Michigan Department of Health and Human Services

STD / HIV Billing Toolkit

Contents

DISCLAIMER

This guide was prepared as a service to the public and is only intended to be a general summary. It is not intended to take the place of either the written law or regulations and is not a substitute for legal advice. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents and to consult with their own legal counsel or other experts for guidance specific to their individual circumstances. Specific coding and payer guidelines should be reviewed prior to the submission of claims for reimbursement. Use of this guide does not guarantee that claims have been formatted or submitted properly or that claims will be reimbursed as billing coding requirements and insurance policies and coverage may change from time-to-time.

SECTION 1 – INTRODUCTION

This document is intended to be a tool that Michigan's STD/HIV clinics and organizations can use to: determine whether to bill; set up and maintain a billing infrastructure; and enhance the potential for revenue generation to sustain their services.

1.1 ORGANIZATION

The tool is organized into multiple sections. The toolkit can be reviewed in full or the reader can go to a relevant section to gather specific information. Throughout the document there are references to appendices and other tools the reader can use to gather more in-depth information on a given topic. Readers can download the following appendices separately for review:

Appendices

1. Michigan Code Suppression List
2. Billing Cost Benefit Analysis Tool
3. Key Health Plan Contact Listing
4. Sample Superbill / Encounter Form
5. Coding Guide
6. Model Medicaid Health Plan Contract (in process)

1.2 HOW TO USE

The reader should use this toolkit to garner a general summary of billing practices and current context. This tool is not intended to serve as a written rule, law, or regulation. Information should be confirmed with individual payers prior to billing and seeking reimbursement.

SECTION 2 – THE STD/HIV BILLING ENVIRONMENT

2.1 THE AFFORDABLE CARE ACT AND ITS IMPLICATIONS

The Affordable Care Act (ACA) created a number of opportunities for the sustainability of STD/HIV service providers. Beyond ensuring coverage for those with pre-existing conditions like HIV, the ACA provided an opportunity to expand the overall number of insured individuals. In Michigan, the uninsured rate reportedly dropped by half between 2012 and 2014[1]. As more individuals are insured, they are more likely to interact frequently with the health system, expanding opportunities for community-based care and prevention. Additional revenue from insured patients can also improve a clinic's ability to care for those who remain uninsured or underinsured.

The ACA additionally supports the inclusion of safety net providers serving those who obtain coverage through the Health Insurance Marketplaces. Qualified Health Plans serving the Health Insurance Marketplaces are required to include a sufficient number of "Essential Community Providers" (ECPs) in their networks. All entities that are eligible to participate in the 340B drug pricing program are defined as ECPs. This includes certain health centers, Ryan White HIV/AIDS program grantees, and STD clinics,

[1] CHRT. Center for Healthcare Research & Transformation Survey Shows Dramatic Improvement in Health Insurance Coverage and Access since 2012. http://www.chrt.org/publication/cover-michigan-survey-2014-coverage-and-health-care-access/

among others[2]. To the extent clinics can leverage their ECP status, they may become more attractive to an insurance plan and be considered an in-network provider and therefore eligible for reimbursement. Information on becoming an ECP is included in Section 4.1.A of the toolkit.

Finally, the ACA expanded access to preventive services at no cost to the patient – including STD screenings for at-risk populations, high-intensity behavioral counseling (to prevent STDs), HPV vaccinations and high-risk HPV DNA testing. The ACA also mandated coverage of HIV testing annually for patients ages 15 to 65 at no cost. Insurance companies in local areas must also cover the above-listed services with no copays in addition to High Intensity Behavioral Counseling (HIBC) to prevent STDs for all sexually active adolescents, sexually active women, and men at increased risk for STDs. [3]

2.2 Shift to Value-Based Payment

With the continued emphasis on the *Triple Aim*[4], the health system is undergoing pressure to yield improved care and experience at lower costs. The Triple Aim, a framework to optimize health system performance, includes three dimensions: (1) improving the patient experience of care, (2) improving the health of populations, and (3) reducing the per capita cost of health care. To further these aims, the Centers for Medicare and Medicaid Services (CMS) has championed a number of initiatives to shift to value-based payment as opposed to paying on a fee-for-service, or volume, basis. To participate in the changing health care environment, providers will need to collect, track, analyze, and report data to demonstrate their impact on outcomes and costs. By establishing the processes to bill for services, STD/HIV providers will take the first steps to better understand and report the types of services that are provided, the costs of providing care, and the overall value of their care.

2.3 Michigan STD/HIV Services Funding Sources

Federal funding sources for STD/HIV services have been declining over time. While the State of Michigan has been able to make up some of this shortfall, budgetary pressures threaten the sustainability of state funds to cover providers' costs. With the rise in insurance coverage through the ACA, STD/HIV providers will likely need to turn to insurers to seek reimbursement for services to supplement grant funding. This section describes the main funding vehicles for STD/HIV services in Michigan.

2.3.A Medicaid Health Plans

A vast majority of Medicaid enrollees are in the Managed Care program, while some populations remain in the traditional fee-for-service program. In October 2015, Michigan awarded Medicaid managed care contracts to 11 plans. For a county listing of insurers currently contracted with Medicaid, please visit the Michigan Department of Health and Human Services website using the following link: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42544_42644-150910--,00.html.

---

[2] Health Resources and Services Administration, 340B Drug Pricing Program and Pharmacy Affairs: Eligibility and Registration (available at http://www.hrsa.gov/opa/eligibilityandregistration/index.html).

[3] National Coalition of STD Directors. Shifting to Third-Party Billing Practices for Public Health STD Services: Policy Context and Case Studies. http://www.ncsddc.org/sites/default/files/media/finalbillingguide.pdf

[4] Berwick, D., Nolan, T. and Whittington, J. The Triple Aim: Care, Health, and Cost. *Health Affairs.* http://content.healthaffairs.org/content/27/3/759.abstract

As part of the current Medicaid contract, plans must ensure that enrollees have adequate access to family planning services, including the detection and/or treatment of STDs[5]. Plans are also encouraged to partner with local health departments to ensure enrollees can receive services for communicable diseases, including HIV/AIDS and STDs. The latest managed care agreement requires plans to allow enrollees to receive treatment services for communicable diseases from local health departments without prior authorization, including those for HIV/AIDS and STDs.

Medicaid Health plans are required to have coordinating agreements with every local health department in their service area, which allows for the provision of basic services such as immunizations and screenings for Health Plan members without authorization. MDHHS' aim is to expand the scope of covered services by negotiating contracts for additional services that have not previously been paid for by the Health Plans. An example of additional services would be the use of Peer Counselors in the field under the category of Community Health Workers.

2.3.B Healthy Michigan Plan

Michigan expanded eligibility for Medicaid and, as of November 2015, enrollment in Medicaid and CHIP grew to 2.3 million, almost a 20% increase since 2013, with almost 600,000 enrolled in the Healthy Michigan Plan. The Healthy Michigan Plan covers family planning services with no out-of-pocket cost, and must also cover services including testing for STDs and HIV/AIDS testing and services[6]. Many of these members were previously uninsured and covered under Ryan White or other grant funding. It is important to check eligibility for all previously uninsured members so that payment can be received from the health plan. This is preferable to covering services through Ryan White or not receiving payment for services rendered.

2.3.C Traditional Medicaid

Traditional Medicaid, or fee-for-service Medicaid, allows for the coverage of diagnosis and treatment of HIV/AIDS and STDs with the same level of benefits as Medicaid Health Plans. Traditional Medicaid would be required to cover family planning services with no out-of-pocket cost and services for STDs and HIV/AIDS testing[7]. It is important to check eligibility for all previously uninsured members so that payment can be received from traditional Medicaid. This is preferable to covering services through Ryan White or not receiving payment for services rendered.

2.3.D Medicare

Medicare Part B covers HIV screenings and sexually transmitted disease (STD) screenings for chlamydia, gonorrhea, syphilis and/or Hepatitis B once every 12 months or at certain times during pregnancy. Those with Medicare Part B who are at increased risk for STDs can also receive up to 2 individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year. The sessions must be ordered by a primary care doctor or other primary care practitioner.

---

[5] Michigan Department of Health and Human Services. Sample Health Plan Contracts. http://www.michigan.gov/documents/contract_7696_7.pdf

[6] Healthy Michigan Plan. The Healthy Michigan Plan Handbook. http://www.michigan.gov/documents/mdch/Healthy_Michigan_Handbook_Final_447363_7.pdf

[7] Healthy Michigan Plan. The Healthy Michigan Plan Handbook. http://www.michigan.gov/documents/mdch/Healthy_Michigan_Handbook_Final_447363_7.pdf

Currently Medicare will only pay for behavioral health counseling sessions if a primary care practitioner provides the service and the service takes place in a primary care doctor's office or primary care clinics.

2.3.E Ryan White Program

Services for People Living With HIV (PLWH) in Michigan have been largely funded through Ryan White federal grants. Originally passed in 1990, the Ryan White Care Act has undergone several reauthorizations, with the most recent version being the Ryan White HIV/AIDS Treatment Extension Act of 2009. In accordance with the National HIV/AIDS Strategy, Ryan White programs aim to: identify and link to medical care people who are previously unaware of their HIV status; re-engage PLWH who have become estranged from medical care; support PLWH in maintaining ongoing HIV medical care; provide resources to reduce HIV-related health disparities; and assist PLWH to achieve positive health outcomes.

To be eligible for Ryan White services, an individual must be HIV-positive, and meet the minimum geographic, income, and insurance requirements set by each Ryan White grant recipient. Ryan White funds programs that assist PLWH "who have no health insurance (public or private), have insufficient health care coverage, or lack financial resources to get the care they need for their HIV disease." [8] These programs can directly address the health care of the PLWH (i.e. core medical services such as outpatient ambulatory medical care, mental health services, medical case management) and/or address social determinants that impact health care (i.e. support services such as psychosocial support groups, medical transportation, housing). As such, Ryan White programs must abide by the "payer of last resort" requirement, which stipulates that funding may only be used for services that cannot be supported by other funding sources, including Medicaid, Medicare, or other third-party payers.

2.3.F Commercial Insurance

Employers and other commercial insurers are additional sources of revenue for HIV and STD services. Individuals may now purchase insurance through the Health Insurance Marketplace or through private insurance companies. Eleven carriers offer health plans on the Individual Marketplace while eight offer small group coverage.

More information on the carriers providing coverage through the Health Insurance Marketplace can be found through the Department of Insurance and Financial Services[9].

2.4 STD/HIV Provider Types

Michigan has a wide variety of STD/HIV providers that are organized in different ways and face distinct opportunities and challenges for billing. Some of these providers include:

- **Local Health Departments**. Many local health departments already have experience seeking revenue outside of grant funding from public insurers like Medicaid and Medicare, as well as from clients. However, the relationship with private insurers may be harder to forge as private insurers may not be as familiar with the services local health departments provide and thus may not seek to include them as an in-network provider. Local health departments can also face unique challenges in terms of being able to staff licensed providers and adopt technology to

[8] Health Resources and Services Administration HIV/AIDS Programs. http://hab.hrsa.gov/
[9] Michigan Department of Insurance and Financial Services. http://www.michigan.gov/difs/0,5269,7-303-12902_35510-310214--,00.html

support billing such as electronic medical records. Many local health departments have overcome these challenges and have successfully taken advantage of revenue from third party billing. This will be discussed later in the document.

- **Public Health Labs.** Since labs may not directly interface with clients, insurance information is gathered from the entity submitting the request and balances are billed to that entity. Similar to Local Health Departments, labs may face constraints on staffing and resources for billing software.
- **Title X Family Planning Grantees and service sites.** Title X grantees are often more advanced in billing as they are encouraged to implement revenue cycle management best practices and to collect charges from clients as part of their grant requirements.
- **Community-based Organizations.** Community-based organizations provide select health care services to a largely uninsured or underinsured population. These agencies rely heavily on grant funding and, as a result, may be prime candidates to partner with other entities that have greater volumes of billable services and more billing experience to draw upon.

SECTION 3 – CONSIDERING BILLING

3.1 BILLING OPPORTUNITIES

Billing third-party payers is a strategy STD/HIV programs and providers can use to diversify their revenue streams and bolster their budgets, leading to financial sustainability over the long term. New revenue streams can help offset the costs of continued care for the uninsured or underinsured in addition to the provision of services not covered by other funders.

Medicaid health plans in Michigan also have an incentive to partner with STD/HIV providers to meet their performance goals as they relate to screening for STDs. For example, a goal in 2016 is to improve Chlamydia (CHL) screening rates based on guidelines and to address racial and ethnic disparities in screening.

3.2 BILLING CHALLENGES

In order to bill, STD/HIV providers will need to establish contractual relationships with payers and create the infrastructure to track and submit a claim for services provided. Medicaid, Medicare, and individual commercial payers all have different protocols and requirements for providers to follow in order to receive payment. Setting up this infrastructure and engaging staff to change their workflows to accommodate billing can be a significant effort.

Providing services for sensitive health conditions such as STD/HIV within a non-traditional health care setting, can pose an additional set of billing challenges. STD/HIV sites in Michigan identified barriers including:

- Credentialing challenges when working with health plans
- Lack of a billing system in place
- Concerns about confidentiality regarding sensitive information
- Lack of staff to work denied claims or lack of understanding of return on investment for pursuing denied claims

These and other challenges are addressed below and throughout this toolkit.

3.2.A Credentialing requirements

STD/HIV clinics use a range of medical providers, including physicians, nurses, social workers, mental health providers, and others. However, private insurers may not recognize all of these as billable providers of services, given that the CPT codes used for billing center around services provided by a physician. To obtain a contract with an insurer, clinics typically must have a physician or nurse practitioner who provides oversight of patient care. Allied health professionals may bill for certain services as if the supervising provider saw the patient *only if* (1) the patient is not being seen at the site for the first time and (2) a doctor is on site to supervise.

The main Evaluation and Management (E/M) code that a Registered Nurse (RN) can bill to independently is 99211, which is essentially defined as a low-level outpatient visit that may not require the presence of a physician to perform or supervise. Evaluation and Management codes typically include a patient history, physical exam, and medical decision making. Common uses for a 99211 in an STD service site are: asymptomatic urine STD screening, stand-alone HIV Counseling and Testing, Chlamydia treatment with a previously written order, or re-testing after treatment for Chlamydia or Gonorrhea[10]. These encounters must be face-to-face.

Since physicians and nurse practitioners can bill for a number of other services, their reimbursement is typically higher than a registered nurse (RN) or other allied health professional. To maximize reimbursement potential under these conditions, STD/HIV providers may want to consider an integrated model of care, where physicians and nurse practitioners see the majority of visits and the RN plays a supporting role for the patients[11]. For example, the RN could gather relevant medical history and provide patient education based on the treatment plan, instead of the physician performing these tasks, to maximize the number of patients the physician can see.

Services provided in the field. STD/HIV providers often offer services outside of the clinic site – in the client's home, at a health fair, or elsewhere in the community - where ordering providers may not be available to prescribe the service and oversee delivery.

In these cases, nurses may provide services using standing orders from the site Medical Director, Physician's Assistant (PA), or Nurse Practitioner (NP), and the services can be billed under the supervising provider's National Provider Identifier (NPI). Other services in the home may be done by Peer Counselors assisting members with care coordination and can be covered under Community Health Worker services. Current Peer Counselors who are not already certified as Community Health Workers, may want to go through the formal process of becoming certified before contracting with Health Plans to provide this service[12].

Nurses can also dispense medication without direct oversight, provided that the local Medical Director has established standing orders and protocols for the dispensing of that medication for that client.

---

[10] STDTAC. RN Billing and Coding FAQ: Clinic Flow, Codes, and Levels of Service. http://stdtac.org/files/2014/06/RN-Billing-FAQ_STDTAC-1.pdf

[11] STDTAC. RN Billing and Coding FAQ: Clinic Flow, Codes, and Levels of Service. http://stdtac.org/files/2014/06/RN-Billing-FAQ_STDTAC-1.pdf

[12] Resources for certification of Community Health Works can be found at the following site: http://www.michwa.org/resources/community-health-workers-101/.

Health plans have different requirements for credentialing providers so you should check with the health plans you are planning to contract with to understand the potential for billing services with your current practitioner mix. Later in this document we discuss partnership opportunities that may allow you to share licensed providers. We also detail health plan credentialing requirements for participating in their networks in Section 4.

3.2.B System requirements

Some STD/HIV providers may not yet have adopted technologies to support billing. Clinics need to make sure their practice management software and billing system is modified to enable insurance coverage verification, electronic billing, and reporting. These steps are covered in more detail in Section 4. Consideration should also be given to obtaining an Electronic Health Records (EHR) System, if the clinic does not already have one. An EHR can efficiently support billing and care coordination processes. Also, numerous studies have shown that the quality reporting and clinical decision support features of an EHR can help improve health care quality.[13]

3.2.C Privacy and security

By billing third party insurers, providers are sharing information about potentially sensitive services outside the walls of the clinic. When a clinic submits a bill to a commercial insurer, that insurer typically sends an Explanation of Benefits (EOB) to the enrollee. If others, such as family members, are able to view that EOB, the client may view this as a breach of confidentiality.

According to a brief by the National Association of County and City Health Officials, Calhoun County protects confidentiality by asking clients upfront if they will let the local health department bill their private insurance. This ensures that clients are aware of their privacy rights and that EOBs are sent by insurance plans. As a result, adult clients who do not want the EOB sent are asked to pay for the services on a sliding scale.[14]

In another example from the Michigan Department of Health and Human Services Laboratory, the lab, in partnership with the MDHHS STD Program, structured the test requisition form to allow clients to request confidential services when being tested for gonorrhea and chlamydia. This was intended to alleviate client concerns related to an EOB for STD testing being seen by the policy holder. If the client did not request confidential services and is insured by a Medicaid provider, the lab would bill Medicaid because Medicaid does not send EOBs for sensitive services. If the client is insured by a non-Medicaid third party, the bill is returned to the submitting agency for payment. This is often charged to the client according to a sliding fee scale. The lab reported that there were only a small number of individuals who only had commercial insurance and requested confidential services.

Medicaid Code Suppression. When billing Traditional Medicaid/fee for service or any of the 11 contracted Medicaid Health Plans in Michigan, privacy and security of sensitive information should not be a concern due to HCPCS/Revenue Codes, Diagnosis Codes, and Pharmacy Classes Currently Excluded from Reporting on the EOB Statement.

---

[13] Cebul RD. "New Research Finds EHRs Improve the Quality of Diabetes Care." https://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/ehr-diabetes-healthcare-cleveland/

[14] http://www.naccho.org/topics/HPDP/billing/upload/issuebrief_billing_jan2014.pdf

Medicaid/Medicaid Health Plans are precluded from printing any EOBs with sensitive information. Patients who seek services at the Health Department or STD/HIV resource centers should be made aware that billing Medicaid fee for service or Medicaid Health Plans will not result in an EOB sent to the member's address. Medicaid Health plans must prove to the State through annual audits that the privacy and security of this information is protected at all times.

Individual county offices may find it beneficial to produce and distribute the guidelines around suppression of sensitive information to patients at the time of service. Patients may be more willing to allow billing to Medicaid fee for service or a Medicaid Health Plan if they are aware of the protection afforded them around sensitive information. This step may increase the ability to bill for, and receive payment from, the insurance companies. This revenue source can support financial stability for county offices who provide services for STD/HIV as uninsured funding is diminished.

The Michigan code suppression list is included as Appendix 1.

3.2.D Client cost liability

By billing insurance, clients are subject to certain co-payments or co-insurance, depending on the service. If the provider is not contracted with the client's health plan and bills a plan for out-of-network services, the client could be responsible for a higher percentage of the charges (up to 100%). It will be important to discuss these issues with clients prior to providing the service, so that clients can make fully informed financial decisions. It is also possible that the added revenue from external billing could allow providers to cover the cost of client co-pays if the client is unable to pay.

