COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

January 26, 1996

ADMINISTRATIVE LETTER 1996-3

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

RE: Virginia Insurance Regulation No. 38: Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers - 1995 Reporting Period

The attached instructions 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 1995 reporting period, pursuant to Virginia Insurance Regulation No. 38 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. The completed Form MB-1 is due on or before May 1, 1996. **Lack of notice, lack of information, lack of means of producing the required data, or other such excuses will not be accepted for not filing a complete and accurate report in a timely manner.**

Companies should refer to Regulation No. 38, Section 4 for an explanation of the circumstances under which a full or an abbreviated report must be filed. This section also describes the circumstances under which a company may be exempt from filing a report.

Companies are reminded that it is not acceptable to submit more than one Form MB-1 for a single company. It is also unacceptable to consolidate information from different companies on one form. Each licensed company must submit a separate Form MB-1.

. **The instructions attached are for clarification and serve to highlight frequent errors and omissions, but it should be noted that these instructions are not complete. All sources of information, including Regulation No. 38, §§ 38.2-3408 through 38.2-3418.11, and § 38.24221 should be consulted in the preparation of this report.**

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

Jacqueline K. Cunningham
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Bureau of Insurance - Life and Health Division
P.O. Box 1157
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Companies are reminded that failure to submit a substantially complete and accurate report pursuant to the provisions of Regulation No. 38 by the due date may be considered a willful violation subject to a penalty as set forth in § 38.2-218 of the Code of Virginia.

Yours truly,

Steven T. Foster
Commissioner of Insurance

STF/tlf
Attachments

Form MB-1 Instructions and Information

Cover Page:

1. The figure entered in question #1 should be consistent with the total accident and sickness premium written in Virginia as reported in the Company's annual statement for the reporting period. This figure should not be adjusted.

2. "Applicable policies" are defined in § 3 of Regulation No. 38. Written premium on applicable policies only should be included. Policies sitused outside of Virginia, and policies sitused in Virginia, but not subject to Mandated Benefits as provided in § 38.2-3408 or § 38.2-4221 and § 38.2-3409 through § 38.2-3419 are not considered applicable policies.

3. Companies submitting an abbreviated report must submit page A- I of Form MB- I as well as the information required by § 4 D of Regulation No. 3 **8.**

Parts A and B

I . **Part A** requires disclosure of specific claim data for each mandated benefit and mandated offer for both individual and group business. **Part B** requires similar data for each mandated provider category. In determining the cost of each mandate, it is expected that claim and other actuarial data will be used. A listing of the CPT-4 and 1CD-9CM Codes which should be used in collecting the required data is attached for your convenience.

2. On the worksheets for individual and group business for columns a and b - "Number of Visits" or "Number of Days" reported should be consistent with the type of service rendered. For example, number of days should not be reported unless the claim dollars being reported were paid or incurred for inpatient or partial hospitalization.

3. 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 of the criteria provided in this section of the Code of Virginia.

4. Claims reported for § 38.2-3410 should include only claims for treatment normally provided by a physician, but which were provided by a dentist. Claims for normal dental services should not be reported.

5. Total claims paid or incurred on individual or group policies "subject to the above requirements" refers to all claims paid or incurred under the types of policies subject to the reporting requirements. This figure should <u>not</u> be the total of claim payments entered in column c, rather a total of all claims paid or incurred under the applicable contracts or certificates.

6. **Column d- Number of Contracts,** (individual business) - companies should report the number of individual contracts 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.

7. **Column d - Number of Certificates,** (group business) should be the number of group **certificates** 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.

8. **Column f - Annual Administrative Cost** should only include 1995 administrative costs (not start-up costs, unless those costs were incurred during the reporting period).

9. **Column g - Percent of Total Health Claims** figures should be calculated using one base for the individual business worksheets and another base for the group business worksheets.

