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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

February 15, 2001

Administrative Letter 2001-2

TO: ALL INSURERS LICENSED TO WRITE ACCIDENT AND SICKNESS INSURANCE IN VIRGINIA, AND ALL HEALTH SERVICES PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS LICENSED IN VIRGINIA

RE: 14 VAC 5-190-10 et seq.: Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers - 2000 Reporting Period

The attached instructions and forms are provided to assist companies in the preparation of the Annual Report of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers for the 2000 reporting period, pursuant to 14 VAC 5-190-10 et seq. and § 38.2-3419.1 of the Code of Virginia. The report must be in the format contained in Form MB-1, a copy of which is also attached to this letter. Form MB-1 has been updated to reflect several new mandates applicable to the 2000 reporting period. The completed Form MB-1 is due on or before **May 1, 2001**. **Lack of notice, lack of information, lack of means of producing the required data, or other such reasons will not be accepted for not filing a complete and accurate report in a timely manner.**

Companies should refer to 14 VAC 5-190-40 for an explanation of the circumstances under which a full and complete or an abbreviated report must be filed. This section also describes the circumstances under which a company may be exempt from filing a report. The total Virginia annual written premium for all accident and sickness policies or contracts referred to in this section of the administrative code is the amount reported to the Commission on the company's **Annual Statement for the year ended December 31, 2000**, and that amount must be used to determine the type of report required.

Each licensed company is required to submit a separate Form MB-1. It is not acceptable to submit more than one Form MB-1 for a single company or consolidate information from different companies on one form.

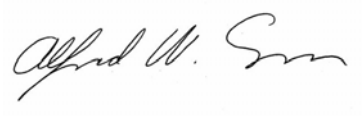
The attached instructions explain the type of information required to complete Form MB-1 and serve to highlight frequent errors and omissions. All sources of information, including 14 VAC 5-190-10 et seq., §§ 38.2-3408 through 38.2-3418.11, as applicable, § 38.2-4221, and CPT and ICD-9-CM Codes should be consulted in the preparation of this report. It should be noted that the attached CPT and ICD-9-CM Codes are not intended to exhaust all medical codes that may be used in collecting data for Form MB-1, but are representative of some of the codes used.

Correspondence regarding this reporting requirement, including Form MB-1 filings, should be directed to:

Mary Ann Mason
Senior Insurance Market Examiner
State Corporation Commission
Bureau of Insurance – Life and Health Division
Post Office Box 1157
Richmond, Virginia 23218
Telephone: (804) 371-9348
FAX: (804) 371-9944

Companies are reminded that failure to submit a substantially complete and accurate report pursuant to the provisions of 14 VAC 5-190 et seq. by **May 1, 2001**, may be considered a violation subject to a penalty as set forth in § 38.2-218 of the Code of Virginia.

Sincerely,



Alfred W. Gross
Commissioner of Insurance

AWG/mam
Attachments: Form MB-1
Form MB-1 Instructions and Information
CPT and ICD-9-CM Codes

Form MB-1 Instructions and Information

COVER SHEET:

The amount entered for **Total Premium for all Accident and Sickness Lines** should be consistent with the total accident and sickness premium written in Virginia as **reported on the Company's Annual Statement for the 2000 reporting period** for all accident and sickness lines. This includes credit accident and sickness, disability income, and all other categories of health insurance without regard to their being subject to the provisions of §§ 38.2-3408 or 38.2-4221 and §§ 38.2-3409 through 38.2-3419 of the Code of Virginia. This amount should not be adjusted.

The amount entered for **Total Premiums on Applicable Policies and Contracts** should be the total accident and sickness premiums written in Virginia on applicable policies and contracts, as defined in 14 VAC 5-190-30 that are subject to the Mandated Benefits and Offers as set forth in §§ 38.2-3408 or 38.2-4221, and §§ 38.2-3409 through 38.2-3419 for the reporting period. Only written premiums on applicable policies and contracts should be included. Policies and contracts issued in Virginia to an individual or group or to a discretionary group situsued outside of Virginia, for which the company is unable to provide documentation required in § 38.2-3522.1 and subject to Mandated Benefits and Offers as provided in § 38.2-3408 or § 38.2-4221, and § 38.2-3409 through § 38.2-3419 are considered applicable policies and contracts.