HIV providers should note that Ryan White funds are available to cover co-pays and deductibles in certain circumstances. Individuals should contact their local case management agency to determine how they can get funding for co-pays and deductibles. The *I Will Survive HIV* tool, available on the Michigan Department of Health & Human Services website (http://www.michigan.gov/hivstd), can direct individuals to the appropriate case management agency.

3.2.E Culture change

Some providers see their role as primarily serving the uninsured and/or do not believe public health services should be billed. Ensuring that leadership is engaged in billing and communicating effectively to staff about the transition will be important for the financial stability of the provider, staff retention and continuity of services. Engagement strategies are included in Section 4 of this toolkit.

3.3 Billable and Non-Billable Service Types

As noted above, Medicaid eligible individuals enrolled through one of the Medicaid Health Plans may receive treatment services for STD/HIV and other communicable diseases from local health departments without prior authorization[15].

Medicaid Health Plans are required to cover all services on the Medicaid fee schedule as defined in the Medicaid State Plan[16]. Qualified Health Plans participating in the Health Insurance Marketplace must

[15] Michigan Health Plan Model Contract. Pg. 30
http://www.michigan.gov/documents/contract_7696_7.pdf?20160128133342
[16] Michigan State Plan. http://www.mdch.state.mi.us/dch-medicaid/manuals/MichiganStatePlan/MichiganStatePlan.pdf

provide a minimum set of benefits, called Essential Health Benefits, which include screening and treatment for STD and HIV care. Each plan details their coverage policies in the provider manual, which you can find on their websites.

3.3.A STD/HIV Billable Services Summary

Appendix 5 provides a detailed list of common billing codes for STD/HIV care. As an example, the list below summarizes some of the services for which public health clinics and labs can bill third party payers:

- Evaluation and Management Services
- Risk assessment counseling
- Information / pamphlets
- HIV counseling and testing
- Linkage to Care & Patient Navigation/ Care Coordination/ Case Management
- Oral health
- Substance Abuse Counseling
- Medical transport

Screening and treatment for:

- Chlamydia
- Syphilis
- Gonorrhea
- Hepatitis B
- Non-gonococcal urethritis
- Scabies
- HPV
- Pubic lice
- HIV/AIDS
- Herpes

To evaluate whether the services you provide are billable according to your carriers' guidelines you can ask the following questions, using materials provided on the carriers' websites[17]:

- Does my program description align to the third-party payers' patient placement criteria?
- What level of care are we providing? Does the way we describe our program meet medical necessity criteria for that level of care?
- Do my practices align with evidence-based practices?

3.3.B Support services for HIV Care

While plans typically cover only "medically necessary" services, there are some cases where services that *support* medical care are covered.

Non-Medical Case Management. Community Health Workers (CHW) can be used to support Care Management in the home for members providing Case Management, which includes medication compliance, social support services, and coordination of community based support services. Each County Office should work with Health Plans in your area to contract these services. Many Heath Plans

[17] The NIATx Third-party Billing Guide. http://www.niatx.net/PDF/BillingGuide/2011NIATx_Third-partyBGuideLR.pdf

have applied for State Innovation Models that incorporate the use of CHWs[18]. The value proposition for the local offices is the experience of working with members in a confidential and home-based way to provide these services.

Case management codes are not recognized by Medicare but other insurers may cover them, so it is important to check with the individual insurers.

Ryan White Funded Support Services. As mentioned earlier, Ryan White Funded services can help boost the coverage available to people with HIV through their existing coverage. For example, support service costs are those costs for services that are needed for individuals with HIV/AIDS to achieve their HIV medical outcomes. Examples[19] include:

- Case management (medical, nonmedical, and family centered)
- Patient transportation to medical appointments
- Translation services, including interpretation services for deaf persons
- Services to assist women to access and remain in HIV medical care, such as child care
- Patient education and education materials
- Outreach to recruit and retain in care women, infants, children, and youth with HIV
- Financial assessment/eligibility counselors
- Staff who assist clients with linkage, engagement, and retention in HIV care

3.4 Revenue and cost expectations

Before moving forward with billing, it is wise to estimate your expected revenue for the calendar year to ensure that the dollars gained from billing for services exceed the costs of setting up a billing infrastructure. The STD-TAC provides a useful Cost/Benefit Analysis Tool that we have included as Appendix 2 so that you can enter the assumptions most relevant to your clinic or lab.

3.4.1 Revenue projection

To estimate your revenue you would need to have a basic understanding of the volume and types of services your site provides as well as the expected portion of those services that would be billed to Traditional Medicaid, Medicaid Managed Care and Healthy Michigan Plans, Medicare, Private Insurance and to the clients who are paying out of pocket.

[18] Michigan Department of Health and Human Services. State Innovation Model (SIM). http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491---,00.html
[19] HRSA. Part D - Services for Women, Infants, Children, Youth & Their Families. http://hab.hrsa.gov/abouthab/partd.html

Once you have this information you can multiply the volume by the rates for each payer to obtain total collections. As noted above, you can locate the Medicaid rates by looking up the latest fee schedule.[20] Commercial insurance rates would be individually negotiated but are usually higher than Medicaid.

Your revenues will be reduced by a portion of denied claims and payments that are not collected from the clients. The Cost/Benefit Analysis Tool provides some assumptions about the rate of these events.

3.4.2 Cost projection

Depending on the way your agency sets up its billing infrastructure, it could be responsible for the full range of costs (e.g. in house billing staff and software) or a portion of the costs if partnering with another organization to bill.

Ongoing costs of billing include the following:

- Staff and supplies
- Software – Practice Management Software, Electronic Health Record System, data storage, system maintenance
- Hardware – Computers, printers, etc.
- Claims processing costs (e.g. fees paid to a clearinghouse)

Once you complete your costs you can subtract them from the collections calculated above and understand your revenue potential.

SECTION 4 – PREPARING TO BILL

This section reviews the following key steps to billing:

- Assessing feasibility
- Exploring potential partnerships
- Obtaining leadership and staff buy-in
- Convening a billing workgroup
- Identifying infrastructure changes
- Beginning the contracting process
- Establishing billing processes and protocols
- Building provider coding capacity
- Building revenue cycle management capacity
- Determining a communications plan

4.1 THE KEY STEPS TO BILLING

The following are typical steps from contemplation to coding that will help organizations decide whether and how to bill. Much of this content was drawn from the STD-Related Reproductive Health Training and Technical Assistance Center (STD-TAC) STD Billing and Reimbursement Toolkit. We encourage readers to visit the STD-TAC website for more information and tools: http://stdtac.org/billing-toolkit/

[20] Michigan Department of Health and Human Services. Provider Specific Information. http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-159815--,00.html

4.1.A Assess feasibility

Each entity will need to assess the feasibility of billing depending on its characteristics and those of its staff and community. After reviewing the steps required to bill, as outlined in this section, consider the following questions:

1) Does my financial forecast indicate a need for diversifying funding streams (e.g. to what extent can I or will I be able to depend on grant funding)?
2) How many individuals are we serving that have moved from uninsured to insured? What payers have they moved to?
3) Does my current payer mix present an adequate opportunity for reimbursement?[21]
4) Could my organization afford to contract out billing services or partner with an organization that already has these capabilities?
5) Would the community accept paying for services if we provided communication in advance about the need to bill? How many patients would benefit from having their services covered by insurance? Are other entities in the community charging for services?
6) Would providers be willing to put in the effort to code for services?
7) Are there competitors in the area who would become a potential partner?

If you determine that billing is likely to benefit your organization, there are a few basic steps you can take to get the process started and position your organization for success:

- Apply for your National Provider Identifier (NPI) number if you do not already have one. The NPI is a unique, 10 digit identification number for health care providers that is used by all health plans to perform transactions. All facilities and individuals must have an NPI to bill third-party payers. Entities eligible to have an NPI include clinics, group practices, laboratories, physicians, dentists, pharmacists, nurses, and many other health care practitioners and professionals.[22] Each county office will need to determine the best approach in selecting the type of NPI for their facility based on medical oversight of staff. Those offices with a Physician, Nurse Practitioner, or Physician Assistant may choose to have individual provider NPIs. Clinics without direct medical oversight may want to select a clinic NPI. It is critical to apply for your NPI in order to maximize revenue from your billable services. Health Plans can only reimburse for services when the claim is accompanied by an NPI. To apply online, visit the National Plan & Provider Enumeration System (NPPES) at the following address: https://nppes.cms.hhs.gov/NPPES.
- Confirm registration as an Essential Community Provider (ECP) with the Michigan Department of Health and Human Services. Getting on this list can help you demonstrate your value when negotiating with health plans. The Center for Consumer Information and Insurance Oversight (CCIIO) also provides a non-comprehensive list of ECPs for each plan year.[23] Eligible providers should check the list released by the CCIIO and email CCIIO

[21] Note: to establish the payer mix, you can perform a survey on a sample of clients that asks whether or not they have insurance and, if so, what type/plan. You can also ask whether or not they plan to use their insurance for these services and why or why not.
[22] Medicare Learning Network. *NPI: What You Need to Know.* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPIBooklet.pdf
[23] CMS, The Center for Consumer Information & Insurance Oversight. *Qualified Health Plans.* https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html

at EssentialCommunityProviders@cms.hhs.gov if they are not on the list or if their contact information is incorrect.

- Review insurer requirements. Visit the websites of the potential insurers with whom you would contract, to get a sense of the requirements and forms needed to submit a claim and receive reimbursement for services.
- Consider which billing model suits your entity. The steps to billing will depend on the type of model you use to bill. For example, if there is a Federally Qualified Health Center (FQHC), Family Planning Provider (FPP), or other provider in your area that is experienced in billing, it may make sense to pursue a partnership. If instead you decide to bill directly, review your payer mix to determine if you will bill just Medicaid or if you have enough clients covered by insurance that you will have to bill multiple entities.

The following table was adapted from a webinar on the transition to billing to illustrate potential billable models[24]. If your agency contracted with a billing service, the billing service would take on some of these functions.

Billable Model	**Key Steps**
1. Establish a contract with health center/clinic or other partner	• Establish formal partnership • Determine services that can be billed • Establish value for each service • Keep track of services provided • Invoice health center/clinic for services provided
2. Bill the State for Medicaid services	• Determine providers and services that are reimbursable • Determine codes and establish system to track services provided • Establish system to determine Medicaid eligibility for clients / patients • Bill State directly for services provided
3. Bill Medicaid and other third party payers *Note: you can contract with a billing agency to do the billing itself*	• Determine reimbursable providers and services, and rates • Determine codes and establish system to track services provided • Establish system to determine third party payer for clients • Collect co-pay / fee • Bill MCD and other third party payers for services provided

- Explore pricing models of billing companies. To determine whether or not to outsource billing, it will help to understand the pricing of billers. Since many charge a flat rate per bill or percentage of collections, you will want to have a sense of the magnitude of your claims prior to contacting such a service. More information about outsourcing billing is provided later in this section.
- Perform a cost analysis / revenue projection. Documenting estimated costs and potential revenue can provide more insight into the cost-benefit of establishing infrastructure to bill for

[24]JSI & RT Welter and Associates. *Transitioning to Billing 1: Assessing your Capacity to Successfully Manage Revenue Cycle as a Key Element of Agency Sustainability.* http://cba.jsi.com/files/2012/09/Transitioning-to-Billing_-1_slides.pdf

services. The STD-TAC offers Clinic and Lab Revenue Projections Tools[25] that can be customized to your setting to assist with estimates.

4.1.B Explore potential partnerships

Partnership with a hospital, clinic, family planning provider, or other entity experienced in billing may shorten the time it takes to set up a billing infrastructure and could provide other benefits, such as increasing patient volume and maximinizing revenue. The following are some of the partnership types you could consider:

- Contract with another provider that already has electronic billing systems or share the cost of a license. Partnering with another hospital, clinic or county office that already has an Electronic Health Record and Practice Management System would allow you to access these systems that are helpful to electronic billing at a lower cost. The entity could charge you a fee per paid claim in exchange for sharing their billing software and personnel.
- Share a billing system across a group of providers. Clinics could sign an agreement, for example a memorandum of understanding (MOU), to share a contract with an outsourced billing agency to process claims. By pooling all of the claims together, providers that have lower volumes of claims can still take advantage of outsourcing billing services.
- Co-location of two separate entities, to share clinic space and other resources. Co-location can mean the sharing of physical space, equipment and/or personnel. Smaller STD or HIV providers may want to share the space of a larger primary care clinic, for example, to take advantage of referrals and reduce costs.
- Sharing a provider across two or more entities. You could contract with a partner to use their provider for a specific number of hours per month if you need certain clinical expertise or coverage. For example, an OB/GYN from another site would come in for a few hours and supervise a nurse practitioner at your site. If the physician is already credentialed with an insurer or Medicaid, it is easier to credential them from your site.
- Referral agreements. Creating a relationship with another provider who can refer patients to you and vice versa could improve access to patients, generating more volume and billing revenue potential. You could sign a MOU with a hospital or other large provider agreeing to make referrals for primary or speciality care in exchange for their referrals for STD or HIV services.
- Subcontracted services. Your clinic could also set up a subcontracted relationship where you would serve as the STD/HIV provider for another organization (e.g. the organization would subcontract STD services of its adolescent patients to your clinic). You would then bill the other organization for the services you completed.

You can visit the STD-TAC website and use the Partnership Tool[26] to learn more about the advantages of each partnership model. The resource includes a checklist to determine what your entity can provide on its own and what tasks the entity may need assistance in executing.

[25] http://stdtac.org/module-2-develop-billing-systems/
[26] http://stdtac.org/files/2014/06/PartnershipTool_STDTAC.pdf

4.1.C Obtain leadership and staff buy-in

Engaging employees in the development of the billing process will be helpful on multiple fronts. First, any new implementation effort almost always benefits from multiple perspectives in terms of how it should work and how to mitigate any foreseeable stumbling blocks. Second, involved staff will more likely buy in to the changes, making for smoother implementation. The table below is from a billing document developed by NIATx[27] and may be a useful tool to ensure roles and responsibilities are clearly understood by the entire team.

Step in the Process	Who is assigned?	When is this task done?	Who is it handed off to?	Who else needs this information?
Verify coverage				
Request prior authorization				
Document authorization				
Provide services				
Document service provided				
Bill for appropriate amount				
Collections: bill paid or denied				
Monitor receivables				
Make corrections and resubmit				
Monitor cash flow				

4.1.D Convene billing workgroup

Establish regular meetings with a group of key stakeholders at your site involved in the implementation of billing changes. Identify and address any concerns the group has related to billing third party insurers and establish a framework and timeline for how the billing infrastructure will be rolled out.

At this point, it may be useful for the billing workgroup to visit a site with experience in billing so that they can share their processes and best practices. The group could also bring in a billing expert to familiarize staff with the details of billing.

4.1.E Identify infrastructure changes

Inventory current capacity and outline needed changes to staffing, equipment, fee structure, policies, and software to accommodate billing. For example:

- Hardware and Software:
    - Billing System to allow for easy tracking and coding of services provided and information for billing. At a minimum, the system should include:

[27] NIATx Third Party Billing Guide. Second Edition. http://www.niatx.net/PDF/BillingGuide/2011NIATx_Third-partyBGuideLR.pdf

        - Sufficient server capacity
        - Ability to integrate billing system with other systems such as eligibility verification software, practice management system/Electronic Health Records systems, public health interfaces and Medicaid Management Information System. The HealthIT.gov website is a good resource for clinics considering whether or not to implement an EHR.[28]
        - Privacy and security capabilities
        - Regular and ad hoc reporting capabilities
    - Credit card machine to collect point-of-service fees
- Construction:
    - Building infrastructure – ensure the check-in area allows adequate privacy to meet HIPAA requirements
- Forms:
    - Intake form to collect client information
    - Encounter forms
    - Consent forms
    - Billing forms
- Staffing:
    - Dedicate resources to eligibility determination, insurance verification, and an insurance company liaison
    - Training on all aspects of billing

In-house vs. Outsourcing. A key decision will be whether to conduct billing in-house or contract out billing services to another entity. For most entities, it will likely be more cost-effective to contract services out as discussed below.

Billing Service: Determine what tasks you will take on in-house versus outsourcing to a partner or billing service. A contracted billing service would manage aspects of your revenue cycle management. This means they could do everything from preparing claims, cleaning and submitting claims, addressing denials, and managing payments. Some of the benefits of leveraging a billing company include:

- Access to experts in billing and insurance requirements and regulations
- Management of accounts receivable
- Identification of opportunities to maximize reimbursement (for example, training staff to correct coding errors)
- Experience appealing and reversing claims denials

Billing services typically charge a flat rate per bill or percentage of collections. On a monthly basis a file containing information required for billing (i.e. patient name, Medicaid number, third party insurance information, test type, request for confidential service, etc.) is generated and sent to the billing company from the clinic or lab. The billing company extracts the required information and submits bills either directly to the insurer or a clearinghouse for insurance billing. There may be benefit to sharing a billing service with multiple other counties to get the best volume based pricing. This can be done by

[28] https://www.healthit.gov/providers-professionals/frequently-asked-questions/423#id91

working with the appropriate program office at MDHHS to find offices who may already have these systems in place.

For contracting with a billing service, a good strategy is to base the contract on payments as opposed to submitted claims. If claims are not sent in correctly, they could be rejected, therefore basing the contract on actual paid claims is a better value. The Healthcare Billing and Management Association (http://www.hbma.org/) is an association of medical billers that lists members by the type of billing they do.

Claims Clearinghouse: For STD/HIV clinics and labs with personnel who are already expert in billing processes, it may be duplicative to hire a billing service. Instead the clinic or lab could contract directly with a clearinghouse, which would handle just the process of cleaning claims and submitting them to the insurers. A claims clearinghouse is a third party that has already established a secure electronic connection with the payer's claims processing system. While your agency can establish direct data entry with payers the cost is prohibitive and the process is inefficient. A clearinghouse offers the following benefits:

- Claim standardization for clean claim submission and a single location to manage all claims
- Fewer claims are delayed or rejected, and reimbursement is faster
- Electronic claims are submitted in batch, rather than submitting separately to each individual payer

Each entity will want to conduct a cost-benefit analysis to determine how the cost of contracting with a billing service or clearinghouse compares to the cost of hiring and training staff and setting up infrastructure internally, considering projected revenue. The steps described in 4.1.I will help outline the required infrastructure to bill.

4.1.F Begin contracting process

Medicaid Health Plans are required to contract with the Health Departments in their approved service areas, which makes expanding services under this contract much easier than starting negotiations from the beginning. This means county offices can work with the Health Plan contact on the "*Key Contact Listing"* in Appendix 3 of this manual to begin the process of expanding services that can be provided by your sites.

Contracting with insurers. To determine which insurers you will want to bill, you will review the payer mix of your patient population. For example, if most of your patients are insured by one or two Medicaid Health Plans, and several commercial health plans, it makes sense to prioritize contracting with the Plans with the most volume associated with your members.

Once you have identified your targeted third-party payers, you should review information about contracting with the plans either through colleagues who may have experience contracting with the plans or directly through the plans' provider department. You can request an application to become a provider with the plan and review the requirements.