Part C

1. Part C requires the company to identify standard individual and group policies, the annual premium for each type of coverage, and the portion of the annual premium attributable to each mandated benefit, offer, and provider. 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 figure 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.**

2. Question #4, the premium for a policy "with mandates" should include all mandated benefits, offers, and providers.

Part D

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

2. Data should only reflect approved claims. Denials should not be included.

General

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

2. Symbols such as (N/A) should not be used in the report. If a particular question or group of questions are not applicable to the company, the corresponding blanks should be left empty. All empty blanks should be explained in a cover letter accompanying the report filing. Zeros inserted in a field in this report indicate that a company has collected data, but has no claims. If a company was unable to collect data, the field should be left empty, not completed with a zero.

3. Note the addition of data to be reported for Bone Marrow Transplants, § 3 8.2-3418. 1: 1. This is the first reporting year for this information. Refer to Administrative Letter 1995-5, dated June 20, 1995.

Form MB-1
Annual Report of Cost and Utilization Data
Relating to Mandated Benefits and Mandated Providers
Pursuant to § 38.2-3419.1 of the Code of Virginia

Reporting Period

Company Name:

Group Name:

Mailing Address:

NAIC #: Group NAIC

Name of Person Completing Report:

Title:

Direct Telephone #:

Mailing Address:

I . Total accident and sickness premiums written in Virginia for all accident and sickness lines including credit, disability income, and all others, whether subject to §§ 38.2-3408 or 38.24221 and §§ 38.2-3409 through 38.2-3419 of the Code of Virginia or not, as reported on the Company's Annual Statement for the reporting period: $

2. Total accident and sickness premiums written in Virginia on applicable policies and contracts, as defined in § 3 of these rules that are subject to §§ 38.2-3408 or 38.2-4221 and §§ 38.23409 through 38.2-3419 for the reporting period: $

3. Does this company claim eligibility to file an abbreviated report under § 4 C of Regulation No. 38 for this reporting period?

( ) Yes, and filing the abbreviated report allowed for in § 4 C. ( ) No, and filing a complete report

Part A: **Claim Information - Benefits***

Enter the basis on which claim data presented throughout this report was collected (either "paid" or "incurred"):

INDIVIDUAL

Va. Code Section	description	a Number of Visits	b Number of Days	c Total Claims Pavinents	d Number of Contracts	e Claim Cost Per Contract	f Annual Administrative Cost	9 Percent of Total Health Claims
38.2-3409	Dependent Children (Handicapped)							
38.2-3410	Doctor to Include Dentist							
38.2-3411	'Newborn Children							
38.2-3412.1	Mental / Emotional Nervous							
	Inpatient							
	Partial Hospital							
38.2-3412.1	Alcohol and Drug Dependence							
	Inpatient							
	Partial Hospital							
38.2-3418	Pregnancy from Rape / Incest							
38.2-3418.1	Mammography							
38.2-3411.1	Child Health Supervision							
38.2-3418.1:1	Bone Marrow Transplants							

Enter total claims paid or incurred on individual policies subject to the above requirements (this figure should be used in calculating the figures required for column g): include information and amounts paid or incurred on hospital bills and other providers

a: number of provider and physician visits

b: number of inpatient or partial hospital days (if applicable)

c: total of claims paid or incurred for this mandate

d: number of contracts in force in Virginia containing the required or optional coverage

e: claim cost per contract = column c divided by column d

f the administrative cost of complying with this mandate during the reporting period

g: claims paid or incurred for this benefit as a percentage of the total amount of health claims paid or incurred on individual policies or contracts subject to this reporting requirement

Part A (continued): Claim Information - Benefits*

Enter the basis on which claim data presented throughout this report was collected (either "paid" or "incurred"):

GROUP

Va. Code Section	Description	Number of Visits	a Number of Days	b Total Claims Payments	c Number of Certificates	d Claim Cost Per Certificate	e Annual Administrative Cost	f Percent of Total Health Claims	9
38.2-3409	Dependent Children (Handicapped)								
38.2-3410	Doctor to Include Dentist								
38.2-3411	Newborn Children								
38.2-3412.1	Mental / Emotional Nervous:								
	Inpatient								
	Partial Hospital								
	Outpatient								
38.2-3412.1	Alcohol and Drug Dependence								
	Inpatient								
	Partial Hospital								
	Outpatient								
38.2-3414	Obstetrical Services								
	Normal Pregnancy								
	All Other								
38.2-3418	Pregnancy from Rape Incest								
38.2-3418.1	Mammography								
38.2-3411.1	Child Health Supervision								
38.2-3418.1:1	Bone Marrow Transplants								