Report Type (Abbreviated or Complete) - the company must determine eligibility to file an abbreviated report under 14 VAC 5-190-40 C or a full and complete report under 14 VAC 5-190-40 A for the **2000 reporting period**. Companies submitting an abbreviated report must submit the cover sheet of Form MB-1 *as well as* a breakdown of the premium by policy type (e.g. Medicare supplement, major medical, disability income, limited benefit) and by situs (e.g. Virginia, Illinois) required by 14 VAC 5-190-40 D.

Part A: Claim Information - Benefits

Part A requires disclosure of specific claim data for each mandated benefit and mandated offer for both individual and group business. Carriers are reminded that the basis on which claim data is presented must be reported, either "**Paid**" or "**Incurred**." "**Paid**" or "**Incurred**" must be entered in the appropriate space at the top of the form, and the basis must be consistent throughout the report.

Total claims paid/incurred, (TOTAL CLAIMS PD/INCURRED) for individual contracts and group certificates refer to all claims paid or incurred under the types of policies that are subject to the Mandated Benefits. This amount should not be the total of claim payments entered in column c, rather a total of all claims for all covered services, including both mandated benefits and those not mandated, and paid or incurred under applicable contracts or certificates. This number has been omitted by several carriers reporting previously. The Bureau cannot compile the information reported without this amount. **It is imperative that this number be entered in column g**. This amount is the only data entered in column g, part A.

Columns a and b - "**Number of Visits" or "Number of Days**" refer to the number of provider and physician visits, and the number of inpatient or partial hospital days, as applicable. The numbers reported should be consistent with the type of service rendered. For example, number of days (column b) should not be reported unless the claim dollars being reported were paid or incurred for inpatient or partial hospitalization.

Claims reported for § 38.2-3409, Handicapped Dependent Children should include only those claims paid or incurred as a result of a continuation of coverage because the dependent has attained the specified age as set forth in the policy for a dependent child.

Claims reported for § 38.2-3410, Doctor to Include Dentist, should include only claims for treatment normally provided by a physician, but was provided by a dentist. Claims for normal or routine dental services should not be reported.

Column c -Total Claims Payments - companies should enter the total of claims paid or incurred for the mandate.

Column d - Number of Contracts/Certificates

> Individual business - companies should report the number of individual **contracts** issued or renewed in Virginia during the reporting period which contain the benefits and providers listed. The number of contracts should be consistent throughout column d, except in the case of mandated offers, which may be less.
>
> Group business - companies should report the number of group **certificates** issued or renewed in Virginia during the reporting period which contain the benefits and providers listed, not the number of group contracts. This number should also be consistent except for mandated offers, which may be less.

Column e - Claim Cost Per Contract/Certificate. This figure is computed by dividing the amount entered in column c by the number entered in column d. **It is not necessary for reporting companies to enter this amount**. The Bureau's software will compute this amount automatically.

Column f - Annual Administrative Cost should only include 2000 administrative costs (not start-up costs, unless those costs were incurred during the reporting period).

Column g - The Percentage of Total Health Claims computed in column g will be computed automatically by the Bureau's software.

PART B: CLAIM INFORMATION - PROVIDERS

In determining the cost of each mandate, it is expected that claim and other actuarial data will be used. A listing of the CPT and ICD-9-CM Codes which should be used in collecting the required data is attached for your convenience.

Column a - **Number of Visits** is the number of visits to the provider group for which claims were paid or incurred.

Column b - **Total Claims Payments** is the total dollar amount of claims paid to the provider group.

Column c - **Cost Per Visit** is computed by dividing the amount entered in column b by the number entered in column a. **It is not necessary for reporting companies to enter this amount**. The Bureau's software will compute this figure automatically.

Column d - **Number of Contracts/Certificates**

Individual business - report the number of individual **contracts** issued or renewed in Virginia during this reporting period that are subject to this reporting requirement.

Group business - report the number of group **certificates** issued or renewed in Virginia during this reporting period that are subject to this reporting requirement.

Column e - **Claim Cost Per Contract/Certificate -** (both individual and group business) is the number entered in column b divided by the number entered in column d. **It is not necessary for reporting companies to enter this number**. The Bureau's software will compute this number automatically.

Column f - Annual Administrative Cost should only include 2000 administrative costs (not start-up costs, unless those costs were incurred during the reporting period).

Column g - Percent of Total Health Claims is the claims paid or incurred for services administered by each provider type as a percentage of the total amount of all health claims paid or incurred subject to this reporting requirement. **It is not necessary for reporting companies to enter this number**. The Bureau's software will compute this number automatically.

