Code Set*. https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

History

September 1, 2024 New Policy, approved

MVP Health Care Payment Policy

Personal Care/Consumer Directed Personal Assistance Services – Service Units Billings

Last Reviewed Date: September 1, 2024

Policy

MVP requires Providers who are billing claims for reimbursement of Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS) units of service for a date of service to bill 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 Medicare Advantage Dual Special Needs Plan, Medicaid, and HARP Members.

Definitions

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

Consumer Directed Personal Assistance Program (CDPAP) 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. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse and are under the instruction, supervision and direction of the consumer or the consumer's designated representative. To be eligible for these services the individual must meet all NYS DOH program eligibility requirements.

Consumer Directed Personal Assistant is an adult who provides Consumer Directed Personal Assistance to a Consumer under the Consumer's instruction, supervision, and direction or under the instruction, supervision and direction of the Consumer's designated representative.

Consumer is the medical assistance recipient who a social services district has determined eligible to participate in the CDPAP.

Designated Representative is an adult to whom a self-directing Consumer has delegated authority to instruct, supervise and direct the Consumer Directed Personal Assistant and to perform the Consumer's responsibilities and who is willing and able to perform these responsibilities. With respect to a non-self-directing Consumer, a "designated representative" means the Consumer's parent, legal guardian or, subject to the social services district's approval, a responsible adult surrogate who is willing and able to perform such responsibilities on the Consumer's behalf.

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

Personal Care Assistant/Aide (PCA) assists an individual with day-to-day activities in their home and community. PCAs assist with ADLs, health-related procedures and tasks, observation, and redirection of behaviors, and IADLs.

Personal Care Services (PCS) are services for chronically ill or disabled individuals who have a medical need for help with activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs) provided by a personal care assistant/aide. To be eligible for these services the individual must meet all NYS DOH program eligibility requirements.

Notification/Prior Authorization Requests

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

Billing/Coding Guidelines

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

Non-Specific Diagnosis Codes:

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

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

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

		Hours)		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.)
UAS Assessment	T2024	Per Visit	n/a	Service Assessment/plan of care development
UAS Reassessment	T2024	Per Visit	n/a	Service Assessment/plan or care development

References

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

History

December 1, 2020 Policy approved
September 1, 2021 Policy reviewed and approved with changes
September 1, 2022 Policy reviewed and approved with changes
September 1, 2023 Policy reviewed and approved with changes
September 1, 2024 Policy reviewed and approved with changes

MVP Health Care Payment Policy

Physical Therapy (PT)

Last Reviewed Date: September 1, 2024

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 and seeks to enhance rehabilitation and recovery by clarifying a Member's impairments and functional limitations and by identifying interventions, treatment goals, and precautions.

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

"Therapeutic Procedures" are defined by the AMA CPT manual 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 policies 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

The following CPT codes are covered for Physical Therapy Providers:

CPT Code	CPT Code
95992	Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day
97161	Physical therapy evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity
97163	Physical therapy evaluation: high complexity
97164	Re-evaluation of physical therapy established plan of care
97010	Application of a modality to one or more areas; hot or cold packs
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy (eg, microwave)
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; contrast baths, 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	Self-care/home management training (e.g., 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
97535	Self-care/home management training (e.g., 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 (e.g., 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
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

For coverage of DME supplies, please see the Durable Medical Equipment Payment Policyfor dispensing guidelines and code coverage.

Non-Reimbursable PT Services

The following treatments are non-reimbursable PT services:

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

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

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

The following treatments are not covered because they are nonmedical, educational, or related to academic or work performance:

- Back to school programs and any program with the primary goal of education on the prevention of back pain or injury
- Work Hardening programs and any program with the primary goal of returning an individual to work (CPT 97545, 97546)
- Educational interventions (e.g., classroom environmental manipulation and academic skills training)
- Services provided within the school setting
- Sensory Integration Therapy (CPT 97533)
- Athletic training and evaluations (CPT 97169 – 97172)
- Equestrian/hippotherapy

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

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

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

Reimbursement Guidelines

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

References

Utilization and Case Management Policy (MVP Provider Policy)

History

March 1, 2019	Policy approved
March 1, 2021	Policy reviewed and approved with no changes
June 1, 2022	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with changes
June 1, 2023	Policy reviewed with changes
September 1, 2024	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Preoperative Lab Testing

Last Reviewed Date: November 1, 2024

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 Policies 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

General Guidelines

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

Examples of diagnostic tests which are often performed routinely prior to surgical procedures include but are not limited to:

- 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
- COVID-19 testing performed as part of any preoperative evaluation when there are no indications for this test

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 alone do not justify coverage. Providers should assign the ICD-10 codes describing the signs, symptoms, or conditions that justify the medical necessity 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
Z01.812	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
Z11.52	Encounter for screening for COVID-19

Reimbursement Guidelines

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

History

June 1, 2017	Policy approved
June 1, 2020	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes
June 1, 2023	Policy approved with changes.
September 1, 2023	Policy reviewed and approved with no changes
September 1, 2024	Policy reviewed and approved with no changes
November 1, 2024	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Preventive Health Care

Last Reviewed Date: May 1, 2025

Policy

MVP covers the full cost of the preventive services listed 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 the visit. Providers should bill MVP for these services appropriately; however, no cost share should be taken at the time of service. Providers should also check the Member's benefits to determine if preventive services apply to the Member's plan.

All standard correct coding practices should be observed. Claims will still be subject to clinical edits and bundling. Payment for preventive services by MVP depends on the correct claim submission, using diagnosis and procedure codes that identify the services as preventive. When billing the primary reason for the visit, the diagnosis codes should be billed at the claim line level in the principal diagnosis position.

Under Section 2713 of the Affordable Care Act, private health plans must provide coverage for a range of recommended evidence-based preventive services and may not impose cost-sharing (such as copayments, deductibles, or co-insurance) on patients receiving these services. The four expert medical and scientific bodies that provide these preventive service recommendations under the Affordable Care Act (ACA) are:

1. U.S. Preventive Services Task Force (USPSTF), Rating "A" or "B" www.uspreventiveservicestaskforce.org
2. Advisory Committee on Immunization Practices (ACIP) www.cdc.gov/acip-recs/hcp/vaccine-specific/
3. Health Resources and Services Administration's (HRSA) Bright Futures Project mchb.hrsa.gov/programs-impact/bright-futures
4. HRSA-sponsored Women's Preventive Services Initiative (WPSI) www.hrsa.gov/womens-guidelines; www.womenspreventivehealth.org/recommendations/

Note: The USPSTF Recommendation "A" or "B" letter grade indicates that the panel finds there is high certainty that the services have a substantial or moderate net health benefit.

This Preventive Health Care guidance may also apply to state regulations that vary from USPSTF guidelines. Examples of these are:

- *A 55-year-old man has a colonoscopy for colorectal cancer screening. The code for this service is billed with CPT code 45378. MVP will not take a co-pay, if, either a modifier 33 is appended to the procedure code 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 diagnosis 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.*
- *A 40-year-old woman has a bilateral mammogram for breast cancer screening. The code for this service is billed with CPT code 77067. There are no other billing requirements. MVP will not take a co-pay for screening mammograms, with or without clinical breast examination, every 1 to 2 years for women, age 40 years and older.*

Notification/Prior Authorization Requests

MVP Payment Policies 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

Please refer to the billing and coding guidelines below for instructions on correct claim submissions, including the use of diagnosis and/or procedure codes. No co-payment, deductible, or co-insurance will be applied when billed in accordance with standard code billing practices.

United States Preventive Service Task Force (USPSTF) Recommendations,
Advisory Committee on Immunization Practices (ACIP) Recommendations, Bright Future Recommendations, Women's Preventive Services Initiative (WPSI) Recommendations:

Abdominal Aortic Aneurysm Screening: Men

(December 2019) Rating B
USPSTF recommends a 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked.

Cost share does not apply. Note: Facilities must bill with an appropriate code and one of the following revenue codes: 0320, 0321, 0322, 0323, 0324, 0329, 0400, 0402, 0409.

Code	Description
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)

Anxiety in Children, Adolescents, and Adults: Screening

(October 2022) Rating B
The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years. This recommendation applies to those who do not have a diagnosed anxiety disorder or are not showing recognized signs or symptoms of anxiety.
(June 2023) Rating B: The USPSTF recommends screening for anxiety disorders in adults aged 19 to 64 years, including pregnant and postpartum persons. This recommendation applies to those who do not have a diagnosed mental health disorder and are not showing recognized signs or symptoms of anxiety disorders.
WPSI recommends screening for anxiety in adolescent and adult women aged 13 and older, including those who are pregnant or postpartum. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, clinicians should consider screening women who have not been recently screened. Consider screening for anxiety in conjunction with screening for depression, which is also recommended, because of their frequent co-occurrence.

Cost share does not apply for the following code:

Code	Description
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication

(September 2021) Rating B
The USPSTF recommends the use of low-dose aspirin (81 mg/day) as preventive medication after twelve (12) weeks of gestation in persons who are at high risk for pre-eclampsia. This recommendation applies to pregnant persons who are at high risk for preeclampsia and who have no prior adverse effects with or contraindications to low-dose aspirin. 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.

Asymptomatic Bacteriuria Screening: Pregnant Persons

(September 2019) Rating B
The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons 12 to 16 weeks of gestation or at the first prenatal visit. This recommendation applies to pregnant persons of any age without signs and symptoms of a urinary tract infection.

WPSI recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at their first prenatal visit.
No cost share for the following codes when billed with pregnancy related diagnosis code. See Pregnancy related diagnosis code set at the end of this Policy.

Code	Description
87086	Culture, bacterial; quantitative colony count, urine
87088	Culture, bacterial; with isolation and presumptive identification of each isolate, urine

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

(August 2019) Rating B
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 (BRCA1/2) 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.

Modifier 33 must be appended to codes 96041 and S0265.
Facilities must bill with appropriate code and one of the following revenue codes: 0500, 0510.

Code	Description
81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements)
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
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 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants
81215	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant
81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant
96041 billed with modifier 33	Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
S0265 billed with modifier 33	Genetic counseling, under physician supervision, each 15 minutes

Breast Cancer: Medication Used to Reduce Risk

(September 2019) Rating B
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. This recommendation applies to asymptomatic women 35 years and older, including women with previous benign breast lesions on biopsy.

Code	Description
99385-99387	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;
99395-99397	Periodic comprehensive preventive medicine re-evaluation and management of an individual including an appropriate age and gender history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient;

Breast Cancer Screening

(April 2024) Rating B
The USPSTF recommends biennial (every 2 years) screening mammography for women aged 40 to 74 years.

WPSI recommends to initiate mammography screening, no earlier than age 40 and no later than age 50 for women at average risk for breast cancer. Screening should continue through at least age 74 and age alone should not be the basis to discontinue screening. WPSI recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services. Patient navigation services involve person-to-person (e.g., in-person, virtual, hybrid models) contact with the patient. Components of patient navigation services should be individualized. Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (e.g., language translation, transportation, and social services), and patient education.

Code	Description
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure). Use in conjunction with 77067.
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

Breast Cancer Screening – Women's Preventive Health

In accordance with 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,

The law removes cost-sharing for mammograms, including:

- A single, baseline mammogram for individuals 35 to 39 years old
- Yearly mammograms for individuals 40 years of age or older, and
- Mammograms for individuals at any age who are at an increased risk of breast cancer because they have a prior history of breast cancer, or they have a first degree relative (e.g., parent, sibling, child) with breast cancer when a physician recommends the mammogram.

The law also removes cost-sharing for those in need of imaging tests other than standard mammograms - such as diagnostic mammograms, breast ultrasounds, and breast magnetic resonance imaging (MRI) for the detection of breast cancer.

