september 2012

providers' news

A publication for participating providers and their office staffs

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Reporting fraud, waste and abuse

If you suspect any potentially fraudulent activity by a provider, beneficiary or another entity, never confront the person suspected; instead call the FRAUD HOTLINE at 1-800-FRAUD-21 (1-800-372-8321). The Fraud Hotline is available 24 hours a day, 7 days a week. All reports are kept strictly confidential, and callers can remain anonymous.

This applies to Arkansas Blue Cross and Blue Shield, its subsidiaries and affiliate companies, including Medi-Pak® Advantage.

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Applied behavior analysis coverage for autism

On October 1, 2011 and upon renewal of group insurance policies and HMO contracts for 2012, Arkansas Blue Cross and Blue Shield and Health Advantage began covering and administering benefits for Applied Behavioral Analysis (ABA) in accordance with Act 196 of 2011, codified at ACA. §23-99-418, enacted by the General Assembly of the State of Arkansas which mandates coverage of Early Intensive Behavioral Intervention (EIBI), with the following conditions:

1. Applied Behavioral Analysis (ABA) must be ordered for a specific individual diagnosed with autism spectrum disorder (ASD) by a licensed physician or psychologist;
2. ABA must be provided or supervised by a therapist certified by the nationally accredited Behavior Analyst Certification Board;
3. The individual with ASD must be less than eighteen years of age; and
4. ABA shall have an annual limitation of $50,000.

The following HCPCS codes should submitted for ABA services:

- **H2012:** Day treatment per hour – supervision by board certified behavior analyst (BCBA) limited to six hours per week; H2019 plus H2012;
- **H0031:** Mental health assessment by non-physician – ABA testing (initial or reassessment) limited to no more often than every three months; record of test must be submitted with the claim;
- **H0032:** Mental health service plan development by non-physician – development of individual treatment plan (ITP); limited to no more often than every six months; record of ITP must be submitted with claim;
- **H2019:** Therapeutic behavioral services (fifteen minutes) – supervision by BCBA; limited to six hours per week; H2019 plus H2012;
- **H2020:** Therapeutic behavioral services (per diem);
- **H0046:** Mental health services, not otherwise specified – direct service provider for ABA per hour. These services may be provided by the BCBA or by an associate trained in direct services for autism. Whether provided by the BCBA or the associate, these services should be billed with the BCBA's provider number. Services are limited to forty hours per week.

Bevacizumab (avastin) for metastatic, triple negative breast cancer (TNBC)

Effective January 1, 2012 bevacizumab was discontinued for the treatment of metastatic breast cancer when the FDA removed the approved indication.

Recently, two sub-group analysis studies investigating the use of bevacizumab in the treatment of triple negative breast cancer (TNBC) have been published. Both articles reported rather good results at one year for a group of women with relatively few treatment options:

- First-line bevacizumab-containing therapy for triple-negative breast cancer: analysis of 585 patients treated in the ATHENA study. Thomssen C, Pierga JY, Pritchard KI, et al. Oncology, 2012; 82:218-227.
- Second-line bevacizumab-containing therapy in patients with triple-negative breast cancer: subgroup analysis of the RIBBON-2 trial. Brufsky A, Valero V, Tiangco B, Dakhil S, Brize A, Rugo HS, Rivera R, Duenne A, Bousfoul N, Yardley DA. Breast Cancer Research Treatment, 2012; 133(3):1067-75.

As a result of these studies, Bevacizumab, as first-line or second-line therapy, will be covered for the treatment of metastatic, triple negative breast cancer.

CMS compliance training

As a contractor with the Centers for Medicare & Medicaid Services (CMS) to provide Medicare Advantage (MA) and Prescription Drug Program (PDP) plans, Arkansas Blue Cross and Blue Shield is required by CMS regulations to develop and maintain a compliance program and to provide annual training to all first-tier, downstream and related entities annually.

Arkansas Blue Cross has established a corporate compliance program and developed standards of conduct training, which Arkansas Blue Cross will provide to all first-tier and downstream entities, including contracted providers. During September, Arkansas Blue Cross will distribute compliance training materials to all Medi-Pak Advantage (PFFS and PPO) and Medi-Pak Rx (PDP) contracted providers to meet CMS training requirements. The CMS training must be completed no later than December 31, 2012.

The Office of the Inspector General (OIG) has issued corporate compliance guidelines that strongly encourage providers to develop and implement a voluntary compliance program as an effective tool in detecting and preventing fraud, waste and abuse. The requirements for provider and plan compliance programs closely track with the requirements found in the Federal Sentencing and OIG Guidelines. The U.S. Federal Sentencing Guidelines are used in issuing sentences for those convicted in federal court and provide for lesser sentences for convicted entities that have an "effective compliance program in place."

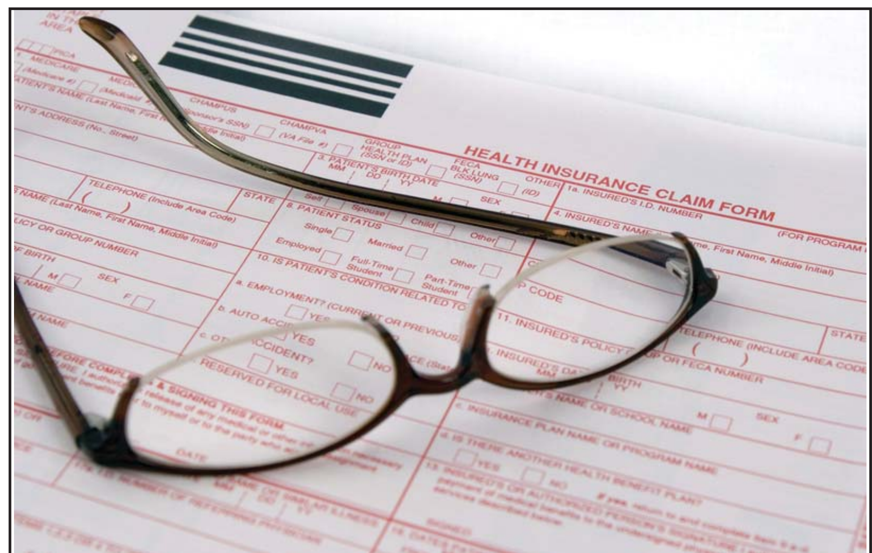
The OIG has issued guidance with reference to "effective compliance programs" for specific health care providers and can be found at http://oig.hhs.gov/fraud/complianceguidance.asp. The Federal Register Notice CMS-4124-FC, CMS clarifies that the training and communication requirements apply to all entities with which Arkansas Blue Cross partners.

Upon completion of the training, an individual authorized to represent your organization must complete an online attestation indicating that all applicable individuals within your organization have completed the training. CMS also requires that all training documentation be kept on file including training logs, demonstrating who was trained, the date they were trained and a copy of the attestation of completion. All records should be kept for 10 years and it is the provider's responsibility to supply such data, if audited.

Thank you in advance for your cooperation. If you have any questions or concerns, please contact your network management representative or the Arkansas Blue Cross Compliance Office at 501-378-2525.

Black UB04 claim forms no longer accepted

Beginning October 1, 2012, paper claims submitted on black UB-04 (CMS-1450) claim forms will be returned to the provider. Paper facility claims should be submitted on the standard UB-04 claim form with red "drop out" ink. These may be obtained through various print vendors that comply with National Uniform Billing Committee (NUBC) specifications. Arkansas Blue Cross and Blue Shield recommends providers submit claims electronically and avoid using paper claim forms when ever possible.



AHCPII: State payers announce new payment initiative

This article is a repeat publication from the June 2012 issue of *Providers' News*. Since the June publication, Arkansas Blue Cross and Blue Shield and its family of companies have published reports for principal accountable providers (PAPs)involved in the AHCPII projects - at this time for Arkansas Blue Cross that includes total hip replacements, total knee replacements, OB/perinatal and congestive heart failure. These reports are on AHIN and should be reviewed as soon as possible by the PAPs.

In addition, AHCPII Town Hall meetings open to the public have been held in ten towns across Arkansas. Representatives from both public and private payers have presented detailed information about AHCPII as well as received very valuable feedback from the provider community. Arkansas Blue Cross and the other payers are using this feedback to help ensure reports are being developed and data gathered to encompass all scenarios as much as possible. Arkansas Blue Cross will be sending contract amendments to PAPs in late September for AHCPII. To obtain information about Arkansas Blue Cross' involvement in the AHCPII, please contact your local Network Development Representative. For detailed questions about the PAP reports produced by Arkansas Blue Cross please call 1-888-800-3283 or email APIICustomerSupport@arkbluecross.com.

As the health care industry faces increasingly stringent demands to control rising costs, both from the private and public sectors, payment transformation has become part of the national conversation. Effective payment transformation should address both the cost and quality of care by aligning incentives across stakeholders to reduce unwarranted variation in quality and increase cost efficient processes and practices. Physicians and hospitals should be rewarded for improved care coordination and improved outcomes. The Arkansas Health Care Payment Improvement Initiative (AHCPII) is an effort on the part of health care payers in Arkansas to transform the provider payment system in the state to reward high quality, cost efficient providers.

The AHCPII is a collaboration between Arkansas Medicaid, Arkansas Blue Cross and Blue Shield (and its affiliated companies Health Advantage and BlueAdvantage Administrators of Arkansas), and QualChoice. It was formed to replace our current payment model, which often rewards activity regardless of value, with a model that rewards health care providers for providing necessary, high quality and cost-effective care.

This Initiative was developed with input from hundreds of individuals and organizations including physician associations, hospital executives, clinicians, patients, advocacy groups and the Center for Medicare & Medicaid Services (CMS). Unrelated to the federal health care reform legislation passed in 2010, the AHCPII puts Arkansas on the leading edge of national efforts to improve health care quality and cost efficiency.

The first phase of the new payment initiative launched July 1, 2012. Initially, six episodes of care will be monitored. They include:

- Upper respiratory infections
- Hip and knee replacements
- Congestive heart failure
- Attention-deficit/hyper-activity disorder (ADHD)
- Pregnancy
- Developmental disabilities

During the first three to six months of the initiative, providers will have access to reports designed to help them understand their current practice patterns and the financial and quality outcomes they generate. The data for those reports will be pulled from existing claims data and from a limited set of data that providers will enter into a provider portal for some of the episodes.

The Provider Network Operations staff will work with providers to help identify opportunities for improved alignment with the new payment methodology. There will be no immediate change to reimbursement. Following this introductory period, reimbursement methodology changes will be implemented by Arkansas Blue Cross and its affiliated companies.

While the private payers (Arkansas Blue Cross and QualChoice) have joined with the public agencies (CMS and Arkansas Medicaid) to work on developing a common approach to assessing, tracking and promoting quality and

cost efficiency, each private payer will separately and independently determine its own specific reimbursement changes and policies that may result from the broader, government-sponsored initiative. In addition, as shown on the following page, the implementation for each measure will be phased in on a payer-by-payer basis.

How is an episode of care defined for each of the six initial diagnoses? The chart below describes the definition of each episode in the initial transformation phase and identifies the payer involved in the episode.

How will the new payment model work? For each of the six episodes of care identified, a Principal Accountable Provider (PAP) will be designated. This PAP will be the provider with responsibility for the majority of care in a given episode. In some cases, the PAP will be a physician. In others, it will be a hospital or facility. (See the chart below for PAPs designated for the initial six episodes.)

The PAP will be eligible for gain and risk sharing based on the overall cost and quality of the care delivered to the patient during the episode period. This summer, PAPs gained access to detailed reports analyzing their performance and thoroughly explaining the PAP role.

A Web site (www.paymentinitiative.org.) is currently available to provide ongoing education, a link to the provider portal, and additional resources related to the Initiative. Payers will offer staff assistance through town hall-style meetings

(Continued on page 6)

Episode	Definition/Scope	Payers Launching July 1	Principal Accountable Provider (Pap)
Hip/Knee Replacements	Surgical procedure plus all related claims from 30 days prior to procedure to 90 days after	• Arkansas Blue Cross and its affiliated companies, • QualChoice, and • Medicare*	Surgeon; hospital may also be consider as a Co-PAP
Perinatal	Pregnancy-related claims for mothers from 40 weeks before to 60 days after delivery; excludes neonatal care	• Arkansas Blue Cross and its affiliated companies, • QualChoice, and • Medicaid	Physician who delivered the baby
Ambulatory URI	21-day window beginning with initial consultation and including URI-related outpatient and pharmacy costs; excludes inpatient costs and surgical procedures	• Medicaid and • Medicare*	Initial treating physician*
Acute/Post-acute CHF	Hospital admission plus care within 30 days of discharge	• Arkansas Blue Cross and its affiliated companies, • QualChoice, and • Medicare*	Hospital
ADHD	12-month episode including all ADHD services and pharmacy costs with exception of initial assessment	• Medicaid	Treating physician or licensed clinical psychologist
Developmental Disabilities	Assessment or annual review plus 12 months of DD services	• Medicaid	Primary DD treating provider

***Episodes appropriate for Medicare if CMS determines that Medicare will participate in this program.**

(Continued from page 5) state payers announce new payment initiative

across the state, informational webinars and other educational resources both online and offline throughout the transition period. No changes in reimbursement will occur during the transition period.