PART C: PREMIUM INFORMATION

Standard Policy

Use what you consider to be your standard individual policy and/or group certificate to complete the deductible amount, the coinsurance paid by the insurer, and the individual/employee out-of-pocket maximum. These amounts should be entered under the heading of Individual Policy and/or Group certificates, as applicable, in the **un-shaded** blocks.

For your standard health insurance policy in Virginia, provide the total **annual premium** that would be charged per unit of coverage assuming inclusion of all of the benefits and providers listed. A separate annual premium should be provided for Individual policies and Group certificates, both single and family.

Premium Attributable to Each Mandate

Provide the portion (dollar amount) of the annual premium for each policy that is attributable to each mandated benefit, offer and provider. If the company does not have a "Family" rating category, coverage for two adults and two children is to be used when calculating the required family premium figures.

Please indicate where coverage under your policy exceeds Virginia mandates. It is understood that companies do not usually rate each benefit and provider separately. **However, for the purpose of this report it is required that a dollar amount be assigned to each benefit and provider based on the company's actual claim experience, such as that disclosed in Parts A and B, and other relevant actuarial information.**

Number of Contracts/Certificates

Provide the number of individual policies and/or group certificates *issued and/or renewed* by the Company in Virginia **during the reporting period** (1/1/00 – 12/31/00) in the appropriate fields under each heading.

Provide the number of individual contracts and/or group certificates *in force* for the company in Virginia as of the **last day of the reporting period** (12/31/00) in the appropriate fields under each heading.

Annual Premium for Individual Standard Policy (30 year old male in Richmond)

Enter the annual premium for an individual policy with no mandated benefits or mandated providers for a 30 year old male in the Richmond area in your standard premium class in the appropriate line. Enter the cost for a policy for the same individual with present mandates in the appropriate line. (Assume coverage including $250 deductible, $1,000 stop-loss limit, 80% co-insurance factor, and $250,000 policy maximum.) If you do not issue a policy of this type, provide the premium for a 30 year old male in your standard premium class for the policy that you offer that is most similar to the one described and summarize the differences from the described policy in a separate form. The premium for a policy "with mandates" should include all mandated benefits, offers, and providers.

Average Dollar Amount for Converting Group to Individual

Companies should provide information concerning the cost of converting group coverage to an individual policy. Information should be provided only as relevant to your company’s practices.

If the company adds an amount to the annual premium of a **group policy or certificate** to cover the cost of conversion to an individual policy, provide the average dollar amount **per certificate** under the “group certificate” heading in the fields for single and family coverages, as appropriate.

If the cost of conversion is covered in the annual premium of the **individual policy**, provide the average dollar amount attributable to the conversion requirement under the heading “Individual Policy” in the fields for single or family coverages, as appropriate.

If the cost of conversion is covered by a **one-time charge** made to the group policyholder for each conversion, provide the average dollar amount under the heading “Group Certificates” in the fields for single or family coverages, as appropriate.

PART D - UTILIZATION AND EXPENDITURES FOR SELECTED PROCEDURES BY PROVIDER TYPE

Selected Procedure Codes are listed in Part D to obtain information about utilization and costs for specific types of services. Please identify expenditures and visits for the Procedure Codes indicated. Other claims should not be included in this Part. Individual and group data must be combined for this part of the report.

Claim data should be reported by procedure code and provider type. "Physician" refers to medical doctors.

Data should only reflect paid claims. Unpaid claims should not be included.

It is not necessary to report the Cost Per Visit. The Bureau's software will compute this amount automatically.

GENERAL

Information provided on Form MB-1 should only reflect the experience of policies or certificates delivered or issued for delivery in the Commonwealth of Virginia and subject to Virginia mandated benefit, mandated offers and provider statutes.

Note the addition of data to be reported in Part A: Claim Information – Benefits, Coverage for Biologically Based Mental Illness, Clinical Trials for Treatment Studies on Cancer, Minimum Hospital Stay for Hysterectomy, Diabetic Equipment, Supplies, Outpatient Management and Hospice Care, Sections 38.2-3412.1:01, 38.2-3418.8, 38.2-3418.9, 38.2-3418.10 and 38.2-3418.11, respectively. This is the first reporting year for this information.

Companies should not enter information in the shaded fields.

A. CPT and ICD-9-CM Codes

The codes provided are from the 2000 edition of *Physicians' Current Procedural Terminology*, and *International Classification of Diseases - Clinical Modification*. Companies are advised to refer to the complete listing of CPT and ICD-9-CM codes to ensure compliance with all reporting requirements. It is the company's responsibility to keep abreast of changes that may appear in revised editions.

