



BUREAU OF INSURANCE

January 22, 1999

ADMINISTRATIVE LETTER 1999 - 1

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 - 1998 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 1998 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, 1999. **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 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 in the company's 1998 Annual Statement, and that amount must be used to determine the type of filing required.

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 Form MB-1 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 38.2-3418.2 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 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

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 1998 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 situated outside of Virginia, and policies situated 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.

Form MB-1 Instructions

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 1998 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. 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 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 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.

Form MB-1 Instructions

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 1998 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.**

Form MB-1 Instructions

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.

Form MB-1 Instructions

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 B: Claim Information - Providers, **Coverage for Services Performed by a Certified Nurse Midwife**, §§ 38.2-3408 and 38.2-4221. 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 1998 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 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 an inpatient
- 90801 Psychiatric diagnostic interview examination

- 90802 Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanism 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

Same as listed above 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 - 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

- 630-677 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 (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 or 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 Continuous epidural analgesia, for labor and cesarean section

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
(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

- 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 - 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

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, screening by cytotechnologist under physician supervision
88150	Cytopathology, smears, cervical or vaginal, up to three smears; screening by technician under physician supervision
88152	with manual cytotechnologist screening and automated rescreening under physician supervision
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 (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
- 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 (e.g., 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 (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 for 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(s)
- 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

<u>Field Values</u>		<u>Report As:</u>
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