Credentialing. In addition to having a National Provider Identifier (NPI) for your facility and individual providers who plan to bill, your clinicians will need to be credentialed with the plan. Credentialing can take up to six months, so it is good to start early and be persistent about follow-up to complete the

process. To credential your clinicians, you can complete the following steps as noted by the STD – TAC in their toolkit:

- Register clinicians with the Council for Affordable Quality Healthcare's (CAQH) – Universal Provider Datasource (UPD)
- Keep on file copies of all clinical licenses, copies of Medical Degrees, DEA information, malpractice insurance information and history, overhead insurance coverage, board members' information, hours of operations, NPIs, Tax ID Number, and SSN of managing officer
- Complete the credentialing application with each plan, keep copies, and follow up regularly on the status

Contracting with Commercial and Medicaid Health Plans. To negotiate a contract with health plans, you will need the following information:

- National Provider Identifier (NPI) for your facility and individual providers (see 4.1.A)
- Provider credentials (see above)
- Prices you plan to charge for your services (which includes understanding your costs). Rates for Medicaid Health Plans should be negotiated at current Michigan Medicaid rates. Pricing information is for internal purposes only and should not be shared with the health plan.
- Information to demonstrate your value as a provider to the plan:
    - Information about the patient population you serve that overlaps with the health plan
    - Essential Community Provider status
    - Participation in any quality programs or delivery system reforms such as Patient-Centered Medical Homes or meaningful use of Electronic Health Records

Once you have this information, review contract terms and rates and document any terms that your clinic / lab cannot meet or that are unfavorable. For example, the contract may require the clinic / lab to bill within a certain timeframe to receive reimbursement. If the clinic cannot meet that timeframe, this term may be negotiable.

Request a fee schedule from the insurer if they did not include one in the contract. Ensure the fee schedule includes the procedure codes and expected reimbursement for all the services you provide, or at least the covered services. Review the fee schedule in relationship to your costs to ensure reimbursement will cover the cost of services.

After you negotiate to ensure you can successfully execute the terms and conditions and receive adequate reimbursement for services, sign the contract and keep it on hand for reference. You will periodically need to update the contract to revise fees. For contracts with Medicaid Health Plans it will be important to use language in your contract that says "rates are the prevailing Michigan Medicaid rates." This will avoid having to constantly update contracts but will ensure payments are automatically updated when Michigan Medicaid rates increase.

New Medicaid Contract. The 2016 Medicaid Contract with the Michigan Department of Health and Human Services for plans to provide Medicaid services includes the following language:

- "Health Plans must describe two recent experiences working with community agencies and advocacy groups as substantive partners to improve care and health status for Medicaid members, beyond narrow community benefit/relations projects. Include at least one example

to support the descriptions. Provide references for each experience presented. References must include the name of the entity and the entity's contact name, phone number and e-mail address.

- Describe your proposed approach for working with community agencies and advocacy groups as substantive partners to improve care and health status for Medicaid members, including the Medicaid Health Plans specific objectives and a timeline for improving partnerships.
- Describe two recent experiences with considering social determinants of health as part of your plan for data analysis and using this information to design interventions to improve the health status of targeted populations. Include at least one example of how an issue impacted by social determinants of health was identified, what interventions were developed, how the impacts of the interventions were assessed and what outcomes were achieved."

These new requirements for Medicaid Health Plans open the door to non-traditional community partnerships with Health Departments, STD/HIV providers and HIV resource centers. Creative models put in place will allow your organizations to have leverage to implement meaningful programs to assist Medicaid Plans in providing compliance with this new mandate.

Medicaid Health Plan Pilots for Expansion of Services. Discussions have begun with three Michigan Medicaid Health Plans to enter into "pilot programs" to refer Medicaid members to county offices for services, or to allow members receiving current treatment to remain in treatment with Heath Departments and STD/HIV providers.

Pilots will also include collaboration with health plans to assist in improving Healthcare Effectiveness Data and Information Set (HEDIS)[29] numbers across the State by ensuring Health Departments, and STD/HIV providers are billing Health Plans for services not currently being billed. When services are not billed to Health Plans it shows under reporting of services members are receiving in the State and affects national reporting for measures like childhood immunizations and chlamydia testing. These pilots will open the door for the provision of additional services provided by Health Departments, and STD/HIV providers such as Peer Counselors being used in the role of Community Health Workers for Care Coordination. The pilots will increase the revenue expectations for Health Departments and STD/HIV providers.

Next steps:

- Identify through internal reports the financial impact of billable services you have provided over the past 12 months that were not billed to health plans. This information can be used to quantify the rationale to add a billing service or partnership with other County offices to share billing services if needed. This will be important information to use to level set the value of changes needed to improve revenue to your leadership.
- Identify internal staff to reach out to health plans to open conversations around expansion of billable services you can offer. This may include introduction to the health plans about the important role you play in the health and wellbeing of shared members.
- Schedule regular meetings with health plans to maintain bi-directional idea sharing and communication, which supports a true partnership. Understanding the roles of the health plans and their understanding of your community based services will reinforce the partnership.

[29] HEDIS is a commonly used tool to measure health plan performance care and service.

- Identify the impact to health plan HEDIS reporting improvements if these services identified were billed to the health plan. Identify opportunities that offer positive impact to the health plan, not just the Health Department and HIV/STD providers. Partnerships begin by finding solutions that offer a win situation for each party.
- Seek approval from health plans to utilize your practitioners as "medical homes" to provide preventative services and primary care services if your site has staffing levels of Physicians, Nurse Practitioners and Physician Assistants to serve in this capacity.
- Monitor out of pocket expenses to identify barriers for members as some health plans can waive copayment requirements to ensure members get the services needed.
- Develop written policies for equitable distribution of out of pocket amounts for your members so money is used to assist members who have no other options such as health plans to assist with out of pocket expenses.
- Assess your internal needs and develop a strategy to negotiate partnerships and shared services with other counties if needed.

4.1.G Establish billing processes and protocols

Policies and protocols can help ensure accurate billing and create standards for your staff to follow. For example, you would establish standards for what patients will be charged depending on their income and set procedures around claims submission and review. Other policies and protocols to adopt include:

- Policy on co-payment, including forms of payment accepted and how to pursue collecting patient payments
- Policy on bookkeeping
- Policy for ensuring confidentiality / HIPAA compliance
- Policy for billing for lab services
- Intake form

The STD – TAC provides examples of these policies, procedures and forms that are linked in their "10 Steps to Billing" document, found here: http://stdtac.org/files/2014/06/10-Steps-To-Billing_STDTAC3.pdf.

4.1.H Build provider coding capacity

Successful billing is partially dependent on accurate and routine coding of the services delivered. Physician notes within the medical record must also support the procedure and diagnostic information in case of audit. By setting up the appropriate forms, procedures and education, your providers will be able to more easily code and to provide evidence to support the coding for their services.

Superbill/Encounter Form. Providers will need a standardized form to document the services that were provided during the visit. This is called a superbill or encounter form. This form includes the Evaluation & Management, Procedure, and Laboratory codes that correspond to services your clinic or lab regularly delivers. This way, once the clinician has completed the services, they can easily check off the appropriate codes on the superbill and staff can total up the charges associated with the services. Having an electronic encounter form allows for easier population of the superbill, as client information is pre-populated, and documentation is more legible.

We have included a sample superbill/encounter form as Appendix 4.

Before you go live with billing, it will be important for providers to practice completing the encounter forms so that productivity is maintained as much as possible.

Education/Training. If your providers are unfamiliar with coding, it is a good idea to enroll them in a training or on-line course. For example, CARDEA provides an online training on best practices in revenue cycle management.[30] The Family Planning National Training Centers also offers education in coding practices.[31] Providers could also shadow other clinicians who are more adept at coding. Another option is to hire support staff as "scribes" to help clinicians with coding and other documentation requirements.

4.1.I Build revenue cycle management capacity

Revenue cycle management encompasses the entire process of managing claims, payment, and revenue generation. The following are elements of the revenue cycle based around the patient's visit to your site.

Elements of the Revenue Cycle	
Pre-Visit	• Collect client information • Verify coverage • Determine client pay amounts • Communicate payment policies prior to service provision
Visit	• For walk-ins collect client information and verify coverage • Collect client pay amounts (co-pay or co-insurance) • Document and code services provided
Post-Visit	• Bill, collect and track payment for services

If your site has clients that make appointments in advance, see the pre-visit information. For those that largely see walk-in clients, skip to the visit section.

Pre-Visit. Information collected before the visit helps to ensure that the clinic or health department has the information it needs to submit a bill. Information collected from patients should include:

- Contact information
- Demographic information
- Insurance plan and membership number (to verify eligibility and benefits)
- Reason for visit

Using the insurance information captured prior to the visit, staff would contact the insurance carrier to determine eligibility and seek pre- authorization for specific visits/providers, as needed. The staff could also seek information about any charges the patient may be responsible for, so that the patient can be informed.

Prior to the visit is a good time to communicate to the patient the process for payment and the possible price of services, depending on their coverage. This way, patients will be more prepared to pay any fees

[30] http://www.cardeaservices.org/resourcecenter/revenue-cycle-management-best-practices-for-public-health
[31] http://fpntc.org/training-and-resources/coding-in-the-reproductive-healthcare-environment-0

or participate in insurance enrollment once they arrive for the visit. Patients should also be advised to bring their insurance card to the visit to assist in eligibility verification.

***Visit*.** As the patient checks-in, you would ask them to confirm their insurance and contact information and make copies of insurance cards. You would also have the client sign any forms, for example authorizing release of information to the insurer, privacy policies and practices and the policy outlining a client's financial obligations. Staff would then verify the billing information to ensure the information is accurate at the time of service.

Obtain from client

- Name
- Date of birth
- Address
- Insurance carrier
- ID number
- Group number
- Date coverage is effective/ending
- Insurance Carrier phone number

Verify with insurer

- Is authorization required
- Is referral required
- Instructions for claims submission
- Is there a co-pay
- Is there a deductible
- In network or out of network

To verify insurance coverage, it will help to gather standardized information from each client. Assigned staff would then use this information to contact the relevant insurer to confirm the client is enrolled. To the left is a helpful graphic adapted from a Title X Billing and Coding Manual that outlines the information you need to obtain from the client and confirm with the client's insurance plan[32].

For Michigan Medicaid members, eligibility verification should be done using the Community Health Automated Medicaid Processing System (CHAMPS) eligibility system at the following link, https://sso.state.mi.us. If you are currently not enrolled in the CHAMPS eligibility system the above link provides enrollment instructions.

If you are considered an "out-of-network" provider, the client could be responsible for up to 100% of the charges. In this case, it will be helpful to discuss this with the client and obtain confirmation of their understanding of the policy for payment prior to being seen.

Upon seeing the client, providers would document and code all services provided to the patient using a standardized encounter form. Once the provider selects the appropriate services on the encounter form, this information would be handed to billing staff for entry into the billing system.

Immediately after the visit the client should come to "check out" in a private area. At this point, you would notify the client of the amount owed (if any) and/or that you will be submitting a claim to their insurance company. Upon payment, you would record this in the system as paid and provide the client with a receipt.

Not all services have co-pays and not all people are required to pay co-pays. For example, services that help you get or stay healthy, like preventive services or certain services or medications that help you manage a chronic condition, may not have co-pays. Also, some patients don't have to pay co-pays at all, like those who are under age 21. Copay requirements for the Healthy Michigan Plan can be found in the

[32] http://rtwelter.com/wp-content/uploads/2014/10/Title-X-Billing-and-Coding-Manual-October-2014-update.pdf

following link: https://www.michigan.gov/documents/mdch/Healthy_Michigan_Copayment-final_452237_7.pdf

All charges and payments should be reconciled and posted to the appropriate accounts at the end of each day.

***Post-Visit*.** After the visit, the services and procedures delivered will be converted into CPT, ICD-10 and HCPCS codes (see Section 5 for more information on codes) and a claim is submitted to the payers.

Claims submission. Most insurers now require secure electronic claims submission. As discussed in an earlier section, if your agency needs to bill multiple different payers and is going to bill electronically, it would benefit you to leverage a claims clearinghouse to submit your claims.

Michigan Medicaid defines the filing limit for claims to be 1 year from date of service or 365 days. Claims filed after the 1 year filing limit will not be paid by Medicaid Health Plans in most cases so it is important to submit claims in date order. The only exception is for claims submitted and rejected due to missing information and will be paid after the filing limit as long as there is activity to resolve, and the claim was received before the 1 year filing limit.

Check with your Commercial Insurance Plans for filing limit information as they may vary.

All traditional Medicaid claims should be submitted and are processed through the CHAMPS system. Paper claims can be submitted and are scanned and converted to the same file format as claims submitted electronically through CHAMPS. If you are not currently set up for CHAMPS billing, information regarding becoming an electronic biller and submitting electronic claims to MDHHS, 835 & 837 Companion Guides, Testing Instructions, and MDHHS Electronic Submission Manual are available at: www.michigan.gov/tradingpartners.

Claims processed through CHAMPS are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and a combination of service edits. MDHHS uses the Medicaid National Correct Coding Initiative (NCCI) policies and edits. (Refer to the Directory Appendix for resource information.)

MDHHS encourages providers to send claims electronically by file transfer or through the Data Exchange Gateway (DEG). Electronic filing is more cost effective, more accurate, payment is received more quickly and administrative functions can be automated. Electronic claims filed by Wednesday may be processed as early as the following week.

Tracking Claims. You will also set up a process to regularly track outstanding claims and prioritize collection of payment. “Accounts Receivable” refers to the outstanding dollars owed to you by an insurer or the client. Most clinics produce an Accounts Receivable Aging report which indicates the length of time within which claims are paid.

Normally a claim from an insurer is paid within 30 days. To follow up on claims, staff or the billing service should proactively contact plans to ensure the claim was received and will be paid. Payment delays can occur due to claims getting lost, getting denied or requiring additional information. Some claims may have to be billed to the payers more than once in order to get payment.

Insurance companies can deny claims for a number of reasons:

1. There were errors in the claim
2. The clinician submitting the claim is not credentialed with the plan
3. Services that required plan authorization were not authorized

If the error can be fixed, you or your billing partner should make corrections and resubmit the bill for payment. If you believe the error is not there, you can file an appeal, assuming the dollar amount of the claim is worth the effort to appeal. Typically, payment on a clean bill is made within 90 days.

It is imperative that Accounts Receivable Aging reports are continuously reviewed for unpaid accounts. Unpaid or denied claims should be corrected and rebilled to the insurer or the clinic must decide to pursue the member, or write-off the outstanding account. Additionally, providers should continuously review their billing to insurers to identify systemic issues in the billing process that are causing denials and correct those issues so outstanding accounts receivable can be minimized.

The amount you get paid from the insurer and the patient (copay/coinsurance) may be less than what you have billed. If you are an in-network provider for an insurer, these outstanding amounts should be written off as a contractual adjustment. Pursuing the outstanding balance from the patient will violate language in your insurer contract regarding balance billing. If you are an out-of-network provider for the insurer, you can elect to pursue the patient for any outstanding balances.

You should not receive payments in excess of what you billed. If an excess amount is received it should be returned to the source of payment, either the patient or the insurer. Keeping these amounts is a violation of your insurer contract and may violate the law.

Below is a sample post-visit workflow, which you can adapt to fit the needs of your clinic or lab:

Sample post-visit workflow.

- Upon completion of the visit, the provider completes the superbill, indicating what services and procedures should be billed. The services and procedures will be linked to a billing or CPT code.
- Clerical staff enter the charges and codes from the superbill into the Practice Management System.
- Claims submission/payment:
    - For Medicaid clients, clerical staff upload the Medicaid claims to CHAMPS in weekly batches
    - For those with private insurance, the Practice Management System generates a bill for the insurance company and files are uploaded to the clearinghouse for claims submission
    - For uninsured patients, clerical staff collect sliding scale out of pocket payment at the time of visit or bills the client every 30 days by mail, if the client has not asked for no mailing
- Claims follow-up and reconciliation

4.1.J Determine communications plan

The change from free care to billing insurance and collecting client co-pays is a significant one that requires appropriate communication and messaging. You should include the following in your communications plan:

- **Client communication**. Develop talking points, flyers and Frequently Asked Question documents to share with clients and post at your site to make them aware of the change. It will be important to assure clients that they will not be turned away due to inability to pay and that they have a choice as to whether or not they want to use insurance for these purposes.
- **Partner communication.** It will also be important to inform your referral partners and community partners of the change and the rationale.

4.2 Successful Practices in Michigan

Health Departments and STD/HIV sites across the State of Michigan are beginning to bill. The following are some of the best practices in place through our observation:

- Clinics that have very organized and streamlined credentialing due to multiple levels of clinicians providing services such as infectious disease and primary care. In some settings, clinics' staffing levels were adequate to become a true medical home for health plan members by using infectious disease physicians to care for members with HIV needs and to do prevention care and general sick visits for conditions other than HIV. These sites also have primary care providers who are open to new members and health plans can assign members to them as the primary care physician who provides preventative care as well as general sick visits. These visits were billable to the area health plans. At this clinic credentialing has been assigned to specific staff who submit the applications to health plans and monitor the process to completion.
- Additional models include counties where hospitals provide the infrastructure for billing as part of their core business which allows the clinics to monitor revenue and track accounts receivables and filing limits. These sites may be willing to share services with other counties in a shared savings model.
- Clinics and community-based organizations that have counseling staff who currently work with members with HIV to ensure medication compliance to assist in the prevention of hospital admissions and readmissions. This is a cost savings to Health Plans and can be used as a contract negotiation tool. The current staff providing these coordination services can become Community Health Worker certified, and become a non-traditional community based partnership
- A best practice model are counties who are paying to have Peer Counselors and non-clinical staff to get certified through the Community Health Worker (CHW) Certification program. This model will allow them to provide CHW services for Medicaid Health plans as required in the current Michigan Medicaid Health Plan contract. Resources for certification of Community Health Works can be found at the following site: http://www.michwa.org/resources/community-health-workers-101/

SECTION 5 – CODING AND DOCUMENTATION FOR STD AND HIV SERVICES

Coding for HIV, STD, and related services is an essential practice for programs that are preparing for billing third party payers. Beginning to properly code for services is a critical step in improving revenue cycle management and developing sustainable systems.

Coding is the process of transforming services, diagnoses, and supplies into alphanumeric codes. Without the coding and related documentation, insurers assume the service never occurred.

- ICD-10 Codes describe the diagnosis – the "why"
- CPT Codes describe the service or treatment performed, such as Evaluation and Management (E&M) – the "what"
- Modifiers describe any exception to the CPT Code, and for example, can be used to describe additional services that were performed that are unrelated to the original procedure – "the additional info"
- HCPCS Codes – often pronounced "hick picks", these codes describe durable medical equipment, prosthetics, orthotics, and supplies – the "what else"

We have included a table from the *Building Sustainability for HIV, STD and Related Services: A Coding Guide for Providers,* compiled by the University of Washington Public Health Capacity Building Center, as Appendix 5. This table outlines the common IDC-10 and CPT Codes for STD/HIV providers.

5.1 Scenarios that demonstrate use of codes

The following are some scenarios that help demonstrate use of the codes, adapted from those provided in the *Building Sustainability for HIV, STD and Related Services: A Coding Guide for Providers* and the *Fundamentals of Coding and Billing for STI Clinical Services in Local Health Departments* webinar.

Example 1: A 20-year-old single male returns to your clinic for HIV screening. He declines other STD testing. He has had recent multiple sexual partners, both male and female. The clinician meets with the patient and counsels him on HIV and risk reduction. Face-to-face counseling is documented as greater than 50% of the 15-minute visit with the clinician. Patient is given an HIV rapid test. Test results are negative. What codes do we need for this visit?

CPT/HCPCS Codes: 99213 for problem focused E/M for an established patient, 86701 with modifier 92 for antibody HIV-1/2 87806 modifier QW (Medicaid) or G0433 modifier QW (Medicare).

Related ICD-10 Codes: Z11.4 Encounter for screening for human immunodeficiency virus (HIV), Z72.53 High risk bisexual behavior, Z71.7 Human immunodeficiency virus (HIV) counseling.