Enter total claims paid or incurred on group policies subject to the above requirements
(this figure should be used in calculating the figures required for column g):

* include information and amounts paid or incurred on hospital bills and other providers for all health care expenses incurred because of this mandate

a: number of provider and physician visits
b: number of inpatient or partial hospital days (if applicable)
c: total of claims paid or incurred for this mandate
d: number of certificates containing the required or optional coverage
e: claim cost per certificate = column c divided by column d
f. the administrative cost of complying with this mandate during the reporting period
g: claims paid or incurred for this benefit as a percentage of the total amount of health claims paid or incur-red on group policies or contracts subject to this reporting requirement

Part B: Claim Information - Providers

WDIVIDUAL

Va. Code Sections 38.2-3408 & 38.2-4221	a Number of Visits	b Total Claims Payments	c Cost Per visit	d Number of Contracts	e Claim Cost Per Contract	f Annual Administrative Cost	9 Total Health Percent of Claims
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist*							
Audiologist							
Speech Pathologist							

rendering mental health services

a: number of visits to this provider group for which claims were paid or incurred in Virginia
b: total dollar amount of claims paid to this provider group in Virginia
c: cost per visit = column b divided by column a
d: number of individual contracts subject to this reporting requirement
e: claim cost per contract = column b divided by column d
f: the administrative cost of complying with this mandate during the reporting period
g: claims paid or incurred for services administered by each provider type as a percentage of the total amount of health claims paid or incurred on individual policies or contracts subject to this reporting requirement

GROUP

Va. Code Sections 38.2-3408 & 38.2-4221	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of Certificates	e Claim Cost Per Certificate	f Annual Administrative Cost	9 Percent of Total Health Claims
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist*							
Audiologist							
Speech Patholo ist							

rendering mental health services

a: number of visits to this provider group for which claims were paid or incurred in Virginia
b: total dollar amount of claims paid to this provider group in Virginia
c: cost per visit = column b divided by column a
d: number of certificates subject to this reporting requirement
e: claim cost per certificate = column 6 divided by column d
f: the administrative cost of complying with this mandate during the reporting period
g: claims paid or incurred for services administered by each provider type as a percentage of the total amount of health claims paid or incurred on group contracts subject to this reporting requirement

Part C: Premium Information

1. Please use what you consider to be your standard policy to answer this question. For the individual policy used as your base calculations in the question below:

   • What is the deductible?
   • What is the coinsurance % paid by the insurer?
   • What is the individual/employee out-of-pocket maximum?

   For the group policy used as your base calculation in the question below:

   • What is the deductible?
   • What is the coinsurance % paid by the insurer?
   • What is the individual/employee out-of-pocket maximum?

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 below. In addition, provide the portion (dollar amount) of the annual premium for each policy that is attributable to each mandate listed. 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's mandates.

	Va. Code Section	Individual Policy		Group Certificates	
		Single	Family	Single	Family
Annual Premium for Standard Policy Described Above					
Premium Attributable to Each Mandate:					
Dependent Children (Handicapped)	38.2-3409				
Doctor to Include Dentist	38.2-3410				
Newborn Children	38.2-3411				
Mental/Emotional/Nervous (Mental Disabilities)	38.2-3412.1				
Inpatient					
Partial Hospitalization					
Outpatient					

Alcohol and Drug Dependence	38.2-3412.1
Inpatient	
Partial Hospitalization	
Outpatient	
*Obstetrical Services	38.2-3414
Normal Pregnancy	
All Other	
Pregnancy from Rape or Incest	38.2-3418
*Mammography	38.2-3418.1
*Bone Marrow Transplants	38.2-3418.1:1
*Child Health Supervision	38.2-3411.1