PAPs will submit claims as usual, as will non-PAPs involved in an episode of care as outlined. Both PAPs and non-PAPS will continue to receive fee-for-service payments throughout the transition period and once the new payment model is implemented.

At the end of the transition period (not sooner than three months and not later than six), providers will be notified that the new payment methodology is being implemented. As noted previously, both PAPs and non-PAPs will continue to file claims and receive reimbursement as usual.

Following each designated performance period, the payer involved will reconcile the results of the episodes completed during that period against previously established and communicated cost thresholds and quality metric. Calculations will be risk-adjusted and consider factors impacting performance such as outliers, average costs, geography, patient population, etc. If the PAP meets or exceeds these target metric, additional incentive will be paid. If performance falls short of the targets, risk amounts will be withheld from future claims payments.

Health care costs are unsustainable. As a nation, as a state and as individuals, we are all paying the price of an uncoordinated delivery system based on misaligned incentives. It is essential that we as stakeholders in health care delivery and financing take the lead in building a new model that will serve our country, our state and our patients and provide the kind of high-quality, affordable care that is our mutual goal.

For more information, visit the Web site at www.paymentinitiative.org or contact your regional Network Development Representative.

EFT requirement

Termination of network participation will begin in the fourth quarter of 2012 for those providers not enrolled in Electronic Funds Transfer with Arkansas Blue Cross and Blue Shield. This article has appeared in each issue of *Providers' News* since September 2011 and serves as advance notification of network termination.

Electronic Funds Transfer (EFT) or direct deposit will be required of all participating providers of Arkansas Blue Cross and Blue Shield's Preferred Payment Plan (PPP), Health Advantage's HMO network and USAble Corporation's Arkansas' FirstSource© PPO and True Blue PPO network effective October 1, 2012. This will be a requirement in order to participate in these provider networks beginning October 1, 2012. Dental providers will not be included at this time.

Implementing EFT will begin as follows:

1. Effective January 1, 2012, all new provider applicants will be required to enroll in EFT, regardless of whether this is a new clinic or an existing practice. For example, if a new physician is applying to participate in any of the networks mentioned previously, and the physician is applying to join an already established clinic, that clinic must be paid via EFT.
2. Effective January 1, 2012, all providers making a change to any of their information will be required to enroll in EFT. For example, a physician's office needs to change a telephone number within its clinic and submit a change of data form. That change will not be made until the clinic has enrolled in EFT.
3. Beginning October 1, 2012, all participating providers must be enrolled into EFT (excluding dental).

EFT enrollment may be completed on the Advanced Health Information Network (AHIN) or contact your regional Network Development Representative. See the "Claims Payments, Refunds & Offsets" section of the Arkansas Blue Cross Provider Manual at arkansasbluecross.com/providers.

Article originally printed in the September 2011 issue of *Providers' News.*

November is national hospice month

The following article was written to remind each of us what a benefit hospice can be for patients.

If you had 30 days...
By Dr. Morgan Sauer

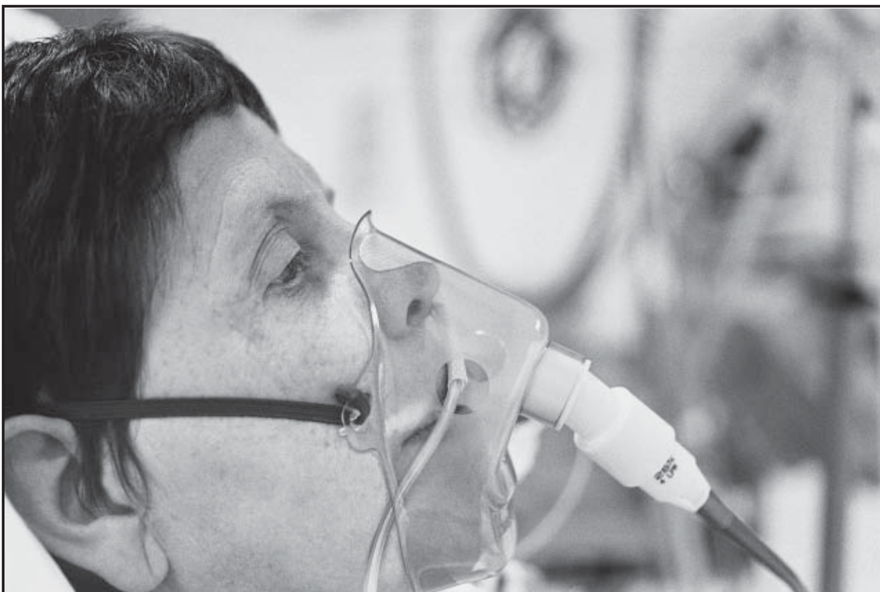
"For the past eight years, I've had the honor of caring for hundreds of patients at Hospice Home Care who are at the end of their life. I've heard stories that almost made me choke with laughter and others which made my soul ache with despair. I've heard the most sacred confessions and witnessed love that could almost be touched.

What has NEVER been requested include the following: more chemotherapy, more radiation, more MRIs, more biopsies, more surgeries, more blasts of electricity through the chest, more life support, more time away from home and separated from family and friends, or more time in an institution.

This serves as a wake-up call on how all members of the health care team can help patients achieve what is important for them at the end of life: quality! It's about quality of LIFE and ensuring patients achieve their goals with the life they have left. This is where the growing trend of hospice is saving patients from artificial prolongation of the dying process. There are studies which show that hospice not only improves quality of life for dying patients, but helps patients live longer. Isn't longer, happier life the entire goal of health care?

Hospice care is a team approach for supporting the patient and family during the end of life in a variety of settings including home, assisted living facilities, nursing homes, and hospice facilities. Sometimes events happen quickly like a severe stroke or heart attack, and hospice care is invaluable during these times. Hospice is even more effective when patients have two to three months of hospice care.

This takes a realistic approach to life expectancies and selected treatments by the medical team.



Proper channels of communication should be respected, so if one team member is not comfortable or skilled at discussing end of life care, utilizing other team members who are comfortable with these situations can be helpful.

It is most important that the team always remember the guiding principle of medical ethics: the Principle of Autonomy. Patients have the right to hear all information of their care in an unbiased manner. Fortunately, hospice care considerations may be started by anyone in the team including patients, their families or friends, doctors, nurses, social workers, chaplains, or case managers.

My life is going to end one day. When it is time, please, love me enough not to prolong the agony of dying. Follow these guidelines for me to honor my life.

- Make any pain non-existent. If anyone thinks I am in pain, give me whatever it takes to keep me comfortable, even if I have to be asleep. Don't let me hurt!
- Make any other symptoms non-existent. Don't let me suffer!
- Treat me with dignity, respect, and unconditional love.
- Keep me clean.
- Support my friends and family while I am dying and after I am gone.

Reviewing these 5 goals can help health care providers recognize the beauty of hospice and how it is enriching and rewarding for patients."

CPCI: Arkansas Blue Cross collaborates to improve primary care in Arkansas through federal initiative

This article is a repeat publication from the June 2012 *Providers News*. Since the June article, CMS has announced and notified the providers it has chosen for the CPCI. Health Advantage is currently the only Arkansas Blue Cross and Blue Shield subsidiary company that is currently participating in the CPCI and Health Advantage provider agreement amendments have been issued to the providers chosen by CMS. Arkansas Blue Cross hopes to add additional networks and membership to CPCI in the future. We also need to remind providers that this is ultimately an CMS Innovations Center project that has been opened up to a few local payers. Health Advantage has limited flexibility regarding certain rules and guidelines of the project. In particular, CMS must choose and approve the primary care providers who may participate in CPCI. To obtain information about Health Advantage's involvement in the CPCI, please contact your local Network Development Representative.

Arkansas Blue Cross and Blue Shield, QualChoice, and Arkansas Medicaid recently teamed together to apply for — and become an initially selected market for — one of seven national four-year health care initiatives by the Centers for Medicare and Medicaid Services (CMS) Innovation Center to help primary care practices deliver higher quality, better coordinated and more patient-centered care.

"We are extremely pleased to be a part of this effort to transform primary care in Arkansas," said Mark White, president and chief executive officer of Arkansas Blue Cross. "This program will help create patient-centered medical homes throughout the state, which will care for our citizens with chronic illnesses, and make a monumental difference in the long-term health of Arkansans."

The Comprehensive Primary Care Initiative (CPCI), sponsored by the CMS Innovation Center, will help fund the transformation of 75 selected primary care practices into patient-centered medical homes through the payment of a per-member-per-month (PMPM) fee to the primary care doctors who participate. The total payment is estimated to be more than $50 million for the affected Medicare beneficiaries. Health Advantage (a subsidiary of Arkansas Blue Cross), QualChoice and Arkansas Medicaid have agreed to also pay a PMPM fee to the providers who participate.

The CPCI practice application eligibility tool is now available at: http://innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html. This tool is a short, straightforward questionnaire for primary care practices to help them understand whether they will be eligible to apply for the initiative. Primary care practices may begin using the application eligibility tool now; it will be held open on the CMS Web site for the entire practice application phase.

Please note that the full list of eligibility criteria has not yet been released and will ultimately determine eligibility for the program. The practice application eligibility tool is not the practice application for the initiative. However, completion of the practice application eligibility tool, which includes leaving a point of contact and e-mail address for the practice, is a prerequisite for receiving the URL of the online application once it becomes available. Practices must complete and submit the CPCI application in order to be considered for selection in the CPCI.

Health Advantage clinics selected by CMS participating in CPCI

City	Practice
Arkadelphia	Bapt Health Family Clinic Arkadelphia
Ash Flat	Bibb, Bradley, MD
Ashdown	Covert Clinic
Batesville	Batesville Family Practice Clinic

City	Practice
Batesville	Brown, Verona T., MD
Beebe	Beebe Family Clinic
Bella Vista	Mercy Clinic Primary Care Lancashire
Benton	Benton Family Clinic

City	Practice
Benton	Saline Med Peds
Bryant	Baptist Health Family Clinic Bryant
Bryant	Bryant Family Practice
Bryant	Bryant Medical Clinic
Cabot	Baptist Health Family Clinic Cabot
Cherokee Village	Internal Medicine Diagnostics Inc
Clinton	Ozark Internal Medicine & Pediatrics
Conway	Conway Family Medical Care
Conway	Freeman Family Medicine
Conway	Lawrence, B Brooks, MD
Crossett	Family Clinic Of Ashley County
Crossett	Thompson, Barry V, MD
DeQueen	Lofton Family Clinic
DeQueen	Walker, Randy D, MD
El Dorado	Sama Healthcare Services
Fayetteville	Washington Reg Clinic For Sr. Health
Fort Smith	Shipley And Sills Family Doctors
Glenwood	Glenwood Family Medicine
Greenbrier	Greenbrier Family Clinic
Hardy	Garner Family Medical Clinic
Harrison	Harrison Family Practice Clinic
Harrison	The Leslie Clinic
Heber Springs	Cowherd Family Medical Center
Helena	Cypert Ridge Family Practice Clinic
Hot Springs	Fountain Lake Family Medicine
Hot Springs	Hamilton West Family Medicine
Jonesboro	UAMS AHEC Northeast
Lincoln	West Washington County Clinic
Little Rock	Autumn Road Family Practice

City	Practice
Little Rock	Baptist Health Family Clinic Baptist Health Drive
Little Rock	Baptist Health Family Clinic Hillcrest
Little Rock	Baptist Health Family Clinic West
Little Rock	Barg-Gray Clinic
Little Rock	Little Rock Family Clinic - West
Little Rock	Little Rock Family Practice - Central
Little Rock	St. Vincent Family Clinic - Chenal
Little Rock	St. Vincent Family Clinic - Rodney Parham
Little Rock	St. Vincent Medical Clinic - Midtowne
Little Rock	St. Vincent Med Group Longevity Ctr
Magnolia	Alexander, John E, Jr., MD
Malvern	Baptist Health Family Clinic Malvern
Malvern	Tilley Diagnostic Clinic
Maumelle	Baptist Health Family Clinic Maumelle
Mtn Home	North Central Arkansas Med Assoc
Mtn View	Dr. Andy's Family Practice
North Little Rock	Baptist Health Family Clinic - Lakewood
Paragould	Burchfield Family Medicine
Perryville	Baptist Health Family Clinic Perryville
Rogers	Mercy Clinic Internal Medicine
Sherwood	Sherwood Family Medical Center
Siloam Springs	Siloam Springs Medical Center
Springdale	UAMS Family Med Center Springdale
Texarkana	UAMS AHEC Southwest
Warren	Foscue Medical Clinic
Warren	Weaver, Michelle, MD
West Memphis	Senior Health Clinic

ASE/PSE

Benefit clarification for members of the Arkansas state and public school groups

Effective October 1 2012, members of the State and Public School groups will have 20% coinsurance applied to some services provided in the PCP and specialist provider offices. The coinsurance will not apply to items such as preventive services, as listed in the Employee Benefits Division (EBD) Coverage Policy ARB0357, allergy injections, minor lab and x-ray services and minor office procedures. The coinsurance will apply to items such as ultrasounds, colonoscopies not covered under wellness, cystoscopies, and Doppler scans.