Code	Description
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
77046	Magnetic resonance imaging, breast, without contrast material, unilateral
77047	Magnetic resonance imaging, breast, without contrast material, bilateral
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization of pharmacokinetic analysis), when performed; unilateral

77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization of pharmacokinetic analysis), when performed; bilateral
77053	Mammary ductogram or galactogram, single duct, radiological supervision & interpretation
77054	Mammary ductogram or galactogram, multiple ducts, radiological supervision & interpretation
77061	Digital breast tomosynthesis; unilateral
77062	Digital breast tomosynthesis; bilateral
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
99385-99387	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;
99395-99697	Periodic comprehensive preventive medicine revaluation 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;
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
C8903	Magnetic resonance imaging with contrast, breast; unilateral
C8905	Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral
C8906	Magnetic resonance imaging with contrast, breast; bilateral
C8908	Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)
S8080	Scintimammography (radioimmunoscintigraphy of the breast), unilateral, including supply of radiopharmaceutical

VT Diagnostic MRI with Screening (Vermont Diagnostic Mammogram Medical Services)

Coverage is provided for medically necessary diagnostic and supplemental breast imaging including MRIs, ultrasounds, and other breast imaging services for a patient for whom the results of a screening mammogram were inconclusive or who has dense breast tissue, or both. Benefits provided shall cover the full cost of the mammography service or ultrasound, as applicable, and shall not be subject to any co-payment, deductible, coinsurance, or other cost-sharing requirement or additional charge.

No cost share for the following codes when billed with one of the following diagnosis codes in the primary diagnosis position: R92.2, R92.30, R92.311, R92.312, R92.313, R92.321, R92.322, R92.323, R92.331, R92.332, R92.333, R92.341, R92.342, R92.343, R92.8, Z12.39

Code	Description
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
77061	Digital breast tomosynthesis; unilateral
77062	Digital breast tomosynthesis; bilateral
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)

**No diagnosis requirement for the following codes. .

Code	Description
77046**	Magnetic resonance imaging, breast, without contrast material, unilateral
77047**	Magnetic resonance imaging, breast, without contrast material, bilateral
77048**	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization of pharmacokinetic analysis), when performed; unilateral
77049**	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization of pharmacokinetic analysis), when performed; bilateral

Breastfeeding: Primary Care Interventions

(October 2016) Rating B

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

Code	Description
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
99411-99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual in a group setting (separate procedure)

Breastfeeding Services and Supplies - Women's Preventive Health (Breastfeeding support, supplies, and counseling)

WPSI recommends comprehensive lactation support services (including consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to optimize the successful initiation and maintenance of breastfeeding.

Code	Description	Business Rule
E0602 E0603 E0604	Breast pump, manual, any type of Breast pump, electric (AC and/or DC), any type Breast pump, hospital grade, electric (AC and/or DC), any type	• No cost share when billed with appropriate code. • HRSA Requirement (Jan. 2023): Comprehensive lactation support services (including consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to optimize the successful initiation and maintenance of breastfeeding. • Breastfeeding equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance)
A4281	Tubing for breast pump, replacement	
A4282	Adapter for breast pump, replacement	
A4283	Cap for breast pump bottle, replacement	
A4284	Breast shield and splash protector for use with breast pump, replacement	
A4285	Polycarbonate bottle for use with breast pump, replacement	
A4286	Locking ring for breast pump, replacement	
K1005	Disposable collection and storage bag for breast milk, any size, any type, each	
S9443	Non-physician conducting a lactation class	
99501	Home visit for postnatal assessment and follow-up care	
99502	Home visit for newborn care and assessment	
99211 99212 99213 99214 99215	Nurse visits usually under 5 minutes Office or other outpatient visit for the evaluation and management of an established patient	

Cervical Cancer: Screening

(August 2018) Rating A
For women, ages 21-29 years the USPSTF recommends screening for cervical cancer every three (3) years with cervical cytology alone. .
For women, ages 30-65 years the USPSTF recommends screening for cervical cancer every three (3) years with cervical cytology alone, every five (5) years with high-risk human papillomavirus (hrHPV) testing alone, or every five (5) years with hrHPV testing in combination with cytology (co-testing).

WPSI recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, the WPSI recommends cervical cancer screening using cervical cytology (Pap test) every three (3) years. Co-testing with cytology and human papillomavirus testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with cytology and human papillomavirus testing every five (5) years or cytology alone every 3 years.

WPSI recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services. Patient navigation services involve person-to-person (e.g., in-person, virtual, hybrid models) contact with the patient. Components of patient navigation services should be individualized. Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (e.g., language translation, transportation, and social services), and patient education.

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
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 (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code[s] for other technical and interpretation 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

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 three smears, by technician under physician supervision
P3001	Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Chlamydia and Gonorrhea: Screening

(September 2021) Rating B

The USPSTF recommends screening for chlamydia and gonorrhea in all sexually active women twenty-four (24) years or younger and in women twenty-five (25) years or older who are at increased risk for infection. This recommendation applies to asymptomatic, sexually active adolescents and adults, including pregnant persons.

Code	Description
86631	Antibody; Chlamydia
86632	Antibody; Chlamydia, IgM
87110	Culture, chlamydia, any source
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87320	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; 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
87590	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87592	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification

Colorectal Cancer: Screening

(May 2021) Rating A and Rating B

Rating A – The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years.

Rating B – The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years.

This Rating BUSPSTF recommendation applies to asymptomatic adults 45 years or older who are at average risk of colorectal cancer (ie, no prior diagnosis of colorectal cancer, adenomatous polyps, or inflammatory bowel disease; no personal diagnosis or family history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer [such as Lynch syndrome or familial adenomatous polyposis]).

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	Colonoscopy Stomal W Removal of foreign body

	33 or PT	
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
44408	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45300	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45303	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with dilation (e.g., balloon, guide wire, bougie)
45305	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with biopsy, single or multiple
45307	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with removal of foreign body
45309	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique
45315	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45317	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snar technique (e.g., laser)
45327	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (Includes predilation)
45330	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45332	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with removal of foreign body
45334	No cost share for Medical or Facility services when one billed with a modifier PT or 33	Sigmoidoscopy with Control Hemorrhage

45337	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with decompression (for Pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45341	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342		Under Endoscopy Procedures on the Rectum. Code is active
45347	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
45378	No cost share when billed with a modifier PT or 33.	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	No cost share when billed with a modifier PT or 33	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45381	No cost share when billed with a modifier PT or 33	Colonoscope, submucous injection
45382	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
45386	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with transendoscopic balloon dilation
45389	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)
81528	No modifier or diagnosis code are required to be covered in full	Oncology (colorectal) screening, quantitative real-time target, and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
G0104	No modifier or diagnosis code is required to be covered in full	Colorectal cancer screening; flexible sigmoidoscopy
82274	No modifier or diagnosis code are required to be covered in full	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
82270	No modifier or diagnosis code are required to be covered in full	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative;
G0105	No modifier or diagnosis code is required to be covered in full	Colorectal cancer screening; colonoscopy on individual at high risk
G0106	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
G0120	No modifier or diagnosis code is required to be covered in full	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0121	No modifier or diagnosis code is required to be covered in full	Colorectal cancer screening; colonoscopy on individual not meeting criteria
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 contracted rate for 99212 Exception:	Colonoscopy consultation performed prior to a screening colonoscopy procedure

	Consistent with Medicare guidelines, code S0285 will not be reimbursed separately for Medicare product lines.	

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	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	Sigmoidoscopy, flexible; with biopsy, single or multiple

	33, PT, or ICD-10 code above billed in principal position	
45333	No cost share when billed with Modifier 33, PT, or ICD-10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s) polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45338	No cost share when billed with Modifier 33, PT, or ICD-10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45346	No cost share when billed with Modifier 33, PT, or ICD-10 code above billed in principal position	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post- dilation and guide wire passage, when performed)
45378	No cost share when billed with Modifier 33, PT, or ICD-10 code above billed in principal position	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 supports. Initial 15 minutes of interservice 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 interservice time, patient ages 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 interservice time.
00811	Bill with Modifier PT or 33 or with one of the following ICD-10 Codes in the first Position. Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
00812	No cost share when billed with Modifier 33, PT, or ICD-10 code above billed in principal position	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy

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

(December 2021)

MVP covers Colorectal Cancer in adults beginning at the age of 45.
In addition, MVP covers follow-up Colonoscopies for New York Members when based on the following requirements:

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

45330, 45331, 45332, 45333, 45334, 45337, 45338, 45341, 45342, 45346, 45347, 82270, 82274, 81528
If one of the above screening tests results in an abnormal or positive test outcome, bill the follow-up Colonoscopy as outlined below.

Code	Billing Instruction	Code Description
45378	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimens(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45380	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45381	No cost share when billed with Modifier 33 or PT	Colonoscopy, submucous injection

45382	No cost share when billed with a modifier PT or thirty-three	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
45384	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with transendoscopic balloon dilation
45388	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45389	No cost share when billed with Modifier 33 or PT	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)

Colorectal Cancer Screening – Vermont Variation

MVP covers colorectal cancer screening for Vermont Members as follows:

- Member is 50 years of age or older with the option of:
    - Annual fecal occult blood testing plus one flexible sigmoidoscopy every five years; or
    - One colonoscopy every 10 years.
- Member is at high risk for colorectal cancer*, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

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

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

- Removal of tissue or other matter;
- Laboratory services;
- Physician services;
- Facility use; and
- Anesthesia

Code	Billing Instruction	Description
Medical & Facility	No cost share for Medical or Facility services when one billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, D50.9, K63.5, Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z12.13, Z13.811, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z85.060, Z85.068, Z86.010, Z86.018, Z87.19.	

44389	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Fiberoptic Colonoscopy; W Biopsy Collect S
44392	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Colonoscopy Stomal W Rem Polyp Les
44394	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Colonoscopy Through Stoma; W Removal of Tumor/ Polyp/ Lesions by Snare
44401	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45305	No cost share when billed with Modifier 33, PT, or above ICD-10 code.	Proctosigmoidoscopy W Biopsy
45309	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Proctosigmoidoscopy, Rigid; W Removal Single Tumor/ Polyp/ Lesion By Snare
45315	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Proctosigmoidoscopy; Multiple Removals
45331	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Sigmoidoscopy, flexible; with biopsy, single or multiple
45333	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45338	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45346	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45378	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, D50.9, K63.5, Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z12.13, Z13.811, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z85.060, Z85.068, Z86.010, Z86.018, Z87.19.	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45380	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45384	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45388	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post- dilation and guide wire passage, when performed)

74263	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Computed Tomographic (CT) colonography, screening, including image post processing
88305	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Surg Pathology; Level 4 Gross & Microscopic examination
99152	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation support. Initial 15 minutes of interservice time, age 5 and older
99153	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, each additional 15 minutes interservice time.
99156	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Initial 15 minutes of interservice time, patient age 5 and older.
99157	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Each additional 15 minutes interservice time.
00811	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
00812	No cost share when billed with Modifier 33, PT, or ICD-10 code above	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy

Depression and Suicide Risk in Children, Adolescents, and Adults: Screening

(October 2022) Rating B

The USPSTF reccommends screening for major depressive disorder (MDD) in adolescents ages 12 to 18 years. This USPTF recommendation applies to those who do not have a diagnosed mental health condition or are not showing recognized signs or symptoms of depression or suicide risk. This recommendation focuses on screening for MDD and does not address screening for other depressive disorders, such as minor depression or dysthymia.

(June 2023) Rating B

The USPSTF recommends screening for depression in the adult population, including pregnant and postpartum persons, as well as older adults. This recommendation applies to adults 19 years or older who do not have a diagnosed mental health disorder or recognizable signs or symptoms of depression or suicide risk. This recommendation focuses

on screening for MDD and does not address screening for other depressive disorders, such as minor depression or dysthymia.

Code	Description
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
G0444	Annual depression screening, 5 to 15 minutes

Screening for Prediabetes and Type 2 Diabetes

(August 2021) Rating B

The USPSTF recommends screening for prediabetes and type 2 diabetes in adults between the age of 35 to 70 years who are overweight or obese. Clinicians should offer or refer patients with prediabetes to effective preventive interventions. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthy diet and physical activity. See Women's Preventive Health section on Screening for Gestational Diabetes Mellitus and Screening for Diabetes Mellitus after Pregnancy.

