BUREAU OF INSURANCE

February 27, 1998

ADMINISTRATIVE LETTER 1998-2

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 - 1997 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 1997 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. *The completed Form MB-1 is due on or before May 1, 1998*. **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 14 VAC 5-190-40 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 explain the type of information required to complete the MB-1 form and serve to highlight frequent errors and omissions, but it should be noted that these instructions are not complete. All sources of information, including 14 VAC 5-190-10 et seq., §§ 38.2-3408 through 38.2-3418.1:1, and § 38.2-4221 should be consulted in the preparation of this report.

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

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Companies are reminded that failure to submit a substantially complete and accurate report pursuant to the provisions of 14 VAC 5-190-10 et seq. 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,

Alfred W. Gross
Commissioner of Insurance

AWG/apb

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

Form MB-1 Instructions and Information

COVER SHEET:

The figure entered for **Total Premium for all Accident and Sickness Lines** should be consistent with the total accident and sickness premium written in Virginia for all accident and sickness lines including credit accident and sickness, disability income, and all others, whether subject to §§ 38.2-3408 or 38.2-4221 and §§ 38.2-3409 through 38.2-3419 of the Code of Virginia or not, **as reported in the Company's Annual Statement for the reporting period**. This figure should not be adjusted.

The figure 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 §§ 38.2-3408 or 38.2-4221 and §§ 38.2-3409 through 38.2-3419 for the reporting period. 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.

Report Type (Abbreviated or Complete) - the company must determine eligibility to file an abbreviated report under 14 VAC 5-190-40 C or a complete report for this reporting period. Companies submitting an abbreviated report must submit the cover sheet of Form MB-1 *as well as* the information 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, either "Paid" or "Incurred" must always be completed. This is entered 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 refers to all claims paid or incurred under the types of policies subject to the reporting requirements. This figure should not 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. This number has been omitted by several carriers reporting previously. The Bureau can not compile the information reported without this number. **It is imperative that this number be entered**. Enter this figure on the corresponding line in Column g. This figure is the only information provided in column g, part A.

Columns a and b - "**Number of Visits" or "Number of Days**" refers 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 of the criteria provided in this section of the Code of Virginia.

Claims reported for § 38.2-3410, Doctor to Include Dentist, should include only claims for treatment normally provided by a physician, but which were 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

Individual business - companies should report the number of individual **contracts** in force in Virginia 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** in force in Virginia 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 figure entered in column d. **It is no longer necessary for reporting companies to enter this figure**. The Bureau's software will compute this figure automatically.

Column f - Annual Administrative Cost should only include 1997 administrative costs (not start-up costs, unless those costs were incurred during the reporting period).

Column g - as noted above, the Percentage of Total Health Claims computed in column g will be computed automatically by the Bureau's software. The only information companies must report in column g is the Total claims paid or incurred, which is entered on the corresponding line in column g, and represents the dollar amount of all claims paid or incurred for individual or group policies, as applicable.

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-4 and ICD-9CM 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 figure entered in column a. **It is no longer necessary for reporting companies to enter this figure**. The Bureau's software will compute this figure automatically.

Column d - Number of Contracts

Individual business - report the number of individual **contracts** subject to this reporting requirement.

Group business - report the number of group **certificates** subject to this reporting requirement.

Column e - Claim Cost Per Contract/Certificate - (both group and individual business) is the amount entered in column b divided by the figure entered in column d. **It is no longer necessary for reporting companies to enter this figure**. The Bureau's software will compute this figure automatically.

Column f - Annual Administrative Cost should only include 1997 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 health claims paid or incurred subject to this reporting requirement. **It is no longer necessary for reporting companies to enter this figure**. The Bureau's software will compute this figure 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 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.**

Number of Contracts/Certificates

Provide the number of individual policies and/or group certificates *issued or renewed* by the Company in Virginia **during the reporting period** in the appropriate fields under each heading.

Provide the number of individual policies and/or group certificates *in force* for the company in Virginia as of the **last day of the reporting period** 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 instead 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 instead 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 no longer necessary to report the Cost Per Visit. The Bureau's software will compute this figure automatically.

GENERAL

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, mandated offer and provider statutes.

Note the addition of data to be reported in Part A: Claim Information - Benefits, **Coverage for Mental Health and Substance Abuse Services** for outpatient treatment with respect to individual policies, § 38.2-3412.1 C, **Obstetrical Benefits; Coverage for Postpartum Services,** § 38.2-3414.1**,** and **Coverage for Pap Smears,** § 38.2-3418.1:2. Also note that, with respect to individual policies, companies must report premium information relative to outpatient treatment for mental health and substance abuse services in Part C of Form MB-1. This is the first reporting year for this information. Refer to Administrative Letter 1997-11, dated October 10, 1997.

Companies should not enter information in the shaded fields.

A. CPT and ICD-9CM Codes

The codes provided are from the 1997 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-9CM 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 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	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, 293-294	Organic Psychotic Conditions
295-299	Other psychoses
300-302, 306-316	Neurotic disorders, personality disorders, sexual deviations, 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
99241-99255	Initial consultation for psychiatric evaluation of a patient includes examination of a patient and exchange of information with primary physician and other informants such as nurses or family members, and preparation of report.
99261-99263	Follow up consultation for psychiatric evaluation of a patient

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 (90841)
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 family 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

Other Psychiatric Therapy

90870	Electroconvulsive therapy, single seizure
90871	Multiple seizures, per day
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 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

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 and
Va. Code Section 38.2-3414.1: Obstetrical Benefits; Coverage for Postpartum 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 - 676
V24	Postpartum care and examination
V24.0	Immediately after delivery
V24.1	Lactating mother
V24.2	Routine postpartum follow-up

CPT Codes

Any codes in the maternity care and delivery range of 59000-59899 associated with ICD Codes 650 and V24 - V24.2 listed above

All Other Obstetrical Services

ICD Codes

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

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 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 or 59515)

Delivery After Previous Cesarean Delivery

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)

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
59899	Unlisted procedure, maternity care and delivery

Anesthesia

00850	Cesarean section
00855	Cesarean hysterectomy
00857	Continuous epidural analgesia, for 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	Immunization, 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 toxoids, and pertussis (DTP) and injectable poliomyelitis vaccine
90712	Poliovirus vaccine, live, 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 1 year)
99382	early childhood (age 1 through 4 years) (99381)
99383	late childhood (age 5 through 11 years) (99381)

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 1 year)

99392	early childhood (age 1 through 4 years) (99391)
99393	late childhood (age 5 through 11 years) (99391)
96110	Developmental testing; limited (eg. Developmental Screening Test II, 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 through 174.9 - female breast

175 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.

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

88150	Cytopathology, smears, cervical or vaginal, up to three smears; screening by technician under physician supervision
88151	requiring interpretation by physician
88155	with definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index

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 (eg, 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

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 (eg, Wassmund or Schuchard)
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 (eg, 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) (eg for hemifacial microsomia)
21480	Closed treatment of temporomandibular dislocation; initial or subsequent
21485	Complicated (eg, 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 (eg, 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

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