Example 2: A 25-year-old female returns to your clinic for her HIV results as a follow-up to an earlier exam. The clinician advises the patient she is HIV+ (asymptomatic HIV). The clinician counsels her about what it means to be HIV+, reviews risk factors, and refers her to an HIV specialist. Face-to-face counseling with the clinician is 15 of the minutes of the 20-minute encounter. What codes do we need for this visit?

CPT/HCPCS Codes: 99213 for established patient problem focused E/M.

Related ICD-10 Codes: Z21 Asymptomatic human immunodeficiency virus (HIV) infection status, Z71.7 Human immunodeficiency virus (HIV) counseling.

Example 3: A 23 year old male who is new to the health department presents for STD screening. He does not have any symptoms, has had three male partners in the last six months and has used condoms inconsistently. He reports having receptive and insertive oral sex, occasional receptive anal sex and occasional anonymous partners. He has no complaints, is in good health, was diagnosed with gonorrhea approximately two years ago, and was tested and treated by a private provider. He had an HIV test six weeks ago with negative results and declines further testing. A clinician tests him for Gonorrhea (GC), Chlamydia (CT) (for reported sites of exposure), and draws blood for a Syphilis rapid plasma regain (RPR) test. The clinician provides face-to-face counseling which was 50% of the 35 minute visit. What codes do we need for this visit?

CPT/HCPCS Codes: 87081 for GC culture, 87591 for GC Nucleic Acid Amplification (NAA) test Genital, Rectal and Pharyngeal, 87491 and 87591 for GC and CT Rectal and Pharyngeal NAA test.

Related ICD-10 Codes: Z72.52 for high risk homosexual behavior to cover medical necessity of services, Z86.19 used to specify a diagnosis based on personal history of other infections and parasitic diseases.

SECTION 6 – CODING AND BILLING FAQS

The following are some of the questions that may come up as your HIV/STD clinic or organization contemplates billing for services.

1) Do you deny service to those who refuse to pay the sliding scale fee?

By statute,[33] all Community Health Centers and FQHC look-alikes must provide health care services regardless of ability to pay. If a patient cannot pay, services will be covered by the clinic. Additionally, clinics funded under Section 330 of the Public Health Service Act who receive Ryan White Program, Part C funding will cover the cost of HIV primary care services as a payer of last resort. However, if it is determined based on income, that the patient should be charged a sliding scale fee and the patient refuses to pay, the clinic should negotiate on an individual basis with the patient a course of action including payment plans, grace periods, and meetings with financial counselors. As a last resort, clinics may discharge patients for refusal to pay, but only after reasonable efforts have been made to secure payments and/or bill for amounts owed to the clinic.

2) What are the most important training components for check-in staff?

It is essential that front desk/check in staff gather all of the necessary information from patients prior to their appointment or at check in. As noted in Section 4, when a patient calls in to schedule an appointment, staff should cover the process for payment and the possible price of services, depending on their coverage. This way, patients will be more prepared to pay any fees or participate in insurance enrollment once they arrive for the visit. Patients should also be advised to bring their insurance card to the visit to assist in eligibility verification. Eligibility verification is key to maximizing reimbursement for services, but it can take significant time, depending on the system capacity. It is also important to train front desk staff to refer uninsured patients to coverage resources including Medicaid, county health plans, and the online Marketplace.

[33] 42 USC Section 254b(k)(3)(F)

3) How do I know if I coded the visit correctly for billing?

Clinics that are new to billing face several common coding challenges. To begin with, physicians may not fill out the super bill/encounter form correctly, leading the billing staff to inadvertently enter the wrong CPT codes on the claim. Secondly, each payer, whether it is Medicaid or commercial carriers, often has unique policies for reviewing and approving claims. These policies are covered in each payer source's provider manual and billing manual. Finally, the transition to ICD-10 codes requires training and education on the new codes and their application. Each insurance carrier may have unique coding requirements, including specific CPT code modifiers. Initial and ongoing training is essential to preparing staff to create and submit bills in a timely and efficient manner and avoid common mistakes. In addition to training, it may also be helpful to contract with a billing service at least initially. Clinic staff can learn from their expertise and decide whether or not to internalize the billing tasks once staff have enough experience. Either way, it will be important to have someone available with billing expertise so your office codes for services correctly and rejected claims can be researched and resolved effectively.

4) What happens if my claim gets denied?

Following up on denied claims can be an especially challenging task, especially for small clinics with limited staff capacity. However, this function is important for clinics to improve their understanding of how to submit claims and thereby improve revenue collections. Each denied claim gets sent back to the clinic with a "denial reason code." Staff can correct the claim and resubmit. However, in some cases, staff will need to call the payer and discuss the denial code and get clarification on how the claim should be corrected before resubmission. If clinic billing staff are observing a theme or consistency in the types of claim denials from a certain payer, it is often helpful to meet to review denial reasons and clarify what codes and modifiers need to be included in the claim for approval.

5) What type of computer systems and software will my clinic need to submit bills and comply with reporting requirements?

At a minimum, clinics need to have a billing system in place to perform the following tasks:

- Generate bills based on medical record documentation
- Maintain patient demographic information and insurance coverage
- Develop reports for payer and program monitoring purposes

6) Will a significant number of clients delay or skip screening/treatment due to charges?

There are cost-related barriers to seeking STD/HIV screening, particularly in asymptomatic individuals. Young people, in particular, fear that a bill for STD services might be sent to their parents. Effective outreach campaigns can help educate individuals on the importance and availability of free or low-cost confidential services.

SECTION 7 – MAINTENANCE OF BILLING PROCESS

Once your billing infrastructure is live, there are a few steps to take to ensure your billing processes and procedures are maintained over time.

*7.*1 Contract Monitoring and Compliance

Each of your contracts, with health plans or billing services, should be regularly reviewed and revised at least every two to three years so that you can make any needed adjustments to rates or other requirements. Clinician credentials must be reviewed and attested to on a quarterly basis.

You will also need to assign staff to ensure compliance with any third party insurer contract requirements. As part of this compliance review, staff or a subcontracted entity would need to review and track the clinic or lab's claims to understand how often claims are being denied and reasons behind the rejection. Periodic review of medical records to ensure your entity is meeting the standards is also recommended for regular monitoring. You should review:

- Are you capturing charges for all services?
- Did staff follow up on claims that were denied?
- Is there documentation in the medical record to support the codes listed?

Staff would also need to review cash flow and collections to ensure the revenue management process is working as intended.

7.2 Performance Monitoring and Improvement. As a contracted plan provider, you are required to maintain a certain level of customer satisfaction, access, and outcomes. To this end you should establish processes to regularly assess patient satisfaction and retention. For example, Advantage Health Centers in Detroit currently posts a patient satisfaction survey on their website to allow for patient feedback.[34]

SECTION 8 – SOURCES OF TECHNICAL ASSISTANCE

The following is a list of online resources to access for further information on billing, coding, contracting, and other topics.

1. **Coding Primers**
    a. Building Sustainability for HIV, STD and Related Services: A Coding Guide for Programs and Providers. http://www.cardeaservices.org/resourcecenter/building-sustainability-for-hiv-std-and-related-services-a-coding-guide-for-programs-and-providers
    b. National Coalition of STD Directors. *Making the Shift from ICD-9 to ICD-10 Primer.* http://www.ncsddc.org/sites/default/files/media/top_15_codes_mapped_to_icd10_10-1-12_0.pdf
    c. Fundamentals of Coding and Billing for STI Clinical Services in Local Health Departments http://phpa.dhmh.maryland.gov/OIDPCS/CSTIP/CSTIPDocuments/Fundamentals%20of%20Coding%20and%20Billing%20for%20STI%20Clin%20Serv%20in%20LHDs%20Webinar%20Slides%2003.11.2014.pdf
    d. Region I STD TAC Webinar: Introduction to Coding and Documentation for STD Services https://vimeo.com/72297075

[34] http://ahcdetroit.org/wp-content/uploads/2013/06/Patient-Satisfaction-Survey.pdf

2. **Contracting**
    a. Health HIV/National Center for Health Care Capacity Building. Health Insurance Contracting for HIV Prevention and Wrap-around Service Providers. http://issuu.com/healthhiv/docs/health_insurance_contracting_for_pr
3. **General Billing Information**
    a. RT Welter & Associates. *Billing and Coding Manual for Title X Family Planning Clinics.* http://rtwelter.com/wp-content/uploads/2014/10/Title-X-Billing-and-Coding-Manual-October-2014-update.pdf
    b. Sexual Health and Reproductive Health Promotion Training and Technical Assistance Center (SHRP-TTAC). *Billing and Reimbursement.* http://shrpttac.jsi.com/resources/billing-reimbursement/
    c. Engaging Safety Net Providers in Expanded Coverage: Tips on Enhancing Billing Capacities. NASHP. http://www.nashp.org/sites/default/files/SNP.tips.billing.capacities.pdf
    d. NIATx Third-party Billing Guide, Third Edition (2014) http://www.niatx.net/Content/ContentPage.aspx?PNID=2&NID=290
    e. National Family Planning & Reproductive Health Association. *Confidentiality, Third-Party Billing, & the Health Insurance Claims Process: Implications for Title X.* http://www.confidentialandcovered.com/file/ConfidentialandCovered_WhitePaper.pdf
    f. HIVMA. HIV Billing and Coding Resources. http://www.hivma.org/HIV_Billing_and_Coding_Resources.aspx
    g. NASTAD. Billing and Reimbursement Resources: Health Departments and Third-Party Billing and Reimbursement. https://www.nastad.org/sites/default/files/NASTAD-Billing-Resource-Bank.pdf
4. **Technical Assistance**
    a. Ryan White Technical Assistance Website https://careacttarget.org/
    b. NASTAD Health Systems Integration https://www.nastad.org/domestic/health-systems-integration
5. **Michigan Specific Guidance**
    a. Expedited Partner Therapy -Provider Guidance and Patient/partner fact sheets http://www.michigan.gov/documents/mdch/EPT_for_Chlamydia_and_Gonorrhea_-_Guidance_for_Health_Care_Providers_494241_7.pdf http://www.michigan.gov/documents/mdch/EPT_Information_Sheet_for_Patients_and_Partners_494242_7.pdf
    b. Questions regarding the toolkit can be addressed to: MDHHS-DHSP-Billing@michigan.gov. This address will be available until December 31, 2016.

Billing Toolkit Appendix 1:

See pages 17-53 for a listing of codes suppressed from the Explanation of Benefits

State of Michigan
Department of Community Health

BV-250 Explanation of Benefits
Requirements Document
Revision Date: November 16, 2015

Printed Date: 3/1/2016 8:14 AM

Table of Contents

1 Document Sign-off

1.1 Requirement Sign-off

This section of the sign-off applies only to Section 2 – Requirements of this document.

Name / Title	Signature	Date

1.2 Design Sign-off

This section of the sign-off applies only to Section 3 – Report Design of this document.

Name / Title	Signature	Date

1.3 Final Report Approval

This section of the sign-off represents acceptance of the report for production deployment.

Name / Title	Signature	Date

2 Requirements

2.1 General Overview – Explanation of Benefits (EOB)

2.1.1 Version and Description

Version 02 contains all payments made by CHAMPS on behalf of a Medicaid Case during the reporting month in Beneficiary sequence. The process will run on the 15th of every month and contain payment information from the prior month. Payments deemed sensitive in nature will not be reported – see section 2.2 and Appendix C for more detailed information.

Version 02.1 contains changes to Appendixes C and D for Sensitive Diagnosis and Surgical Procedure Codes, HCPCS Code descriptions, and changes to the EOB Caption Selection Criteria.

Version 03 updates the report layout to match the requirements that were signed off. Also contains changes to Appendixes C and D for Sensitive Diagnosis and Surgical Procedure Codes, HCPCS Code descriptions, and changes to the EOB Caption Selection Criteria. Created Appendix E for the suppressed Reporting codes.

2.1.2 Report Purpose

This report is Federally mandated to ensure that Medicaid Recipients review and give feedback when needed on claims and payments made on their behalf by the Michigan Medicaid Program. It is used by the Beneficiary and Medicaid Integrity Sections.

2.1.3 Assumptions

The report will contain all original paid Medicaid-funded Claims residing on the Data Warehouse Fee-for-Service Database for Selected Cases on a given month based on the selection criteria defined in Section 2.2 below.

2.2 Technical Requirements

2.2.1 On-Demand Parameters

The report will calculate the reporting period based on inputting either ‘current’ which will report on payments made the prior month or, if a special monthly reporting period is requested, an optional four-digit year and two-digit month can be input instead.

2.2.2 Report Selection Criteria

The report contains a 5% case sampling of all Medicaid payments identified by Benefit Plan for a given month by the State of Michigan with a maximum of 15,000 cases. The Benefit Plans reported include ABW, ABW-ESO, MA, MA-ESO, MA-HMP,MA-HMP-ESO,BMP, MA-MICHILD, MICHILDESO and NH.

Payments that will not be reported include:

- Pended, Rejected or Adjusted Payments (bsns_status_CID not = 71).
- Cases with deceased Beneficiaries (date of death is not null).
- Capitated/Managed Care Payments
- Gross Adjustments (Claim Type CID = 67)
- Payments identified by Policy staff as Sensitive. These include:
  - Payments related to Family Planning, Mental Health and Substance Abuse. These are identified by Diagnosis, Procedure, Surgical Procedure, Revenue and DRG codes and Pharmacy Classes.
    - These codes need to be reviewed by DCH Policy staff every January and the required updates performed to the EOB tables and queries - see code matrixes in Appendix C.
    - Look up tables will be developed to maintain all sensitive codes required for exclusion in the EOB Process. Tables to be maintained by Policy Staff.
  - ICF/MR - Claim Type CID = 46
  - State Psych Facilities – Claim Type CID = 69
  - Family Planning Clinics (LHD) - Claim Type CID = 70
  - Pharmacy Claims (Claim Type CID = 24) classified as Contraceptives, Antivirals for possible treatment of STD and HIV, Psychotropic Drugs (18 and over) and those used for Substance Abuse treatment (all).

In order to obtain the correct Mailing Name and Address information for the EOB, the selection logic is outlined in Appendix A, "Criteria for Identifying MEDICAID Grantees to be sent an Explanation of Benefits Statement".

Due to privacy and sensitivity issues, the "Services Provided" caption on the EOB is a generalized description based on claim type, procedure, revenue, DRG, provider specialty code or a combination of these. The logic is based on the matrix in Appendix D – "Selection Criteria used to assign EOB Caption".

2.2.3 Retention Requirements

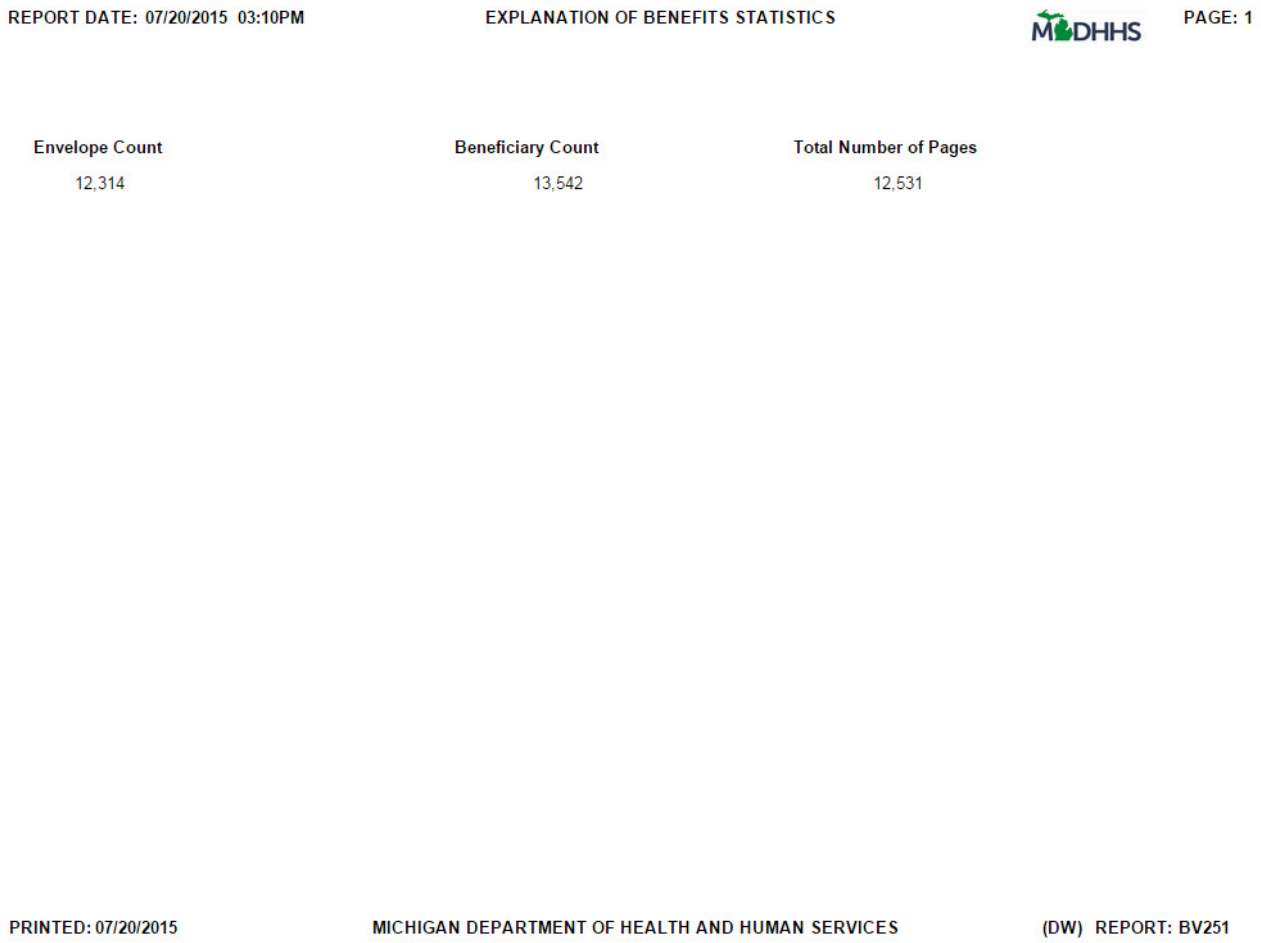
The Medical Services staff has requested 10 years retention for auditing purposes.

2.2.4 Notification Requirements

Selected members from the Office of Inspector General and the Enrollment Services staff receive success/failure notification when the BV250 reports are run in Business Objects.

2.2.5 Special Processes

Medical Services Administration staff needs to be informed of the number of letters sent and the number of pages produced for each monthly run, so a statistical report – BV-251 will be created within the same process that the EOB is created. It will be available to the manager and staff of the Eligibility Services, Policy and Medicaid Integrity Section to view. Below is a facsimile of this report:



REPORT DATE: 07/20/2015 03:10PM EXPLANATION OF BENEFITS STATISTICS MDHHS PAGE: 1

Envelope Count	Beneficiary Count	Total Number of Pages
12,314	13,542	12,531

PRINTED: 07/20/2015 MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (DW) REPORT: BV251

3 Report Design

3.1 Sort Sequence

The EOB report is sorted by ascending zip code, case ID, beneficiary ID, and date of service.

3.2 Paging Criteria

Due to Printing and Mailing Handling constraints, the Explanation of Benefits is limited to producing a maximum of 20 data lines per page, 6 pages per envelope and a maximum of 15,000 envelopes. In order to accommodate this process, cases exceeding 105 claims will not be reported.