Code	Billing Instruction	Code Description
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 25.0 – 29.9: ICD-10: Z68.25, Z68.26, Z68.27, Z68.28, Z68.29 BODY MASS INDEX 30.0 – 39.9: ICD-10: Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39 BODY MASS INDEX 40.0 AND OVER: ICD-10: Z68.41, Z68.42, Z68.43, Z68.44, Z68.45	Medical & Facility Annual wellness Visit Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness Glucose; quantitative, blood (except reagent strip).
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 Community-Dwelling Older Adults: Interventions

(June 2024) Rating B

The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.

Folic Acid: Supplementation

(August 2023) Rating B

Folic Acid Supplementation to Prevent Neural Tube Defects: Preventive Medication

The USPSTF recommends that all persons planning to or who could become pregnant take a daily supplement containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid.

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

Gestational Diabetes: Screening

(August 2021) Rating B

The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after. 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. WPSI recommends screening pregnant women for gestational diabetes mellitus after 24 weeks' gestation (preferably between 24 and 28 weeks) to prevent adverse birth outcomes. Screen pregnant women with risk factors for type 2 diabetes before 24 weeks of gestation, ideally at the first prenatal visit. In addition, screen women with a history of gestational diabetes who are not currently pregnant and who have not been previously diagnosed with type 2 diabetes.

No cost share for the following codes when billed with appropriate pregnancy related ICD-10 diagnosis code billed in the principal diagnosis position.

Code	Description
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; blood, reagent strip
82950	Glucose; post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)
82952	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)
83036	Hemoglobin; glycosylated (A1C)

Healthy Weight and Weight Gain During Pregnancy: Behavioral Counseling Interventions

(May 2021) Rating B

"Task Force" Recommendation

The USPSTF recommends that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.

Code	Billing Instruction	Code Description
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	No cost share when billed for healthy weight and weight gain during pregnancy
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	No cost share when billed for healthy weight and weight gain during pregnancy
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	No cost share when billed for healthy weight and weight gain during pregnancy

99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	No cost share when billed for healthy weight and weight gain during pregnancy
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	No cost share for women when billed with appropriate pregnancy related ICD-10 Diagnosis code
97803	Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15 minutes	No cost share for women when billed with appropriate pregnancy related ICD-10 Diagnosis code
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes	No cost share for women when billed with appropriate pregnancy related ICD-10 Diagnosis code
S9470	Nutritional counseling, dietitian visit	No cost share for women when billed with appropriate pregnancy related ICD-10 Diagnosis code

Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions

(November 2020) Rating B

The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.

No cost share for the following codes when billed with appropriate pregnancy related ICD-10 diagnosis code billed in the principal diagnosis position.

Code	Description
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

Hearing Loss Screening: Newborns

(July 2008) Rating B

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

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

The USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection. This recommendation applies to asymptomatic, nonpregnant adolescents and adults at increased risk for HBV infection, including those who were vaccinated before being screened for HBV infection. The USPSTF has made a separate recommendation on screening in pregnant women.

No cost share for the following codes when billed with one of the following diagnosis codes: Z00.00, Z00.01, Z11.59, Z57.8, Z11.3, Z11.4, Z20.2, Z20.6, Z72.51, Z72.52, Z72.53:

Code	Description
86704	Hepatitis B core antibody (HBcAb); total
86705	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
87340	Infectious agent antigen detection by immunoassay technique, qualitative or semiquantitative; hepatitis B surface antigen (HBsAg)
G0499	Hepatitis B screening in nonpregnant, high-risk individual includes hepatitis B surface antigen (HBSAG), antibodies to HBSAG (anti-HBS) and antibodies to hepatitis B core antigen (anti-HBC), and is followed by a neutralizing confirmatory test, when performed, only for an initially reactive HBSAG result

Hepatitis B Virus Infection in Pregnant Women: Screening

(June 2019) Rating A

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

No cost share for the following codes when billed with appropriate pregnancy related ICD-10 diagnosis code billed in the principal diagnosis position.

Code	Description
86704	Hepatitis B core antibody (HBcAb); total
86705	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
87340	Infectious agent antigen detection by immunoassay technique, qualitative or semiquantitative; hepatitis B surface antigen (HBsAg)

Hepatitis C Virus Infection in Adolescents and Adults: Screening

(March 2020) Rating B

The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years without known

liver disease.

Code	Description
86803	Hepatitis C antibody
86804	Hepatitis C antibody; confirmatory test (eg, immunoblot)
G0472	Hepatitis C antibody screening for individual at high risk and other covered indication(s)

Hypertension in Adults: Screening

(April 2021) Rating A

The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

Code	Description
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)

Hypertensive Disorders of Pregnancy: Screening

(September 2023) Rating B

The USPSTF recommends screening for hypertensive disorders in pregnant persons without a known diagnosis of a hypertensive disorder of pregnancy or chronic hypertension. Blood pressure should be measured at every prenatal visit throughout pregnancy.

Note: Blood pressure measurements should be performed and included in the antenatal visit. Reimbursement will occur under antenatal visit which will be global if delivery is performed by the same physician group.

Human Immunodeficiency Virus (HIV) Infections: Screening for Pregnant Persons, Adolescents, and Adults 15–65)

(June 2019) Rating A

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 the bill with the appropriate code.

Code	Description
86701	Antibody; HIV-1
86702	Antibody; HIV-2
86703	Antibody; HIV-1 and HIV-2, single result
87389	Infectious agent antigen detection by immunoassay technique, qualitative or semiquantitative; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result
87390	Infectious agent antigen detection by immunoassay technique, qualitative or semiquantitative; HIV-1
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening
G0475	HIV antigen/antibody, combination assay, screening
S3645	HIV-1 antibody testing of oral mucosal transudate

Prevention of Acquisition of Human Immunodeficiency Virus (HIV): Preexposure Prophylaxis

(August 2023) Rating A
The USPSTF recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV.

Note: This benefit also includes the following services:

- Kidney function testing (creatinine),
- Serologic testing for Hepatitis B and C virus,
- Testing for other STIs,
- Pregnancy testing (when appropriate), and
- Ongoing follow-up and monitoring including HIV testing every 3 months

*Refer to the plan's pharmacy benefit for details on prescription medications available under the plan's preventive benefit.

The codes listed below must be billed with one of the following diagnosis codes: Z11.3, Z11.4, Z20.2, Z20.6, Z29.81, Z72.51, Z72.52, Z72.53

36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (eg, finger, heel, ear stick)
81025	Urine pregnancy test, by visual color comparison methods
82565	Creatinine; blood
82570	Creatinine; other source
84702	Gonadotropin, Chorionic; Quantitative

84703	Gonadotropin, Chorionic; Qualitative
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)
87147	Culture, typing; immunologic method, other than immunofluorescence (eg, agglutination grouping), per antiserum
87391	Infectious agent antigen detection by immunoassay technique, qualitative or semiquantitative; HIV-2
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
87806	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies
87810	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Chlamydia trachomatis
87850	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Neisseria gonorrhoeae
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)
99202-99205	Office or other outpatient visit for the evaluation and management of a new patient
99212-99215	Office or other outpatient visit for the evaluation and management of an established patient
G0463	Hospital outpatient clinic visit for assessment and management of a patient
J0739	Injection, cabotegravir, 1 mg, FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV)
J7050	Emtricitabine, 200 mg and tenofovir disoproxil fumerate 300 mg, oral, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV). Use this code for Truvada fpr PReP.
J7051	Emtricitabine, 200 mg and tenofovir alafenamide 25mg, oral, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV) . Use this code for Descovy for PReP.

Please refer to supporting policies:

- Sexually Transmitted Infections Counseling
- Screening for Chlamydia and Gonorrhea
- Hepatitis B Screening: Virus Infection in Adolescents and Adults at increased risk
- Hepatitis B Virus Infection Screening: Pregnant Women
- Hepatitis C Virus Infection Screening: Adults
- Syphilis Infection in Nonpregnant Adults and Adolescents: Screening
- Syphilis Screening: Pregnant Persons
- Human Immunodeficiency Virus (HIV) Infection: Screening for Pregnant Persons, Adolescents, and Adults 15–65

Hypothyroidism Screening (Newborns)

(March 2008) Rating A

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, Elder Abuse, and Abuse of Vulnerable Adults: Screening

(October 2018) Rating B

The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and older or vulnerable adults without recognized signs and symptoms of abuse and provide or refer women who screen positive to ongoing support services.

The WPSI reccomends screening adolescents and women for interpersonal and domestic violence, at least annually. When needed, provide or refer for initial intervention services that include, but are not limited to, counseling, education, harm reduction strategies, and appropriate supportive services.

Code	Description
99385-99387	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;
99395-99397	Periodic comprehensive preventive medicine revaluation 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;
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)

Latent Tuberculosis Infection in Adults: Screening

(May 2023) Rating B
The USPSTF recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk.

HRSA's Bright Futures Project recommends testing should be performed on recognition of high-risk factors

There will be no cost share for the following codes when billed with one of the following diagnosis codes:
Z111, Z117, Z201, Z227, Z8615

Code	Description
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

Lung Cancer: Screening

(March 2021) Rating B
The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

Note: Prior authorization is required for 71271.

Code	Description
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)

Maternal Depression Screening

New York State Department of Financial Services to Title 11 NYCRR 52, Amendment 52 (Insurance Regulation 62) Sections: 52.1l, 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.

Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication

(January 2019) Rating A

The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.

Prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum is considered part of standard neonatal care and is included in the global fee for infant nursery care during inpatient admission.

Osteoporosis to Prevent Fractures: Screening Postmenopausal women younger than 65 years with 1 or more risk factors for osteoporosis

(January 2025) Rating B

The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk for an osteoporotic fracture as estimated by clinical risk assessment. This recommendation applies to adults 40 years or older without known osteoporosis or history of fragility fractures. It does not apply to persons with secondary osteoporosis due to an underlying medical condition (eg, cancer, metabolic bone diseases, or hyperthyroidism) or chronic use of a medication (eg, glucocorticoids) associated with bone loss.

Code	Description
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

Osteoporosis to Prevent Fractures: Screening women 65 years or older

(January 2025) Rating B

The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in women 65 years or older.

Code	Description
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

Perinatal Depression: Preventive Interventions

(February 2019) Rating B

The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.

Code	Description

96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
G0444	Annual depression screening, 5 to 15 minutes

Preeclampsia Screening

(April 2017) Rating B

The USPSTF recommends screening for pre-eclampsia in pregnant persons with blood pressure measurements throughout pregnancy.

Code	Billing Instruction	Code Description
99394 99395 99396		Established Patient comprehensive preventive medicine evaluation and management.

Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions

(December 2021) Rating B

The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

The USPSTF also recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.

Code	Description
99188	Application of topical fluoride varnish by a physician or other qualified health care professional
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)

Note: Codes D1206 and D1208 are not reimbursable under the medical benefit.

Rh(D) Incompatibility: Screening Pregnant women, during the first pregnancy-related care visit and Screening Unsensitized Rh(D)-negative pregnant women

(February 2004) Rating A

The USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.

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	Description
86901	Blood typing, serologic; Rh (D)

Sexually Transmitted Infections Counseling

(August 2020) Rating B

The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).

WPSI recommends behavioral counseling by a health care clinician or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for sexually transmitted infections (STIs). WPSI recommends that clinicians review a woman's sexual history and risk factors to help identify those at an increased risk of STIs. Risk

factors include, but are not limited to, age younger than 25, a recent history of an STI, a new sex partner, multiple partners, a partner with concurrent partners, a partner with an STI, and a lack of or inconsistent condom use. For adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgment.