Premium rates for the 2012 plan year were based on the member paying the 20% coinsurance. However, refunds will not be sought for services that paid from January 1, 2012 through September 30, 2012 without applying coinsurance.

For a complete list of services that will not take the 20% coinsurance please review Policy ARB0444 at www.ARBenefits.org.

There will be no benefit changes for the plan year 2013.

Pharmacy

NBI MEDIC prescriber prescription verification requests

As part of the ongoing effort to combat fraud, waste, and abuse in the Medicare Part D program, the NBI MEDIC (Health Integrity, LLC) requests prescriber prescription verification during the course of an investigation.

A key element in the early phase of an investigation into potential prescription drug fraud and abuse includes prescriber prescription verification. The NBI MEDIC routinely mails the prescriber a prescription verification form containing the beneficiary's name, the name of the medication, the date prescribed, and the quantity given. The form also asks the prescriber to check yes or no to indicate whether the prescriber wrote the prescription. The prescriber is asked to respond within two weeks. If no response is received, then the investigator follows up with a second request.

NBI MEDIC investigators report that no more than 5% to 10% of prescribers respond to these requests. The inability to obtain prescription verification can:

- Limit the investigator's ability to determine the validity of the allegation, which could lead to closing a valid complaint due to lack of sufficient evidence;
- Inhibit the investigator's ability to confirm that the identity of the physician or beneficiary has been compromised; and/or
- Result in a Part D Sponsor paying for invalid prescriptions before a fraudulent or inappropriate payment pattern has been substantiated.

A timely and complete response to prescription verification will result in the likelihood of an appropriate action by confirming or eliminating an allegation of wrongdoing and/or preventing the payment for fraudulent prescriptions.

CMS is requesting that Part D Sponsors take appropriate action to encourage their downstream entities engaged in the administration or delivery of the Medicare Part D prescription drug benefit to respond to prescription verifications when contacted by the NBI MEDIC.

If you have any questions regarding this HPMS alert, please contact Frank Tetkoski at frank.tetkoski@cms.hhs.gov.

AHIN

New toll free number for AHIN customer support

For users outside the local area, AHIN Customer Support now has a toll free phone number. The toll free number is (855) 822-AHIN (2446). If you have always dialed (501) 378-2336, you may now call (855) 822-2446 free of charge. The same customer service representatives will be available to take your calls and help you with your issues at this new number.

AHIN Customer Support:
(501) 378-2336 OR
(855) 822-2446
Fax: (501)378-2484
Email: customersupport@ahin.net

Claims filing rule reminders for durable medical equipment, laboratory, and specialty pharmacy

The following article was originally published in the December 2011 issue of *Providers' News* under the "BlueCard" heading. While the claims filing policies and rules are required for BlueCard, these same claims filing rules apply to ALL laboratories, durable medical equipment/home medical suppliers and specialty pharmacies. In addition, based on further review of services being submitted for payment, the required claims data elements for durable medical equipment will be required for all Prosthetic and Orthotic providers and the specialty pharmacy required claims data elements will apply to home infusion therapy providers.

In 2004, the Blue Cross and Blue Shield Association (the Association) revised its BlueCard claims filing rules for providers specializing in independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy. While these revisions are several years old, the Association has only recently tightened system requirements related to these rules. These rules apply to all provider networks and claims related to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage.

Claims for independent clinical laboratory, durable/home medical equipment and supply, and specialty pharmacy are filed to the local Blue Cross and Blue Shield Plan (sometimes called the Host Plan). The local Blue Cross Plan is usually defined as the Plan in whose service area the services are rendered. The Blue Plan that issued coverage for a given member, or that contracted with their employer to administer their self-funded health plan, is referred to as the Home Plan.

Please note: Host Plan and Home Plans are in every case independent companies so that the Host Plan is not responsible for funding of any insurance issued by a Home Plan. The Host Plan's role is limited to a claims processing and customer services assistance function with respect to the out-of-state provision of services to the Home Plan's member.

Clinical Lab:

For clinical lab, the local Blue Cross Plan is defined as the plan in whose service area the specimen was drawn.

Example: a blood specimen is drawn at a physician's office in Little Rock that participates in the Health Advantage network on a member who has Health Advantage benefit coverage. The lab is sent to New York to be processed and is billed from North Carolina. This laboratory participates in the Health Advantage network. The claim must be billed directly to Health Advantage as the specimen was drawn in Arkansas. The claim will be processed as in network for covered services.

(Continued on page 12)

(Continued from page 11) claims filing rule reminders

Another example: A blood specimen is drawn in Hot Springs on a member who has health plan coverage administered through BlueAdvantage Administrators of Arkansas. The clinic where the specimen is obtained is not in any Arkansas Blue Cross provider networks. The lab specimen is sent to Denver, Colorado to be processed and will be billed by the lab from Denver. The lab is also not in any Arkansas Blue Cross or affiliates' provider network. The claim must be billed directly to BlueAdvantage as the specimen was obtained in Arkansas. The claim will be processed as out of network for covered services.

Information required on claims submitted for clinical lab:

- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.

Durable/Home Medical Equipment and Supply

For durable/home medical equipment and supply, the local Blue Plan is the plan in which service area the equipment was shipped to or purchased at a retail store.

For example: a member with Arkansas Blue Cross insurance living in Fort Smith, Arkansas orders diabetic supplies from a mail order supplier in Ohio. The supplier participates in the Host Plan's network in Ohio but not Arkansas. The claim must be filed directly to Arkansas Blue Cross because Arkansas is where the supplies were shipped. The claim will be processed as out of network for covered services.

Information required on claims submitted for durable/home medical equipment:

- Patient's Address, Field 5 on CMS 1500 Health Insurance Claim Form or in loop 2010CA on the 837 Professional Electronic Submission.
- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.
- Place of Service, Field 24B on the CMS 1500 Health Insurance Claim Form or in loop 2300, segment CLM05-1 on the 837 Professional Electronic Submission.
- Service Facility Location Information, Field 32 on CMS 1500 Health Insurance Form or in loop 2310 A (claim level) on the 837 Professional Electronic Submission.

Specialty Pharmacy

For specialty pharmacy, the local Blue Plan is defined as the plan in whose service area the ordering physician is located.

For example: a physician whose clinic is in Pine Bluff orders specialty drugs for a Health Advantage member who lives in Stuttgart. The specialty pharmacy is located in Jackson, Mississippi and is in the Mississippi Blue Cross and Blue Shield provider networks, but not in any Arkansas Blue Cross or affiliates' networks. The claim must be filed directly to Health Advantage as the ordering physician's practice location is in Arkansas.

The claim will be processed as out of network as the specialty pharmacy is not in any Arkansas Blue Cross or affiliates' provider networks. Information required on claims submitted for specialty pharmacy:

- Referring Provider, Field 17 on CMS 1500 Health Insurance Claim Form or loop 2310A (claim level) on the 837 Professional Electronic Submission.

The BlueCard program has always relied on the provider agreement status and pricing of the local Blue Plan and that is still true. The mere fact that a claim is required to be submitted directly to a certain Blue Plan does not obligate any local Blue Plan to offer contracts to any lab, durable medical equipment supplier or specialty pharmacy.

However, the Association's rules for BlueCard have been revised to allow Blue Plans to contract with out of state clinical labs, durable medical equipment suppliers and specialty pharmacies. Each local Blue Plan will make its own decisions related to provider contracting and pricing.

Provider Type	How to file (Required fields)	Where to file	Examples
Independent Clinical Laboratory (any type of non hospital based laboratory) **Types of service include, but are not limited to:** Blood, urine, samples, analysis, etc.	**Referring Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form **or** • Loop 2310A (claim level) on the 837 Professional Electronic	File the claim to the Plan in whose state the specimen was drawn* * Where the specimen was drawn will be determined by which state the referring provider is located.	Blood is drawn* in lab or office setting located in **Arkansas.** Blood analysis is done in New York. **File to: Arkansas.** *Claims for the analysis of a lab must be filed to the Plan in whose state the specimen was drawn.
Durable/Home Medical Equipment and Supplies (D/HME) **Types of service include, but are not limited to**: Hospital beds, oxygen tanks, crutches, etc.	**Patient's Address:** • Field 5 on CMS 1500 Health Insurance Claim Form **or** • Loop 2010CA on the 837 Professional Electronic Submission. **Ordering Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form **or** • Loop 2420E (line level) on the 837 Professional Electronic Submission. **Place of Service:** • Field 24B on the CMS 1500 Health Insurance Claim Form **or** • Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions. **Service Facility Location Information:** • Field 32 on CMS 1500 Health Insurance Form **or** • Loop 2310C (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan in whose state the equipment was shipped to or purchased in a retail store.	A. Wheelchair is purchased at a retail store in Arkansas. **File to: Arkansas** B. Wheelchair is purchased on the internet from an online retail supplier in Ohio and shipped to Arkansas. **File to: Arkansas**
Specialty Pharmacy Types of Service: Non-routine, biological therapeutics ordered by a health care professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.	**Referring Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form **or** • Loop 2310A (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan whose state the ordering physician is located.	Patient is seen by a physician in Illinois who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in Arkansas where the member lives for 6 months of the year. **File to: Illinois**

Coverage policy manual updates

Since June 2012, the following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. To view entire policies, access the coverage policies located our Web site at arkansasbluecross.com.

New / Updated Policies:

Policy#	Policy Name
1997061	Coronary Artery Calcium Scoring, Screening, to Predict Risk for Coronary Artery Disease
1997089	Endometrial Ablation
1997210	Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy Gamma Knife Surgery, Linear Accelerator, Cyberknife, Tomo Therapy
1997216	Apheresis, Therapeutic (Plasma Exchange Transfusion)
1998051	Genetic Test: BRCA1 or BRCA2 Mutations
2003042	Semi-Implantable and Fully Implantable Middle Ear Hearing Aid for Moderate to Severe Sensorineural Hearing Loss
2003057	Soft Tissue Substitues Orthobiologic Implant
2005007	PET Scan, Positron Emission Tomography for Cervical Cancer
2006001	HDC & Autologous Stem &/or Progenitor Cell Support-Waldenstrom's Macroglobulinemia
2006019	Brachytherapy, Prostate, High-Dose Rate Temporary
2007021	HIV Tropism, Testing
2008028	Galsulfase (Naglazyme TM)
2008031	Rilonacept (Arcalyst)
2010015	Genetic Test: Colon Cancer, Gene Expression Profiling (Oncotype DX, Colon PRS, Onco Defender-CRC, ColoPrint)
2012018	Preventive Services for Non-grandfathered Plans: Skin Cancer, Behavioral Counseling for Prevention
2012019	Genetic Testing: Acute Myeloid Leukemia, Predict Response to High Dose Chemotherapy
2012020	Endothelial Function Testing, Noninvasive
2012021	Preventive Services for Non-grandfathered Plans: Intimate Partner Violence; Screening In Women
2012022	PET or PET/CT for Renal Cell Carcinoma
2012023	PET or PET/CT for Lymphadenopathy of Unknown Cause
2012024	PET or PET/CT for Thymoma/Thymic Carcinoma
2012025	Biomarkers for Liver Disease
2012026	PET or PET/CT, Beta Amyloid Imaging for Alzheimer's Disease or Cognitive Impairment
2012027	PET Scan for Multiple Myeloma, Plasmacytoma
2012028	Allergy Testing, Serial Endpoint Testing
2012029	Novel Lipid Risk Factors in Risk Assessment and Management of Cardiovascular Disease (apolipoprotein B) (apolipoprotein A-1) (HDL subclass) (LDL subclass) (apolipoprotein E) (Lipoprotein A)
2012030	Sinus Spacers and Stents, Implantable, following Endoscopic Sinus Surgery

Policy#	Policy Name
2012031	Preventive Services For Non-grandfathered (PPACA) Plans: Well-Woman Visits For Adult Women
2012032	Preventive Services For Non-grandfathered (PPACA) Plans: Gestational Diabetes Screening
2012033	Preventive Services For Non-grandfathered (PPACA) Plans: Human Immunodeficiency Virus (HIV), Counseling And Screening, Annually For Sexually Active Women
2012034	Preventive Services For Non-grandfathered (PPACA) Plans: Human Papilloma virus Virus (HPV), Screening For Sexually Active Women
2012035	Preventive Services For Non-grandfathered (PPACA) Plans: Contraceptive Use And Counseling

Preventive care services update non-grandfathered/PPACA wellness summary

Over the last several months Arkansas Blue Cross and Blue Shield has had calls and questions on the differences between the pre PPACA wellness benefits and the PPACA wellness benefits for non-grandfathered health plans. We hope that the following Preventive Care Services Summary in this Provider News will help providers have a clearer understanding of the preventive services covered; these of course are subject to change.