Va. Code Section 38.2-3410: Doctor to Include Dentist

(Medical services legally rendered by dentists and covered under contracts other than dental)

ICD Codes

520-529	Diseases of oral cavity, salivary glands and jaws

Va. Code Section 38.2-3411: Newborn Children

(children less than 32 days old)

ICD Codes

740-759	Congenital anomalies
760-763	Maternal causes of perinatal morbidity and mortality
764-779	Other conditions originating in the perinatal period

CPT Codes

99295	Initial neonatal intensive care, per day, for the evaluation and management of a critically ill neonate or infant
99296	Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill and unstable neonate or infant
99297	Subsequent neonatal intensive care, per day, for the evaluation and management of a critically ill though stable neonate or infant
99431	History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records

99432	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)
99433	Subsequent hospital care, for the evaluation and management of a normal newborn, per day
99440	Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

Va. Code Section 38.2-3412.1: Mental/Emotional/Nervous Disorders
(must use UB-82 place-of-service codes from Section B of this Appendix to differentiate between inpatient, partial hospitalization, and outpatient claims)

ICD Codes

290, 290-294	Organic Psychotic Conditions
295-299	Other psychoses
300-316	Neurotic disorders, personality disorders, and other non-psychotic mental disorders
317-319	Mental retardation

CPT Codes

99221-99223	Initial hospital care, per day, for the evaluation and management of a patient
99231-99233	Subsequent hospital care, per day, for the evaluation and management of a patient
99238	Hospital discharge day management; 30 minutes or less
99241-99245	Office or other outpatient consultations for psychiatric evaluation
99251-99255	Initial inpatient consultations for psychiatric evaluation
99261-99263	Follow up consultation for psychiatric evaluation of an inpatient
90801	Psychiatric diagnostic interview examination

90802 Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication

90804 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient

90805 with medical evaluation and management services

90806 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

90807 with medical evaluation and management services

90808 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient

90809 with medical evaluation and management services

90810 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient

90811 with medical evaluation and management services

90812 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

90813 with medical evaluation and management services

90814 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient

90815 with medical evaluation and management services

90816 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient

90817	with medical evaluation and management services
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
90819	with medical evaluation and management services
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
90822	with medical evaluation and management services
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient
90824	with medical evaluation and management services
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
90827	with medical evaluation and management services
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
90829	with medical evaluation and management services
90845	Psychoanalysis
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)

90857 Interactive group psychotherapy

90885 Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes

96100 Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour

Other Psychiatric Services or Procedures

90862 Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

90865 Narcosynthesis for psychiatric diagnostic and therapeutic purposes

90870 Electroconvulsive therapy, single seizure

90871 multiple seizures, per day

90880 Hypnotherapy

90882 Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions

90887 Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient

90889 Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers

90899 Unlisted psychiatric service or procedure

Va. Code Section 38.2-3412.1: Alcohol and Drug Dependence

ICD Codes

291 Alcoholic Psychoses

303 Alcohol dependence syndrome

292 Drug Psychoses

304 Drug dependence

305 Nondependent abuse of drugs

CPT Codes

80100 Drug, screen, multiple drug classes, each procedure
80101 Single drug class, each drug class
80102 Drug confirmation, each procedure
80103 Tissue preparation for drug analysis

Use appropriate codes for Mental/Emotional/Nervous Disorders, but for above listed conditions.

Va. Code Section 38.2-3412.1:01. Biologically Based Mental Illness

ICD Codes

295.0-295.9 Schizophrenia/Schizoaffective disorder
299.9 Schizophrenia, childhood type
296.4-296.7 Bipolar affective disorder
296.2-296.3 Major depressive disorder
300.01 Panic disorder
309.0 Predominant disturbance of emotions
300.3 Obsessive-compulsive disorders
314.0 Attention deficit disorder
314.01 With hyperactivity
299.0 Infantile autism
291 Alcoholic psychoses
303 Alcohol dependence syndrome
292 Drug psychoses
304 Drug dependence

CPT Codes

Use appropriate codes for Mental/Emotional/Nervous Disorders, but for above listed conditions.