Code	Description
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
99411-99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual in a group setting (separate procedure)
G0445*	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior

*Limited to 2x a year

Skin Cancer Prevention: Behavioral Counseling

(March 2018) Rating B

The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

Code	Description
99383-99385	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;
99393-99395	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;
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)

Statin Preventive Medication

(Aug 2022) Rating B

Adults age 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

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

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		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 Adolescents, Adults, and Pregnant Women: Screening

(September 2022) Rating A
The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.

(September 2018) Rating A
The USPSTF recommends early screening for syphilis infection in all pregnant women.

HRSA's Bright Futures Project : recommends for high-risk teens, screen for syphilis at least once a year.

Code	Description
86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
86593	Syphilis test, non-treponemal antibody; quantitative
86780	Antibody; Treponema pallidum

Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons

(January 2021) Rating A

The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)– approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.
The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.
Reimbursement restricted to the following specialties:

- Primary Care Physicians: Family Practice, Internal Medicine, General Practitioners
- Specialists: OB/GYN, Pediatricians Services (included in Preventive E&M codes)

Note: MVP considers Smoking, Tobacco, Vaping/ E-cigarettes included under this recommendation.

Code	Description
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Tobacco Use Interventions: Children and Adolescents

(Aug 2020) Rating B

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	Description
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

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

(November 2018) Rating B

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.

HRSA's Bright Futures Project reccomends substance use should be evaluated as part of an age-appropriate comprehensive history. Reviewing the adolescent's environment can identify risk and protective factors for the development of alcohol or drug abuse.

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
G0442	Annual alcohol misuse screening, 5 to 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Unhealthy Drug Use: Screening

(July 2020) Rating B

The USPSTF Recommends screening by asking questions about unhealthy drug use in adults aged 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)

HRSA's Bright Futures Project recommends that substance use should be evaluated as part of an age-appropriate comprehensive history. Reviewing the adolescent's environment can identify risk and protective factors for the development of alcohol or drug abuse.

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

Vision in Children Ages 6 Months to 5 Years: Screening

(September 2017) Rating B

The USPSTF recommends vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors.

Code	Description
99173	Screening test of visual acuity, quantitative, bilateral

Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions

(September 2018) Rating B

The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as

weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.

WPSI recommend a to counsel midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5–29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity

Code	Description
99385-99387	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;
99395-99397	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;
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
G0447	Face-to-face behavioral counseling for obesity, 15 minutes

Women's Preventive Health-Contraception methods and counseling

- No cost share when billed with appropriate code.
- HRSA Requirement (Jan. 2023): WPSI recommends that adolescent and adult women have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve birth outcomes. Contraceptive care includes screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period). Contraceptive care also includes follow-up care (e.g., management, evaluation and changes, including the removal, continuation, and discontinuation of contraceptives).
- WPSI recommends that the full range of U.S. Food and Drug Administration (FDA)- approved, -granted, or -cleared contraceptives, effective family planning practices, and sterilization procedures be available as part of contraceptive care.
- The full range of contraceptives includes those currently listed in the FDA's Birth Control Guide****: (1) sterilization surgery for women, (2) implantable rods, (3) copper intrauterine devices, (4) intrauterine devices with progestin (all durations and doses), (5) injectable contraceptives, (6) oral contraceptives (combined pill), 7) oral contraceptives (Progestin only), (8) oral contraceptives (extended or continuous use), (9) the contraceptive patch, (10) vaginal contraceptive rings, (11) diaphragms, (12) contraceptive sponges, (13) cervical caps, (14) condoms, (15) spermicides, (16) emergency contraception (levonorgestrel), and (17) emergency contraception (ulipristal acetate), and any additional contraceptives approved, granted, or cleared by the FDA.

Code	Description
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)

Contraceptive Use and Counseling

Code	Billing Instruction	Code Description
11976	Removal Only Implanted Contraceptive Cap	No cost share for contraceptive use and counseling for women when billed with appropriate CPT codes
11980	Subcutaneous hormone pellet implantation (Implantation of estradiol and/or testosterone pellets beneath the skin)	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
11981	Insertion, non-biodegradable drug delivery implant	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
11982	Removal, non-biodegradable drug delivery implant	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
11983	Removal with reinsertion, non-biodegradable drug delivery implant	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
S4993	Contraceptive pills for birth control	No cost share for contraceptive use and counseling for women when billed with appropriate code (left)
57170	Diaphragm or cervical cap fitting with instructions	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
58300	Insertion of intrauterine device (IUD)	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
58301	Removal of intrauterine device (IUD)	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
A4267	Mail Condom (obtained thru Pharmacy with prescription	
S4981	Insertion of levonorgestrel- releasing intrauterine system	No cost share for contraceptive use and counseling for women when billed with appropriate code
S4989	Contraceptive intrauterine device (e.g., progestacert iud), including implants and supplies	No cost share for contraceptive use and counseling for women when billed with appropriate code
S4993	Contraceptive pills for birth control	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4261	Cervical cap for contraceptive use	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4266	Diaphragm for contraceptive use	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4268	Contraceptive supply, condom, female, each	No cost share for contraceptive use and counseling for women when billed with appropriate code
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each	No cost share for contraceptive use and counseling for women when billed with appropriate code
J1050	Injection, medroxyprogesterone acetate, 1 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position

J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7297	Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7298	Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7300	Intrauterine copper contraceptive	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7301	Levonorgestrel releasing intrauterine contraceptive system, 13.5 mg	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7304	Contraceptive supply, hormone containing patch, each	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies	No cost share for contraceptive use and counseling for women when billed with appropriate code
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
00851	Anes, Intraperitoneal Procedures in Lower Abdomen Including Laparoscopy; Tubal Ligation/ Transection.	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code
00840	Anesthesia intraperitoneal lower abd w/laps nos	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
00940	Anesthesia vaginal procedure w/biopsy nos	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position.
00952	Anes hysteroscopy&/hysterosalpingography w/bx	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
81025	Urine pregnancy test, by visual color comparison methods	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
74018	Radiologic exam abdomen 1 view	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
76857	Ultrasound pelvic nonobstetric image DCMTN limited/f/u	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
76830	Ultrasound transvaginal	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
76998	Ultrasonic guidance intraoperative	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position

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

T8331XA, T8331XD, T8331XS, T83.32XA, T83.32XD, T83.32XS , T83.39XA, T8339XD, T8339XS, Z30.011, Z30.012, Z30.013, Z30.014, Z30.015, Z30.016, Z30.017, Z30.018, Z30.019, Z30.02, Z30.09, Z30.2, Z30.40, Z30.41, Z30.42, Z30.430, Z30.431, Z30.432, Z30.433, Z30.44, Z30.45, Z30.46, Z30.49, Z30.8, Z30.9, Z97.5, Z98.51

Women's Preventive Health – Contraceptive Methods and Counseling

Vermont Only
In accordance with 8 V.S.A. § 4099c. Reproductive health equity in health insurance coverage,

no cost share for contraceptive use and counseling for women when billed with the following codes and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position.

Code	Description
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

Women's Preventive Health-Well-woman Preventive Visits

Code	Billing Instruction	Code Description
99202-99215	The 1st prenatal visit is global to the total OB Delivery charges with the entire global OB allowable amount reimbursed on the Global delivery claim. * No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position	• No cost share when billed with appropriate code. • HRSA Requirement (Jan. 2023): WPSI recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure the provision of all recommended preventive services, including preconception and many services necessary for prenatal and interoception care, are obtained. • The primary purpose of these visits should be the delivery and coordination of recommended preventive services as determined by age and risk factors. These services may be completed at a single or as part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors. • Well-women visit also include pre-pregnancy, prenatal, postpartum and interpregnancy visits. • See Policies: Pediatric and Adult Preventive Exams
99401-99404	E&M Codes Preventive medicine counseling and/ or risk factor reduction intervention(s) provided to an individual without specific illness.	
99381-99387	New Patient comprehensive preventive medicine evaluation and management	
99391-99397	• Established Patient comprehensive preventive medicine evaluation and management	
S0610	Annual Gynecological Examination	
S0612	Annual Gynecological Examination	
S0613	Annual breast exam	
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visi	
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	

Pediatric and Adult Preventive Exams

No cost share will be billed for routine preventive exams.

Code	Description
99381-99387	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;
99391-99397	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;
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
S0610	Annual Gynecological Examination, new patient
S0612	Annual Gynecological Examination, established patient
S0613	Annual Gynecological Examination, clinical breast examination without pelvic evaluation

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
90375	Rabies immune globulin (RIg), human, for intramuscular and/or subutaneous use
90376	Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use
90377	Rabies immune globulin, heat-and solvent/detergent-treated (RIg-HT S/D), human, for intramuscular use
90380	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use
90381	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use
90587	Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use
90611	Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous use
90619	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use Ages 16–23 years
90622	Vaccinia (smallpox) virus vaccine, live, lyophilized, 0.3 mL dosage, for percutaneous use
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
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 aged 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
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
90672	Influenza virus vaccine, quadrivalent, live (LAIV4, for intramuscular use
90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90675	Rabies vaccine, for intramuscular use
90676	Rabies vaccine, for intradermal use
90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
90678	Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use
90679	Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use
90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use
90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use.
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL, 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
90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 ml dosage, intramuscular36 use
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
90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
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
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use Ages 6 weeks – 15 months
90750	Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular useShingrix® age 50 years & older, Zostavax® age 60 years & older
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use
90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use
J3530	Nasal vaccine inhalation ACIP recommendati–n - 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

No cost share will be billed for the following codes when reported with an appropriate immunization code (above).

Code	Description
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
90461	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 each additional vaccine or toxoid component administered. (List separately in addition to code for primary procedure)
90471	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 each additional vaccine or toxoid component administered. (List separately in addition to code for primary procedure)
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)
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)

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)
96380	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional
96381	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection
G0008	Administration of influenza virus vaccine
G0009	Administration of pneumococcal vaccine
G0010	Administration of hepatitis B vaccine

COVID-19 Vaccine and Administrative Billing Guidelines

MVP covers approved COVID-19 vaccines at no cost-share to Members in all plans, when administered by a Participating Provider. MVP will reimburse providers for the administration of the COVID-19 vaccine when the guidance below is followed when submitting for reimbursement for administration of the COVID-19 vaccine.

Code	Description	Age Range	Administration Code
Pfizer Vaccine Codes and Age Ranges			
91318	Sever acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	6 months through 4 years	90480
91319	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, preservative free 10mcg/0.2 mL dosage, tris-sucrose formulation, for intramuscular use	5 years through 11 years	90480
91320	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, preservative free 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	12 years and older	90480
Moderna Vaccine Codes and Age Ranges			
91321	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, preservative free, 25 mcg/0.25 mL dosage for intramuscular use	6 months through 11 years	90480
91322	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, preservative free, 50 mcg/0.5 mL dosage for intramuscular use	12 years and older	90480
Novavax Vaccine Code and Age Range			
91304	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5mcg/0.5 mL dosage, for intramuscular use	12 years and older	90480

Administration code 90480 is to be used with all COVID-19 vaccine product codes. As with previous, more granular COVID-19 vaccine administration codes, counseling is included in code 90480 and should not be reported separately.

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 preventive 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 preventive 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 preventive visit when billed with the appropriate CPT code (left).