3.3 Report Layout (Portrait)

Michigan Department of Health and Human Services
PO Box 30752
Lansing MI 48909

MDHHS

03/02/2010

MCPHAIL DEBORAH K
Apt. 321
2225 E GRASS LAKE RD
CLARE MI 48617

Dear Beneficiary:

The Michigan Department of Health and Human Services Medicaid Program has paid the services listed below for you or a family member.

BENEFICIARY ID	BENEFICIARY NAME/ SERVICE PROVIDED BY	SERVICE DATE	SERVICE DESCRIPTION	AMOUNT PAID
1234567890	MCPHAIL MAISY KAYE			
	PUNCHES PHARMACY PLUS	11/16/2007	Prescription	51.78
1234567891	MCPHAIL SHANNA RAE			
	PUNCHES PHARMACY PLUS	11/16/2007	Prescription	52.03
	MEIJER PHARMACY	11/19/2007	Prescription	14.81
	J & B MEDICAL SUPPLY CO INC	11/20/2007	Medical Supplies	10.00
1234567892	MCPHAIL ELIZABETH			
	CHIPPEWA CO WAR MEM HOSP INC	11/01/2007	Medical Supplies	52.26
	ARFSTROM PHARMACY	11/01/2007	Prescription	71.60

Printed 03/02/2010 10:32 AM **Michigan Department of Health and Human Services** **(DW) Report: <Rept #||Vers #>**

3.4 Report Template (Portrait)

Michigan Department of Health and Human Services
PO Box 30752
Lansing MI 48909

MDHHS

H1

H2
H3
H4
H5

Dear Beneficiary:

The Michigan Department of Health and Human Services Medicaid Program has paid the services listed below for you or a family member.

BENEFICIARY ID	BENEFICIARY NAME/ SERVICE PROVIDED BY	SERVICE DATE	SERVICE DESCRIPTION	AMOUT PAID
D1	D2			
	D3	D4	D5	D6
D1	D2			
	D3	D4	D5	D6
D1	D3	D4	D5	D6
	D3	D4	D5	D6
D1	D2			
	D3	D4	D5	D6
	D3	D4	D5	D6

Printed 03/02/2010 10:32 AM **Michigan Department of Health and Human Services** **(DW) Report: <Rept #||Vers #>**

3.5 Report Field Definitions

Ref #	Report Field Name	Field Category	Description
H1	Report Date	Heading	The date the report is printed. Uses the current system date.
H2	EOB Mailing Address Name	Heading	Uses dch_ee_views.ee_member_detail_h.Case_Name or dch_ee_views.ee_contact_info_h.First and Last Name based on the logic in Appendix A – Criteria for Identifying Medicaid Grantees to be sent an EOB.
H3	EOB Mailing Address Attention Line	Heading	If available, includes.attention line.
H4	EOB Mailing Street Address	Heading	Uses address based on the Beneficiary number of the selected CIS Case and the Address Type Code
H5	EOB Mailing City, State, Zip	Heading	Uses address.city, state and zip based on the Case number of the selected CIS Case and the Address Type Code..
D1	Beneficiary ID	Detail 1	The 10-digit Beneficiary ID for which the Claim was paid..
D2	Beneficiary Name	Detail 1	The Name of the Beneficiary for which the Claim was paid.
D3	Service Provided By	Detail 2	The Name of the Provider in which the Service was provided by.
D4	Service Date	Detail 2	The Service Begin Date residing on the Claim.
D5	Service Description	Detail 2	Short Description of service obtained by either Claim Type CID, Procedure Code, Place of Service of a combination of any of the three. See Appendix D - “Selection Criteria used to assign EOB Caption” for more information.
D6	Amount Paid	Detail 2	The non-zero amount paid by MDCH. (Will now display claims paid $0.00)

4 Technical Specifications

4.1 Field Crosswalk

Ref #	Database Name	Database Table Name	Database Field Name	Description / Comments
	DCH_EE_VIEWS DCH_EE_VIEWS	EE_MEMBER_DETAIL_H EE_CONTACT_INFO_H	Case Name/ First and Last Names,	45 Character field used as the EOB mailing name. First and last names are concatenated
	DCH_EE_VIEWS	EE_ADDRESS_H	Street 2	30 Character field used in EOB mailing address when available.
	DCH_EE_VIEWS	EE_ADDRESS_H	Street 1	30 Character field used in EOB mailing address.
	DCH_EE_VIEWS	EE_ADDRESS_H	City_Town_Name	30 Character field used in EOB mailing address.
	DCH_EE_VIEWS	EE_ADDRESS_H	State_Prvnc_Code	2 Character field used in EOB mailing address.
	DCH_EE_VIEWS	EE_ADDRESS_H	Postal_Code	5 Character field used in EOB mailing address.
	DCH_CE_VIEWS	CEP_CLM_HDR_INFORMATION_H	MBR_IDENTIFIER	10 digit field used as “Beneficiary ID” on EOB.
	DCH_EE_VIEWS	EE_MEMBER_DEMOGRAPHICS	First,Middle,Last Name and Suffix	Concatenated 45 digit field used as “Beneficiary Name” on EOB.
	DCH_PE_VIEWS	PE_PROVIDER_DETAILS_H	Org_Bsns_Name/Legal Name/First MI Last Name Suffix_Lkpcd,	41 Character field used as “Service Provided By” on EOB. Takes next selection if previous is null, First, MI,Last and Suffix are concatenated.
	DCH_CE_VIEWS	CEP_CLM_HDR_INFORMATION_H	From_Service_Date	Date format field used as “Service Date” on EOB.
	DCH_CE_VIEWS	CEP_CLM_LINE_DERIVED_ELEMENT_H CEP_CLM_HDR_DERIVED_ELEMENT_H	Paid_Amount	9- Decimal field used as “Amount Paid” on EOB. For Institutional Claims uses HDR_DERIVED (Clm_Type_CID = 2). LINE_DERIVED for all other Claim Type CIDs. .

5 Report Facsimile

Michigan Department of Health and Human Services
PO Box 30752
Lansing, MI 48909

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

07/17/2015

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ٣١٩٥-٦٤٢-٨٠٠-١

Dear Beneficiary:

THIS IS NOT A BILL OR A REQUEST FOR PAYMENT

The Michigan Department of Health and Human Services Medicaid Program has paid the services listed below for you or a family member.

BENEFICIARY ID	BENEFICIARY NAME/ SERVICE PROVIDED BY	ON DATE	SERVICE PROVIDED	MDHHS PAID

If you or the family member listed on this form did not receive these services, please tell us. We need to know if these services were not provided or if the services listed are different from what were actually received. Please use the back of this form to tell us what you disagree with. If you are willing to provide a telephone number, we may wish to call you to discuss your concerns. If you do provide a phone number, please let us know if we can leave a message. Send the form to the following address:

Michigan Department of Health and Human Services Office of Inspector General P.O. Box 30062 Lansing, Michigan 48909-7979	call: 1-855-MI-FRAUD (1-855-643-7283) or visit: www.michigan.gov/fraud

Use of this statement of services to obtain payment from another insurance company is a violation of federal law. Any attempt to use it for such purposes should be reported to: Medicaid Financial Management and Administrative Services, Health Insurance Liability Section, P.O. Box 30435, Lansing, Michigan 48909-9634.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Michigan Department of Health and Human Services office in your area.

COMPLETION: Is voluntary.

AUTHORITY: Title XIX of the Social Security Act.

MSA-110-EOB (07/15) This edition obsoletes previous editions.

5.1 Changes made to EOB layout

Once testing of the form began, the report was reviewed and approved, but there were problems with the MDCH logo clarity. Several tests were shared with us before a clear logo was produced. We reviewed the logo and approved the final test without reviewing the entire report because we did not realize changes were made to the entire report. RFS CSR-2013-000056 was submitted because we have determined that required language was removed from the approved report. Upon reviewing the test, we now realize that there were also typos and spacing errors made that are not consistent with the approved report.

Changed the Logo because of new director and updated the revision date to be 02/14.

6 Appendix A – Criteria for Identifying MEDICAID Grantees to be sent an Explanation of Benefits Statement

EOB Pull: Bypass individual Beneficiary EOB record if DOD on file.			
Table	**Attribute to Qualify**	**Qualify Value**	**Attribute to Select**
Member Demographics	Operational Flag	Equal: A (Active)	
Member Demographics	Calc quality flag	Equal: 1 (Active)	
Member Demographics	End date	Equal: 12/31/2999	
Member Demographics	Mortality date	Equal: Null	
MA - Address Query			
MA - Guardian Address Query: Pull if Third Party Correspondence code = 0,3,5; else Case address.			
Table	**Attribute to Qualify**	**Qualify Value**	**Attribute to Select**
Member Details	Third Party Correspondence	Equal: 0, 3, 5	N/A
Member Contact	Address Type CID	Equal: 21 (Guardian Address)	
Member Contact	Data Source	Equal: MA	
Member Contact	Operational Flag	Equal: A (Active)	
Member Contact	Calc quality flag	Equal: 1 (Active)	
Member Contact	End date	Equal: 12/31/2999	First Name, Last Name
Member Address	Address Type CID	Equal: 21 (Guardian Address)	
Member Address	Data Source	Equal: MA	
Member Address	Operational Flag	Equal: A (Active)	
Member Address	Calc quality flag	Equal: 1 (Active)	

Member Address	End date	Equal: 12/31/2999	address line 2, address line 1, City, State, Zip code, Zip Plus Four
MA - Case Address Query			
Table	**Attribute to Qualify**	**Qualify Value**	**Attribute to Select**
Member Details	Third Party Correspondence	Not Equal: 0, 3, 5,	N/A
Member Details	Data Source	Equal: MA	
Member Details	Calc quality flag	Equal: 1 (Active)	
Member Details	End date	Equal: 12/31/2999	Case name
Member Address	Address Type CID	Equal: 20 (Case Address)	
Member Address	Operational Flag	Equal: A (Active)	
Member Address	Calc quality flag	Equal: 1 (Active)	
Member Address	End date	Equal: 12/31/2999	address line 2, address line 1, City, State, Zip code, Zip Plus Four

7 Appendix B – Narrative of Queries to Create the EOB Extract Table

The Explanation of Benefits Extract table is the final input into creating the monthly Explanation of Benefits mailings. The following describes what is performed in order to create the final table results.

Determination of the Case Population

Creation of a 5% Case Sample

Creation of EOB Beneficiary Table

Creation of EOB Extract Table

Identifying and Removing Sensitive data from the EOB table

Policy staff will annually review the EOB Suppress table and the conditionals in the queries to identify what procedures/CPT codes need to be excluded from EOB reporting. These codes include those related to but not limited to Family Planning, HIV/STD treatment/diagnosis, Mental Health and Substance Abuse treatment. These items are denoted by setting an age factor flag in the EOB Suppress table to a '0' when the suppression applies to all ages; to a '1' for beneficiaries over 13 years; to a '2' for those that should be suppressed when beneficiaries are under 18 years of age and to a '3' for those that apply to beneficiaries over 17 years of age. For a list of the current

CPT/Revenue codes being suppressed and the contents of the EOB Suppress Table, see Appendix C.

There are other sensitive conditions that do not allow for claims with certain drugs, DRGs, Diagnosis and Procedure Codes to be reported on the EOB. These currently include:

1. Contraceptive claims, Antivirals for possible STD and HIV treatment, Psychotropic Drugs and Substance Abuse Treatment Drugs – see Appendix C, Section 8.2 "Pharmacy Data Exclusion".
2. Sensitive DRG Claims – see Appendix C, Section 8.4 "DRG Codes to Suppress".
3. Sensitive Diagnosis_Codes – see Appendix C, Section 8.3 "Diagnosis Codes to Suppress".

Deletion of Cases with over 105 Claims

After editing claims for sensitivity, a count is taken of the number of claims per case and if there are more than 105 claims, the case is eliminated from the EOB reporting process. This is to accommodate the 6 page print limit per envelope.

Creation of a 15,000 maximum Case Sample

With the final outcome of the previous queries and by using the SQL SAMPLE function once again, a 15,000 case sample is extracted, giving a final EOB Extract table. This extract table now either contains 15,000 cases or less.

Assigning Procedure Code Descriptions

The Procedure code descriptions are assigned based on a combination of Provider Type, Procedure code, Revenue code, DRG code or Place of Service. Appendix D in Section 15 lists all the Descriptions and the selection criteria used to assign the descriptions.

Obtain Mailing Name and Address Information

At this point we have the basic claim information for the EOB report and need to obtain the mailing information. This will be obtained based on the business rules defined in Appendix A Criteria for Identifying MEDICAID Grantees to be sent an Explanation of Benefits Statement

8 Appendix C – HCPCS/Revenue Codes, Diagnosis Codes, DRG Codes, Surgical Procedure Codes and Pharmacy Classes Currently Excluded from Reporting on the Explanation of Benefits Statement

Following are the matrixes of all the codes identifying sensitive claims. All of these codes need to be reviewed periodically by Policy staff and updated as needed.

8.1 EOB Suppress

Following is the list of HCPCS/Revenue codes currently on the CRCHAMPSTABLES.T_BV250_EOBCodeSuppress Table:

HCPCS Or Revenue Code	Short Description	0=Suppress all ages 1=Suppress over 13 (SA/DMH) 2=Suppress under 18 3=Suppress over 17	Procedure Code Indicator R=Revenue H=HCPCS
0112	Room & Board - Private (Medical or General) - OB	2	R
0114	Room & Board - Private (Medical or General) – Psychiatric	3	R
0116	Room & Board - Private (Medical or General) – Detoxification	1	R
0122	Room & Board - Semi-Private Two Bed (Medical or General) - OB	2	R
0124	Room & Board - Semi-Private Two Bed (Medical or General) – Psychiatric	3	R
0126	Room & Board - Semi-Private Two Bed (Medical or General) - Detoxification	1	R
0132	Room & Board - Semi-Private - Three and Four Beds - OB	2	R
0134	Room & Board - Semi-Private - Three and Four Beds - Psychiatric	3	R
0136	Room & Board - Semi-Private - Three and Four Beds - Detoxification	1	R
0142	Room & Board - Private (Deluxe) - OB	2	R
0144	Room & Board - Private (Deluxe) - Psychiatric	3	R

0146	Room & Board - Private (Deluxe) - Detoxification	1	R
0152	Room & Board - Ward (Medical or General) - OB	2	R
0154	Room & Board - Ward (Medical or General) - Psychiatric	3	R
0156	Room & Board - Ward (Medical or General) - Detoxification	1	R
0204	Intensive Care - Psychiatric	3	R
0023T	Phenotype drug test, hiv 1	0	H
0513	Clinic - Psychiatric Clinic	3	R
0514	Clinic - OB-GYN Clinic	2	R
0720	Labor Room/Delivery - General Classification	2	R
0721	Labor Room/Delivery – Labor	2	R
0722	Labor Room/Delivery – Delivery	2	R
0723	Labor Room/Delivery – Circumcision	2	R
0724	Labor Room/Delivery - Birthing Center	2	R
0729	Labor Room/Delivery - Other Labor Room/Delivery	2	R
00842	Anesth amniocentesis	2	H
00846	Anesth hysterectomy	0	H
00851	Anesth, tubal ligation	0	H
0900	Psychiatric/Psychological Treatments - General Classification	3	R
0901	Psychiatric/Psychological Treatments - Electroshock Treatment	3	R
0902	Psychiatric/Psychological Treatments - Milieu Therapy	3	R
0903	Psychiatric/Psychological Treatments - Play Therapy	3	R
0904	Psychiatric/Psychological Treatments - Activity Therapy	3	R
0905	Psychiatric/Psychological Treatments - Intens OP Services – Psychiatric	3	R
0906	Psychiatric/Psychological Treatments - Intens OP Services – Chemical Dependence	3	R
0907	Psychiatric/Psychological Treatments - Community Behavioral Health Program	3	R
0909	Psychiatric/Psychological Treatments - Other Psychiatric/Psychological Treatment	3	R
0910	Psychiatric/Psychological Services - General Classification	3	R
0911	Psychiatric/Psychological Services - Rehabilitation	3	R
0912	Psychiatric/Psychological Services - Partial Hosp	3	R
0913	Psychiatric/Psychological Svcs - Partial Intensive	3	R
0914	Psychiatric/Psychological Services - Individual Therapy	3	R
0915	Psychiatric/Psychological Services - Group Therapy	3	R
0916	Psychiatric/Psychological Services - Family Therapy	3	R
0917	Psychiatric/Psychological Services - Bio Feedback	3	R
0918	Psychiatric/Psychological Services – Testing	3	R
0919	Psychiatric/Psychological Services - Other Psychiatric/Psychological Service	3	R
00921	Anesth, vasectomy	0	H
00922	Anesth sperm duct surgery	0	H
0925	Other Diagnostic Services - Pregnancy Test	2	R
00926	Anesth removal of testis	0	H
00928	Anesth removal on testis	0	H
00930	Anesth testis suspension	0	H
00932	Anesth amputation of penis	0	H
00938	Anesth, insert penis device	0	H
00944	Anesth, vaginal hysterectomy	0	H

0944	Other Therapeutic Services (Also see 095X, an extension of 094X) - Drug Rehabilitation	1	R
0945	Other Therapeutic Services (Also see 095X, an extention of 094X) - Alcohol Rehabilitation	1	R
0961	Professional Fees (also see 097X and 098X) - Psychiatric	3	R
01996	Hosp manage cont drug admin	1	H
1000	BEHAVIORAL HEALTH ACCOMMODATIONS GENERAL CLASSIFICATION	3	R
1001	BEHAVIORAL HEALTH ACCOMMODATIONS RESIDENTIAL TREATMENT PSYCHIATRIC	3	R
1002	BEHAVIORAL HEALTH ACCOMMODATIONS RESIDENTIAL TREATMENT CHEMICAL DEPENDENCY	3	R
1003	BEHAVIORAL HEALTH ACCOMMODATIONS SUPERVISED LIVING	3	R
1004	BEHAVIORAL HEALTH ACCOMMODATIONS HALFWAY HOUSE	3	R
1005	BEHAVIORAL HEALTH ACCOMMODATIONS GROUP HOME	3	R
11975	Insert contraceptive cap	0	H
11976	Removal of contraceptive cap	0	H
11980	Implant hormone pellet(s)	0	H
36460	Transfusion service, fetal	2	H
38207	Cryopreserve stem cells	0	H
45126	Pelvic exenteration	0	H
54120	Partial removal of penis	0	H
54125	Removal of penis	0	H
54130	Remove penis & nodes	0	H
54135	Remove penis & nodes	0	H
54400	Insert semi-rigid prosthesis	0	H
54401	Insert self-contd prosthesis	0	H
54402	Remove penis prosthesis	0	H
54405	Insert multi-comp penis pros	0	H
54406	Remove muti-comp penis pros	0	H
54407	Remove multi-comp prosthesis	0	H
54408	Repair multi-comp penis pros	0	H
54409	Revise penis prosthesis	0	H
54410	Remove/replace penis prosth	0	H
54411	REMOV/REPLC PENIS PROS COMP	0	H
54415	Remove self-contd penis pros	0	H
54416	Remv/repl penis contain pros	0	H
54417	REMV/REPLC PENIS PROS COMPL	0	H
54438	Replantation of penis	0	H
54520	Removal of testis	0	H
54522	ORCHIECTOMY PARTIAL	0	H
54530	Removal of testis	0	H
54690	LAPAROSCOPY ORCHIECTOMY	0	H
55150	Removal of scrotum	0	H
55200	Incision of sperm duct	0	H
55400	Repair of sperm duct	0	H
55600	Incise sperm duct pouch	0	H
55605	Incise sperm duct pouch	0	H
55650	Remove sperm duct pouch	0	H
54900	Fusion of spermatic ducts	0	H