Va. Code Section 38.2-3414: Obstetrical Services

Normal Delivery, Care in Pregnancy, Labor and Delivery

ICD Codes

650 Delivery requiring minimal or no assistance, with or without episiotomy, without fetal manipulation [e.g., rotation version] or instrumentation [forceps] of spontaneous, cephalic, vaginal, full-term, single, live born infant. This code is for use as a single diagnosis code and is not to be used with any other code in the range 630 – 677

V22 Normal pregnancy

CPT Codes

Any codes in the maternity care and delivery range of 59000-59899 associated with ICD Code 650 listed above

All Other Obstetrical Services

ICD Codes

630-677 Complications of pregnancy, childbirth, and the puerperium

V23 Supervision of high-risk pregnancy

CPT Codes

Incision, Excision, Introduction, and Repair

59000 Amniocentesis, any method

59012 Cordocentesis (intrauterine), any method

59015 Chorionic villus sampling, any method

59020 Fetal contraction stress test

59025 Fetal non-stress test

59030 Fetal scalp blood sampling

59050 Fetal monitoring during labor by consulting physician (i.e., non-attending physician) with written report; supervision and interpretation

59100 Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)

59120 Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach

59121 tubal or ovarian, without salpingectomy and/or oophorectomy (59120)

59130 abdominal pregnancy (59120)

59135 interstitial, uterine pregnancy requiring total hysterectomy (59120)

59136 interstitial, uterine pregnancy with partial resection of uterus (59120)

59140 cervical, with evacuation (59120)

59150 Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy

59151 with salpingectomy and/or oophorectomy (59150)

59160 Curettage, postpartum

59200 Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)

59300 Episiotomy or vaginal repair, by other than attending physician

59320 Cerclage of cervix, during pregnancy; vaginal

59325 abdominal (59320)

59350 Hysterorrhaphy of ruptured uterus

Vaginal Delivery, Antepartum and Postpartum Care

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 including postpartum care (59409)

59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta (separate procedure)
59425	Antepartum care only; 4-6 visits
59426	7 or more visits (59425)
59430	Postpartum care only (separate procedure)

Cesarean Delivery

59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only
59515	including postpartum care (59514)
59525	Subtotal or total hysterectomy after cesarean delivery (list in addition to 59510, 59514, 59515)

Abortion

99201-99233	Medical treatment of spontaneous complete abortion, any trimester
59812	Treatment of incomplete abortion, any trimester, completed surgically
59820	Treatment of missed abortion, completed surgically; first trimester
59821	second trimester (59820)
59830	Treatment of septic abortion, completed surgically
59840	Induced abortion, by dilation and curettage
59841	Induced abortion, by dilation and evacuation
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;

59851	with dilation and curettage and/or evacuation (59850)
59852	with hysterotomy (failed intra-amniotic injection) (59850)

Other Procedures

59870	Uterine evacuation and curettage for hydatidiform mole
59871	Removal of cerclage suture under anesthesia (other than local)
59899	Unlisted procedure, maternity care and delivery

Anesthesia

00850	Cesarean section
00855	Cesarean hysterectomy
00857	neuraxial analgesia/anesthesia for labor ending in a cesarean delivery (includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)

Va. Code Section 38.2-3414.1: Obstetrical benefits; Coverage for postpartum services

ICD Codes

V24	Postpartum care and examination
V24.0	Immediately after delivery
V24.1	Lactating mother
V24.2	Routine postpartum follow-up

CPT Codes

59610	Routine obstetric care and postpartum care, after previous cesarean delivery
59614	including postpartum care (59612)
59618	Routine obstetric care including postpartum care, following attempted vaginal delivery after previous cesarean delivery

59622 including postpartum care (59620)

Use same codes as obstetrical services in cases where coverage is provided solely due to the provisions of § 38.2-3414.1

Va. Code Section 38.2-3418: Pregnancy from Rape/Incest

Same Codes as Obstetrical Services/Any Other Appropriate in cases where coverage is provided solely due to the provisions of § 38.2-3418 of the Code of Virginia

Va. Code Section 38.2-3418.1: Mammography

CPT Codes

76092 Screening mammography, bilateral (two view film study of each breast)

Va. Code Section 38.2-3411.1: Child Health Supervision Services

CPT Codes

90645 Hemophilus Influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use

90646 Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use

90647 Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use

90648 Hemophilus influenza b vaccine (Hib), PRO-T conjugate (4 does schedule), for intramuscular use

90700 Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP)