Women's Preventive 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 Preventive Health – Counseling and screening for human immune-deficiency virus

Code	Description	Business Rule
86701	Antibody; HIV-1	• No cost share when billed with appropriate code. HRSA Requirement (Jan. 2023): WPSI recommends • All adolescent and adult women, ages 15 and older, receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk, and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. • WPSI recommends risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk. A screening test for HIV is recommended for all pregnant persons upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant persons who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission.
86702	Antibody; HIV-2	
86703	Antibody; HIV-1 and HIV-2, single result	
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot	
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening	
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV2, screening	
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening	
G0475	HIV antigen/antibody, combination assay, screening	
S3645	HIV-1 antibody testing of oral mucosal transudate	

Women's Preventive Health – Obesity Prevention in Midlife Women

Code	Description	Business Rule
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	• No cost share when billed with appropriate code. • HRSA Requirement (Jan. 2023): WPSI recommends counseling midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.529.9 kg/m2) • to maintain weight or limit • Bill with appropriate BMI code: • Z68.1 = BMI 19.9 or less Z68.2 = BMI 20 – 29
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes	
99401 – 99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness	
99385 – 99387	New Patient comprehensive preventive medicine evaluation and management	
993–5 -	Established Patient comprehensive preventive medicine	

99397	evaluation and management	

Women's Preventive Health – Sterilization Surgery

Code	Description	Business Rule
58565	Hysteroscopy, surgical	No cost share for contraceptive use and counseling for women when billed with appropriate CPT codes
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58661	Removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	No cost share for female sterilization surgery when billed with the appropriate CPT codes (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	No cost share for contraceptive use and counseling for women when billed with appropriate CPT codes
58555	Hysteroscopy diagnostic separate procedure	No cost share for female sterilization surgery when billed with the appropriate CPT codes (left) and appropriate contraceptive related ICD10 diagnosis code set billed in the principal diagnosis position
58562	Hysteroscopy removal impacted foreign body	No cost share for female sterilization surgery when billed with the appropriate CPT codes (left) and appropriate contraceptive related ICD10 diagnosis code set billed in the principal diagnosis position
58340	Saline or contrast material / cath & saline/contrast sonohyster/hysterosalpi	No cost share for female sterilization surgery when billed with the appropriate CPT codes (left) and appropriate contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
74740	Hysterosalpingography	No cost share for female sterilization surgery when billed with the appropriate cpt codes (left) and appropriate contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position
88302	Level II Surgical Pathology Gross & Microscope Exam	No cost share for contraceptive use and counseling for women when billed with appropriate CPT code (left) and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position

Women's Preventive Health – Screening for Gestational Diabetes Mellitus

Code	Description	Business Rule
82947	Glucose; quantitative, blood (except reagent strip).	• No cost share for women when billed with appropriate Pregnancy related ICD-10 Diagnosis code. • HRSA Requirement (Dec. 2016): Recommends screening pregnant persons for gestational diabetes mellitus after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) in order to
82950	Glucose; post-glucose dose	
82951	Glucose: tolerance test (GTT),3 specimens (includes glucose)	

82952	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)	prevent adverse birth outcomes. Screening with a 50-g oral glucose challenge test (followed by a 3-hour 100-g oral glucose tolerance test if results on the initial oral glucose challenge test are abnormal) is preferred because of its high sensitivity and specificity. This recommendation also suggests that women with risk factors for diabetes mellitus be screened for preexisting diabetes before 24 weeks of gestation—ideally at the first prenatal visit, based on current clinical best practices. • Also see Pre-Diabetes Screening and Gestational Diabetes Screening in the Preventive Healthcare Payment Policy.
82948	Glucose; blood, reagent strip	
83036	Hemoglobin; glycosylated (A1c)	

Women's Preventive Health – Screening Diabetes Mellitus after Pregnancy

Code	Description	Business Rule
82947	Glucose; quantitative, blood (except reagent strip).	• No cost share for women when billed with a Pregnancy diagnosis Z86.32 (personal history of gestational diabetes) or Z39.2 (routine postpartum) • HRSA Requirement (Dec. 2017): The Women's Preventive Services Initiative recommends women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus should be screened for diabetes mellitus. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum. • Women with a negative initial postpartum screening test result should be rescreened at least every 3 years for a minimum of 10 years after pregnancy • Also see Pre-Diabetes Screening and Gestational Diabetes Screening in the Preventive Healthcare Payment Policy.
82950	Glucose; post-glucose dose	
(includes glucose)	Glucose: tolerance test (GTT),3 specimens (includes glucose)	
82951	Glucose; tolerance test (GTT),3 specimens (includes glucose)	
82952	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)	
82948	Glucose; blood, reagent strip	
83036	Hemoglobin; glycosylated (A1c)	

Women's Preventive Health – Screening for Urinary Incontinence

Business Rule:

No cost share for screening women for urinary incontinence annually.

99385-99387	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;
99395-99397	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;
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)

Men's Preventive Health—Contraception Consultation and Voluntary Sterilization

(Vermont Only)

In accordance with 8 V.S.A. § 4099c. Reproductive health equity in health insurance coverage, a health insurance plan shall provide coverage for voluntary sterilization procedures for men and women without any deductible, coinsurance, co-payment, or other cost-sharing requirement, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223. This includes consultation services associated with providing the procedures covered under this section.

For Non-HDHP Plans, no cost share will be billed for male counseling when billed with the following codes and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position.

For Qualified HDHP Plans,no cost share will be applied after deductible for male counseling when billed with the following codes and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position.

Code	Description
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

Men's Preventive Health—Elective Sterilization Vasectomy Surgery

(Vermont Only)

8 V.S.A. § 4099c. Reproductive Health Equity in Health Insurance Coverage

A health insurance plan shall provide coverage for voluntary sterilization procedures for men and women without any deductible, coinsurance, co-payment, or other cost-sharing requirement, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. sec 223.

For non-HDHP Plans, no cost share will be billed for male sterilization surgery when billed with the following codes.
For Qualified HDHP Plans, no cost share will be applied after deductible for male sterilization surgery when billed with the following codes.

Code	Description
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral
55250	Vasectomy, unilateral or bilateral (separate procedure) including postoperative semen examinations(s)
88302	Level IV - Surgical pathology, gross and microscopic examination

Men's Preventive Health— Post-Surgical Lab work

For Non-HDHP Plans, no cost share will be billed for lab work when billed with the following codes and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position.
For Qualified HDHP Plans, no cost share will be applied after deductible for lab work when billed with the following codes and appropriate Contraceptive related ICD-10 diagnosis code set billed in the principal diagnosis position.

Code	Description
89320	Semen analysis; volume, count, motility, and differential
89321	Semen analysis; sperm presence and motility of sperm, if performed.

Medicaid Product Variation

Medicaid and HARP Long-Acting Reversible Contraception (LARC) Provided as an Inpatient Post-Partum Service Long-Acting Reversible Contraception (LARC) is covered for Medicaid and HARP products only when provided to women during their postpartum inpatient hospital stay.

Code	Description	Business Rule
J7300	Intrauterine copper contraceptive	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code.
J7301	Levonorgestrel releasing intrauterine contraceptive system, 13.5 mg	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code.
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code.
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code.

J7297	Levonorgestrel releasing intrauterine contraceptive system, 52 mg, 3-year duration	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code.
J7307	Levonorgestrel releasing intrauterine contraceptive system,52 mg, 5 year duration	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code.

Modifier PT and Modifier 33

Modifier PT

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

Modifier 33

*Each preventive care service will identify the specific billing rules as to when to apply Modifier 33 or when Modifier is not needed to be billed.

Code	Description	Business Rule
Preventive Services	When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.	The Member's co-pay/co-insurance/cost share for this service will be waived as appropriate.

Code Sets

Pregnancy-related ICD-10 diagnosis code set billed in the principal diagnosis position:
A34, O00-O9A, , Z03.71, Z03.72, Z03.73, Z03.74, Z03.75, Z03.79, Z33.1, Z33.3, Z34.00, Z34.01, Z34.02, A34.03, 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

History

June 1, 2019	New Policy approved
October 1, 2019	Policy reviewed and approved with changes
January 1, 2020	Policy reviewed and approved with changes
March 1, 2020	Policy reviewed and approved with changes

June 1, 2020	Policy reviewed and approved with changes
September 1, 2020	Policy reviewed and approved with changes
December 1, 2020	Policy reviewed and approved with changes
March 1, 2021	Policy reviewed and approved with changes
September 1, 2021	Policy reviewed and approved with changes
December 1, 2021	Policy reviewed and approved with changes
March 1, 2022	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with changes
December 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with changes
June 1, 2023	Policy reviewed and approved with changes
September 1, 2023	Policy reviewed and approved with changes
December 1, 2023	Policy reviewed and approved with changes
March 1, 2024	Policy reviewed and approved with no changes
July 1, 2024	Policy reviewed and approved with changes
May 1, 2025	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Radiology

Last Reviewed Date: February 1, 2025

Policy

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

MVP requires an overread by a Radiologist or a Specialist Physician within the scope of their specialty when diagnostic images are performed and read by a Primary Care Physicians, Physician Assistants and Nurse Practitioners. Physician specialists are required to have the image overread by a Radiologist if the imaging is outside the scope of their practice.

Prior Authorization Requests

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

Billing/Coding Guidelines

Diagnostic Radiology Reading

MVP reimburses for only one reading of a diagnostic radiology test. Duplicate readings are not eligible for reimbursement.

Diagnostic Radiology Prior Authorization

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

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

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

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

Tuesday, December 10, 2024 4:01 PM

Authorization Lookup

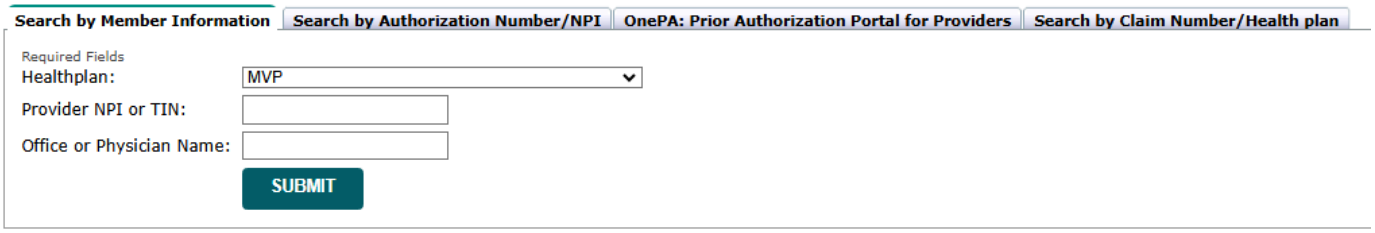
Search by Member Information | Search by Authorization Number/NPI | OnePA: Prior Authorization Portal for Providers | Search by Claim Number/Health plan

Required Fields
Healthplan:

PRINT

Click here for help

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.

Tuesday, December 10, 2024 4:01 PM

Authorization Lookup

Search by Member Information | Search by Authorization Number/NPI | OnePA: Prior Authorization Portal for Providers | Search by Claim Number/Health plan

Required Fields
Healthplan: MVP
Provider NPI or TIN: 1111111111
Office or Physician Name: test
Patient ID:
Patient Date of Birth:
MM/DD/YYYY

Optional Fields
Case Number:
or
Authorization Number:
or
Plan Of Care:

PRINT SEARCH

Click here for help

Results will be returned for all authorization requests and approvals will be displayed for the Member. The Authorization number, the status (pended, approved, or denied), the approval date, the expiration date of the authorization and the authorized procedures will be displayed. If records are not returned the Member does not have an authorization for the service.

History

September 1, 2018	New policy, approved
September 1, 2020	Policy reviewed and approved with no changes
December 1, 2021	Policy reviewed and approved with no changes
March 1, 2022	Policy reviewed and approved with changes
March 1, 2023	Policy reviewed and approved with no changes
February 1, 2025	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Radiopharmaceuticals

Last Reviewed Date: September 1, 2024

Policy

Radiopharmaceuticals commonly used in nuclear medicine and molecular imaging will be reimbursed in accordance with ( ) billing guidelines. Billing and coding guidelines vary based on product lines, and certain radiopharmaceutical codes for product lines will require an invoice as supporting documentation.