The preventive services component of the law was a requirement that all "non-grandfathered" health insurance plans are required to cover those preventive medicine services given an "A" or "B" recommendation by the U.S. Preventive Services Task Force (USPSTF). Arkansas Blue Cross has studied these recommendations and has developed a coverage policy on each of these preventive medicine services; please refer to www.arkbluecross.com or www.heathadvantage-hmo.com .

Arkansas Blue Cross has now added a new AHIN display to assist the provider community in determining what type of wellness benefits a member has, Traditional or PPACA.

When a routine service type is selected such as Routine Physical, a link will be displayed on AHIN in the Coverage Basis area that will take the user to a site that will contain additional wellness information. The type of wellness (PPACA or Traditional wellness) will be displayed in the benefit information section of the service type. (See the example located on page 16)

In order to comply with the new health care reform law (PPACA or the Patient Protection and Affordability Act), Women's Preventive Services will be added to many health plans. On August 1, 2012, the change will be made to certain employer-sponsored health insurance plans. The change will take place on January 1, 2013 for certain individual health plans.

Arkansas Blue Cross and Blue Shield encourages each physician and other providers of preventive services to become familiar with the USPSTF, Bright Futures, and Women's Health Initiative recommendations and Arkansas Blue Cross coverage policies. Most of the inquiries Arkansas Blue Cross has received are on lab (urinalysis) and other services such as chest x-rays, electrocardiograms, breathing capacity tests, catheter for hysterography, vitamins, B-12 injections, cardiovascular stress tests, CT for bone density, CT for head/brain, removing ear wax, consultations, etc., that are not included in the USPSTF, Bright Futures, or Women's Health Initiative recommendations for screening, and are not part of Arkansas Blue Cross coverage policy for non-grandfathered/ PPACA Preventive Services. Claims for these services, if billed for screening, therefore would be provider write-offs as not meeting Primary Coverage Criteria or Not Medically Necessary, and are not member liability if billed with a preventive diagnosis unless the ordering provider has obtained from the member a signed waiver specifically stating why the requested service would not be covered.

(Continued on page 16)

Summary of Arkansas Blue Cross Blue Shield and Health Advantage Coverage Polices

The Federal Patient Protection and Preventive Care Act (PPACA) was passed by Congress and signed into law by the President in March 2010. The preventive services component of the law became effective September 23, 2010. A component of the law was a requirement that all "non-grandfathered" health insurance plans are required to cover those preventive medicine services given an "A" or "B" recommendation by the U.S. Preventive Services Task Force (USPSTF).

Plans are not required to provide coverage for the preventive services if they are delivered by out-of-network providers.

Task Force recommendations are graded on a five-point scale (A-E), reflecting the strength of evidence in support of the intervention. Grade A: There is good evidence to support the recommendation that the condition be specifically considered in a periodic health examination. Grade B: There is fair evidence to support the recommendation that the condition be specifically considered in a periodic health examination. Grade C: There is insufficient evidence to recommend for or against the inclusion of the condition in a periodic health examination, but recommendations may be made on other grounds. Grade D: There is fair evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination. Grade E: There is good evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.

Those preventive medicine services listed as Grade A & B recommendations are covered without cost sharing (i.e., deductible, coinsurance, or co-pay) by Health Plans for appropriate preventive care services provided by an in-network provider. If the primary purpose for the office visit is for other than Grade A or B USPSTF preventive care services, deductible, coinsurance, or copayment may be applied.

Services are typically included as part of a normal wellness visit; the appropriate office visit code should be used. Evaluation and Management codes for preventive services 99381-99397 will always be considered preventive. CPT Codes 99401-99404, when used to designate a preventive service, must have the applicable wellness/ preventive diagnosis code as the primary reason for the visit.

Note: (99401-99404 are considered components of 99386-99387 if billed on the same date-of-service.)

81 Routine Physical
Routine medical exams provided by physicians, hospitals, and other healthcare providers.

	In Network	Out of Network
Coverage Basis	Name: Arkansas Blue Cross Blue Shield Website: http://www.arkansasbluecross.com/members/report.aspx?policynumber=2011066	**RSP14**
Individual Deductible	**$0.00** Universal deductible does not apply to this service type PPACA Wellness	**RSP15**
Family Deductible	**$0.00** Universal deductible does not apply to this service type PPACA Wellness **$0.00 (Remaining)** PPACA Wellness	**RSP16** **RSP17**
Coinsurance	**0%** PPACA Wellness	**RSP13**

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be billed with Modifier 33.

The correct coding as listed for both ICD-9 and CPT or HCPCS codes in this summary is also required along with Modifier 33. CPT Codes Copyright © 2011 American Medical Association.

The Arkansas State and Public School Employees Plan is a self-insured plan and does not always use the coding structure listed in the following article or chart published in this newsletter. For coverage and coding information for the Gold and Bronze Plans administered by Health Advantage, please go to the EBD Coverage Policies at www.ARBenefits.org.

Summary of Women's Preventive Services

Effective August 1, 2012, for certain employer-sponsored health insurance plans. The change will take place on January 1, 2013 for certain individual health plans.

- Well-woman visits: Annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their doctors determine they are necessary.
- Gestational diabetes screening: For women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
- HPV DNA testing: Women who are 30 years of age or older will have access to high-risk human papilloma virus (HPV) DNA testing every three years, regardless of pap smear results.
- STI counseling, and HIV screening and counseling: Sexually active women will have access to annual counseling on HIV and sexually transmitted infections (STIs).
- Contraception and contraception counseling: Coverage of prescription contraceptives on the drug list (brand contraceptives may have a copayment if a generic is available without a copayment), sterilization procedures and patient education and counseling. Plan B (morning-after pill) when prescribed for members under 18 will be covered. Any drugs used to cause abortion (e.g. RU 486) are not covered. Over-the-counter birth control methods, even if prescribed by a doctor, are not covered.
- Breast feeding support, supplies and counseling: Pregnant and postpartum women will have coverage for lactation counseling from applicable health care providers. Manual breast pumps are covered; electric breast pumps and supplies are not covered. NOTE: Pregnancy services including prenatal, delivery and postnatal care subject to member copayments, deductibles and coinsurance.
- Domestic violence screening: Screening and counseling for interpersonal and domestic violence will be covered for all women.

Subject to change as regulations and further clarifications are received, please refer to additional clarifications at the end of this article.

The Arkansas State and Public School Plan will not implement the new Women's Preventive Services until January 1, 2013.

For Self-funded plans with SPD language

Certain self-funded plans may have a different list of preventive care benefits. Please refer to the enrollee's plan specific SPD for coverage. Group specific policy will supersede this policy when applicable. This policy does not apply to the Walmart Associates Group Health Plan participants.

Note: Please encourage your patients to update their personal Health Record with information gathered during a preventive visit.

Note: The cost of drugs, medications, equipment, vitamins or supplements that are recommended or prescribed for preventive measures are generally not covered as a preventive care benefit. Examples include, but are not limited to:

A. Aspirin for any indication, including but not limited to, aspirin for prevention of cardiovascular disease.
B.. Supplements, including but not limited to, oral fluoride supplementation, and folic acid supplementation.
C. Tobacco cessation products or medications.
D. Condoms, diaphragms, sponges, spermicides, etc.
E. Electric Breast Pumps.

Coding guidelines for PPACA preventive benefits plans

Subject to change as regulations and further clarifications are received, please refer to Arkansas Blue Cross and Health Advantage Coverage Policy: arkbluecross.com or healthadvantage-hmo.com. These coverage policies are updated frequently.

Abdominal Aortic Aneurysm, Screening (Coverage Policy 2011011)
USPSTF Recommendation
The USPSTF recommends one-time screening for abdominal aortic aneurysm (AAA) screening for men ages 65 – 75 who have ever smoked. (Grade B)
CPT/HCPCS Codes:
G0389 – Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening
ICD-9 Codes
V15.82 – Personal history of tobacco use, presenting hazards to health
V81.2 – Other and unspecified cardiovascular conditions

Alcohol Misuse; Counseling and/or Screening (Coverage Policy 2011012)
USPSTF Recommendation
The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (Grade B)
CPT/HCPCS Codes
99408 – Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409 – Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
G0442 – Annual alcohol misuse screening, 15 minutes
G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
ICD-9 Codes
305.00-305.03 – Non dependent alcohol abuse
V79.1 – Screening for alcoholism

Alcohol and Drug Use Screening for Adolescents Beginning at Age 11-18 (Coverage Policy 2011012)
HRSA (Bright Futures) Recommendation
Bright Futures recommends initiating questioning regarding alcohol or drug use and if positive, to follow with an alcohol or drug screening tool for children ages 11-18.
CPT/HCPCS Codes
99408 – Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409 – Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes (These above codes are recommended by the AAP [Coding for Pediatric Preventive Care, 2011])
G0442 – Annual alcohol misuse screening, 15 minutes
G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
ICD-9 Codes
305.00-305.03 Non dependent alcohol abuse
V79.1 Screening for alcoholism

Anemia, Screening In Infants, Children & Adolescents (Coverage Policy 2012036)
HRSA (Bright Futures) Recommendations
Hemoglobin & hematocrit should be screened for at the four month well-child visit in children who are pre term or who are low birth weight infants, and those not on iron-fortified formula.
Hemoglobin & hematocrit should be screened for routinely at the 12 month well-child visit.
Hemoglobin & hematocrit should be screened selectively for children who are positive for risk screening questions at the 3 – 21 year visits
CPT/HCPCS Codes
85014 – Blood count, hematocrit
85018 – Blood count, hemoglobin (These codes are recommended by the AAP [Coding for Pediatric Preventive Care, 2011])
ICD-9 Codes
V78.0 – Special screening, iron deficiency anemia

Aspirin to Prevent Cardiovascular Disease in Adults (Coverage Policy 2011013)
USPSTF Recommendations
The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. (Grade A)
The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage. (Grade A)
CPT/HCPCS Codes
99386-99387 – Initial comprehensive preventive medicine evaluation and management of an individual
99396-99397 – Periodic comprehensive preventive medicine reevaluation and management of an individual
99401 – Preventive medicine counseling; 15 minutes
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes **99403 and 99404 require review of records.* *(99401-99404 are considered components of 99386-99387 if billed on the same date-of-service [CPT-4 coding instructions])*
ICD-9 Codes
V70.0 – General medical exam

Autism, Screening (Coverage Policy 2012045)
HRSA (Bright Futures) Recommendation
Provide the autism specific screening test at the 18 month well child visit
CPT/HCPCS Codes
96110 – Developmental testing, limited (e.g., Developmental Screening test II, Early Language Milestone Screen), with interpretation and report. (The above code is recommended by the AAP Coding for Pediatric Preventive Care, 2011)
G0451 – Developmental testing, with interpretation and report, per standardized instrument form.
ICD-9 Codes
V79.3 – Special screening for developmental handicaps in early childhood, with interpretation and report

(Continued from page 19) Coding guidelines for PPACA preventive benefits plans

Bacteriuria, Screening in Pregnant Women (Coverage Policy 2011020)
USPSTF Recommendation
The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later. (Grade A)
CPT/HCPCS Codes
87081 – Culture, presumptive, pathogenic organisms, screening only
87084 – Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart
87086 – Culture, bacterial; quantitative colony count, urine
87088 – Culture, bacterial; with isolation and presumptive identification of each isolate, urine
ICD-9 Codes
V22.0-V22.2 – Prenatal Visits
V23.0-V23.9 – Prenatal visits for patients with high risk pregnancies

Bicycle Helmet Use For Children & Adolescents, Counseling For (Coverage Policy 2012044)
HRSA (Bright Futures)
Give parents who do not require their children to use a helmet extensive information about the risks of bicycle –related head injuries, including the TIPP [AAP Injury Prevention Program] sheets and details of state or local legislation or regulations. Whenever available, provide discount coupons for approved helmets. Children who answer that they do not use a bicycle helmet should be given information appropriate to their age and cognitive level on the need for helmets. (Performing Preventive Services: A Bright Futures Handbook)
CPT/HCPCS Codes
99382 – Initial preventive medicine early childhood (age 1 through 4 years))
99383 – Initial preventive medicine late childhood (age 5 through 11 years)
99384 – Initial preventive medicine adolescent (age 12 through 17 years)
99385 – Initial preventive medicine 18-39 years
99392 – Periodic preventive medicine early childhood (age 1 through 4 years)
99393 – Periodic preventive medicine late childhood (age 5 through 11 years)
99394 – Periodic preventive medicine adolescent (age 12 through 17 years)
99395 – Periodic preventive medicine 18-39 years
99401 – Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 15 minutes) (This code is recommended by the AAP (Coding for Pediatric Preventive Care, 2011)) (99401 is considered a component of 99382-99395 if billed on the same date-of-service [CPT-4 coding instructions])
ICD-9 Codes
V65.43 – Counseling on injury prevention
V20.2 – Routine infant and child health check