54901	Fusion of spermatic ducts	0	H
55250	Removal of sperm duct(s)	0	H
55450	Ligation of sperm duct	0	H
55870	Electroejaculation	0	H
55970	SEX TRANSFORMATION M TO F	0	H
55980	SEX TRANSFORMATION F TO M	0	H
57170	Fitting of diaphragm/cap	0	H
58150	Total hysterectomy	0	H
58152	Total hysterectomy	0	H
58180	Partial hysterectomy	0	H
58200	Extensive hysterectomy	0	H
58210	Extensive hysterectomy	0	H
58240	Removal of pelvis contents	0	H
58260	Vaginal hysterectomy	0	H
58262	Vag hyst including t/o	0	H
58263	Vag hyst w/t/o & vag repair	0	H
58267	Vag hyst w/urinary repair	0	H
58270	Vag hyst w/enterocele repair	0	H
58275	Hysterectomy/revise vagina	0	H
58280	Hysterectomy/revise vagina	0	H
58285	Extensive hysterectomy	0	H
58290	Vag hyst complex	0	H
58291	Vag hyst incl t/o, complex	0	H
58292	Vag hyst t/o & repair, compl	0	H
58293	Vag hyst w/uro repair, compl	0	H
58294	Vag hyst w/enterocele, compl	0	H
58300	Insert intrauterine device	0	H
58301	Remove intrauterine device	0	H
58321	Artificial Insemination	0	H
58322	Artificial Insemination	0	H
58323	Sperm Washing	0	H
58345	Reopen fallopian tube	0	H
58350	Reopen fallopian tube	0	H
58541	Lsh, uterus 250 g or less	0	H
58542	Lsh w/t/o ut 250 g or less	0	H
58543	Lsh uterus above 250 g	0	H
58544	Lsh w/t/o uterus above 250 g	0	H
58548	Lap radical hyst	0	H
58550	Laparo-asst vag hysterectomy	0	H
58552	Laparo-vag hyst incl t/o	0	H
58553	Laparo-vag hyst, complex	0	H
58554	Laparo-vag hyst w/t/o, compl	0	H
58558	Hysteroscopy, biopsy	0	H
58565	Hysteroscopy, sterilization	0	H
58600	Division of fallopian tube	0	H

58605	Division of fallopian tube	0	H
58611	Ligate oviduct(s) add-on	0	H
58615	Occlude fallopian tube(s)	0	H
58670	Laparoscopy, tubal cautery	0	H
58671	Laparoscopy, tubal block	0	H
58700	Removal of fallopian tube	0	H
58720	Removal of ovary/tube(s)	0	H
58825	Transposition, ovary(s)	0	H
58920	Partial removal of ovary(s)	0	H
58940	Removal of ovary(s)	0	H
58943	Removal of ovary(s)	0	H
58950	Resect ovarian malignancy	0	H
58951	Resect ovarian malignancy	0	H
58952	Resect ovarian malignancy	0	H
58953	TAH RAD DISSECT FOR DEBULK	0	H
58954	Tah rad debulk/lymph remove	0	H
58956	BSO OMENTECTOMY W/TAH	0	H
58970	Retrieval of oocyte	0	H
58974	Transfer of embryo	0	H
58976	Transfer of embryo	0	H
59000	Amniocentesis, diagnostic	2	H
59001	Amniocentesis, therapeutic	2	H
59012	Fetal cord puncture,prenatal	2	H
59015	Chorion biopsy	2	H
59020	Fetal contract stress test	2	H
59025	Fetal non-stress test	2	H
59030	Fetal scalp blood sample	2	H
59050	Fetal monitor w/report	2	H
59051	Fetal monitor/interpret only	2	H
59070	Transabdom amnioinfus w/us	2	H
59072	Umbilical cord occlude w/us	2	H
59074	Fetal fluid drainage w/us	2	H
59076	Fetal shunt placement, w/us	2	H
59120	Treat ectopic pregnancy	0	H
59121	Treat ectopic pregnancy	0	H
59130	Treat ectopic pregnancy	0	H
59135	Treat ectopic pregnancy	0	H
59136	Treat ectopic pregnancy	0	H
59140	Treat ectopic pregnancy	0	H
59150	Treat ectopic pregnancy	0	H
59151	Treat ectopic pregnancy	0	H
59160	D & C after delivery	2	H
59200	Insert cervical dilator	2	H
59300	Episiotomy or vaginal repair	2	H
59320	Revision of cervix	2	H

59325	Revision of cervix	2	H
59350	Repair of uterus	2	H
59400	Obstetrical care	2	H
59409	Obstetrical care	2	H
59410	Obstetrical care	2	H
59412	Antepartum manipulation	2	H
59414	Deliver placenta	2	H
59425	Antepartum care only	2	H
59426	Antepartum care only	2	H
59430	Care after delivery	2	H
59510	Cesarean delivery	2	H
59514	Cesarean delivery only	2	H
59515	Cesarean delivery	2	H
59525	Remove uterus after cesarean	0	H
59610	Vbac delivery	2	H
59612	Vbac delivery only	2	H
59614	Vbac care after delivery	2	H
59618	Attempted vbac delivery	2	H
59620	Attempted vbac delivery only	2	H
59622	Attempted vbac after care	2	H
59812	Treatment of miscarriage	0	H
59820	Care of miscarriage	0	H
59821	Treatment of miscarriage	0	H
59830	Treat uterus infection	0	H
59840	Abortion	0	H
59841	Abortion	0	H
59850	Abortion	0	H
59851	Abortion	0	H
59852	Abortion	0	H
59855	Abortion	0	H
59856	Abortion	0	H
59857	Abortion	0	H
59866	Abortion (mpr)	0	H
59871	Remove cerclage suture	2	H
59897	Fetal invas px w/us	2	H
59898	Laparo proc, ob care/deliver	2	H
59899	Maternity care procedure	2	H
70555	Fmri brain by phys/psych	3	H
74710	X-ray measurement of pelvis	0	H
74712	Mri fetal sngl/1st gestation	2	H
74713	Mri fetal ea addl gestation	2	H
74740	X-ray, female genital tract	0	H
74742	X-ray, fallopian tube	0	H
74775	X-ray exam of perineum	0	H
76801	Ob us < 14 wks, single fetus	2	H

76802	Ob us < 14 wks, addl fetus	2	H
76805	Ob us >/= 14 wks, sngl fetus	2	H
76810	Ob us >/= 14 wks, addl fetus	2	H
76811	Ob us, detailed, sngl fetus	2	H
76812	Ob us, detailed, addl fetus	2	H
76813	Ob us nuchal meas, 1 gest	2	H
76814	Ob us nuchal meas, add-on	2	H
76815	Ob us, limited, fetus(s)	2	H
76816	Ob us, follow-up, per fetus	2	H
76817	Transvaginal us, obstetric	2	H
76818	Fetal biophys profile w/nst	2	H
76819	Fetal biophys profil w/o nst	2	H
76820	Umbilical artery echo	2	H
76821	Middle cerebral artery echo	2	H
76825	Echo exam of fetal heart	2	H
76826	Echo exam of fetal heart	2	H
76827	Echo exam of fetal heart	2	H
76828	Echo exam of fetal heart	2	H
80055	Obstetric panel	2	H
80081	Obstetric panel	2	H
80100	Drug screen, qualitate/multi	1	H
80101	Drug screen, single	1	H
80102	Drug confirmation	1	H
80103	Drug analysis, tissue prep	1	H
80154	Assay of benzodiazepines	1	H
80173	Assay of haloperidol	1	H
80299	Quantitative assay, drug	1	H
80300	Drug screen non tlc devices	1	H
80301	Drug screen class list a	1	H
80302	Drug screen prsmptv 1 class	1	H
80303	Drug screen one/mult class	1	H
80304	Drug screen one/mult class	1	H
80320	Drug screen quantalcohols	1	H
80321	Alcohols biomarkers 1or 2	1	H
80322	Alcohols biomarkers 3/more	1	H
80323	Alkaloids nos	1	H
80324	Drug screen amphetamines 1/2	1	H
80325	Amphetamines 3or 4	1	H
80326	Amphetamines 5 or more	1	H
80327	Anabolic steroid 1 or 2	1	H
80328	Anabolic steroid 3 or more	1	H
80329	Analgesics non-opioid 1 or 2	1	H
80330	Analgesics non-opioid 3-5	1	H
80331	Analgesics non-opioid 6/more	1	H
80332	Antidepressants class 1 or 2	3	H

80333	Antidepressants class 3-5	3	H
80334	Antidepressants class 6/more	3	H
80335	Antidepressant tricyclic 1/2	3	H
80336	Antidepressant tricyclic 3-5	3	H
80337	Tricyclic & cyclicals 6/more	3	H
80338	Antidepressant not specified	3	H
80342	Antipsychotics nos 1-3	3	H
80343	Antipsychotics nos 4-6	3	H
80344	Antipsychotics nos 7/more	3	H
80345	Drug screening barbiturates	1	H
80346	Benzodiazepines1-12	3	H
80347	Benzodiazepines 13 or more	3	H
80348	Drug screening buprenorphine	1	H
80349	Cannabinoids natural	1	H
80350	Cannabinoids synthetic 1-3	1	H
80351	Cannabinoids synthetic 4-6	1	H
80352	Cannabinoid synthetic 7/more	1	H
80353	Drug screening cocaine	1	H
80354	Drug screening fentanyl	1	H
80356	Heroin metabolite	1	H
80357	Ketamine and norketamine	1	H
80358	Drug screening methadone	1	H
80359	Methylenedioxyamphetamines	1	H
80360	Methylphenidate	3	H
80361	Opiates 1 or more	1	H
80362	Opioids & opiate analogs 1/2	1	H
80363	Opioids & opiate analogs 3/4	1	H
80364	Opioid &opiate analog 5/more	1	H
80365	Drug screening oxycodone	1	H
80367	Drug screening propoxyphene	1	H
80368	Sedative hypnotics	1	H
80369	Skeletal muscle relaxant 1/2	1	H
80370	Skel musc relaxant 3 or more	1	H
80371	Stimulants synthetic	1	H
80372	Drug screening tapentadol	1	H
80373	Drug screening tramadol	1	H
80375	Drug/substance nos 1-3	1	H
80376	Drug/substance nos 4-6	1	H
80377	Drug/substance nos 7/more	1	H
81025	Urine pregnancy test	0	H
81507	Fetal aneuploidy trisom risk	2	H
82055	Assay of ethanol	1	H
82075	Assay of breath ethanol	1	H
82205	Assay of barbiturates	1	H
82731	Assay of fetal fibronectin	2	H

83001	Gonadotropin (FSH)	0	H
83002	Gonadotropin (LH)	2	H
83030	FETAL HEMOGLOBIN CHEMICAL	2	H
83033	Fetal hemoglobin assay, qual	2	H
83661	L/S RATIO FETAL LUNG	2	H
83662	Foam stability, fetal lung	2	H
83663	Fluoro polarize, fetal lung	2	H
83664	LAMELLAR BDY FETAL LUNG	2	H
83840	Assay of methadone	1	H
84702	Chorionic gonadotropin test	0	H
84703	Chorionic gonadotropin assay	0	H
85460	HEMOGLOBIN FETAL	2	H
85461	HEMOGLOBIN FETAL	2	H
86485	Skin test, candida	0	H
86628	Candida antibody	0	H
86631	Chlamydia antibody	0	H
86674	Giardia lamblia antibody	0	H
86687	Htlv-i antibody	0	H
86688	Htlv-ii antibody	0	H
86689	HTLV/HIV confirmatory test	0	H
86692	Hepatitis, delta agent	0	H
86694	Herpes simplex test	0	H
86695	Herpes simplex test	0	H
86696	Herpes simplex type 2	0	H
86701	HIV-1	0	H
86702	HIV-2	0	H
86703	HIV-1/HIV-2, single result	0	H
86704	Hep b core antibody, total	0	H
86705	Hep b core antibody igm	0	H
86706	Hep b surface antibody	0	H
86707	Hep be antibody	0	H
86708	Hep a antibody, total	0	H
86709	Hep a antibody, igm	0	H
86803	Hepatitis c ab test	0	H
86804	Hep c ab test, confirm	0	H
87106	Fungi identification, yeast	0	H
87110	Chlamydia culture	0	H
87207	Smear, special stain	0	H
87255	Genet virus isolate, hsv	0	H
87269	Giardia ag, if	0	H
87270	Chlamydia trachomatis ag, if	0	H
87273	Herpes simplex 2, ag, if	0	H
87274	Herpes simplex 1, ag, if	0	H
87320	Chylmd trach ag, eia	0	H
87329	Giardia ag, eia	0	H

87340	Hepatitis b surface ag, eia	0	H
87341	Hepatitis b surface, ag, eia	0	H
87350	Hepatitis be ag, eia	0	H
87380	Hepatitis delta ag, eia	0	H
87389	Hiv-1 ag w/hiv-1 & hiv-2 ab	0	H
87390	Hiv-1 ag, eia	0	H
87391	Hiv-2 ag, eia	0	H
87480	Candida, dna, dir probe	0	H
87481	Candida, dna, amp probe	0	H
87482	Candida, dna, quant	0	H
87485	Chylmd pneum, dna, dir probe	0	H
87486	Chylmd pneum, dna, amp probe	0	H
87487	Chylmd pneum, dna, quant	0	H
87490	Chylmd trach, dna, dir probe	0	H
87491	Chylmd trach, dna, amp probe	0	H
87492	Chylmd trach, dna, quant	0	H
87515	Hepatitis b, dna, dir probe	0	H
87516	Hepatitis b, dna, amp probe	0	H
87517	Hepatitis b, dna, quant	0	H
87520	Hepatitis c, rna, dir probe	0	H
87521	Hepatitis c, rna, amp probe	0	H
87522	Hepatitis c, rna, quant	0	H
87525	Hepatitis g, dna, dir probe	0	H
87526	Hepatitis g, dna, amp probe	0	H
87527	Hepatitis g, dna, quant	0	H
87528	Hsv, dna, dir probe	0	H
87529	Hsv, dna, amp probe	0	H
87530	Hsv, dna, quant	0	H
87531	Hhv-6, dna, dir probe	0	H
87532	Hhv-6, dna, amp probe	0	H
87533	Hhv-6, dna, quant	0	H
87534	Hiv-1, dna, dir probe	0	H
87535	Hiv-1, dna, amp probe	0	H
87536	Hiv-1, dna, quant	0	H
87537	Hiv-2, dna, dir probe	0	H
87538	Hiv-2, dna, amp probe	0	H
87539	Hiv-2, dna, quant	0	H
87590	N.gonorrhoeae, dna, dir prob	0	H
87591	N.gonorrhoeae, dna, amp prob	0	H
87592	N.gonorrhoeae, dna, quant	0	H
87620	Hpv, dna, dir probe	0	H
87621	Hpv, dna, amp probe	0	H
87622	Hpv, dna, quant	0	H
87623	Hpv low-risk types	0	H
87624	Hpv high-risk types	0	H

87625	Hpv types 16 & 18 only	0	H
87660	Trichomonas vagin, dir probe	0	H
87661	Trichomonas vaginalis amplif	0	H
87806	Hiv antigen w/hiv antibodies	0	H
87808	Trichomonas assay w/optic	0	H
87810	Chylmd trach assay w/optic	0	H
87850	N. gonorrhoeae assay w/optic	0	H
87900	Phenotype, infect agent drug	0	H
87901	Genotype, dna, hiv reverse t	0	H
87902	Genotype, dna, hepatitis C	0	H
87903	Phenotype, dna hiv w/culture	0	H
87904	Phenotype, dna hiv w/clt add	0	H
88141	Cytopath c/v interpret	0	H
88142	Cytopath c/v thin layer	0	H
88143	Cytopath c/v thin layer redo	0	H
88147	Cytopath c/v automated	0	H
88148	Cytopath c/v auto rescreen	0	H
88150	Cytopath c/v manual	0	H
88152	Cytopath c/v auto redo	0	H
88153	Cytopath c/v redo	0	H
88154	Cytopath c/v select	0	H
88155	Cytopath c/v index add-on	0	H
88160	Cytopath smear other source	0	H
88161	Cytopath smear other source	0	H
88162	Cytopath smear other source	0	H
88164	Cytopath tbs c/v manual	0	H
88165	Cytopath tbs c/v redo	0	H
88166	Cytopath tbs c/v auto redo	0	H
88167	Cytopath tbs c/v select	0	H
88172	Cytp dx eval fna 1st ea site	0	H
88173	Cytopath eval fna report	0	H
88174	Cytopath c/v auto in fluid	0	H
88175	Cytopath c/v auto fluid redo	0	H
88177	Cytp fna eval ea addl	0	H
89250	Cultr oocyte/embryo <4 days	0	H
89251	Cultr oocyte/embryo <4 days	0	H
89252	Assist oocyte fertilization	0	H
89253	Embryo hatching	0	H
89254	Oocyte identification	0	H
89255	Prepare embryo for transfer	0	H
89256	Prepare cryopreserved embryo	0	H
89257	Sperm identification	0	H
89258	CRYOPRESERVATION EMBRYO(S)	0	H
89259	CRYOPRESERVATION SPERM	0	H
89260	SPERM ISOLATION SIMPLE	0	H

89261	Sperm isolation, complex	0	H
89264	Identify sperm tissue	0	H
89268	Insemination of oocytes	0	H
89272	Extended culture of oocytes	0	H
89280	Assist oocyte fertilization	0	H
89281	Assist oocyte fertilization	0	H
89290	Biopsy, oocyte polar body	0	H
89291	BIOPSY OOCYTE POLAR BODY	0	H
89300	Semen analysis w/huhner	0	H
89310	Semen analysis w/count	0	H
89320	Semen anal vol/count/mot	0	H
89321	Semen anal, sperm detection	0	H
89322	Semen anal, strict criteria	0	H
89325	Sperm antibody test	0	H
89329	Sperm evaluation test	0	H
89330	Evaluation, cervical mucus	0	H
89331	Retrograde ejaculation anal	0	H
89335	Cryopreserve testicular tiss	0	H
89337	Cryopreservation oocyte(s)	0	H
89342	STORAGE/YEAR EMBRYO(S)	0	H
89343	STORAGE/YEAR SPERM/SEMEN	0	H
89344	STORAGE/YEAR REPROD TISSUE	0	H
89346	Storage/year; oocyte(s)	0	H
89350	Sputum specimen collection	0	H
89352	THAWING CRYOPRESRVED EMBRYO	0	H
89353	THAWING CRYOPRESRVED SPERM	0	H
89354	Thaw cryoprsvrd; reprod tiss	0	H
89355	Exam feces for starch	0	H
89356	THAWING CRYOPRESRVED OOCYTE	0	H
90651	Hpv vaccine non valent im	0	H
90785	PSYTX COMPLEX INTERACTIVE	3	H
90791	PSYCH DIAGNOSTIC EVALUATION	3	H
90792	PSYCH DIAG EVAL W/MED SRVCS	3	H
90801	Psy dx interview	3	H
90802	Intac psy dx interview	3	H
90804	Psytx, office, 20-30 min	3	H
90805	Psytx, off, 20-30 min w/e&m	3	H
90806	Psytx, off, 45-50 min	3	H
90807	Psytx, off, 45-50 min w/e&m	3	H
90808	Psytx, office, 75-80 min	3	H
90809	Psytx, off, 75-80, w/e&m	3	H
90810	Intac psytx, off, 20-30 min	3	H
90811	Intac psytx, 20-30, w/e&m	3	H
90812	Intac psytx, off, 45-50 min	3	H
90813	Intac psytx, 45-50 min w/e&m	3	H