90701 Diphtheria and tetanus toxoids and whole cell pertussis vaccine (DTP)

90702 Diphtheria and tetanus toxoids (DT)

90703 Tetanus toxoid

90704 Mumps virus vaccine, live

90705 Measles virus vaccine, live

90706 Rubella virus vaccine, live

90707 Measles, mumps and rubella virus vaccine (MMR), live

90708 Measles and rubella virus vaccine, live

90709 Rubella and mumps virus vaccine, live

90710 Measles, mumps, rubella, and varicella vaccine (MMRV), live

90712 Poliovirus vaccine, (any type(s)) (OPV), live, for oral use

90713 Poliovirus vaccine, inactivated (IPV), for subcutaneous use

90716 Varicella virus vaccine, live

90720 Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib)

New Patient

99381 Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)

99382 early childhood (age 1 through 4 years) (99381)

99383 late childhood (age 5 through 11 years) (99381)

Established Patient

96110 Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

99391 Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)

99392 early childhood (age 1 through 4 years) (99391)

99393 late childhood (age 5 through 11 years) (99391)

81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy

84030 Phenylalanine (PKU), blood

86580 Tuberculosis, intradermal

86585 Tuberculosis, tine test

Va. Code Section 38.2-3418.1:1: Bone Marrow Transplants (applies to Breast Cancer Only)

ICD Codes

174 through 174.9 – malignant neoplasm of female breast

175 through 175.9 – malignant neoplasm of male breast

CPT Codes

36520 Therapeutic apheresis (plasma and/or cell exchange)

38241 autologous

The Bureau is aware that because of the changing and unique nature of treatment involving this diagnosis, and treatment procedures, reporting only those claim costs associated with these codes will lead to significant under reporting. Accordingly, if one of the ICD Codes <u>and</u> any of the CPT Codes shown above are utilized, the insurer should report <u>all</u> claim costs incurred within thirty (30) days prior to the CPT Coded procedure as well as <u>all</u> claim costs incurred within ninety (90) days following the CPT Coded procedure.

Va. Code Section 38.2-3418.1:2: Coverage for Pap Smears

ICD Codes

V72.3 Papanicolaou smear as part of general gynecological examination

V76.2 Routine cervical Papanicolaou smear

CPT Codes

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

88150 Cytopathology, slides, cervical or vaginal; manual screening under physician supervision

88152 with manual screening and computer-assisted rescreening under physician supervision

88155 Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (e.g., maturation index karyopyknotic index, estrogenic index)

88160-88162 Cytopathology, smears, any other source; preparation, screening and interpretation

88164-88167 Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician

Va. Code Section 38.2-3418.2: Procedures Involving Bones and Joints

ICD Codes

524.6 - 524.69 Temporomandibular Joint Disorders

719 - 719.6, 719.9 Other and Unspecified Disorders of Joint

719.8 Other Specified Disorders of Joint

CPT Codes

20605 Intermediate joint, bursa or ganglion cyst (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)

21010 Arthrotomy, temporomandibular joint

21050 Condylectomy, temporomandibular joint (separate procedure)

21060 Meniscectomy, partial or complete, temporomandibular joint (separate procedure)

21070 Coronoidectomy (separate procedure)

21116 Injection procedure for temporomandibular joint arthrography

21125 Augmentation, mandibular body or angle; prosthetic material

21127 with bond graft, onlay or interpositional (includes obtaining autograft)

21141 Reconstruction midface. LeFort I; single piece, segment movement in any direction, without bone graft

21142 Two pieces, segment movement in any direction, without bone graft

21143 Three or more pieces, segment movement in any direction, without bone graft

21145 single piece, segment movement in any direction, requiring bone grafts

21146 two pieces, segment movement in any direction, requiring bone grafts

21147 three or more pieces, segment movement in any direction, requiring bone grafts

21150 Reconstruction midface, LeFort II; anterior intrusion

21151 any direction, requiring bone grafts

21193 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft

21194 with bone graft (includes obtaining graft)

21195 Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation.

21196 with internal rigid fixation

21198 Osteotomy, mandible, segmental

21206 Osteotomy, maxilla, segmental

21208 Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)

21209 reduction

21210 Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)

21215 mandible (includes obtaining graft)

21240 Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)

21242 Arthroplasty, temporomandibular joint, with allograft

21243 Arthroplasty, temporomandibular joint, with prosthetic joint replacement

21244 Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)

21245 Reconstruction of mandible or maxilla, subperiosteal implant; partial

21246 complete

21247 Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)