BRCA Testing, Genetic Counseling and Evaluation (Coverage Policy 2011016)
USPSTF Recommendation
The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing. (Grade B)

CPT/HCPCS Codes:
96040 – Genetic counseling service
99401 – Preventive medicine counseling; 15 minutes (96040 is not reportable by physicians (CPT-4 coding instructions))
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes **99403 and 99404 require review of records.* (99401-99404 are considered components of 99386-99387 if billed on the same date-of-service [CPT-4 coding instructions])
S0265 – Genetic counseling
ICD9 Codes:
V16.3 – Family history of breast cancer
V16.41 – Family history of ovarian cancer
V26.33 – Genetic counseling

Breast Cancer, Preventive Medication (Coverage Policy 2011017)
USPSTF Recommendation
The USPSTF recommends that clinicians discuss chemo prevention with women at high risk for breast cancer and at low risk for adverse effects of chemo prevention. Clinicians should inform patients of the potential benefits and harms of chemo prevention. (Grade B)
CPT/HCPCS Codes
99384-99387 – Initial comprehensive preventive medicine evaluation and management of an individual
99394-99397 – Periodic comprehensive preventive medicine reevaluation and management of an individual
99401 – Preventive medicine counseling; 15 minutes
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes **99403 and 99404 require review of records.* (99401-99404 are considered components of 99386-99387 if billed on the same date-of-service [CPT-4 coding instructions])
ICD-9 Codes
217 – Benign neoplasm of breast
610.8 – Other benign mammary dysplasia
V10.3 – Personal history of malignant neoplasm, breast
V16.3 – Family history of breast cancer
V84.01 – Genetic susceptibility to breast cancer

Breast Cancer, Screening (Mammography) (Coverage Policy 2011018)
USPSTF Recommendation
The USPSTF currently recommends biennial screening mammography for women with or without clinical breast examination, every 1-2 years for women aged 40 and older. (Grade B)

(Continued from page 21) Coding guidelines for PPACA preventive benefits plans

CPT/HCPCS Codes
77051 – Computer aided detection, with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography.
77052 – Computer aided detection, with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography
77055 – Mammography; unilateral
77056 – Mammography; bilateral
77057 – Screening mammography, bilateral
G0202 – Screening mammography, producing direct digital image, bilateral, all views
G0204 – Diagnostic mammography, producing direct digital image, bilateral, all views.
G0206 – Diagnostic mammography, producing direct digital image, unilateral, all views
ICD-9 Codes
V76.11 – Screening mammogram for high risk patient
V76.12 – Other screening mammogram

Breast Feeding, Counseling (Coverage Policy 2011019)
USPSTF Recommendation
The USPSTF recommends interventions during pregnancy and after birth to promote and support breast feeding. (Grade B)
CPT/HCPCS Codes
99401 – Preventive medicine counseling; 15 minutes
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes
E0602 – Breast Pump, manual, any type
**99403 and 99404 require review of records.*
ICD-9 Codes
V24.1 – Postpartum care and examination of lactating mothers.

Cardiometabolic Risks Of Obesity In Children And Adolescents, Counseling (Coverage Policy 2012047)
HRSA (Bright Futures) Recommendation
Although Bright Futures does not include screening recommendations for this syndrome, the American Academy of Pediatrics (AAP) has issued a recent policy statement regarding lipid screening and cardiovascular health in childhood, which includes blood pressure assessment. Anticipatory guidance to help children maintain normal blood lipids and blood pressure—2 key components involved in metabolic syndrome—is a crucial part of preventive services for children and adolescents.
CPT Codes
99381 – Initial comprehensive preventive medicine evaluation, new patient, infant
99382 – Initial comprehensive preventive medicine evaluation, new patient, 1-4 years
99383 – Initial comprehensive preventive medicine evaluation, new patient, 5-11 years
99384 – Initial comprehensive preventive medicine evaluation, new patient, 12-17 years
99385 – Initial comprehensive preventive medicine evaluation, new patient, 18-39 years
99391 – Comprehensive preventive medicine re-evaluation, infant

99392 – Comprehensive preventive medicine re-evaluation, 1-4 years
99393 – Comprehensive preventive medicine re-evaluation, 5-11 years
99394 – Comprehensive preventive medicine re-evaluation, 12-17 years
99395 – Comprehensive preventive medicine re-evaluation, 18-39 years
ICD-9 Codes
V20.2 – Routine infant or child health care check
V70.0 – Routine general medical examination at a health care facility

Cervical Cancer, Screening (Coverage Policy 2011021)
USPSTF Recommendation
The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papilloma virus (HPV) testing every 5 years. (Grade A)
HRSA (Bright Futures) Recommendation
Bright Futures recommends screening for cervical dysplasia with Pap smear within 3 years of onset of sexual activity.
CPT/HCPCS Codes
88141-88143 Cytopathology, cervical or vaginal
88147-88148 – Cytopathology smears, cervical or vaginal
88150, 88152-88154 – Cytopathology slides, cervical or vaginal
88164-88167 – Cytopathology slides, cervical or vaginal
88174-88175 – Cytopathology, cervical or vaginal
G0101 – Cervical or vaginal cancer screening
G0123-G0124 – Screening cytopathology; cervical or vaginal
G0141 – Screening cytopathology smears, cervical or vaginal
G0143-G0145 – Screening cytopathology, cervical or vaginal
G0147-G0148 – Screening cytopathology smears, cervical or vaginal
P3000-P3001 – Screening Papanicolaou smear
Q0091 – Screening Papanicolaou smear
S0610 – Annual gynecological exam, new patient
S0612 – Annual gynecological exam, established patient
ICD-9 Codes
V72.31 – Routine gynecological examination
V72.32 – Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear
V76.2 – Special screening for malignant neoplasm of the cervix

Chlamydia Infection, Screening In Women & Adolescents (Coverage Policy 2011022)
USPSTF Recommendation
The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk. (Grade A)
The USPSTF recommends screening for chlamydial infection for all pregnant women age 24 and younger and for older pregnant women who are at increased risk. (Grade B)

(Continued from page 23) Coding guidelines for PPACA preventive benefits plans

HRSA (Bright Futures) Recommendation
Screen sexually active adolescents for chlamydia using tests approx to patient population & clinical setting.
CPT/HCPCS Codes:
87270 – Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87320 – Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; Chlamydia trachomatis
87490 – Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia, direct probe, trachomatis, direct probe technique
87491 – Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87800 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87801 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique.
87810 – Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis observation; Chlamydia trachomatis
ICD-9 Codes
V22.0 – V22.2 – Prenatal Visits
V23.0 – V23.9 – Prenatal visits for patients with high risk pregnancies
V69.2 – High risk sexual behavior
V73.88 – Special screening examination for other specified chlamydial diseases
V73.98 – Special screening examination for unspecified chlamydial disease
V74.5 – Special screening exam for venereal disease

Colorectal Cancer, Screening (Coverage Policy 2011045)
USPSTF Recommendation
The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary. (Grade A)
CPT/HCPCS Codes:
Use of the PT modifier with these codes will help identify the procedure as preventive; refer to coverage policy for coverage of polyp removal during a preventive service.
00810 – Anesthesia for lower intestinal endoscopic procedures (Restricted to medical necessity)
45330 – Sigmoidoscopy, flexible; diagnostic
45331 – Sigmoidoscopy, flexible; with biopsy, single or multiple
45333 – Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other; hot biopsy forceps or cautery lesion(s) by hot biopsy forceps or bipolar cautery
45338 – Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other, by snare technique
45339 – Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45378 – Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45380 – Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45381 – Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection

45383 – Colonoscopy, flex, proximal to splenic flexure; with ablation of tumor(s), polyp(s) or other lesion(s)
45384 – Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45385 – Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique.
82270 – Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with singe determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection
82274 – Blood, occult, by fecal hemoglobin determined by immunoassay, qualitative, feces, 1-3 simultaneous determinations
88305 – Level IV – Surgical pathology, gross and microscopic examination
G0104 – Colorectal cancer screening; flexible sigmoidoscopy
G0105 – Colorectal cancer screening; colonoscopy on individual at high risk
G0121 – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0328 – Colorectal cancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations
ICD-9 Codes:
V76.41 – Screening for malignant neoplasm of the rectum
V76.51 – Special screening for malignant neoplasms, colon

Congenital/Inherited Metabolic Disorders & Hemoglobinopathies (Coverage Policy 2012040)
HRSA (Bright Futures) Recommendation
Conduct screening as required by the state. (Arkansas statute requires newborn screening for metabolic (inborn errors of metabolism) and hemoglobinopathies); the tests are usually done prior to discharge from the hospital following birth of the infant).
CPT/HCPCS Codes
S3620 – Newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel
ICD9 Codes
V77.0 – Special screening for thyroid disorders
V77.3 – Special screening for phenylketonuria
V77.4 – Special screening for galactosemia
V77.7 – Special screening for other inborn errors of metabolism
V78.2 – Special screening for sickle cell disease
V78.3 – Special screening for other hemoglobinopathies

Contraceptive Use & Counseling (Coverage Policy 2012035)
HRSA (Women's Health Initiative) Recommendation (Effective August 2012)
Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education & counseling. These recommendations don't include abortifacient drugs.
OTC products (condoms, sponges, spermicides, etc.) are not covered. There is a $0 copayment for all generic prescription contraceptives. If there is no generic in the class/subclass, then brand contraceptive is at $0 copayment. Emergency contraceptives for members who are less than 18 years old for Plan B and those who are less than 17 years old for Plan B One-Step if they present a prescription for coverage. Note: Those patients at or above the ages previously mentioned do not need a prescription to get access to emergency contraceptives as they are available OTC in these age groups and are not covered.

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CPT/HCPCS Codes
11980 – Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
11981 – Insertion, non-biodegradable drug delivery implant (e.g., Implanon)
11983 – Removal with reinsertion, non-biodegradable drug delivery implant (e.g., Implanon)
57170 – Diaphragm or cervical cap fitting with instructions
58300 – Insertion of intrauterine device (IUD)
58565 – Hysteroscopy, surgical, with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (e.g., Essure)
58600 – Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58611 – Ligation or transection of fallopian tube(s), when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure)
58605 – Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral
58615 – Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58661 – Laparoscopy, surgical, with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy
58671 – Laparoscopy, surgical, with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58720 – Salpingo-oophorectomy, complete or partial, unilateral, or bilateral (separate procedure)
97372 – Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (e.g., Lunelle)
99384 – Initial comprehensive preventive medicine, 12-17 years
99385 – Initial comprehensive preventive medicine, 18-39 years
99386 – Initial comprehensive preventive medicine, 40-64 years
99394 – Periodic comprehensive preventive medicine reevaluation & management, 12-17
99395 – Periodic comprehensive preventive medicine reevaluation & management, 18-39
99396 – Periodic comprehensive preventive medicine reevaluation & management, 40-64
G0438 – Annual wellness visit; includes personalized prevention plan, initial visit
G0439 – Annual wellness visit; includes personalized prevention plan, subsequent
S4981 – Insertion of levonorgestrel-releasing intrauterine system (e.g., Mirena)
S4989 – Contraceptive intrauterine device (e.g., Progestasert IUD)
S4993 – Contraceptive pill for birth control (Only billed by Family Planning Clinics
A4261 – Cervical cap for contraceptive use
A4264 – Permanent implantable contraceptive intratubal occlusion device(s) and delivery system (should not be reported with CPT 58565, as CPT 58565 includes the allowance for A4264 when performed in the office site-of-service
J1055 – Medroxyprogesterone acetate for contraceptive use
J7303 – Contraceptive supply, hormone containing vaginal ring, each
J7304 – Contraceptive supply, hormone containing patch
J7306 – Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307 – Etonogestrel (contraceptive) implant system, including implant and supplies
ICD-9 Codes:
V25.01 – Prescription of oral contraceptives

V25.02 – Initiation of other contraceptive measures
V25.03 – Encounter for emergency contraceptive counseling and prescription
V25.04 – Counseling and instruction in natural family planning to avoid pregnancy
V25.09 – Encounter for contraceptive management, general counseling and advice; other
V25.11 – Encounter for insertion of intrauterine contraceptive device
V25.13 – Encounter for removal and reinsertion of intrauterine contraceptive device
V25.41 – Surveillance of previously prescribed contraceptive methods for contraceptive pill
V25.42 – Surveillance of previously prescribed contraceptive methods for intrauterine contraceptive device
V25.43 – Surveillance of previously prescribed contraceptive methods for implantable subdermal contraceptive
V25.49 – Surveillance of previously prescribed contraceptive methods for other contraceptive methods
V25.5 – Encounter for insertion of implantable subdermal contraceptive

Dental Caries In Preschool Children (Coverage Policy 2011029)
USPSTF Recommendation
The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. (Grade B)
HRSA (Bright Futures) Recommendation
Oral fluoride supplementation if the primary water source is deficient in fluoride from age 1 to 6.
CPT HCPCS Codes:
99381-99383 – Initial comprehensive preventive medicine evaluation and management of an individual.
99391-99393 – Periodic comprehensive preventive medicine reevaluation and management of an individual
ICD-9 Codes
V20.2 – Routine infant or child health check
V07.31 – Need for prophylactic fluoride administration