90814	Intac psytx, off, 75-80 min	3	H
90815	Intac psytx, 75-80 w/e&m	3	H
90816	Psytx, hosp, 20-30 min	3	H
90817	Psytx, hosp, 20-30 min w/e&m	3	H
90818	Psytx, hosp, 45-50 min	3	H
90819	Psytx, hosp, 45-50 min w/e&m	3	H
90821	Psytx, hosp, 75-80 min	3	H
90822	Psytx, hosp, 75-80 min w/e&m	3	H
90823	Intac psytx, hosp, 20-30 min	3	H
90824	Intac psytx, hsp 20-30 w/e&m	3	H
90826	Intac psytx, hosp, 45-50 min	3	H
90827	Intac psytx, hsp 45-50 w/e&m	3	H
90828	Intac psytx, hosp, 75-80 min	3	H
90829	Intac psytx, hsp 75-80 w/e&m	3	H
90832	PSYTX PT&/FAMILY 30 MINUTES	3	H
90833	PSYTX PT&/FAM W/E&M 30 MIN	3	H
90834	PSYTX PT&/FAMILY 45 MINUTES	3	H
90836	PSYTX PT&/FAM W/E&M 45 MIN	3	H
90837	PSYTX PT&/FAMILY 60 MINUTES	3	H
90838	PSYTX PT&/FAM W/E&M 60 MIN	3	H
90839	PSYTX CRISIS INITIAL 60 MIN	3	H
90840	PSYTX CRISIS EA ADDL 30 MIN	3	H
90845	Psychoanalysis	3	H
90846	Family psytx w/o patient	3	H
90847	Family psytx w/patient	3	H
90849	Multiple family group psytx	3	H
90853	Group psychotherapy	3	H
90857	Intac group psytx	3	H
90862	Medication management	3	H
90863	PHARMACOLOGIC MGMT W/PSYTX	3	H
90865	Narcosynthesis	3	H
90870	Electroconvulsive therapy	3	H
90875	Psychophysiological therapy	3	H
90876	Psychophysiological therapy	3	H
90880	Hypnotherapy	3	H
90885	Psy evaluation of records	3	H
90887	Consultation with family	3	H
90899	Psychiatric service/therapy	3	H
90901	Biofeedback train, any meth	3	H
90911	Biofeedback peri/uro/rectal	3	H
96100	Psychological testing	3	H
96101	Psycho testing by psych/phys	3	H
96102	Psycho testing by technician	3	H
96103	Psycho testing admin by comp	3	H
96117	Neuropsych test battery	3	H

96118	Neuropsych tst by psych/phys	3	H
96119	Neuropsych testing by tec	3	H
96120	Neuropsych tst admin w/comp	3	H
96150	Assess hlth/behave, init	3	H
96151	Assess hlth/behave, subseq	3	H
96152	Intervene hlth/behave, indiv	3	H
96153	Intervene hlth/behave, group	3	H
96154	Interv hlth/behav, fam w/pt	3	H
97150	Group therapeutic procedures	3	H
99406	Behav chng smoking 3-10 min	1	H
99407	Behav chng smoking > 10 min	1	H
99408	Audit/dast, 15-30 min	1	H
99409	AUDIT/DAST OVER 30 MIN	1	H
99500	HOME VISIT PRENATAL	2	H
99501	HOME VISIT POSTNATAL	2	H
99502	HOME VISIT NB CARE	2	H
A0130	Noner transport wheelch van	3	H
A4260	Levonorgestrel implant	0	H
A4261	Cervical cap contraceptive	0	H
A4264	Intratubal occlusion device	0	H
A4266	Diaphragm	0	H
A4267	Male condom	0	H
A4268	Female condom	0	H
A4269	Spermicide	0	H
A4281	Replacement breastpump tube	2	H
A4282	Replacement breastpump adpt	2	H
A4283	Replacement breastpump cap	2	H
A4284	Replcmnt breast pump shield	2	H
A4285	Replcmnt breast pump bottle	2	H
A4286	Replcmnt breastpump lok ring	2	H
A4561	Pessary rubber, any type	0	H
A4562	Pessary, non rubber,any type	0	H
E0602	Manual breast pump	2	H
E0603	Electric breast pump	2	H
E0604	Hosp grade elec breast pump	2	H
G0027	Semen analysis	0	H
G0141	Scr c/v cyto,autosys and md	0	H
G0143	Scr c/v cyto,thinlayer,rescr	0	H
G0144	Scr c/v cyto,thinlayer,rescr	0	H
G0145	Scr c/v cyto,thinlayer,rescr	0	H
G0147	Scr c/v cyto, automated sys	0	H
G0148	Scr c/v cyto, autosys, rescr	0	H
G0298	Hiv combination assay	0	H
G0375	Smoke/tobacco counselng 3-10	1	H
G0376	Smoke/tobacco counseling >10	1	H

G0396	Alcohol/subs interv 15-30 min	1	H
G0397	Alcohol/subs interv > 30 min	1	H
G0409	CORF related serv 15 mins ea	3	H
G0410	Grp psych partial hosp 45-50	3	H
G0411	Inter active grp psych parti	3	H
G0430	DRUG SCREEN MULTI CLASS	1	H
G0431	DRUG SCREEN MULTIPLE CLASS	1	H
G0432	EIA HIV-1/HIV-2 screen	0	H
G0433	ELISA HIV-1/HIV-2 screen	0	H
G0434	DRUG SCREEN MULTI DRUG CLASS	1	H
G0435	Oral HIV-1/HIV-2 screen	0	H
G0436	TOBACCO-USE COUNSEL 3-10 MIN	1	H
G0437	TOBACCO-USE COUNSEL>10MIN	1	H
G0442	ANNUAL ALCOHOL SCREEN 15 MIN	1	H
G0443	BRIEF ALCOHOL MISUSE COUNSEL	1	H
G0444	DEPRESSION SCREEN ANNUAL	3	H
G0445	HIGH INTEN BEH COUNS STD 30M	3	H
G0459	Telehealth int pharm mgmt.	3	H
G0472	Hep c screen high risk/other	0	H
G0475	Hiv combination assay	0	H
G0476	Hpv combo assay ca screen	0	H
G0477	Drug test presump optical	1	H
G0478	Drug test presump opt inst	1	H
G0479	Drug test presump not opt	1	H
G0480	Drug test def 1-7 classes	1	H
G0481	Drug test def 8-14 classes	1	H
G0482	Drug test def 15-21 classes	1	H
G0483	Drug test def 22+ classes	1	H
G6030	Assay of amitriptyline	3	H
G6031	Assay of benzodiazepines	1	H
G6032	Assay of desipramine	3	H
G6034	Assay of doxepin	3	H
G6036	Assay of imipramine	3	H
G6037	Assay of nortiptyline	3	H
G6039	Assay of acetaminophen	1	H
G6040	Assay of ethanol	1	H
G6041	Assay of urine alkaloids	1	H
G6042	Assay of amphetamines	3	H
G6043	Assay of barbiturates	1	H
G6044	Assay of cocaine	1	H
G6045	Assay of dihydrocodeinone	1	H
G6046	Assay of dihydromorphinone	1	H
G6047	Assay of dihydrotestosterone	1	H
G6048	Assay of dimethadione	1	H
G6050	Assay of ethchlorvynol	1	H

G6051	Assay of flurazepam	3	H
G6052	Assay of meprobamate	3	H
G6053	Assay of methadone	1	H
G6055	Assay of nicotine	1	H
G6056	Assay of opiates	1	H
G6057	Assay of phenothiazine	3	H
G6058	Drug confirmation	1	H
H0001	Alcohol and/or drug assess	1	H
H0002	Alcohol and/or drug screenin	1	H
H0003	Alcohol and/or drug screenin	1	H
H0004	Alcohol and/or drug services	1	H
H0005	Alcohol and/or drug services	1	H
H0006	Alcohol and/or drug services	1	H
H0007	Alcohol and/or drug services	1	H
H0008	Alcohol and/or drug services	1	H
H0009	Alcohol and/or drug services	1	H
H0010	Alcohol and/or drug services	1	H
H0011	Alcohol and/or drug services	1	H
H0012	Alcohol and/or drug services	1	H
H0013	Alcohol and/or drug services	1	H
H0014	Alcohol and/or drug services	1	H
H0015	Alcohol and/or drug services	1	H
H0016	Alcohol and/or drug services	1	H
H0017	Alcohol and/or drug services	1	H
H0018	Alcohol and/or drug services	1	H
H0019	Alcohol and/or drug services	1	H
H0020	Alcohol and/or drug services	1	H
H0021	Alcohol and/or drug training	1	H
H0022	Alcohol and/or drug intervene	1	H
H0023	Alcohol and/or drug outreach	1	H
H0024	Alcohol and/or drug preventi	1	H
H0025	Alcohol and/or drug preventi	1	H
H0026	Alcohol and/or drug preventi	1	H
H0027	Alcohol and/or drug preventi	1	H
H0028	Alcohol and/or drug preventi	1	H
H0029	Alcohol and/or drug preventi	1	H
H0030	Alcohol and/or drug hotline	1	H
H0031	MH health assess by non-md	3	H
H0032	MH svc plan dev by non-md	3	H
H0033	Oral med adm direct observe	3	H
H0034	Med trng & support per 15min	3	H
H0035	MH partial hosp tx under 24h	3	H
H0036	Comm psy face-face per 15min	3	H
H0037	Comm psy sup tx pgm per diem	3	H
H0038	Self-help/peer svc per 15min	3	H

H0039	Asser com tx face-face/15min	3	H
H0040	Assert comm tx pgm per diem	3	H
H0041	Fos c chld non-ther per diem	3	H
H0042	Fos c chld non-ther per mon	3	H
H0043	Supported housing, per diem	3	H
H0044	Supported housing, per month	3	H
H0045	Respite not-in-home per diem	3	H
H0046	Mental health service, nos	3	H
H0047	Alcohol/drug abuse svc nos	1	H
H0048	Spec coll non-blood a/d test	1	H
H0049	Alcohol/drug screening	1	H
H0050	Alcohol/drug service 15 min	1	H
H1000	Prenatal care atrisk assessm	2	H
H1001	Antepartum management	2	H
H1002	Carecoordination prenatal	2	H
H1003	Prenatal at risk education	2	H
H1004	Follow up home visit/prental	2	H
H1005	Prenatalcare enhanced srv pk	2	H
H1010	Nonmed family planning ed	0	H
H1011	Family assessment	3	H
H2000	Comp multidisipln evaluation	0	H
H2001	Rehabilitation program 1/2 d	1	H
H2010	Comprehensive med svc 15 min	1	H
H2011	Crisis interven svc, 15 min	3	H
H2012	Behav hlth day treat, per hr	3	H
H2013	Psych hlth fac svc, per diem	3	H
H2014	Skills train and dev, 15 min	3	H
H2015	Comp comm. supp svc, 15 min	3	H
H2016	Comp comm. supp svc, per diem	3	H
H2017	Psysoc rehab svc, per 15 min	3	H
H2018	Psysoc rehab svc, per diem	3	H
H2019	Ther behav svc, per 15 min	3	H
H2020	Ther behav svc, per diem	3	H
H2021	Com wrap-around sv, 15 min	3	H
H2022	Com wrap-around sv, per diem	3	H
H2023	Supported employ, per 15 min	3	H
H2024	Supported employ, per diem	3	H
H2025	Supp maint employ, 15 min	3	H
H2026	Supp maint employ, per diem	3	H
H2027	Psychoed svc, per 15 min	3	H
H2028	Sex offend tx svc, 15 min	3	H
H2029	Sex offend tx svc, per diem	3	H
H2030	MH clubhouse svc, per 15 min	3	H
H2031	MH clubhouse svc, per diem	3	H
H2032	Activity therapy, per 15 min	3	H

H2033	Multisys ther/juvenile 15min	3	H
H2034	A/D halfway house, per diem	1	H
H2035	A/D tx program, per hour	1	H
H2036	A/D tx program, per diem	1	H
H2037	Dev delay prev dp ch, 15 min	3	H
J0400	ARIPIPRAZOLE INJECTION	3	H
J0401	Inj Aripiprazole Ext Rel 1mg	3	H
J0515	Inj benztropine mesylate	3	H
J0571	Buprenorphine oral 1mg	1	H
J0572	Buprenorphin/nalox up to 3mg	1	H
J0573	Buprenorph/nalox 3.1 to 6mg	1	H
J0574	Buprenorph/nalox 6.1 to 10mg	1	H
J0575	Buprenorph/nalox over 10mg	1	H
J0696	Ceftriaxone sodium injection	0	H
J1050	Medroxyprogesterone acetate	0	H
J1055	Medrxyprogester acetate inj	0	H
J1056	MA/EC contraceptiveinjection	0	H
J1324	ENFUVIRTIDE injection	0	H
J1630	Haloperidol injection	3	H
J1631	Haloperidol decanoate inj	3	H
J2060	Lorazepam injection	3	H
J2680	Fluphenazine decanoate 25 MG	3	H
J2794	Risperidone, long acting	3	H
J3485	ZIDOVUDINE	0	H
J3486	Ziprasidone mesylate	3	H
J7297	Levonorgestrel iu 52mg 3 yr	0	H
J7298	Levonorgestrel iu 52mg 5 yr	0	H
J7300	Intraut copper contraceptive	0	H
J7301	Skyla 13.5mg	0	H
J7302	Levonorgestrel iu contracept	0	H
J7303	Contraceptive vaginal ring	0	H
J7304	Contraceptive hormone patch	0	H
J7306	Levonorgestrel implant sys	0	H
J7307	Etonogestrel implant system	0	H
J7310	Ganciclovir long act implant	0	H
M0064	Visit for drug monitoring	3	H
Q0090	Skyla 13.5mg	0	H
Q5008	Hospice in inpatient psych	3	H
S0163	Injection risperidoneLA	3	H
S0166	Inj olanzapine 2.5mg	3	H
S0180	Etonogestrel implant system	0	H
S0190	Mifepristone, oral, 200 mg	0	H
S0191	Misoprostol, oral, 200 mcg	0	H
S0199	Med abortion inc all ex drug	0	H
S0610	Annual gynecological examina	0	H

S0612	Annual gynecological examina	0	H
S2255	Hysterosc oviduct occlus	0	H
S2260	Induced abortion 17-24 weeks	0	H
S2262	Abortion maternal indic>=25w	0	H
S2265	Induced abortion 25-28 wks	0	H
S2266	Induced abortion 29-31 wks	0	H
S2267	Abortion >=32wks fetal indic	0	H
S2400	Fetal surg congen hernia	2	H
S2401	Fetal surg urin trac obstr	2	H
S2402	Fetal surg cong cyst malf	2	H
S2403	Fetal surg pulmon sequest	2	H
S2404	Fetal surg myelomeningo	2	H
S2405	Fetal surg sacrococ teratoma	2	H
S2409	Fetal surg noc	2	H
S4011	IVF package	0	H
S4013	Compl GIFT case rate	0	H
S4014	Compl ZIFT case rate	0	H
S4015	Complete IVF nos case rate	0	H
S4016	Frozen IVF case rate	0	H
S4017	IVF canc a stim case rate	0	H
S4018	F EMB trns canc case rate	0	H
S4020	IVF canc a aspir case rate	0	H
S4021	IVF canc p aspir case rate	0	H
S4022	Asst oocyte fert case rate	0	H
S4023	Incompl donor egg case rate	0	H
S4025	Donor serv IVF case rate	0	H
S4026	Procure donor sperm	0	H
S4027	Store prev froz embryos	0	H
S4028	Microsurg epi sperm asp	0	H
S4030	Sperm procure init visit	0	H
S4031	Sperm procure subs visit	0	H
S4035	Stimulated IUI case rate	0	H
S4036	Intravag cult case rate	0	H
S4037	Cryo embryo transf case rate	0	H
S4040	Monit store cryo embryo 30 d	0	H
S4042	Ovulation essi per cycle	0	H
S4980	Levonorgestrel ius	0	H
S4981	Insert levonorgestrel ius	0	H
S4989	Contracept IUD	0	H
S4993	Contraceptive pills for bc	0	H
S9442	Birthing class	2	H
S9484	Crisis intervention per hour	0	H
S9485	Crisis intervention mental h	3	H
T1011	Alcohol/Substance Abuse NOC	1	H
T1012	Alcohol/Substance Abuse Skil	1	H

T2034	Crisis interven waiver/diem	3	H
T2101	Breast milk proc/store/dist	2	H

8.2 Pharmacy Data Exclusion

EOB EXCLUSION CRITERIA for Pharmacy claims (CHAMPS Clm_Type_CID = 24)

1. Family Planning (Contraceptives): (All ages)
   msauserview.GCNSEQNO.THER_CLASS_CODE_GENERIC = '47' (Contraceptives)

2. Antivirals that may possibly be used in treatment of STDs:(All ages)
   msauserview.GCNSEQNO.HIC3_SPECIFIC_THER_CODE= 'W5A, W5D, W5H, W5S, Q6V, Q5V'

3. Antivirals for HIV: (All ages)
   msauserview.GCNSEQNO.HIC3_SPECIFIC_THER_CODE= 'W5B, W5C, W5I, W5J, W5K, W5L, W5M, W5N, W5O, W5P, W5Q, W5T, W5U, W5X'

4. Psychotropic drug products (beneficiaries 18 years of age or older):
   msauserview.GCNSEQNO.HIC3_SPECIFIC_THER_CODE= 'H2A, H2D, H2E, H2F, H2G, H2H, H2I, H2J, H2K, H2L, H2M, H2N, H2O, H2P, H2Q, H2S, H2U, H2V, H2W, H2X, H2Y, H4B, H4C, H6B, H7A, H7B, H7C, H7D, H7E, H7J, H7K, H7L, H7M, H7O, H7P, H7Q, H7R, H7S, H7T, H7U, H7V, H7X, H7Y, H7Z, H8B, J5B'

5. Substance Abuse treatment drug products (all ages):
   msauserview.GCNSEQNO.HIC_INGRED_CODE_SEQ_NUM = '529, 1745, 1762, 1875, 10731, 24846'

Please note: New pharmaceutical products are continually being developed. As new products are approved by the FDA, additional drug classes may be added, so the coding for antivirals (STD and HIV treatments) and Psychotroics and Substance Abuse should be reviewed annually to be certain new classes are also excluded in EOBs.

Further note: These rules are contained as conditionals in the query and not contained in the EOB Suppress table.

8.3 Diagnosis Codes to Suppress

Following is a matrix of the Diagnosis codes identified as Sensitive and should not be included on the Explanation of Benefits statement. These codes reside on a table under CRCHAMPSTABLES.T_BV250_DXSuppress and need to be reviewed periodically by policy staff for any changes or updates.