Denotes mandated offer

Chiropractor	38.2-3408/38.24221
Optometrist	38.2-3408/38.2-4221
Optician	38.2-3408/38.2-4221
Psychologist	38.2-3408/38.2-4221
Clinical Social Worker	38.2-3408/38.2-4221
Podiatrist	38.2-3408/38.2-4221
Professional Counselor	38.2-3408/38.24221
Physical Therapist	38.2-3408/38.24221
Clinical Nurse Specialist**	38.2-3408/38.2-4221
Audiologist	38.2-3408/38.2-4221
Speech Pathologist	38.2-3408/38.2-4221

***rendering mental health services

2. What is the number of individual policies and/or group certificates issued or renewed by the Company in Virginia during the reporting period?

	Single	Family		Single	Family
Individual			Group		

3. What is the number of individual policies and/or group certificates in force for your company in Virginia as of the last day of the reporting period?

	Single	Family		Single	Family
Individual			Group		

4. What would be 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? What would be the cost for a policy for the same individual with present mandates? (Assume coverage including $250 deductible, $1,000 stop-loss limit, 80% co-insurance factor, $250,000 policy maximum.) If you do not issue a policy of this type, please 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.

Without Mandates $ With Mandates $

Differences in Policy

5. The following questions concern the cost of converting group coverage to an individual policy. Answer only those questions which are relevant to your company's practices.

   a. 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:

      Single: Family:

   b. If the cost of conversion is instead covered in the annual premium of the individual policy, provide the average dollar amount attributable to the conversion requirement:

      Single: Family:

   c. If the cost of conversion is instead covered by a onetime charge made to the group policyholder for each conversion, provide the average dollar amount:

      Single: Family:

Part D: Utilization and Expenditures for Selected Procedures by Provider Type

Selected Procedure Codes are fisted here 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 here. Individual and group data must be combined for this pIrt gf the rgport.

1. Procedure Code 99203

Office Visit, Intermediate Service to New Patient

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Clinical Social Worker			
Physical Therapist			
Podiatrist			
Professional Counselor			
Psychologist			
Physician			

2. Procedure Code 90844

Medical Psychotherapy, 45 to 50 Minute Session

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist*			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

3. Procedure Code 90853
Group Medical Psychotherapy

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist*			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

4. Procedure Code 92507

Speech, Language or Hearing Therapy; Individual

	Number of Visits	Claims Payments	Cost Per Visit
Audiologist			
Clinical Social Worker			
Physical Therapist			
Professional Counselor			
Speech Pathologist			
Physician			

5. Procedure Code 97110

Physical Medicine Treatment, each 15 minutes, Therapeutic Exercise

	Number of Visits	Claims Payments	
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			
Speech Pathologist			

6. Procedure Code 97124

Physical Medicine Treatment, Massage

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

7. **Procedure Code 97035**
Physical Medicine Treatment, Ultrasound

	Number of Visits	Claims Pavments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

8. Procedure Code 92352
Fitting of Spectacle Prosthesis for Aphakia,

	8. Number of Visits	Claims Payments	Cost Per visit
Ophthalmologist			
Optician			
Optometrist			
Physician			

9. Procedure Code 11750
Excision of Nail and Nail Matrix, Partial or Complete, for Permanent Removal

	Number of Visits	Claims Payments
Physician		
Podiatrist		

CPT and 1CD-9CM Codes

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 NICU care, per day, for the evaluation and management of a critically ill neonate or infant
99296	Subsequent NICU care, per day, for the evaluation and management of a critically ill and unstable neonate or infant 99297 Subsequent NICU 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	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 LTB-82 place-of-service codes from Section B of this Appendix to differentiate between inpatient, partial hospitalization, and outpatient claims where necessary)

ICD Codes

290, 293-294 Organic Psychotic Conditions

295-299	Other psychoses
300-302, 306-316	Neurotic disorders, personality disorders, 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-	Consultation for psychiatric evaluation of a patient includes examination of a

99263 patient and exchange of information with primary physician and other informants such as nurses or family members, and preparation of report.