Notification/Prior Authorization Requests

MVP Payment policies 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

For Commercial, Exchange, and Medicaid Claims. Codes will be paid up to $100 without an invoice

A9541	Technetium tc-99m sulfur colloid, diagnostic, per study dose, up to 20 millicuries
A9560	Technetium tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries
A9576	Injection, gadoteridol, (prohance multipack), per ml
The following Radiopharmaceutical codes will be paid up to $160 without an invoice	
A9500	Technetium te-99m sestamibi, diagnostic, per study dose
A9576	Injection, gadoteridol, (prohance multipack), per ml
The following Radiopharmaceutical codes will be paid up to $160 without an invoice	
A9500	Technetium te-99m sestamibi, diagnostic, per study dose
A9502	Technetium tc-99m tetrofosmin, diagnostic, per study dose
A9505	Thallium tl-201 thallous chloride, diagnostic, per millicurie
A9538	Technetium tc-99m pyrophosphate, diagnostic, per study dose, up to 25 millicuries
The following Radiopharmaceutical codes will be paid up to $250 without an invoice	
A9562	Technetium tc-99m mertiatide, diagnostic, per study dose, up to 15 millicuries
A9555	Rubidium Rb-82, diagnostic, per study dose, up to 60 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

An invoice is required regardless of the billed charge amount. Without an invoice, services will be reimbursed at the Medicare Fee Schedule or at a reasonable and customary rate as set by MVP.

History

December 1, 2020	Policy reviewed and approved with changes
September 1, 2022	Policy reviewed and approved with no changes
December 1, 2023	Policy reviewed and approved with changes
September 1, 2024	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Robotic and Computer Assisted Surgery

Last Reviewed Date: September 1, 2024

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. Image-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.

Computer assisted stereotactic technology for cranial procedures, also known as neuronavigation, combines preoperative imaging with navigational computer software to localize surgical targets. The goal of neuronavigation is to facilitate presurgical planning and to provide intraoperative guidance to the surgeon.

Notification/Prior Authorization Requests

MVP Payment Policies 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**.

CPT Codes	Guidelines
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less
S2900	Surgical techniques requiring use of robotic surgical system
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image guided navigation
61781	Stereotactic computer-assisted (navigational) procedure; cranial, intradural
61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural
61783	Stereotactic computer-assisted (navigational) procedure; spinal

Reimbursement Guidelines

MVP provides coverage for surgical procedures that are medically necessary and meet the criteria in MVP Medical Policies. The use of specific surgical techniques, instrumentation, and surgical approaches is left to the discretion of the surgeon. MVP does not provide additional professional or technical reimbursement and it will not be made to hospitals, surgery centers or facilities for use of robotic, or computer assisted instrumentation utilizing CPT codes 0054T, 0055T, 20985, 31627, 61781, 61782, 61783 and S2900 because payment is included in the reimbursement for the primary procedure. CPT-4 or HCPC Level II Codes indicating robotic surgical system(s) or computer-assisted navigation will be denied as inclusive or global as they are not eligible for separate payment. This policy applies to both professional and facility providers.

Use of Modifier 22 (increased procedural services) appended to the primary surgical procedure is not appropriate if used exclusively for the purpose of reporting the use of robotic assistance. Modifier 22 may only be used when substantial additional work is performed, (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, and physical and mental effort required) that is unrelated to robotic assistance.

References

1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.
2. Burnett RS, Barrack RL. Computer-assisted total knee arthroplasty is currently of no proven clinical benefit: a systematic review. Clin Orthop Relat Res. 2013 Jan;471(1):264-76
3. Hoppe S, Mainzer JD, Frauchiger L et al. More accurate component alignment in navigated total knee arthroplasty has no clinical benefit at 5-year follow-up. Acta Orthop 2012; 83(6):629-33.
4. Beyer F, Pape A, Lutzner C, et al. Similar outcomes in computer-assisted and conventional total knee arthroplasty: ten-year results of a prospective randomized study. BMC Musculoskelet Disord. Aug 18 2021; 22(1): 707
5. 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
6. 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
7. 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
8. Computer-navigated versus conventional total knee arthroplasty a prospective randomized trial. J Bone Joint Surg Am. Kim YH, Park JW, Kim JS. November 2012
9. Robotic surgery. A current perspective. Annals of Surgery. Lanfranco, AR, Castellanos, AE, Desai, JP, Meyers, WC. January 2004
10. 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
11. 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
12. Advantages and limits of robot-assisted laparoscopic surgery: preliminary experience. Surg Endosc. Corcione F, Esposito C, Cuccurullo D, et al. January 2005

History

June 1, 2021 Policy approved

September 1, 2022	Policy reviewed and approved with changes
September 1, 2023	Policy reviewed and approved with changes.
September 1, 2024	Annual review of policy. No changes to policy.

MVP Health Care Payment Policy

Services Not Separately Reimbursed

Last Reviewed Date: May 1, 2025

Policy

MVP does not reimburse separately for the services that fall under the categories listed below; these services are inclusive of other payments made by MVP. The services addressed in this policy apply to MVP's commercial products and Medicaid Managed Care (MMC) plans. The services in this policy would be paid in accordance with original Medicare claims processing guidelines for MVP's Medicare Advantage products.

Notification/Prior Authorization Requests

MVP Payment policies 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**.

Reimbursement Guidelines

Services and CPT codes that are considered inclusive of other payments and are not separately reimbursed include but are not limited to:

Category	CPT Codes
Care Management Services (including care planning, care plan oversight, assessment, care management home visits, and medication therapy management) **Note:** Facilities that have been identified by MVP as a Health Home will be reimbursed separately for these services as outlined by New York State Guidelines.	99366, 99367, 99368, G0076, G0077, G0078, G0079, G0080, G0081, G0082, G0083, G0084, G0085, G0086, G0087, G0088, G0089, G0090, G0323, G2215, G2216, 99379, 99380, S0315, S0316, S0317, S0320, S0280, S0281, 99605, 99606, 99607, G0506, G9001, G9005, G9038, G9037, T2022, T2023
Chronic Care Management **Note:** Chronic Care Management will be reimbursed separately for Medicare plans.	99424, 99425, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, G3002, G3003
Bundled Payments for Care Improvement Advanced	G9978, G9979, G9980, G9981, G9982, G9983, G9984, G9985, G9986, G9987
Results/Data Collection & Review	93793, G0452, 0019M
Informational Codes	0001F – 9999F, G0519-G0531, G2173 – G2210, G9888. M0001 – M0005, M0010, M1146 – M1370
Review of Medical Records	99358, 99359, S9981, S9982

Miscellaneous Special Services, Procedures, and Reports	C1747, P9603, P9604, H0048, S3600, S3601, 99000, 99001, 99002, 99024, 99070, 99080, S8415, 99091, 98961, 98962, S2900, Q0511, Q0512, Q0513, S5000, S5001
On Call & Standby Service	99026, 99027, 99360
Miscellaneous Laboratory Services, Procedures, and Supplies	0751T – 0856T
Evaluation and Management	Principle Illness Navigation G0023, G0024, G0140, G0146 Visit Complexity G2211 Community Health Integration G0019, G0022, G0136 Pelvic examination 99459
Digitization of glass microscope slides	0827T, 0828T, 0829T, 0830T, 0831T, 0832T, 0833T, 0834T, 0835T, 0836T, 0837T, 0838T, 0839T, 0840T, 0841T, 0842T, 0843T, 0844T, 0845T, 0846T, 0847T, 0848T, 0849T, 0850T, 0851T, 0852T, 0853T, 0854T, 0855T, 0856T
Surgical	G0561

History

September 1, 2019 New Policy, approved
June 1, 2020 Policy reviewed and approved with no changes
June 1, 2021 Policy reviewed and approved with changes
December 1, 2022 Policy reviewed and approved with changes
December 1, 2023 Policy reviewed and approved with changes
June 1, 2024 Policy reviewed and approved with changes
May 1, 2025 Policy reviewed and approved with changes

MVP Health Care Payment Policy

Speech Therapy (ST)

Last Reviewed Date: February 1, 2025

Policy

Speech Therapy (ST) 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 policies 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

The following CPT codes are covered for Speech Therapy providers:

CPT Code	CPT Code
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92609	Therapeutic services for the use of speech-generating device, including programming and modification
92610	Evaluation of oral and pharyngeal swallowing function
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording
92612	Flexible endoscopic evaluation of swallowing by cine or video recording;
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes
92630	Auditory rehabilitation; prelingual hearing loss
92633	Auditory rehabilitation; post lingual hearing loss
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
S9128	Speech therapy, in the home, per diem
S9152	Speech therapy, re-evaluation
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)

For reimbursement of DME supplies, please see the Utilization Management in the MVP Provider and Payment Policies 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)
- Speech therapy in a group setting (92508) is only covered for Medicare Advantage Plans.
- 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
- Laryngoscopy, flexible or rigid telescopic, with stroboscopy (CPT 31579) is a diagnostic procedure to be performed by a physician. It may not be performed by a speech-language pathologist
- Sensory Integration Therapy (CPT 97533) is excluded from coverage. See the Speech Therapy (Outpatient) and Cognitive Rehabilitation Medical Policy for details.

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

About CMS | CMS

History

March 1, 2019 Policy approved
March 1, 2021 Policy reviewed and approved with no changes
June 1, 2022 Policy reviewed and approved with changes
June 1, 2023 – Policy reviewed and approved with changes
March 1, 2024 – Policy reviewed and approved with changes
February 1, 2025 – Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Surgical Supplies

Last Reviewed Date: September 1, 2024

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) Relative Value Unit (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)
- Staffing 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 Policies 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

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 • Lacrrimal duct implants are considered part of the practice expense RVU for E&M and procedure codes

References

CMS Regulations and Guidance:
r11287cp.pdf (cms.gov)

History

September 1, 2019	Policy approved
June 1, 2020	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes
September 1, 2023	Policy reviewed and approved with no changes
September 1, 2024	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Telehealth

Last Reviewed Date: May 1, 2025

Related Policies:
Modifier Payment Policy
Provider Responsibilities

Policy

MVP reimburses Virtual Check-ins, Interprofessional Telephone/Internet/Electronic Health Record Consultations (eConsults), and Telehealth Services when used appropriately to increase efficiencies in delivering patient care. Telehealth Services, which are live audio-only or audio-visual services provided through electronic information and communication devices to patients at a site (originating site) that is not the same as the Provider (distant site), may also be accessible through MyVisitNow® or Gia Urgent Care. This policy serves as a guide to assist providers in accurate telehealth claims submissions for Medicare, Medicaid, Health and Recovery Plan ("HARP"), Essential Health Plans, Child Health Plus and Commercial plans, and is not meant to be an exhaustive list for every payment scenario. Guidance from federal and state authorities may be updated from time to time, and the reference links within this policy are provided to assist providers in accessing currently available guidance. Definitions related to Telehealth can be found in the applicable statute, regulation and/or guidance.

Notification/Prior Authorization Requests

MVP Payment Policies 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.

Billable Codes and Descriptions

Professionals

The following Place of Service Codes should be used when billing for Telehealth Services on Professional Claims:

Place of Service Code	Description
02	Telehealth is delivered in a setting other than the home of the patient.
10	The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology

Modifiers

The following Modifiers should be used when billing for Telehealth Services to the extent applicable:

Modifier	Description
95	Denotes a telehealth system that provides two-way, real time audiovisual conferencing between a patient and the provider, in which the provider at a distant site provides healthcare services including an examination for a patient at a different location. The patient must be an active participant in the telehealth visit.

93	Synchronous Telehealth services rendered via telephone or other real-time interactive audio-only telecommunications systems (i.e., audio-only). NOTE: Modifier 93 is to be used for all audio-only services, including mental health services furnished via audio-only. For Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and Opioid Treatment Programs (OTPs), modifier 93 must be used, but modifier FQ should be used as well when services are furnished in such settings.
FQ	Telehealth service was furnished using real-time audio-only communication technology. For RHCs, FQHCs and OTPs, this modifier must be used in conjunction with modifier 93.
FR	A supervising practitioner was present through a real-time two-way, audio/video communication technology.
GQ	Telehealth services are delivered via asynchronous telecommunication system (store and forward technology).
GT	Telehealth services are delivered via interactive audio and video telecommunication systems.
25	Significant, separately identifiable Evaluation and Management (E&M) service by the same physician or other qualified health care professional on the same day as a procedure or other services. For example, the Member has a psychiatric consultation via telemedicine on the same day as a primary care E&M visit at the originating site. The E&M service should be appended with the 25 modifier.
HD	Used with maternal remote patient monitoring; denotes pregnant/postpartum services.
U1	Used in conjunction with other modifiers for enhanced reimbursement for certain services. Only to be used with codes 99451 and 99452

Medicare, Essential Health Plans, and Commercial Plans

MVP will reimburse for covered Telehealth Services and in compliance with the CMS List of Telehealth Services for each calendar year, including audio-only services. However, audio-video services are highly encouraged over audio-only services for quality of care. MVP also encourages the Provider to notate the reason for the services to be audio-only and any Member preference for providing audio-only services.

