

Commonwealth of Virginia

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STATE CORPORATION COMMISSION BUREAU OF INSURANCE

March 3, 1997

ADMINISTRATIVE LETTER 1997-3

TO: ALL INSURERS, HEALTH SERVICES PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS LICENSED TO WRITE ACCIDENT AND SICKNESS INSURANCE 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 1996 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 1996 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. Please note that this form has been modified this year for compatibility with the Bureau's software. The completed Form MB-1 is due on or before May 1, 1997. **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 (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.

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.

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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. The instructions also include some **information previously included as footnotes in prior versions of Form MB-1.**

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

Althelia P. Battle
Senior Insurance Market Examiner
Forms and Rates Section
Bureau of Insurance - Life and Health Division
P.O. Box 1157
Richmond, VA 23218
Telephone: (804) 371-9495
FAX: (804) 371-9944

Companies are reminded that failure to submit a substantially complete and accurate report pursuant to the provisions of 14 VAC 5-190-10 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/jkc

Attachments: Form MB-1

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

Form MB-1

**Annual Report of Cost and Utilization Data Relating to Mandated Benefits and
Mandated Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia**

Cover Sheet

NAIC#

Group NAIC#:

Reporting Year:

Company Name:

Group Name:

Mailing Address:

Contact:

Title:

Direct Phone

Mailing Address:

Total Premium for all Accident and Sickness Lines:

Total Premiums on Applicable Policies and Contracts:

Report Type (Abbreviated or Complete):

[CLAIM96.XLW]Cover Sheet

Page I

Part A: Claim Information - Benefits

Enter the basis on which claim data presented throughout		this report was collected (either "Paid" or "Incurred"):						
		a	b	c	d	e	f	g
VA Code Section	Description	Number of Visits	Number of Days	Total Claims Payments	Number of Contracts/Certificates	Claim Cost Per Contract/Certificate	Annual Administrative Cost	Percent of Total Health Claims
INDIVIDUAL	Total claims paid/incurred:							
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							
38.2-3412.1	Partial ffos-pital Alcoholand Drug Dependence Inpatient							
38.2-3418	Partial Hospital Pregnancy from Rape Incest							
38.2-3418.1	Mammography							
38.2-3411.1	Child Health Supervision							
38.2-3418.1:1	Bone Marrow Transplants							
38.2-3418.2	Bones and Joints							

Part A: Claim Information - Benefits

Enter the basis on which claim data presented throughout this report was collected (either "Paid" or "Incurred");

VA Code Section	Description	a Number of Visits	b Number of Days	c Total Claims Payments	d Number of Contracts/ Certificates	e Claim Cost Per Contract/ Certificate	f Annual Administrative Cost	g Percent of Total Health Claims
GROUP	Total claims paid/incurred:							
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							
	Palial Hospital							
	Outpatient							
Y8-.2-3-4-14	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							
138.2-3418.2	1 Bones and Joints							

Part B: Claim Information - Providers

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

Par B: Claim Information - Providers

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

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Part C: Premium Information

					-T-
	VA Code	Individual Policy		Group Certificates	
	Section	Single	Family	Single	Family
Standard Policy:					
Deductible					
Co-Insurance Percentage Paid by Insurer					
Individual/Employee Out-of-Pocket Maximum					
Annual Premium					
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				
Bones and Joints-	38.2-3418.2				
Child Health Supervision	38.2-3411.1				
Chiropractor	38.2-3408/4221				
Optometrist	38.2-3408/4221				
Optician	38.2-3408/4221				
Psychologist	38.2-3408/4221				

Part C: Premium Information

	VA Code	Individual Policy		Group Certificates	
	Section	Single	Family	Single	Family
Clinical Social Worker	38.2-3408/4221				
Podiatrist	38.2-3408/4221				
Professional Counselor	38.2-3408/4221				
Physical Therapist	38.2-3408/4221				
Clinical Nurse Specialist	38.2-3408/4221				
Audiologist	38.2-3408/4221				
Speech Pathologist	38.2-3408/4221				
Number of Con tracts/Certificates:					
Issued or Renewed					
In Force					
Annual Premium for Individual Standard Policy (30 year old male in Richmond):					
Without Mandates					
With Mandates					
Average Dollar Amount for Converting Group to Individual:					
Covered in Policy or Certificate					
Onetime Charge					

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

Procedure Code / Provider Type	Number of Visits	Claims Payments	Cost Per visit
1. 99203. - Office Visit, Intermediate Service to New Patient			
Chiropractor			
Clinical Social Worker			
Physical Therapist			
Podiatrist			
Professional Counselor			
Psychologist			
Physician			
2. 90844 - Medical Psychotherapy, 45 to 50 Minute Session			
Clinical Nurse Specialist			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist-----			
Physician			
3. 90853 - Group Medical Psychotherapy			
Clinical Nurse Specialist			
Clinical Social Worker			
Professional -Counselor-.-----			
Psychiatrist			
Psychologist			
Physician			

D: Utilization and Expenditures for Selected Procedures by Provider Type

Procedure Code / Provider Type	Number of Visits	Claims Payments	Cost Per Visit
4. 92507 - Speech, Language or Hearing Therapy; Individual			
Audiologist			
Clinical Social Worker			
Physical Therapist			
Professional Counselor			
Speech Pathologist			
Physician			
5. 97110 - Physical Medicine Treatment, each 15 minutes, Therapeutic Exercise			
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			
Speech Pathologist			
6. 97124 - PhysicWI -Medicine Treatment, Massage			
Chiropractor			
Physical Therapist			
Physician			
.Podiatrist			

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

Procedure Code / Provider Type	Number of Visits	Claims Payments	Cost Per Visit
7 . 97035 - Physical Medicine Treatment, Ultrasound, each 15 minutes			
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			
8 . 92352 - Fitting of Spectacle Prosthesis for Aphakia, monofocal			
Oph-thalm-ologist			
Optician			
Optometrist			
Physician			
9 . 11750 - Excision of Nail and Nail Matrix, Partial or Complete, for Permanent	Removal		
Physician			
Podiatrist			

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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 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- I 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 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.**

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 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 1996 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 this benefit 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 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 1996 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 **unshaded** 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 *inforce* 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.

Companies should not enter information in the shaded fields.

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 M113-1 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 for **Coverage of Procedures Involving Bones and Joints**, § 38.23418.2. This is the first reporting year for this information. Refer to Administrative Letter 1996-16, dated December 4, 1996.

A.

CPT and ICD-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 I-Estory 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 LJB-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, Neurotic disorders, personality disorders, sexual deviations,- other non-psychotic
306-316 mental disorders
317-319 Mental retardation

CPT Codes

99221- Initial hospital care, per day, for the evaluation and management of a patient
99223
99231- Subsequent hospital care, per day, for the evaluation and management of a
99233 patient
99238 Hospital discharge day management; 30 minutes or less
99241- Initial consultation for psychiatric evaluation of a patient includes examination of a
99255 patient and exchange of information with primary physician and other informants such as nurses or family members, and preparation of report.
99261- Follow up consultation for psychiatric evaluation of a patient
99263
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

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- 96100 Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg. WAIS-R, Rorschach, MIAPI) 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 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

90889 examinations and procedures, or other accumulated data to family or other responsible persons, or advising them to assist patient
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 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 (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 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) including postpartum care (59409)
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 595 10 or 59515)

Abortion

99201- Medical treatment of spontaneous complete abortion, any trimester
99233
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 (H[B] 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) (993 8 1)
 - 99383 late childhood (age 5 through 11 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 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 11, 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 38.2-3418.2: 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 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 (eg, 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

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