90801 Psychiatric diagnostic interview examination, including history, mental status, or disposition

90820 Interactive medical psychiatric diagnostic interview examination

90825 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, eg. WAIS-R, Rorschach, MMPI) with interpretation and report, per hour

90835 Narcosynthesis for psychiatric diagnostic and therapeutic purposes

90841 Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy; (face to face with the patient); time unspecified

90842 approximately 75 to 80 minutes (90841)

90843 approximately 20 to 30 minutes (90841)

90844 approximately 45 to 50 minutes (9084 1)

90845 Medical psychoanalysis

90846 Family medical psychotherapy (without the patient present)

90847 Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated

90849	Multiple &mily group medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated
90853	Group medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated
90855	Interactive individual medical psychotherapy
90857	Interactive group medical psychotherapy
90862	Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy
90870	Electroconvulsive therapy, single seizure
90871	Multiple seizures, per day
	Other Psychiatric Therapy
90880	Medical 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 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
	Other Procedures
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

Same as listed above for Mental/Emotional/Nervous Disorders, but for above listed conditions.

Va. Code Section 38.2-3414: Obstetrical Services

Normal Pregnancy

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 iffant. This code is for use as a single diagnosis code and- is not to be used with any other code in the range 630 - 676

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

630-648, Complications of pregnancy, childbirth, and puerperium

651-676

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 (ie., non-attending physician) with written report (separate procedure); 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 (separate procedure)
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)
59300	Episiotomy or vaginal repair, by other than attending physician
59320	Cerclage or cervix, during pregnancy; vaginal

59325	abdominal (59320)
59350	Hysteroffhaphy 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 epi.siotomy 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 5 95 10 or 59515)

Abortion

99201-99235	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
59899	Unlisted procedure, maternity care and delivery

Anesthesia

00850	Cesarean section
00855	Cesarean hysterectomy
00857	Continuous epidural analgesia ffir labor and cesarean section

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 (Well Baby Care)

CPT Codes

90700	hmunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine

	(DTaP)
90701	Diphtheria and tetanus toxoids and pertussis vaccine (DTP)
90702	Diphtheria and tetanus toxoids (DT)
90703	Tetanus toxoid
90704	Mumps virus vaccine, live
90705	Measles virus vaccine, live, attenuated
90706	Rubella virus vaccine, live
90707	Measles, mumps and rubella virus vaccine, live
90708	Measles, and rubella virus vaccine, live
90709	Rubella and mumps virus vaccine, live
90710	Measles, mumps, rubella, and varicella. vaccine
90711	Diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine
90712	Poliovirus vaccine, five, oral (any type (s))
90716	Varicella (chicken pox) vaccine
90720	Diphtheria, tetanus toxoids, and pertussis (DTP) and Hemophilus influenza B (HIB) vaccine
90737	Hemophilus influenza B

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 I year)
99382	early childhood (age I through 4 years) (993 8 1)
99383	late childhood (age 5 through I I years) (993 8 1)

Established Patient

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 I year)
99392	early childhood (age I through 4 years) (993 9 1)

99393	late childhood (age 5 through I I years) (99391)
96110	Developmental testing; limited (eg. Developmental screening Test H, Early Language Milestone Screen), with interpretation.and report
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

174.0 through 174.9 - female breast
175.0 through 175.9 - male breast

CPT Codes

36520	Therapeutic apheresis (plasma and/or cell exchange)
38241	autologous
86950	Leukocyte transfusion

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 and any of the CPT codes shown above are utilized, the insurer should report all claim costs incurred within thirty (30) days prior to the CPT Coded procedure as well as all claim costs incurred within ninety (90) days following the CPT Coded procedure.

B. Uniform Billing Code Numbers (UB-82)

PLACE OF SERVICE CODES

Field Values		Report
10	Hospital, inpatient	Inpatient
iS	Hospital, affiliated hospice	Inpatient
lZ	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

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