Medicaid, HARP, and Child Health Plus

MVP will reimburse Telehealth Services for Medicaid, HARP and Child Health Plus Members in accordance with guidance provided by NY Department of Health, Office of Mental Health (OMH), Office for People With Developmental Disabilities (OPWDD), and Office of Addiction Services and Supports (OASAS). Telehealth Services include audio-visual services, store and forward technology, remote patient monitoring, after-hours services, virtual check-ins, virtual patient education, and in for certain Providers, virtual eTriage. Telehealth Services provided through audio-only should only be used in rare occasions to meet the personalized needs of each Member and in compliance with the most current guidelines developed by the NY Department of Health, which can be found on their website.

For Medicaid products, licensed physicians or Nurse Practitioners may bill for Telehealth Services provided in an Article 28 Facility setting; however, the Ambulatory Patient Group (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.

Allowable Telehealth Platforms

Authorized Providers who deliver Telehealth Services must use non-public facing communication technologies and/or platforms that comply with the HIPAA rules.

Remote Patient Monitoring

Remote Patient Monitoring (RPM) may be utilized as Telehealth Services when medically necessary to monitor Members with certain health conditions and must be discontinued when their condition is determined to have stabilized. RPM must be ordered by a New York licensed physician, nurse practitioner or midwife who has examined the Member and with whom the Member has an established, documented, and ongoing relationship. Member health information or data may be received at the Distant Site by a New York licensed registered nurse. While ordering RPM, the Provider must see the Member in-person, as needed, for follow-up care.

Certified Home Health Agencies ("CHHA") are ineligible to provide RPM Telehealth Services to a Member if they are receiving home health care services through the CHHA.

OMH Specific Requirements

Providers licensed by the Office of Mental Health (OMH) or listed as a designated Provider, must follow current OMH guidelines for Telehealth Services, including but not limited to obtaining approval to use telehealth. Additional criteria and information specific to OMH Providers are listed in the OMH guidelines referenced above.

Billing for services by an OMH licensed or designated provider follows the NY Department of Health Guidelines and the billing instructions listed above for Medicaid, HARP and Child Health Plus.

EConsults

eConsults are only permitted between a treating/requesting provider and a consultative provider, limited to physicians, psychiatrists, physician assistants, nurse practitioners, and midwives, for answering patient-specific treatment questions based on clinical information provided during the consultation or the Member's electronic health record, without the need for an in-person visit. These consultations cannot be used to arrange referrals for in-person visits. Providers must obtain verbal consent from the Member before providing virtual services, which must be documented in the Member's chart, and inform Members that these services will be subject to applicable Deductibles, Co-insurance, or Copays according to the Member's benefits. Additionally, the virtual check-in or eConsult must be medically necessary and the medical record must include information from the treating/requesting provider about i) the written or verbal consent made by the Member for the eConsult; ii) the request made by the treating/requesting provider; and iii) the recommendation and rationale from the consultative provider.
Effective June 1, 2025, a modifier combination of U1, U1 must be appended to the claim line to receive the enhanced rate.

Additional Billable Codes and Descriptions

In addition to the CMS allowable Place of Service Codes and Modifiers above, the NY Department of Health separately provides the following Billable Codes and Descriptions applicable to Medicaid, HARP, and Child Health Plus programs.

Services	Codes	Description	Notes
Tele-dentistry	D9995	Synchronous tele-dentistry services using audio-visual technology; can include urgent visits, follow-up visits, and new patient screening	Modifier cannot be used.
Tele-dentistry	D9996	Asynchronous transmission of recorded health information (store and forward technology)	Modifier cannot be used.
Telehealth Facility (including Tele-dentistry)	Q3014	Originating Site Facility Fee	For facilities only; Only facilities should use this code and the Member must be physically present in the originating facility to receive reimbursement.
Remote Patient Monitoring	99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring)	Can only be billed one time per Member per month.
E Consults – Consultative Provider	99451	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care	Documentation and Records standards by treating/requesting provider must be in accordance with current NYS DOH guidelines. Consultation does not lead to a transfer of care or other face-to-face services within the next 14-

		professional, 5 minutes or more of medical consultative time.	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). For Medicaid products, beginning on Effective March 1, 2025, Hospital Outpatient Departments (OPDs), freestanding Diagnostic and Treatment Centers (D&TCs), and Federally Qualified Health Centers (FQHCs) that have opted into the Ambulatory Patient Group (APG) reimbursement methodology will be eligible for reimbursement for eConsult services by utilizing the CPT codes 99451 and 99452 through the APG fee schedule in an outpatient clinic setting. Effective June 1, 2025, a new modifier combination of U1, U1 must be appended to the claim line to receive the enhanced rate. •Only one consult can be billed within a 7-day period by the consulting physician
E Consults – Treating/Requesting Provider	99452	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.	Documentation and Records standards by treating/requesting provider must be in accordance with NYS DOH guidelines. 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 • For Medicaid products, beginning on Effective March 1, 2025, Hospital Outpatient Departments (OPDs),

			freestanding Diagnostic and Treatment Centers (D&TCs), and Federally Qualified Health Centers (FQHCs) that have opted into the Ambulatory Patient Group (APG) reimbursement methodology will be eligible for reimbursement for eConsult services by utilizing the CPT codes 99451 and 99452 through the APG fee schedule in an outpatient clinic setting. • Effective June 1, 2025, Aa new modifier combination of U1, U1 must be appended to the claim line to receive the enhanced rate.
Telephone/Internet/Electronic Health Record Consultation:	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 health care professional. 5-10 minutes of medical consultative discussion and review.	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
Telephone/Internet/Electronic Health Record Consultation:	99447	Same as CPT Code 99446, except 11-20 minutes	
Telephone/Internet/Electronic Health Record Consultation:	99448	Same as CPT Code 99446, except 21–30 minutes	
Telephone/Internet/Electronic Health Record Consultation:	99449	Same as CPT Code 99446, except 31 or more minutes	
Remote Patient Monitoring (Pregnancy/Post-partum)	99453 + HD modifier	Remote monitoring of physiologic parameters (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) initial; set-up and patient education on use of equipment.	One-time billing of service.
Remote Patient Monitoring (Pregnancy/Post-partum)	99454+HD	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. Every 30 days when a minimum of 16 days of data is collected within the 30-day period.	This is a once per 30-day fee regardless of the number of devices used to monitor the pregnant/post-partum individual. NOTE: 99454 and 99091 cannot be billed on the same day. FQHCs that have opted out of APGs are unable to bill for RPM services

After-Hours	99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.	Bill with modifiers 93, 95, GT or FQ as appropriate. Please review the MVP After-Hours Payment Policy for additional information on this service.
After-Hours	99051		Bill with modifiers 93, 95, GT or FQ as appropriate. Please review the MVP After-Hours Payment Policy for additional information on this service.
Virtual Patient Education	0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day	Bill with modifiers 95 and GT as appropriate
Virtual Patient Education	0488T	Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days.	Coaches must be able to track participant progress through online modules. To bill, the patient must complete a minimum of three sessions per month and adhere to the CDC guidelines regarding coaching support (no less than once per week first six months and no less than once per month next six months); No applicable modifiers
Virtual Patient Education	D1320	Tobacco counseling for the control and prevention of oral disease. Billable only as an individual session, greater than 3 minutes.	Bill with modifiers 95 and GT as appropriate
Virtual Emergency eTriage	Base rate procedure code + A0425 (milage code) + modifier	This permits ambulance companies responding to 911 calls to provide treatment in place or transport patients to destinations other than the emergency room. Providers must be approved to participate in both the CMS ET3 model AND the NYS DOH parallel model in order to bill for this service.	Use the following destination modifier as appropriate: C – Community Mental Health Ctr (including substance use disorder Ctr) F – FQHC O – Physician's office U – Urgent care W – Treatment in place by a licensed healthcare practitioner either in person or via telehealth (no mileage permitted with this modifier)
All Other Services, including audio-only and additional patient education codes		See *List of Telehealth Services | CMS*	

Telehealth CPT Codes – Covered for all Lines of Business

Place of Service Code	Description
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.
G0544	Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month

G0545	Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious diseases specialist, including disease transmission risk assessment and mitigation, public health investigation, analysis, testing, and complex antimicrobial therapy counseling and treatment (add-on code, list separately in addition to hospital inpatient or observation evaluation and management visit, initial, same day discharge, subsequent, or discharge)
G0546	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review
G0547	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11-20 minutes of medical consultative discussion and review
G0548	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21-30 minutes of medical consultative discussion and review
G0549	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review
G0550	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time
G0551	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes

Virtual Check-in (eConsult) Codes:

Code	Description	Reimbursement
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management [E/M] services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	• This code can only be used with established patients of the Provider. Members must have seen the Provider in person within 3-years of the Virtual Check-in by the billing Provider or by a Provider within the Provider's group who has the same specialty, and for Providers eligible to bill for an Evaluation and Management (E/M) services • Patients must not have been seen in the office for 7 days prior to the virtual check in or within 24hours of the virtual check in • This code can only be used with established patients of the Provider. Members must have seen the Provider in person within 3 years of the Virtual Check-in by the billing Provider or by a Provider within the Provider's group who has the same specialty, and for Providers eligible to bill for an Evaluation and Management (E/M) services • Patients must not have been seen in the office for 7 days prior to the virtual check in or within 24 hours of the virtual check in.
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.	

G2252	Brief communication technology-based service by a physician or other qualified health care professional who can report E&M services, not originating from a related E&M service provided within the previous seven days nor leading to a E&M service or procedure within the next 24 hours or soonest available appointment; *11 to 20 minutes of medical discussion.*	Bill with modifiers 93, 95, FQ, GT and GQ as appropriate

Additional information

- Tele-dentistry: New York State Medicaid Update February 2019 Special Edition Volume 35 Number 2 (ny.gov); New York State Medicaid Update January 2020 Volume 36 Number 1 (ny.gov)
- Maternal Remote Patient Monitoring: New York State Medicaid Update September 2022 Volume 38 Number 10 (ny.gov)
- Emergency Virtual eTriage: New York State Medicaid Update November 2021 Volume 37 Number 13 (ny.gov)
- More information on physician fee schedules can be found at the following CMS sites:
- Physician Fee Schedule | CMS
- Medicare payment policies during COVID-19 | Telehealth.HHS.gov
- List of Telehealth Services | CMS

Exclusions

The following services are excluded from services:

- eConsults, which are interprofessional consultations between a treating/requesting Provider with a consulting Provider, without a member present, are currently not reimbursable for CHP plans.
- The acquisition, installation and maintenance of telecommunication devices or systems is not reimbursable
- Electronic mail messages, text messages or facsimiles are not reimbursable telehealth services
- Telehealth services during which all or part of the service was undeliverable due to a failure of transmission or other technical difficulty
- Services where the originating site and the distant site are the same location
- Facility fees when neither the originating site or the distant site is a clinic or facility
- Individual Practitioner Services for Individuals with Developmental Disabilities (IPSIDD)

References

Physician Fee Schedule | CMS
Medicare payment policies during COVID-19 | Telehealth.HHS.gov
List of Telehealth Services | CMS
New York State Medicaid Update - February 2023 Volume 39 - Number 2 (ny.gov)
Telehealth Services Guidance for OMH Providers - April 2023 (ny.gov)
Federal Register :: Second Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications
Vermont Telemedicine Requirements
New York State Medicaid Update – January 2024 Volume 40- Number 1

42 USC §1395m(m)
42 CFR §410.78

42 CFR §422.135
New York Insurance Law §§ 3217-h, 4306-g;
New York Public Health Law §§ 2999-cc; 2999-dd;
14 N.Y.C.R.R. Parts 538 (Medicaid reimbursement); 596 (OMH); Parts 679, 635 (OPWDD); Part 830 (OASAS); and 585.28 (CDPAS)

History

September 1, 2018	New Policy, approved
December 1, 2019	Reviewed, approved with changes
July 1, 2022	Reviewed, approved with changes
September 1, 2022	Reviewed, approved with changes
May 11, 2023	Reviewed, approved with changes
March 11, 2024	Reviewed, approved with changes
September 1, 2024	Reviewed, approved with changes
February 1, 2025	Reviewed and approved with changes
May 1, 2025	Reviewed and approved with changes

MVP Health Care Payment Policy

Transitional Care and Management

Medicare Advantage Plan Only

Last Reviewed Date: February 1, 2025

Policy

Transitional Care Management (TCM) services are for a patient whose medical and/or psychosocial problems require moderate- or high-complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital, inpatient psychiatric hospital), partial hospital, observation status in a hospital, or skilled nursing facility (SNF)/nursing facility to the patient's community setting (e.g., home, domiciliary, nursing facility or assisted living facility). TCM services begin on the date of patient discharge and continues for the next 29 days.
TCM services are reimbursable only for the MVP Medicare Advantage products. All other products do not include TCM services as a Covered Benefit.