21480 Closed treatment of temporomandibular dislocation; initial or subsequent

21485 complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent

21490 Open treatment of temporomandibular dislocation

29800 Arthroscopy, temporomandibular joint, diagnostic, with or without synovial
biopsy (separate procedure)

29804 Arthroscopy, temporomandibular joint, surgical

69535 Resection temporal bone, external approach (For middle fossa approach, see 69950-69970)

70100 Radiologic examination, mandible; partial, less than four views

70110 complete, minimum of four views

70328 Radiologic examination, temporomandibular joint, open and closed mouth; unilateral

70330 bilateral

70332 Temporomandibular joint arthrography, radiological supervision and interpretation

70336 Magnetic resonance (e.g., proton) imaging, temporomandibular joint

70486 Computerized axial tomography, maxillofacial area; without contrast material

70487 with contrast material(s)

70488 without contrast material, followed by contrast material(s) and further sections

Virginia Code § 38.2-3418.3 Hemophilia, Congenital Bleeding Disorders

ICD Codes

286.0-286.9 Coagulation defects
287.0-287.9 Purpura and other hemorrhagic conditions

CPT Codes

85170 Clot retraction
85175 Clot lysis time, whole blood dilution
85210 Clotting; factor II, prothrombin, specific
85220 factor V (AcG or proaccelerin), labile factor
85230 factor VII (proconvertin, stable factor)
85240 factor VIII (AHG), one stage
85244 factor VIII related antigen
85245 factor VIII, VW factor, ristocetin cofactor
85246 factor VIII, VW factor antigen
85247 factor VIII, Von Willebrands factor, multimetric analysis
85250 factor IX (PTC or Christmas)
85260 factor X (Stuart-Prower)
85270 factor XI (PTA)
85280 factor XII (Hageman)
85290 factor XIII (fibrin stabilizing)
85291 factor XIII (fibrin stabililzing), screen solubility
85292 prekallikrein assay (Fletcher factor assay)
85293 high molecular weight kininogen assay (Fitzgerald factor assay)
85300 Clotting inhibitors or anticoagulants; antithrombin III, activity
85301 antithrombin III, antigen assay
85302 protein C, antigen
85303 protein C, activity
85305 protein S, total
85306 protein S, free
85335 Factor inhibitor test
85337 Thrombomodulin
85345 Coagulation time; Lee and White
85347 activated

85348 other methods
85360 Euglobulin lysis
85362 Fibrin (ogen) degradation (split) products (FDP)(FSP); agglutination slide, semiquantitative
85366 paracoagulation
85370 quantitative
85378 Fibrin degradation products, D-dimer; semiquantitative
85379 quantitative
85384 Fibrinogen; activity
85385 antigen
85390 Fibrinolysins or coagulopathy screen, interpretation and report
85400 Fibrinolytic factors and inhibitors; plasmin
85410 alpha-2 antiplasmin
85415 plasminogen activator
85420 plasminogen, except antigenic assay
85421 plasminogen, antigenic assay
85441 Heinz bodies; direct
85445 induced, acetyl phenylhydrazine
85460 Hemoglobin or RBCs, fetal, for fetomaternal hemorrhage; differential lysis (Kleihauer-Betke)
85461 rosette
85475 Hemolysin, acid
85520 Heparin assay
85525 Heparin neutralization
85530 Heparin-protamine tolerance test
85535 Iron stain (RBC or bone marrow smears)
85540 Leukocyte alkaline phosphatase with count
85547 Mechanical fragility, RBC
85549 Muramidase
85555 Osmotic fragility, RBC; unincubated
85557 incubated
85576 Platelet; aggregation (in vitro), each agent
85585 estimation on smear, only
85590 manual count
85595 automated count
85597 Platelet neutralization
85610 Prothrombin time;
85611 substitution, plasma fractions, each
85651 Sedimentation rate, erythrocyte; non-automated
85652 automated
85670 Thrombin time; plasma
85675 titer
85705 Thromboplastin inhibition; tissue
85730 Thromboplastin time, partial (PTT); plasma or whole blood
85732 substitution, plasma fractions, each
85810 Viscosity
85999 Unlisted hematology and coagulation procedure

Virginia Code § 38.2-3418.4 Reconstructive Breast Surgery

ICD Codes

V50.1	Other plastic surgery for unacceptable cosmetic appearance
V52.4	Breast prosthesis and implant

CPT Codes

19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastectomy or in reconstruction
19350	Nipple/areola reconstruction
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361	Breast reconstruction with latissimus dorsi flap, with or without prosthetic iimplant
19364	Breast reconstruction with free flap
19366	Breast reconstruction with other technique
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
19368	with microvascular anastomosis (supercharging)
19369	Breast reconstruction with transverse rectus addominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
19499	Unlisted procedure, breast