Depression, Screening In Adults (Coverage Policy 2011043)
USPSTF Recommendation
The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. (Grade B)
CPT/HCPCS Codes:
99385-99387 – Initial comprehensive preventive medicine evaluation and management of an individual
99395-99397 – Periodic comprehensive preventive medicine reevaluation and management of an individual
99401 – Preventive medicine counseling; 15 minutes
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes
G0444 – Depression Screening, 15 minutes **99403 and CPT 99404 require review of records.* (99401-99404 are considered components of 99381-99397 if billed on the same date-of-service [CPT-4 coding instructions])
ICD-9 Code
V79.0 – Screening for depression

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Depression, Screening In Adolescents (Coverage Policy 2011044)
USPSTF Recommendation
The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. (Grade B)
CPT HCPCS Codes:
99384-99385 – Initial comprehensive preventive medicine evaluation and management of an individual.
99394-99395 – Periodic comprehensive preventive medicine reevaluation and management of an individual
99401 – Preventive medicine counseling; 15 minutes
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes **99403 and 99404 require review of records.* (99401-99404 are considered components of 99381-99397 if billed on the same date-of-service [CPT-4 coding instructions])
G0444 – Depression Screening, 15 minutes
ICD-9 Code
V79.0 – Screening for depression

Developmental Screening (Coverage Policy 2012048)
HRSA (Bright Futures) Recommendation
Begin structured developmental screening at the 18 month well child visit, with repeat evaluation at 2½ years
CPT/HCPCS Codes
96110 – Developmental testing, limited (e.g., Developmental Screening test II, Early Language Milestone Screen), with interpretation and report (This code is recommended by the AAP (Coding for Pediatric Preventive Care, 2011))
G0451 – Developmental testing, with interpretation and report, per standardized instrument form.
ICD-9 Codes
V79.3 – Special screening for developmental handicaps in early childhood
V79.8 – Special screening for other specified mental disorders and handicaps

Diabetes Mellitus, Type 2, Screening In Adults (Coverage Policy 2011026)
USPSTF Recommendation
The USPSTF recommends screening for Type 2 Diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. (Grade B)
CPT/HCPCS Codes
82947 – Glucose; quantitative, blood (Except reagent strip)
82950 – Glucose; post glucose dose (includes glucose)
83036 – Hemoglobin; glycosylated (A1C)
ICD-9 Codes:
V77.1 – screening for diabetes mellitus

Diabetes Mellitus, Screening In Pregnant Women 24 & 28 Weeks Gestation And At First Prenatal Visit For Pregnant Women Identified As High Risk For Diabetes (Coverage Policy 20120302)
HRSA (Women's Health Initiative) Recommendation (Effective August 2012)
The Women's Health Initiative recommends screening for Diabetes Mellitus in pregnant women 24 and 28 weeks gestation and at first prenatal visit for pregnant women identified as high risk for diabetes.
CPT/HCPCS Codes
82947 – Glucose; quantitative, blood (Except reagent strip)
ICD-9 Codes
V77.1 – Screening for diabetes mellitus

Folic Acid, Prevention Of Neural Tube Defects (Coverage Policy 2011041)
USPSTF Recommendation
The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) (Grade A) of folic acid. Not routinely covered for "all women capable of pregnancy". (Grade A)
CPT/HCPCS Codes
None. Information on folic acid is typically provided during an office visit.
ICD-9 Codes
V65.49 – Other specified counseling

Gonorrhea, prophylaxis, newborn ophthalmic (coverage policy 2011035)
USPSTF Recommendation
The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against ophthalmia neonatorum. (Grade A)
CPT/HCPCS Code:
99461 – Initial care, per day, for evaluation and management of normal newborn infant seen in other than a hospital or birthing center.
ICD 9 Code:
V07.8 – Need for other specified prophylactic measure

Gonorrhea, Screening (Coverage Policy 2011038)
USPSTF Recommendation
The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant for gonorrhea infection if they are at increased risk for infection (i.e., if young or have other individual or population. (Grade B)
HRSA (Bright Futures) Recommendation
Screen sexually active adolescents for chlamydia using tests appropriate to the patient population and clinical setting.
CPT/HCPCS Codes
87590 – Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
87591 – Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87800 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) tech
87801 – Infectious agent detection by nucleic acid (DNA or RNA), mult organisms; amplified probe(s) tech

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87850 – Infectious agent antigen detect by immunoassay with direct optical observ.; Neisseria gonorrhoeae
ICD-9 Codes
V69.2 – High risk sexual behavior
V74.5 – Special Screening Exam for Venereal Disease

Hearing Loss, Screening In Newborns (Coverage Policy 2011036)
USPSTF Recommendation
The USPSTF recommends screening for hearing loss in all newborn infants. (Grade B)
HRSA (Bright Futures) Recommendation
If not done at birth (e.g., newborn delivered at home or discharged from Neonatal Intensive Care Unit) screening should be completed within the first month of life.
After the 4th month, if there are positive responses to risk screening questions, the infant should be referred for diagnostic audiologic assessment.
At years 4, 5, and 6, audiometry screening is recommended, universally, and subsequent to that, if there are positive responses to risk screening questions, audiometry is recommended.
CPT/HCPCS Codes:
92586 – Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587 – Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
92552 – Pure tone audiometry (threshold); air only
92579 – Visual reinforced audiometry
92582 – Conditional play audiometry
99381 – Initial comprehensive preventive medicine evaluation and management of an individual.
99391 – Periodic comprehensive preventive medicine reevaluation and management of an individual
99461 – Initial care, per day, for evaluation and management of normal newborn infant seen in other than a hospital or birthing center.
ICD 9 Codes:
V20.2 – Routine infant or child health check
V20.31 – Health supervision for newborn under 8 days old
V20.32 – Health supervision for newborn 8 to 28 days old
V72.19 – Other examination of ears and hearing

Hepatitis B Virus Infection In Pregnancy, Screening (Coverage Policy 2011039)
USPSTF Recommendation
The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit (Grade A)
CPT/HCPCS Codes:
CPT 80055 – Obstetric panel
CPT 87340 – Hepatitis B associated antigen
ICD-9 Codes
V22.0–V22.2 – Prenatal Visits
V23.0–V23.9 – Prenatal visits for patients with high risk pregnancies
V28.9 – Antenatal screening NOS

High Blood Pressure, Screening In Adults (Coverage Policy 2011015)
USPSTF Recommendation
The USPSTF recommends screening for high blood pressure in adults aged 18 and older. (Grade A)
CPT/HCPCS Codes
99385-99387 – Initial comprehensive preventive medicine evaluation and management of an individual
99395-99397 – Periodic comprehensive preventive medicine reevaluation and management of an individual
ICD-9 Codes
V81.1 – Screening for hypertension

High Blood Pressure, Screening In Infants, Children & Adolescents (Coverage Policy 2012037)
HRSA (Bright Futures) Recommendation
Infants & children with specific risk factors for high blood pressure should be screened up through age 2½; blood pressure examination is included in the complete physical examination done routinely after 2½.
CPT/HCPCS Codes
99381 – Initial comprehensive preventive medicine evaluation, new patient, infant
99382 – Initial comprehensive preventive medicine evaluation, new patient, 1-4 years
99383 – Initial comprehensive preventive medicine evaluation, new patient, 5-11 years
99384 – Initial comprehensive preventive medicine evaluation, new patient, 12-17 years
99385 – Initial comprehensive preventive medicine evaluation, new patient, 18-39 years
99391 – Comprehensive preventive medicine re-evaluation, infant
99392 – Comprehensive preventive medicine re-evaluation, 1-4 years
99393 – Comprehensive preventive medicine re-evaluation, 5-11 years
99394 – Comprehensive preventive medicine re-evaluation, 12-17 years
99395 – Comprehensive preventive medicine re-evaluation, 18-39 years
ICD-9 Codes
V20.2 – Routine infant or child health check
V70.0 – Routine general health examination
V81.1 – Screening for hypertension

Human Immunodeficiency Virus (HIV), Screening (Coverage Policy 2011040)
USPSTF Recommendation
The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection. (Grade A)
HRSA (Bright Futures) Recommendation
Sexually active adolescents who are positive on risk questions should be screened for HIV
ICD-9 Codes
V01.79 – Contact or exposure to other viral diseases
V08 – Asymptomatic HIV infection status
V22.0 – V22.2 - Prenatal Visits

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V23.0 – V23.9 - Prenatal visits for patients with high risk pregnancies
V65.44 – Human immunodeficiency virus counseling
V69.2 – Problems related to high-risk sexual behavior
V73.8 – Special screening examination for other specified viral diseases

Human Immunodeficiency Virus (HIV), Counseling And Screening, Annual Coverage Policy 2012033)
HRSA (Women's Health Initiative) Recommendation (Effective August 2012)
The Women's Health Initiative strongly recommends that clinicians counsel and screen for human immunodeficiency virus (HIV), annually.
CPT/HCPCS Codes:
86689 – HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86701 – Antibody; HIV-1
86703 – Antibody; HIV-1 and HIV-2, single assay
87390 – Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; HIV-1
87535 – Infectious agent antigen detection by enzyme immunoassay technique qualitative or semi quantitative; HIV-1 amplified probe technique
99401 – Preventive medicine counseling; 15 minutes
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes **99403 and 99403 require review of records.* (CPT 99401-99404 are considered components of 99381-99397 if billed on the same date-of-service [CPT-4 coding instructions])
G0432 – Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
G0433 – Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0435 – Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2 screening
ICD-9 Codes
V65.44 – Human immunodeficiency virus counseling
V69.2 – Problems related to high-risk sexual behavior

Human Papilloma Virus Testing (Coverage Policy 2012034)
HRSA (Women's Health Initiative) Recommendation (Effective August 2012)
The Women's Health Initiative recommends HPV testing every 3 years beginning at age 30 for sexually active women.
CPT/HCPCS Codes
87621 – HPV Testing
ICD 9 Codes
V72.31 – Routine gynecological examination
V73.81 – Special screening examination, human papilloma virus [HPV]
V76.2 – Screening for malignant neoplasm of the cervix

Hypothyroidism, Screening In Newborns (Coverage Policy 2011023)
USPSTF Recommendation
The USPSTF recommends screening for congenital hypothyroidism in newborns. (Grade A)
HRSA (Bright Futures) Recommendation
Conduct screening as required by the state. (Arkansas statute requires newborn screening for hypothyroidism; this test is usually done prior to discharge from the hospital following birth of the infant).
CPT/HCPCS Codes
84436 – Thyroxine; Total
84437 – Thyroxine; requiring elution (e.g..neonatal)
84439 – Thyroxine; free
84443 – Thyroid stimulating hormone (TSH)
ICD-9 Codes
V77.0 – Screening for thyroid disorder

Intimate Partner Violence, Screening/Counseling Of Women, Annually (Coverage Policy 2012021)
HRSA (Women's Health Initiative) Recommendation (Effective August 2012)
The Women's Health Initiative recommends screening/counseling for intimate partner violence annually.
CPT/HCPCS Codes
99385-99387 – Initial comprehensive preventive medicine evaluation and management of an individual
99395-99397 – Periodic comprehensive preventive medicine reevaluation and management of an individual
99401 – Preventive medicine counseling; 15 minutes
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes
*99403 and 99404 require review of records. (99401-99404 are considered components of 99381-99397 if billed on the same date-of-service [CPT-4 coding instructions])
ICD 9 Codes
V61.11 – Counseling for victim of spousal and partner abuse
V70.0 – General medical exam

Iron Deficiency Anemia Screening In Pregnant Women (Coverage Policy 2011014)
USPSTF Recommendation
USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant (Grade B).
CPT/HCPCS Codes
80050 – General Health Panel
80055 – Obstetrical panel
85013 – Blood count; Spun Micro hematocrit
85014 – Blood count; hematocrit (Hct)
85018 – Blood count; hemoglobin (Hgb)
85025 – Complete (CBC), automated (Hgb, Hct, RBC, WBC & Platelet count) and automated differential WBC count

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85027 – Complete (CBC), automated (Hgb, Hct, RBC, WBC and Platelet count)
G0306 – Complete CBC
G0307 – Complete CBC
ICD-9 Codes
V22.0–V22.2 - Prenatal Visits
V23.0–V23.9 - Prenatal visits for patients with high risk pregnancies

Iron Supplementation For Children (Coverage Policy 2011042)
USPSTF Recommendation
The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. (Grade B)
ICD-9 Codes
V20.2 – Routine infant or child health check

Lead Screening in Infants Children and Through Age 6 (Coverage Policy 2012038)
HRSA (Bright Futures) Recommendation
Begin screening at the six month well-child visit for children who are positive on risk screening questions. Continue as routine screening for children from high prevalence area or on Medicaid, and screen selectively children from low prevalence areas and not on Medicaid
CPT/HCPCS Codes
83655 – Lead
ICD-9 Codes
V82.5 – Screening for chemical poisoning & other contamination