Definitions

TCM services includes one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction. Members may receive the following TCM services via telehealth as per Medicare guidelines.

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

99495	Transitional Care Management Services (Moderate Complexity): • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two (2) business days post-discharge. • Medical decision making of at least moderate complexity during the service period. • Face-to-face visit, within 14 calendar days post-discharge.
99496	Transitional Care Management Services (High Complexity): • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two (2) business days post-discharge. • Medical decision making of high complexity during the service period. • Face-to-face visit, within 7 calendar days post-discharge.

Notification/Prior Authorization Requests

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

Billing/Coding Guidelines

TCM services are only reimbursable only for a MVP Medicare Advantage products.
The CPT TCM codes can be billed only once per patient within 30 days after the original patient discharge for which a TCM code has been billed. These services may be billed by only one individual during the 30-day period after discharge.
The physician billing for TCM services should have an ongoing relationship with the patient and the intended use of these codes is for community-based primary care physicians. It is unlikely that most hospitalists will have the post-discharge relationship with a patient necessary to fulfill the required services.
Non-physicians who may bill TCM codes are Nurse Practitioner's (NP), Physician Assistant's (PA), Clinical Nurse Specialist's (CNS), and Certified Nurse Midwives (CNM), unless they are otherwise limited by their scope of practice as defined by the state in which they are licensed and/or certified.
There is a distinction between the discharge day management and TCM services. MVP seeks to avoid any implication that the E & M services furnished on the day of discharge as part of discharge management services could be considered to meet the requirement for TCM services that must be conducted within seven (7) or 14 calendar days of discharge.
The physician billing discharge day management could also be the physician who is regularly responsible for the patient's primary care (this may be especially the case in rural communities). However, MVP will not allow both discharge and TCM services to be billed on the same day.
The CPT TCM codes may not be billed when patients are discharged to an SNF. For patients in SNFs there are separate E&M codes for initial, subsequent, and discharge care, and the visit for the annual facility assessment, Initial nursing home visits are coded with 99304-99306. Subsequent nursing home visits are coded 99307–99310.
TCM services provided during a post-surgery period for a service with a global period will not be reimbursed because such services shall be included in the payment for the underlying procedure.
Practitioners can bill for TCM services only once in the 30 days after discharge, even if the patient may be readmitted and subsequently discharged two (2) or more times within the 30-day period.

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

- Care Plan Oversight services (CPT codes 99374-99380)
- Chronic Care Management Services (CCM and TCM service periods cannot overlap)

Reimbursement Guidelines

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

References

Centers For Medicare & Medicaid Services Transitional Care Management Services Medicare Learning Network (MLN) Booklet July 2024 Available:
cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management
cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908628

American Academy of Family Physicians Transitional Care Management ©2024 Available: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/transitional-care-management.html

History

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

March 1, 2023 Policy reviewed and approved with changes
February 1, 2025 Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Unlisted CPT Code

Last Reviewed Date: September 1, 2024

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 be denied 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 Policies 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**.

History

January 1, 2018 New policy, approved
December 1, 2019 Policy reviewed and approved with no changes

June 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes
September 1, 2023	Policy reviewed and approved with no changes
September 1, 2024	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Urgent Care

Last Reviewed Date: September 1, 2024

Policy

Urgent care reimbursements require coding which specifically describes the services provided. Consistent with CPT coding and billing guidelines 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 Policies 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

Code	Description	Rule
E&M Codes		The appropriate Evaluation and Management and/or procedures codes that describe the type of services performed should be billed. POS Bill with Place of Service code 20 (urgent care facility).
S9088	Services provided in an urgent care center (list in addition to code for service)	Informational only as it pertains to the place of service and not the components of the specific service(s) provided. MVP does not reimburse for CPT code, whether billed alone or with any other service.
S9083	Global fee urgent care centers	Global code which does not provide encounter level specificity MVP does not reimburse for CPT code, whether billed alone or with any other service.

History

December 1, 2018	Policy approved
December 1, 2019	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with no changes
September 1, 2022	Policy reviewed and approved with no changes
September 1, 2023	Policy reviewed and approved with no changes
September 1, 2024	Policy reviewed and approved with no changes

MVP Health Care Payment Policy

Vaccine Administration (Vermont-Only)

Last Reviewed Date –May 1, 2025

Policy

Routine immunizations are reimbursed according to Medical Policy guidelines. This policy applies to Commercial and ASO products only.

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, and if not excluded by member contract/certificate

Notification/Prior Authorization Requests

MVP Payment policies 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

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.

CPT 90593 Chikungunya virus vaccine, recombinant, for intramuscular use is not covered
The following G codes should be billed for all claims:

Code	Description	ICD-10 Diagnosis
G0008	Flu Vaccine Administration	Z23
G0009	Pneumococcal Vaccine Administration	Z23

These services will be denied if not submitted with the appropriate administration code, specific vaccination or toxoid code(s) and the State supplied modifier, when applicable.

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

COVID-19 Vaccine and Administration Billing Guidelines

MVP covers FDA approved COVID-19 vaccines at no cost-share to Members in all plans. For commercial and ASO Members, MVP will reimburse Participating Providers for the vaccine and administration of the COVID-19 vaccine when the guidance below is followed.

Administration Code	Short Description	Vaccine Code	Effective Date
90480	Novavax Covid-19 Vaccine, Adjuvanted 5mcg/0.5 mL dosage (Ages 12 years and older)	91304	7/13/2022
90480	Pfizer-BioNTech COVID-19 Vaccine 2024-2025Formula (Yellow Cap) 3 mcg/0.2 mL dosage (Ages 6 months through 4 years)	91318	8/22/2024-TBD
90480	Pfizer-BioNTech COVID-19 Vaccine 2024-2025Formula (Blue Cap) 10mcg/0.2 mL dosage (Ages 5 years through 11 years)	91319	8/22/2024-TBD
90480	Pfizer-BioNTech COMIRNATY COVID-19 Vaccine 2024-2025 Formula 30 mcg/0.3 mL dosage (Ages 12 years and older)	91320	8/22/2024-TBD
90480	Moderna COVID-19 Vaccine 2024-2025Formula 25 mcg/0.25 mL dosage (Ages 6 months through 11 years)	91321	8/22/2024-TBD
90480	Moderna SPIKEVAX COVID-19 Vaccine 2024-2025Formula 50 mcg/0.5 mL dosage (Ages 12 years and older)	91322	8/22/2024-TBD

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
Vaccine Pricing | CMS

History

September 1, 2018	Policy approved
December 1, 2019	Policy reviewed and approved with no changes
June 1, 2021	Policy reviewed and approved with changes
June 1, 2022	Policy reviewed and approved with changes
June 1, 2023	Policy reviewed and approved with changes
December 1, 2023	Policy reviewed and approved with changes
June 1, 2024	Policy reviewed and approved with changes
May 1, 2025	Policy reviewed and approved with changes

MVP Health Care Payment Policy

Viscosupplementation of the Knee: Non-Coverage for Medicaid Managed Care (MMC) Plans

Last Reviewed Date: May 1, 2025

Policy

For Members enrolled in a Medicaid Managed Care (MMC) plan, MVP follows New York State (NYS) Medicaid's limit for reimbursement for viscosupplementation of the knee. Specifically, MVP will no longer cover viscosupplementation of the knee for an enrollee with a diagnosis of osteoarthritis of the knee. All other diagnosis associated with viscosupplementation will continue to be reimbursed.

Definitions

Viscosupplementation of the knee is a procedure in which a gel-like fluid called hyaluronic acid is injected into the knee joint. Hyaluronic acid is a natural occurring substance found in the synovial (joint) fluid. Individuals with osteoarthritis ("wear-and-tear" arthritis) of the knee have a lower-than-normal concentration of hyaluronic acid in their joints.

Notification/Prior Authorization Requests

MVP Payment policies 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 the Providers account at **mvphealthcare.com**.

Reimbursement Guidelines

Based on the current available evidence, for NYS Medicaid Managed Care (MMC) Plans, MVP will no longer cover viscosupplementation of the knee to a Member diagnosed with osteoarthritis of the knee. This coverage decision was based on research presented which included the potential harms attached to viscosupplementation (including joint infection, hematoma, inflammation), and the fact that viscosupplementation is only marginally effective in practice.

Billing/Coding Guidelines

The following ICD-10 diagnosis codes are associated with the non-coverage decision:

- ICD-10: M17 – Osteoarthritis of knee

- ICD-10: M17.0 – Bilateral primary osteoarthritis of knee
- ICD-10: M17.0 – Unilateral primary osteoarthritis of knee
- ICD-10: M17.4 – Other bilateral secondary osteoarthritis of knee
- ICD-10: M17.5 – Other unilateral secondary osteoarthritis of knee
- ICD-10: M17.9 – Osteoarthritis of knee, unspecified
- ICD-10: M17.10 – Unilateral primary osteoarthritis, unspecified knee
- ICD-10: M17.11 – Unilateral primary osteoarthritis, right knee
- ICD-10: M17.12 – Unilateral primary osteoarthritis, left knee

There will be no reimbursement provided by MVP when the following thirteen (13) medication codes are reported with the ICD-10 diagnosis codes listed above:

- J7318 – Hyaluronan or derivative, Durolane, for intra-articular injection, 1 mg
- J7320 - Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
- J7321 - Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose
- J7322 - Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
- J7323 - Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
- J7324 - Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
- J7325 - Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
- J7326 - Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
- J7327 – Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
- J7328 – Hyaluronan or derivative, GELSYN-3, for intra-articular injection, 0.1 mg
- J7329 – Hyaluronan or derivative, Trivisc, for intra-articular injection, 1 mg
- J7331 – Hyaluronan or derivative, SYNOJOYNT, for intra-articular injection, 1 mg
- J7332 - Hyaluronan or derivative, Triluron, for intra-articular injection, 1 mg

References

New York State Medicaid Update – March 2014 Volume 30 – Number 3. Viscosupplementation of the Knee: Non-Coverage Decision Available: https://www.health.ny.gov/health_care/medicaid/program/update/2014/2014-03.htm#vis
New York State Department of Health Medicaid Update – April 2022 Volume 38 – Number 4. Reminder: Non-Coverage Decision for Viscosupplementation of the Knee. Available: https://www.health.ny.gov/health_care/medicaid/program/update/2022/docs/mu_no4_apr22_pr.pdf

History

April 1, 2022	New policy, approved
June 1, 2024	Policy reviewed and approved with no changes
May 1, 2025	Policy reviewed and approved with no changes