Virginia Code § 38.2-3418.5 Coverage for Early Intervention Services

ICD Codes

V57	Care involving use of rehabilitation procedures
V57.0	Breathing exercises
V57.1	Other physical therapy
V57.2	Occupational therapy and vocational rehabilitation
V57.3	Speech therapy
V57.4	Orthoptic training
V57.8	Other specified rehabilitation procedure
315.3	Developmental speech or language disorder

315.4	Coordination disorder
315.5	Mixed development disorder
315.8	Other specified delays in development
315.9	Unspecified delay in development
317-319	Mental retardation

CPT Codes

92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
92508	group, two or more individuals
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97003	Occupational therapy evaluation
97004	Occupational therapy re-evaluation
97010	Application of a modality to one or more areas; hot or cold packs
97012	traction, mechanical
97014	electrical stimulation (unattended)
97016	vasopneumatic devices
97018	paraffin bath
97020	microwave
97022	whirlpool
97024	diathermy
97026	infrared
97028	untraviolet
97032	Electrical stimulation (manual)
97033	iontophoresis
97034	contrast baths
97035	ultrasound
97036	Hubbard tank
97039	Unlisted modality
97110	Therapeutic procedure
97112	neuromuscular reeducation
97113	aquatic therapy with therapeutic exercises
97116	gait training
97124	massage therapy
97139,97799	Unlisted therapeutic service or procedure (specify)
97140	Manual therapy techniques
97150	Group Therapeutic Procedures
97504	Orthotics fitting and training
97520	Prosthetic training
97530	Therapeutic activities
97535	Activities of daily living
97537	Community/work reintegration

97542	Wheelchair management
97545-97546	Work hardening/conditioning
97703	Checkout for orthotic/prosthetic use
97750	Physical performance test or measurement
97770	Cognitive skills development
98925-98929	Osteopathic manipulative treatment

Virginia Code § 38.2-3418.7 Coverage for PSA Testing

CPT Codes

84153	Prostate specific antigen (PSA); total
84154	free
86316	Immunoassay for tumor antigen

Virginia Code § 38.2-3418.8 Clinical Trials for Treatment Studies on Cancer

ICD Codes

V70.7	Examination for normal comparison or control in clinical research

Virginia Code Section 38.2-3418.9 Minimum Hospital Stay for Hysterectomy

CPT Codes

58260-58285
58550-58551

Virginia Code Section 38.2-3418.10 Diabetes Equipment, Supplies, Outpatient Management

ICD Codes

V53	Fitting and adjustment of other device
V65.3	Dietary surveillance and counseling
V65.4	Other counseling, not elsewhere classified

CPT Codes

99201-99215	Office or other outpatient services (new patient)
99241-99245	Office or other outpatient services (new or established patient)

99078 Diabetic instructions

Virginia Code Section 38.2-3418.11: Hospice Care

ICD Codes

V66.7 Hospice care

CPT Codes

99377 Physician supervision of a hospice patient

B. Uniform Billing Code Numbers (UB-82)

PLACE OF SERVICE CODES

Field Values		Report As:
10	Hospital, inpatient	Inpatient
1S	Hospital, affiliated hospice	Inpatient
1Z	Rehabilitation hospital, inpatient	Inpatient
20	Hospital, outpatient	Outpatient
2F	Hospital-based ambulatory surgical facility	Outpatient
2S	Hospital, outpatient hospice services	Outpatient
2Z	Rehabilitation hospital, outpatient	Outpatient
30	Provider's office	Outpatient
3S	Hospital, office	Outpatient
40	Patient's home	Outpatient
4S	Hospice (Home hospice services)	Outpatient
51	Psychiatric facility, inpatient	Inpatient
52	Psychiatric facility, outpatient	Outpatient
53	Psychiatric day-care facility	Partial Hospitalization
54	Psychiatric night-care facility	Partial Hospitalization
55	Residential substance abuse treatment facility	Inpatient
56	Outpatient substance abuse treatment facility	Outpatient
60	Independent clinical laboratory	Outpatient
70	Nursing home	Inpatient
80	Skilled nursing facility/extended care facility	Inpatient
90	Ambulance; ground	Outpatient
9A	Ambulance; air	Outpatient
9C	Ambulance; sea	Outpatient
00	Other unlisted licensed facility	Outpatient