Lipid (Cholesterol), Screening (Coverage Policy 2011010)
USPSTF Recommendations
USPSTF strongly recommends screening men aged 35 and older for lipid disorders. (Grade A)
USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. (Grade B)
USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease. (Grade A)
USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease. (Grade B)
HRSA (Bright Futures) Recommendation
Begin screening with lipid profile for children who test positive on risk screening questions beginning at age 2. Screening would not be repeated unless the child or adolescent's risk factors changed. If the risk factors change, screening could be repeated at 4 years, 6 years, 8 years, 10 years, between 11 and 14 years, between 15 and 17 years and between 18 and 21 years.
CPT/HCPCS Codes:
80061 – Lipid panel. This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
82465 – Cholesterol

83718 – Lipoprotein, direct measurement, high density cholesterol
ICD-9 Codes:
V20.2 - Routine infant or child health check V70.0 – General medical exam
V70.9 – General Medical exam, NOS
V77.91 – Screening for lipoid disorders

Media Use By Children & Adolescents, Screening & Counseling For (Coverage Policy 2012042)
HRSA (BRIGHT FUTURES) Recommendation
Screening:
To screen for media usage, clinicians should ask 2 questions about media use at health supervision visits: 1) How much screen time per day does the child spend? 2) Is there a TV set or Internet connection in the child's bedroom?
Counseling:
Since they potentially influence numerous aspects of child and adolescent health, the media may represent the most important area of anticipatory guidance in well-child visits. One study has shown that a minute or two of office counseling about media violence and guns could reduce violence exposure for nearly 1 million children per year. Given the sheer number of hours children spend with media, counseling is imperative.
CPT/HCPCS Codes
99383 – Initial comprehensive preventive medicine, late childhood (age 5 through 11 years
99384 – Initial comprehensive preventive medicine, adolescent (age 12 through 17)
99385 – Initial comprehensive preventive medicine, 18-39 years
99393 – Periodic comprehensive preventive medicine reevaluation & management (5 through 11)
99394 – Periodic comprehensive preventive medicine reevaluation & management (12 through 17)
99395 – Periodic comprehensive preventive medicine reevaluation & management (18 – 39)
ICD-9 Codes
V65.49 – Other specified counseling
V65.40 – Counseling, Not Otherwise Specified

Nutrition (Dietary) Counseling, Adults (Coverage Policy 2011034)
USPSTF Recommendation
The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. (Grade B)
CPT/HCPCS Codes
97802–97803 – Medical Nutrition Therapy **(CPT-4 instructs these codes are not to be reported by physicians)**
99401 – Preventive medicine counseling; 15 minutes
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes **99403 and 99404 require review of records.*
G0108 – Diabetes training services
G0270 – Medical Nutrition Therapy

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S9140-S9141 – Diabetic management program
S9452 – Nutrition Classes
S9455-S9465 – Diabetic management program
S9470 – Nutritional counseling
ICD-9 Codes:
V65.3 – Dietary surveillance and counseling

Obesity in Adults and Children 6 Years or Older; Screening and Counseling (Coverage Policies 2011025 and 2011030)
USPSTF Recommendation (Updated June 2012)
Effective June 2012:
USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions. (Grade B)
Prior to June 2012:
USPSTF recommends that clinicians screen all adult patients and children 6 years or older for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese individuals. For children clinicians should offer then or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status. (Grade B)
HRSA (Bright Futures – Anticipatory Guidance)
Bright Futures identifies healthy weight promotion as 1 of 2 critical themes within the guidelines. Recommendations in Bright Futures are consistent with the Prevention and Prevention Plus stages outlined in the Expert Committee Recommendations regarding the Prevention, Assessment, and Treatment of Child Adolescent Overweight and Obesity. This recommendation applies to children age 6 and above.
CPT/HCPCS Codes
99383-99387 – Initial comprehensive preventive medicine evaluation and management of an individual
99393-99397 – Periodic comprehensive preventive medicine reevaluation and management of an individual
99401 – Preventive Medicine counseling: 15 minutes
99402 – Preventive medicine counseling: 30 minutes
99403* - Preventive medicine counseling: 45 minutes
99404* - Pre Preventive medicine counseling: 60 minutes **99403 and 99404 require review of records.* (99401 – 99404 are considered components of 99381 or 99397 if billed on the same date-of-service [CPT-4 coding instructions])
G0447 – Face-to-Face counseling
ICD-9 Codes
V70.0 – General medical exam
V77.8 – Screening for obesity

Osteoporosis Screening in Women (Coverage Policy 2011031)
USPSTF Recommendation
The USPSTF recommends screening for osteoporosis in women age 65 and older, be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. (Grade B).

CPT/HCPCS Codes
77080 – Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)
ICD-9 Codes
V82.81 – Special screening for osteoporosis

Phenylketonuria Screening in Newborns (Coverage Policy 2011028)
USPSTF Recommendation
The USPSTF recommends screening for phenylketonuria (PKU) in newborns. (Grade A)
HRSA (Bright Futures) Recommendation
Conduct screening as required by the state. (Arkansas statute requires newborn screening for phenylketonuria; this test is usually done prior to discharge from the hospital following birth of the infant).
CPT/HCPCS Code
CPT 84030 – Phenylalanine (PKU), blood
ICD-9 Codes:
V77.3 – Screening for Phenylketonuria (PKU)

Pregnancy, Screening, In Sexually Active Females Without Contraception, Late Menses, Or Amenorrhea (Coverage Policy 2012041)
HRSA (Bright Futures) Recommendation
The USPSTF recommends screening for pregnancy with urine human chorionic gonadotrophin in sexually active females who do not practice contraception, who have late menses, or amenorrhea, ages 11 to 21.
CPT/HCPCS Codes
81025 – Urine pregnancy test, by visual color comparison methods
84703 – Gonadotrophin, chorionic (hCG); qualitative
ICD9 Code
V70.0 – General medical exam

RH Incompatibility Screening (Coverage Policy 2011027)
USPSTF Recommendations
The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.(Grade A)
The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative. (Grade B)
CPT/HCPCS Codes:
80055 – Obstetrical Panel
86901 – Blood typing; Rh (D)
ICD-9 Code
V22.0–V22.2 – Prenatal Visits
V23.0–V23.9 – Prenatal visits for patients with high risk pregnancies

(Continued from page 37) Coding guidelines for PPACA preventive benefits plans

Sexually Transmitted Infections (STI's); Counseling and Screening (Coverage Policy 2011032)
HRSA (Women's Health Initiative) Recommendation (Effective August 2012)
The Women's Health Initiative recommends that clinicians counsel all sexually active women, annually.
CPT/HCPCS Codes
99401 – Preventive medicine counseling; 15 minutes
99402 – Preventive medicine counseling; 30 minutes
99403* – Preventive medicine counseling; 45 minutes
99404* – Preventive medicine counseling; 60 minutes *99403 and 99404 require review of records.
G0445 – High intensity behavioral counseling to prevent sexually transmitted infection; face to face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes.
ICD-9 Codes
V65.45 – Counseling on other sexually transmitted diseases
V69.2 – Problems related to high-risk sexual behavior

Sickle Cell Screening Disease, Newborn Screening (Coverage Policy 2011032)
USPSTF Recommendation
The USPSTF recommends screening for sickle cell disease in newborns. (Grade A)
HRSA (Bright Futures) Recommendation
Conduct screening as required by the state. (Arkansas statute requires newborn screening for hemoglobinopathies; this test is usually done prior to discharge from hospital following birth of the infant).
CPT/HCPCS Codes
83020 – Hemoglobin fractionation and quantitation; electrophoresis (e.g., A2, S, C, and/or F)
83021 – Hemoglobin fractionation and quantitation; chromatography (e.g., A2, S, C, and/or F)
S3620 – Newborn metabolic screening panel, includes test kit, postage and laboratory tests specified by the state for inclusion in this panel (e.g., galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-d; phenylalanine (PKU) and thyroxine, total
ICD9 Code
V78.2 – Special screening for sickle cell disease or trait.

Skin Cancer Counseling For Persons 10-24 Years (Coverage Policy 2012018)
USPSTF Recommendation (Effective July 2012)
USPSTF recommends counseling children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer. (Grade B)
CPT/HCPCS Codes
99383 – Initial comprehensive preventive medicine exam, age 5 through 11 years
99384 – Initial comprehensive preventive medicine exam, age 12 through 17 years
99385 – Initial comprehensive preventive medicine exam, age 18 through 24 years

99393 – Periodic comprehensive preventive medicine exam, age 5 through 11 years
99394 – Periodic comprehensive preventive medicine exam, age 12 through 17 years
99395 – Periodic comprehensive preventive medicine exam, age 18 through 24 years
ICD9 Codes
V20.2 – Routine infant or child health check
V70.0 – General Medical Examination

Syphilis Screening (Coverage Policy 2011037
USPSTF Recommendation
The USPSTF recommends that clinicians screen all persons at increased risk for syphilis infection, and all pregnant women for syphilis infection. (Grade A)
HRSA Recommendation (Bright Futures)
Bright Futures recommends screening for syphilis in all adolescents who are sexually active and positive for high risk.
CPT/HCPCS Codes:
80055 – Obstetric Panel
86592 – Syphilis Test; qualitative
86780 – Antibody; Treponema pallidum
ICD-9 Codes
V22.0 – V22.2 - Prenatal Visits
V23.0 – V23.9 - Prenatal visits for patients with high risk pregnancies
V69.2 – Problems related to high risk sexual behavior
V74.5 – Screening examination for venereal disease

Tobacco Use, Screening, Counseling and Interventions (Coverage Policy 2011024)
USPSTF Recommendation
The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (Grade A)
The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke. (Grade A)
HRSA (Bright Futures) Recommendation
Bright Futures recommends that health care professionals screen for tobacco use and tobacco smoke exposure, encourage tobacco use cessation, and provide tobacco use cessation strategies and resources at most visits for adolescents ages 11 through 21.
CPT/HCPCS Codes:
99406 – Smoking and tobacco use cessation counseling visit; intermediate; 3-10 minutes
99407 – Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes
(Bright Futures recommends these codes when reporting tobacco use by parents)
G0436 – Smoking and tobacco use cessation counseling visit; intermediate; 3-10 minutes
G0437 – Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes

(Continued from page 39) Coding guidelines for PPACA preventive benefits plans

ICD9 Codes
305.1 – Tobacco dependence
649.0 – Smoking complicating pregnancy
V15.82 – History of tobacco use
V15.89 – Other specified personal history presenting hazards to health, Other)
V22.0 – V22.2 – Prenatal Visits
V23.0 – V23.9 – Prenatal visits for patients with high risk pregnancies
V65.49 – Other specified counseling (Bright Futures recommends these codes when reporting tobacco use by parents

Tuberculosis, Screening (Coverage Policy 2012039)
HRSA (Bright Futures) Recommendation
Begin selective screening for tuberculosis with the tuberculin skin test for infants, children, and adolescents who are at increased risk based on risk screening questions, at the first month well-child visit and continue through adolescence.
CPT/HCPCS Codes
86580 – Skin test, tuberculosis, intradermal
ICD9 Code
V74.1 – Screening for pulmonary tuberculosis

Visual Impairment, Screening In Children (Coverage Policy 2011033)
USPSTF Recommendation
The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors (Grade B)
HRSA (Bright Futures) Recommendation
Selective screening or newborn, infants, and children through age 2, to assess for abnormal funduscopic examination, particularly if premature or other risk conditions.
Objective measurement of vision with age-appropriate visual acuity measurement using HOTV, tumbling E tests, Snellen letters, Snellen numbers, or Picture tests such as Allen figures or LEA symbols.
CPT/HCPS Code
99173 – Screening test of visual acuity, quantitative, bilateral
99174 – Ocular photoscreening, interpretation, report, bilateral
ICD9 Codes:
V20.2 – Routine infant or child health check
V72.0 – Examination of eyes and vision
V80.2 – Special screening for “other eye conditions”, including congenital anomaly of eye

Well Child Visits, Newborn, Infant, Children, Adolescents, & Ages 18-21 (Coverage Policy 2012046)
HRSA (Bright Futures) Recommendation
Bright Futures recommends well child visits at birth, first week after birth, at age 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 2½ years, 3 years, 4 years, 5 years, 6 years, 7 years, 8 years, 9 years, 10 years, between 11-14 years, between 15-17 years, and 18 to 21 years.
Coverage for these visits are similar to that required by Arkansas Statute.
CPT/HCPCS
99381 – Initial comprehensive preventive medicine exam, infant
99382 – Initial comprehensive preventive medicine exam, age 1 through 4 years
99383 – Initial comprehensive preventive medicine exam, age 5 through 11 years
99384 – Initial comprehensive preventive medicine exam, age 12 through 17 years
99385 – Initial comprehensive preventive medicine exam, age 18 through 21 years
99391 – Periodic comprehensive preventive medicine exam, age younger than 1 year
99392 – Periodic comprehensive preventive medicine exam, age 1 through 4 years
99393 – Periodic comprehensive preventive medicine exam, age 5 through 11 years
99394 – Periodic comprehensive preventive medicine exam, age 12 through 17 years
99395 – Periodic comprehensive preventive medicine exam, age 18 through 21 years
ICD9 Codes
V20.2 – Routine infant or child health check (ages infant through 17)
V70.0 – Routine general health exam at a health care facility

Well Woman Visit For Adult Women (Coverage Policy 2012031)
HRSA (Women's Health Initiative)
CPT/HCPCS Codes
99385 – Initial comprehensive preventive medical exam, 18-39 years
99386 – Initial comprehensive preventive medical exam, 40-64 years
99387 – Initial comprehensive preventive medical exam, 65 years and older
99395 – Periodic comprehensive preventive medicine exam, 18-39 years
99396 – Periodic comprehensive preventive medicine exam, 40-64 years
99387 – Periodic comprehensive preventive medicine exam, 65 years and older
G0438 – Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
G0439 – Annual wellness visit; includes a personalized prevention plan of service (PPS), subsequent visit
ICD9 Codes
V70.0 – General Medical Examination

Coding guidelines for PPACA: other preventive services

ACIP Immunizations Recommendations
An immunization that does not fall under one of the exclusions in the Certificate of Coverage is considered covered after all of the following conditions are satisfied: (1) FDA approval; (2) explicit ACIP recommendation published in the Morbidity & Mortality Weekly Report (MMWR) of the Centers for Disease Control and Prevention (CDC). Implementation will typically occur within 60 days after publication in the MMWR.
Immunization Administration Codes::
90460 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxic component (This code is effective 1/1/2011)
90461 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxic component (List separately in addition to code for primary procedure)
90471 – Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472 – Immunization administration (add)
90473 – Immunization admin by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474 – Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
G0008 – Administration of influenza virus vaccine
G0009 – Administration Pneumococcal
G0010 – Administration of hepatitis B vaccine

Immunization/Vaccine Codes
90375 – Rabies immune globulin, (Rig), for intramuscular and/or subcutaneous use
90376 – Rabies immune globulin, heat treated (Rlg-HT), human, for intramuscular and/or subcutaneous use
90632 – Hepatitis A vaccine, adult, for intramuscular use; (Appropriate ICD9 code is V05.3)
90633 – Hepatitis A vaccine, pediatric/adolescent dosage - 2 dose schedule, for intramuscular use (Appropriate ICD (code is V05.3)
90634 – Hepatitis A vaccine, pediatric/adolescent dosage - 3 dose schedule, for intramuscular use.
90636 – Hepatitis A and hepatitis B vaccine (Hep A - Hep B), adult dosage, for intramuscular use (Appropriate ICD9 code is V05.3)
90645 – Hemophilus influenza B vaccine (HIB), HbOC conjugate (4 dose schedule), for intramuscular use (Appropriate ICD9 code is V03.81)
90646 – Hemophilus influenza B vaccine (HIB), PRP-D conjugate, for booster use only, intramuscular use (Appropriate ICD9 code is V03.81)
90647 – Hemophilus influenza B vaccine (HIB), PRP-OMP conjugate (3 dose schedule), for intramuscular use (Appropriate ICD9 code is V03.81)

90648 – Hemophilus influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use (Appropriate ICD9 code is V03.81)
90649 – Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use. Note: coverage for 90649 is limited to female adolescents and adults ages 11 – 26 and Male adolescents and adults ages 9-21. (Males effective July 2010.) (Appropriate ICD9 code is V04.89))
90650 – Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, intramuscular use
90655 – Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use (Appropriate ICD9 code is V04.81)
90656 – Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use (Appropriate ICD9 code is V04.81)
90657 – Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use (Appropriate ICD9 code is V04.81)
90658 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Appropriate ICD9 code is V04.81)
90660 – Influenza virus vaccine, live, for intranasal use Note: coverage is limited to ages 2 – 49 (Appropriate ICD9 code is V04.81)
90669 – Pneumococcal vaccine.
90670 – Pneumococcal conjugate vaccine, 13 valent, for intramuscular use (Appropriate ICD9 code V03.82)
90675 – Rabies Vaccine for intramuscular use. Only for Very Select Persons Who Meet Specific Criteria.
90680 – Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use (Appropriate ICD9 code: V04.89)
90681 – Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use (Appropriate ICD9 code is V04.89)
90690 – Typhoid vaccine, live, oral. Only for Very Select Children 6 years of age & over, Adolescents, or Adults who meet certain criteria (Appropriate ICD9 code is V03.1)
90691 – Typhoid vaccine, Vi capsular polysaccharide, intramuscular. Only for Very Select Children 2 years of age & over, Adolescents, & Adults who meet certain criteria. (Appropriate ICD9 code is V03.1)
90692 – Typhoid vaccine, heat &phenol inactivated. Only for Very Select Children 6 months of age & over, Adolescents, or Adults who meet certain criteria. (Appropriate ICD9 code is V03.1)
90696 – Diphtheria, tetanus toxoids, acellular pertussis vaccine & polio vaccine, inactivated. Children 4-6 years of age Only. (Appropriate ICD9 code is V06.8).
90698 – Diphtheria, tetanus toxoids, acellular pertussis vaccine, hemophilus influenza type B, and poliovirus vaccine. Infants & Children Only less than 4 (Appropriate ICD9 code is V06.8).
90700 – Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use (Appropriate ICD9 code is V06.1).
90702 – Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use
90703 – Tetanus toxoid adsorbed, for intramuscular use
90704 – Mumps virus vaccine, live, for subcutaneous use (Appropriate ICD9 code is V04.6).
90705 – Measles virus vaccine, live, for subcutaneous use (Appropriate ICD9 code is V04.2).

(Continued from page 43) Coding guidelines for PPACA: other preventive services

90706 – Rubella virus vaccine, live, for subcutaneous use (Appropriate ICD9 code is V04.3).
90707 – Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use (Appropriate ICD9 code is V06.4).
90710 – Measles, mumps, rubella, and vericella vaccine (MMRV), live for subcutaneous use (Appropriate ICD9 code is V06.8).
90712 – Poliovirus vaccine, live, oral. Only for Very Select Children, Adolescents, or Adults who meet certain criteria. (Appropriate ICD9 code is V04.0).
90713 – Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use (Appropriate ICD9 code is V04.0).
90714 – Tetanus and diphtheria toxoids (Tc) absorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use (Appropriate ICD9 code is V06.5).
90715 – Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), when administered to individuals 7 years or older, for intramuscular use (Appropriate ICD9 code is V06.1).
90716 – Varicella virus vaccine, live, for subcutaneous use (Appropriate ICD9 code is V06.4).
90717 – Yellow fever vaccine, live. Only for Very Select Infants, Children, Adolescents, or Adults who meet certain criteria. For travel to endemic areas or for laboratory workers. (Appropriate ICD9 code is V04.4).
90718 – Tetanus and diphtheria toxoids (Td) adsorbed when administered to individuals 7 years or older, for intramuscular use (Appropriate ICD9 code is V06.5).
90721 – DTAP/HIB Vaccine
90732 – Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use (Appropriate ICD9 code is V03.82).
90733 – Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use (Appropriate ICD9 code is V03.89).
90734 – Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use (Appropriate ICD9 code is V03.9).
90735 – Japanese encephalitis virus vaccine. Vaccine Not Commercially Available. Some Vaccine Available for Children & Adolescents 1-16 Years of Age thru Sanofi-Pasteur for Travel to Endemic Areas and for lab workers. (Appropriate ICD9 code is V05.0).
90736 – Zoster (shingles) vaccine, live, for subcutaneous injection
90738 – Japanese encephalitis virus vaccine, inactivated. Adolescents age 17-18, and Adults, for Travel to Endemic Areas. (Appropriate ICD9 code is V05.0).
90740 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90743 – Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
90746 – Hepatitis B vaccine, adult dosage, for intramuscular use
90747 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use

90748 – Hepatitis B and Hemophilus influenza B vaccine (Hep B - HIB), for intramuscular use (Appropriate ICD9 code is V06.8 or V06.9).
90749 – Unlisted Vaccine Toxoid

Prostate Cancer Screening
Arkansas State Mandate
Act 75 of 2009 requires payment for prostate cancer screening annually for men age 40 and over as recommended by the National Comprehensive Cancer Network effective January 2009.
CPT/HCPCS Codes
84153 – Prostate specific antigen (PSA)
G0102 – Prostate cancer screening; digital rectal examination
G0103 – Prostate cancer screening; prostate specific antigen test (PSA)
ICD-9 Code
V76.44 – Screen malignant neoplasm-prostate

Miscellaneous Procedures Covered Under Wellness, But Not Listed Under PPACA, Allowed Only Once A Year In Conjunction With An Annual Wellness Exam
CPT/HCPCS Codes
99385 – Initial comprehensive preventive medical exam, 18-39 years
99386 – Initial comprehensive preventive medical exam, 40-64 years
99387 – Initial comprehensive preventive medical exam, 65 years and older
99395 – Periodic comprehensive preventive medicine exam, 18-39 years
99396 – Periodic comprehensive preventive medicine exam, 40-64 years
99387 – Periodic comprehensive preventive medicine exam, 65 years and older
80050 – General Health Panel (Must include comprehensive metabolic panel, Blood count, complete, thyroid stimulating hormone)
81000 – Urinalysis by dipstick or tablet reagent, non-automated, with microscopy
81001 – Urinalysis, by dipstick or tablet reagent, automated, with microscopy
ICD9 Codes
V70.0 – General Medical Examination

Fee Schedule

Fee schedule additions and updates

The following CPT and HCPCS codes were updated on the Arkansas Blue Cross and Blue Shield fee schedule.

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
81240	$474.81	$142.44	$332.37	$0.00	$142.44	$0.00
81241	$518.26	$155.48	$362.78	$0.00	$155.48	$0.00
90581	BR	$0.00	$0.00	$0.00	$0.00	$0.00
90654	$12.87	$0.00	$0.00	$0.00	$0.00	$0.00
90662	$12.87	$0.00	$0.00	$0.00	$0.00	$0.00
95970	$80.68	$35.67	$0.00	$35.67	$35.67	$0.00
0302T	BR	BR	BR	$0.00	$0.00	$0.00
0303T	BR	BR	BR	$0.00	$0.00	$0.00
0304T	BR	BR	BR	$0.00	$0.00	$0.00
0305T	BR	BR	BR	$0.00	$0.00	$0.00
0306T	BR	BR	BR	$0.00	$0.00	$0.00
0307T	BR	BR	BR	$0.00	$0.00	$0.00
0308T	BR	BR	BR	$0.00	$0.00	$0.00
C9368	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9369	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
E0676	$0.00	$25.00	$0.00	$0.00	$0.00	$0.00
G0447	$42.78	$0.00	$0.00	$40.14	$0.00	$0.00
G9148	BR	BR	BR	$0.00	$0.00	$0.00
G9149	BR	BR	BR	$0.00	$0.00	$0.00
G9150	BR	BR	BR	$0.00	$0.00	$0.00
G9151	BR	BR	BR	$0.00	$0.00	$0.00
G9152	BR	BR	BR	$0.00	$0.00	$0.00
G9153	BR	BR	BR	$0.00	$0.00	$0.00
H0046	$24.00	$0.00	$0.00	$0.00	$0.00	$0.00
J0878	$0.57	$0.00	$0.00	$0.00	$0.00	$0.00
J7500	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7502	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7506	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7507	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7509	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7510	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7515	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7517	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7518	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J7520	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
J8501	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8510	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8515	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8520	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8521	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8530	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8540	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8560	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8561	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8562	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8565	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8600	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8610	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8650	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8700	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
J8705	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0092	$29.90	$0.00	$29.90	$29.90	$0.00	$29.90
Q0166	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0167	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0168	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0169	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0170	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0171	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0172	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0175	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0176	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0180	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q0181	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Q9954	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
R0070	$178.40	$0.00	$178.40	$178.40	$0.00	$178.40
R0075	$44.60	$0.00	$44.60	$44.60	$0.00	$44.60
R0076	$44.60	$0.00	$44.60	$44.60	$0.00	$44.60
S0190	BR	BR	BR	$0.00	$0.00	$0.00
S0610	$56.12	$0.00	$0.00	$42.53	$0.00	$0.00
S0612	$56.12	$0.00	$0.00	$42.53	$0.00	$0.00
S8421	$82.54	$0.00	$0.00	$0.00	$0.00	$0.00
S9452	$22.08	$0.00	$0.00	$21.70	$0.00	$0.00
S9455	$19.95	$0.00	$0.00	$0.00	$0.00	$0.00
S9460	$65.84	$0.00	$0.00	$0.00	$0.00	$0.00
S9465	$65.84	$0.00	$0.00	$0.00	$0.00	$0.00
S9470	$42.78	$0.00	$0.00	$40.14	$0.00	$0.00

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providers' news staff

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Please Note

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield and its affiliated companies. The newsletter does not pertain to Medicare. Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501) 378-2307 or (800) 827-4814.

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