Dx From	Dx To	Description	Age Factor Flag	ICD Flag
		Sensitive Dx codes Under 18		
V22	V24.2	PREGNANCY/DELIVERY	2	9
V270	V39.99	PREGNANCY/DELIVERY	2	9
760	779.99	COMPLICATIONS OF THE PERINATAL PERIOD	2	9
640	677	PREGNANCY COMPLICATIONS/DELIVERY	2	9
678	679.14	MATERNAL AND FETAL COMPLICATIONS	2	9
V72.3	V72.49	GYN EXAMS	2	9
O09.00	O09.93	SUPERVISION OF HIGH RISK PREGNANCY	2	10
O10.011	O29.93	PREGNANCY COMPLICATIONS/MATERNAL DISORDERS PREDOMINANTLY RELATED TO PREGNANCY	2	10
O30.001	O3103X9	MATERNAL CARE RELATED TO FETUS/AMNIOTIC CAVITY AND POSSIBLE DELIVERY PROBLEMS	2	10
O318X10	O3493	OTHER COMPLICATIONS SPECIFIC TO MULTIPLE GESTATION, MATERNAL CARE FOR MALPRESENTATION OF FETUS DISPROPORTION OF REPRODUCTIVE ORGANS	2	10
O360110	O3623X9	MATERNAL CARE FOR ISOIMMUNIZATIONS	2	10
O365110	048.1	MATERNAL CARE FOR FETAL PROBLEMS, POLYHYDRAMNIOS, INFECTIONS,AS WELL AS FALSE AND LATE PREGNANCIES	2	10
O60.00	O77.9	COMPLICATIONS OF LABOR/DELIVERY	2	10
O80	O82	ENCOUNTER FOR DELIVERY	2	10
O85	O92.79	PUERPERIUM COMPLICATIONS	2	10
O94	O94	OTHER OBSTETRIC CONDITIONS NEC	2	10
O98411	O9863	MATERNAL VIRAL AND PROTOZOAL DISEASES	2	10
O98811	O99285	OTHER MATERNAL INFECTIOUS AND PARASITIC DISEASES COMPLICATING PREGNANCY, AND/OR CHILDBIRTH AND THE PUERPERIUM	2	10
O99350	O9A.53	DISEASES OF THE BODY SYSTEMS AND OTHER DISEAES AND CONDITIONSS COMPLICATING PREGNANCY,AND/OR CHILD BIRTH AND THE PUERPERIUM	2	10
P00.0	P01.5	CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD	2	10
P01.7	P04.0	NEWBORN (SUSPECTED TO BE) AFFECTED BY COMPLICATIONS OF MATERNAL, PLACENTA, CORD, MEMBRANES, LABOR AND DELIVERY	2	10
P05.00	P35.1	NEWBORN DISORDERS, ABNORMALFINDINGS, DISEASES AND INFECTIONS	2	10

P35.3	P36.9	PERINATAL CONGENTIAL VIRAL DISEASES AND BACTERIAL SEPSIS	2	10
P37.1	P92.9	PERINATAL OTHER CONGENITAL INFECTIOUS AND PARASITIC DISEASES, AND DISORDERS	2	10
P94.0	P94.9	DISORDERS OF MUCLE TONE IN NEWBORN	2	10
P96.0	P96.0	CONGENITAL RENAL FAILURE ORIGINATING IN THE PERINATAL PERIOD	2	10
P96.3	P96.9	OTHER CONDITIONS ORIGINATING IN THE PERINATAL PERIOD	2	10
T8030XA	T8049XS	INCOMPATIBILITY OF ABO AND RH	2	10
T80A0XA	T80A9XS	INCOMPATIBILITY OF ABO AND RH	2	10
Z01.411	Z01.42	GYN EXAM	2	10
Z32.00	Z33.1	PREGNANCY	2	10
Z34.00	Z37.0	ENCOUNTER FOR SUPERVISION OF PREGNANCY AND OUTCOME OF DELIVERY	2	10
Z37.2	Z37.2	OUTCOME OF DELIVERY TWINS, BOTH LIVEBORN	2	10
Z37.50	Z3759	OTHER MULTIPLE BIRTHS, ALL LIVEBORN	2	10
Z37.9	Z37.9	OUTCOME OF DELIVERY, UNSPECIFIED	2	10
Z38.00	Z38.8	LIVEBORN INFANT, UNSPECIFIED AS TO PLACE OF BIRTH	2	10
Z39.0	Z39.2	ENCOUNTER FOR MATERNAL POSTPARTUM CARE AND EXAMINATION	2	10
Z3A00	Z3A.49	WEEKS OF GESTATION, AND OTHER LIVEBORN INFANT, UNSPECIFIED AS TO PLACE OF BIRTH	2	10
Z87.51	Z87.59	PERSONAL HX OF PREGNANCY/DELIVERY/POSTPARTUM COMPLICATIONS	2	10
		Sensitive Dx codes Over 13		
290	319.99	MENTAL DISORDERS	1	9
V40	V40.99	MENTAL/BEHAVIORAL PROB	1	9
V61	V63.99	COUNSELING	1	9
V65.42	V65.42	Counslng sbstn use abuse	1	9
V66.30	V66.30	PALLATIVE CARE FOLLOWING PSYCHOTHERAPY	1	9
V70.1	V70.79	UNSPECIFIED MENTAL CONDITIONS	1	9
V79	V79.99	SCREENING-MENTAL DISORDERS	1	9
F01.50	F99	MENTAL, BEHAVIORAL, AND NEURODEVELOPMENTAL DISORDERS	1	10
R41.0	R41.9	SYMPTOMS/SIGNS INVOLVING COGNITIVE	1	10

		FUNCTIONS/AWARENESS		
R45.0	R45.89	SYMPTOMS/SIGNS INVOLVING EMOTIONAL STATE	1	10
R78.0	R78.6	FINDINGS OF DRUGS IN BLOOD	1	10
Z02.0	Z02.9	ADMINISTRATIVE EXAMS	1	10
Z04.6	Z04.6	GENERAL PSYCHIATRIC EXAMINATION	1	10
Z55.0	Z56.9	PROBLEMS RELATED TO EDUCATION/EMPLOYMENT	1	10
Z59.0	Z65.9	PROBLEMS RELATED TO SOCIOECONOMIC/PSYCHOSOCIAL CIRCUMSTANCES	1	10
Z69.010	Z71.6	ENCOUNTER FOR MENTAL HEALTH SERVICES/COUNSELING	1	10
Z73.0	Z73.9	PROBLEMS RELATED TO LIFE MANAGEMENT DIFFICULTY	1	10
Z74.01	Z74.9	PROBLEMS RELATED TO CARE PROVIDER DEPENDENCY	1	10
Z75.0	Z75.9	PROBLEMS RELATED TO MED FACILITIES/OTHER HEALTHCARE	1	10
Z81.0	Z81.8	FAMILY HX OF MENTAL/BEHAVIORAL DISORDERS	1	10
Z86.51	Z86.59	PERSONAL HX OF MENTAL/BEHAVIORAL DISORDERS	1	10
Z91.83	Z91.83	WANDERING IN DISEASES CLASSIFIED ELSEWHERE	1	10
		Sensitive Dx codes All ages		
131	139.99	TRICHOMONIASIS/PARASITES	0	9
357.5	357.99	ALCOHOLIC POLYNEUROPATHY	0	9
425.5	425.59	ALCOHOLIC CARDIOMYOPATHY	0	9
535.3	535.39	ALCOHOLIC GASTRITIS	0	9
630	639.99	ABORTION AND ECTOPIC PREGNANCY	0	9
797	799.99	ILL-DEFINDED CAUSES OF MORBIDITY/MORTALITY/COMPLICATIONS	0	9
909	909.99	LATE EFFECTS OF EXTERNAL CAUSES	0	9
960	999.9	POISONING/TOXIC EFFECTS	0	9
010	018.99	TB	0	9
042	042.99	HIV	0	9
054	054.99	HERPES SIMPLEX	0	9
090	099.99	SYPHILIS AND OTHER VENEREAL DISEASES	0	9
606.0	606.9	MALE INFERTILITY	0	9
628.0	628.99	INFERTILITY-FEMALE	0	9
648.30	648.49	DRUG DEPENDENCE	0	9
651.30	651.69	FETAL DEATH	0	9
655.30	655.99	DAMAGE TO FETUS	0	9
656.40	656.49	FETAL DEATH	0	9
760.70	7619	COMPLICATIONS OF THE PERINATAL PERIOD	0	9
779.4	779.6	COMPLICATIONS OF THE PERINATAL PERIOD	0	9
780.10	780.19	SYMPTOMS CONVULSIONS, HALLUCINATIONS	0	9
79.4	79.499	HPV	0	9
79.50	79.52	HTLV	0	9
79.53	79.539	HIV	0	9

795.00	795.19	ABNORMAL PAP	0	9
795.6	795.6	FALSE POSITIVE FOR SYPHILIS	0	9
795.71	795.71	HIV	0	9
796.70	796.79	HPV	0	9
E950	E959.9	SUICIDE AND SELF-INFLICTED INJURY	0	9
E960.1	E960.1	RAPE	0	9
E980	E989	INJURY UNDERTERMINED CIRCUMNSTANCES	0	9
V01.1	V01.1	TUBERCULOSIS CONTACT	0	9
V01.6	V01.6	VENEREAL DIS CONTACT	0	9
V01.79	V01.79	VIRAL DIS CONTACT NEC	0	9
V02.60	V02.8	CARRIER OR SUSPECTED CARRIER OF INFECTIOUS DISEASES	0	9
V03.2	V03.2	VACCIN FOR TUBERCULOSIS	0	9
V08	V08.9	HIV	0	9
V11.3	V11.39	ALCOHOLISM	0	9
V25.0	V26.99	FAMILY PLANNING	0	9
V27.1	V27.1	STILLBORN	0	9
V27.3	V27.4	STILLBORN	0	9
V27.6	V27.7	STILLBORN	0	9
V32.00	V32.2	STILLBORN	0	9
V35.00	V36.2	STILLBORN	0	9
V65.44	V65.45	HIV/STD COUNSELING	0	9
V66.70	V66.79	PALLATIVE CARE	0	9
V69.2	V69.39	PROBLEMS RELATED TO LIFESTYLES	0	9
V71.01	V71.99	OBSERVATION	0	9
V73.80	V73.99	SCREENING HPV	0	9
V74.50	V74.59	VENEREAL DISEASE	0	9
A15.0	A19.9	TB	0	10
A50.01	A64	INFECTIONS WITH A PREDOMINANTLY SEXUAL MODE OF TRANSMISSION	0	10
B00.0	B00.9	HERPESVIRAL (HERPES SIMPLEX) INFECTIONS	0	10
B20	B20	HIV	0	10
B33.3	B33.3	RETROVIRUS	0	10
B90.0	B90.9	SEQUEALAE OF TB	0	10
B97.30	B97.39	RETROVIRUS	0	10
B97.7	B97.7	HPV AS CAUSE OF DISEASES CLASSIFIED ELSEWHERE	0	10
G62.1	G62.1	ALCOHOLIC POLYNEUROPATHY	0	10
I42.6	I42.6	ALCOHOLIC CARDIOMYOPATHY	0	10
J65	J65	PNEUMOCONIOSIS ASSOCIATED WITH TB	0	10
K29.20	K29.21	ALCOHOLIC GASTRITIS	0	10
N46.01	N46.9	MALE INFERTILITY	0	10
N97.0	N97.9	FEMALE INFERTILITY	0	10

O00.0	O08.9	PREGNANCY WITH ABORTIVE OUTCOME	0	10
O31.10X0	O31.33X9	CONTINUING PREGNANCY AFTER SPONTANEOUS ABORTION/INTRAUTERINE DEATH/ELECTIVE REDUCTION	0	10
O35.0XX0	O35.9XX9	MATERNAL CARE FOR KNOWN/SUSPECTED FETAL ABNORMALITY/DAMAGE	0	10
O36.4XX0	O36.4XX9	MATERNAL CARE FOR INTTRAUTERINE DEATH	0	10
O98.011	O98.03	TB COMPLICATING PREGNANCY	0	10
O98.111	O98.33	INFECTIONS WITH A PREDOMINANTLY SEXUAL MODE OF TRANSMISSION COMPLICATING PREGNANCY	0	10
O98.711	O98.73	HIV COMPLICATING PREGNANCY	0	10
O99.310	O99.345	SUBSTANCE USE AND MENTAL DISORDERS COMPLICATING PREGNANCY	0	10
P01.6	P01.6	NEWBORN AFFECTED BY MATERNAL CONDITIONS AND COMPLICATIONS OF PREGNANCY	0	10
P04.1	P04.9	NEWBORN AFFECTED BY NOXIOUS SUBSTANCE	0	10
P35.2	P35.2	CONGENITAL HERPESVIRAL (HERPES SIMPLEX) INFECTION	0	10
P37.0	P37.0	CONGENITAL TB	0	10
P93.0	P93.8	REACTIONS AND INTOXICATION DUE TO DRUGS ADMINSTERED TO NEWBORN	0	10
P95	P95	STILLBIRTH	0	10
P96.1	P96.2	WITHDRAWAL SYMPTOMS FROM MATERNAL USE OF DRUGS AND THRAPEUTIC USE OF DRUGS IN NEWBORN	0	10
Q86.0	Q86.8	CONGENITAL MALFORMATION SYNDROMES OF EXOGENOUS CAUSES	0	10
R09.01	R09.2	SYMPTOMS/SIGNS OF RESPIRATORY SYSTEM	0	10
R44.0	R44.3	HALLUCINATIONS	0	10
R64	R64	CACHEXIA	0	10
R68.0	R68.0	HYPOTHERMIA	0	10
R68.13	R68.13	APPARENT LIFE THREATENING EVENT IN INFANT	0	10
R68.82	R68.82	DECREASED LIBIDO	0	10
R75	R75	INCONCLUSIVE LAB EVIDENCE OF HIV	0	10
R85.81	R85.82	ANAL HPV DNA TEST POSITIVE	0	10
R87.810	R87.821	HPV DNA TEST POSITIVE FROM FEMALE GENITAL ORGANS	0	10
R99	R99	ILL-DEFINED/UNKNOWN CAUSE OF MORTALITY	0	10
T360X2A	T7692XS	POISONING/ADVERSE EFFECT/UNDERDOSING OF DRUGS/MEDICAMENTS/BIOLOGICAL SUBSTANCES	0	10
X71.0XXA	X83.8XXS	INTENTIONAL SELF-HARM	0	10
Z00.5	Z00.6	GENERAL EXAMS OTHER THAN ROUTINE	1	10
Z03.6	Z04.3	OBSERVATION/SUSPECTED CONDITIONS NOT FOUND	0	10
Z04.41	Z04.42	EXAM FOLLOWING ALLEGED RAPE	0	10
Z04.71	Z04.72	EXAM FOLLOWING ALLEGED PHYSICAL ABUSE	0	10
Z11.1	Z11.1	ENCOUNTER SCREENING FOR RESPIRATORY TUBERCULOSIS	0	10

Z11.3	Z11.3	ENCOUNTER FOR SCREENING OF INFECTIONS WITH A PREDOMINANTLY SEXUAL MODE OF TRANSMISSION	0	10
Z11.4	Z11.4	ENCOUNTER FOR SCREENING FOR HIV	0	10
Z11.51	Z11.51	ENCOUNTER FOR SCREENING HPV	0	10
Z13.4	Z13.4	SCREENING FOR DEVELOPMENTAL DISORDERS	0	10
Z14.01	Z15.89	GENETIC CARRIER/SUSCEPTIBILITY	0	10
Z20.1	Z20.1	CONTACT/SUSPECTED EXPOSURE TO TUBERCULOSIS	0	10
Z20.2	Z20.2	EXPOSURE TO INFECTIONS WITH A PREDOMINANTLY SEXUAL MODE OF TRANSMISSION	0	10
Z20.5	Z20.5	CONTACT/SUSPECTED EXPOSURE TO VIRAL HEPATITIS	0	10
Z20.6	Z20.6	CONTACT/SUSPECTED EXPOSURE TO HIV	0	10
Z20.828	Z20.828	CONTACT/SUSPECTED EXPOSURE TO OTHER VIRAL COMMUNICABLE DISEASES	0	10
Z21	Z21	ASYMPTOMATIC HIV	0	10
Z22.4	Z22.4	CARRIER OF INFECTIONS WITH A PREDOMINANTLY SEXUAL MODE OF TRANSMISSION	0	10
Z22.50	Z22.59	CARRIER OF VIRAL HEPATITIS	0	10
Z30.011	Z31.9	ENCOUNTER FOR PROCREATIVE MANAGEMENT	0	10
Z33.2	Z33.2	ELECTIVE TERMINATION OF PREGNANCY	0	10
Z37.1	Z37.1	SINGLE STILLBIRTH	0	10
Z37.3	Z37.4	TWINS, ONE LIVEBORN AND ONE STILLBORN	0	10
Z37.60	Z37.7	OTHER MULTIPLE BIRTHS, SOME LIVEBORN AND STILLBORN	0	10
Z51.5	Z51.5	PALLIATIVE CARE	0	10
Z71.7	Z71.7	HUMAN IMMUNODEFICIENCY VIRUS COUNSELING	0	10
Z72.51	Z72.811	PROBLEMS RELATED TO LIFESTYLE	0	10
Z79.01	Z79.899	LONG TERM (CURRENT) DRUG THERAPY	0	10
Z83.0	Z83.0	FAMILY HX OF HIV	0	10
Z86.11	Z86.11	PERSONAL HX OF TB	0	10
Z87.710	Z87.79	PERSONAL HX OF (CORRECTED) CONGENITAL MALFORMATION	0	10
Z98.51	Z98.52	STERILIZATION STATUS	0	10

8.4 DRG Codes to Suppress

Following is a list of DRG codes that are to be suppressed for all Beneficiaries from printing on the Explanation of Benefits Statement. Currently the DRG Codes are checked via a conditional in the query, and if the claim meets the criteria, it is deleted from being reported on the EOB Report.

DRG	Description	When to Suppress
744, 745	Tubal Ligation	All Ages
769, 770, 779	Abortions	All Ages
765 – 770	Pregnancy Related	Under 18
774 – 782	Pregnancy Related	Under 18
789, 789.1	Pregnancy Related	Under 18
876	Mental Health	Over 17
880 – 887	Mental Health	Over 17
894 – 897	Substance Abuse	Over 13
969, 970	HIV Related	All Ages
974 – 977	HIV Related	All Ages

8.5 Surgical Procedure Codes to Suppress

Following is a list of Surgical Procedure codes that are to be suppressed for all Beneficiaries from printing on the Explanation of Benefits Statement. Currently the codes are checked against the CRCHAMPSTABLES.T_BV250_SPSuppress table, and if the claim Surgical Procedure code falls into the range on the table, it is deleted from being reported on the EOB Report. The CRCHAMPSTABLES.T_BV250_SPSuppress table will need to be reviewed periodically by policy staff for any changes or updates.

8.5.1 Surgical Procedure Codes to Suppress*:*

SP CODE MIN	SP CODE MAX	SP_DESCRIPTION	AGE FACTOR	ICD 9/10
		Sensitive SP codes All ages		
6370	6370	Male Sterilization NOS	0	9
6371	6371	Ligation of Vas Diferens	0	9
6372	6372	Spermatic cord ligation	0	9
6373	6373	Vasectomy	0	9
6381	6381	Suture Vas & Epidid Lac	0	9
6382	6382	Postop vas reconstruct	0	9
6383	6383	Epididymovasostomy	0	9
6389	6389	Vas & Epididy Repair NEC	0	9
6392	6392	Epididymotomy	0	9
6399	6399	Cord/Epid/Vas/OPS NEC	0	9
6411	6411	Penile Biopsy	0	9
6531	6564	OOPHORECTOMY	0	9
6572	6572	Oth Reimplant of Ovary	0	9
6575	6575	Lap Reimplant of Ovary	0	9
6611	6611	Fallopian Tube Biopsy	0	9
6621	6621	Bilat Endosc Crush Tube	0	9
6622	6622	Bilat Endosc Divis Tube	0	9
6629	6629	Bilat Endos Occ Tube NEC	0	9
6631	6631	Bilat Tubal Crushing NEC	0	9
6632	6632	Bilat Tubal Division NEC	0	9
6639	6639	Bilat Tubal Desctruct NEC	0	9
664	664	TOTAL UNILATERAL SALPINGECTOMY	0	9
6651	6651	Removal both Fallopian tubes	0	9
6652	6652	Removal remaining Fallopian tube	0	9
6662	6662	Remov tube & ectop preg	0	9
6692	6694	OPERATION ON FALLOPIAN TUBE	0	9
6711	6711	Endocervical Biopsy	0	9
6712	6712	Cervical Biopsy NEC	0	9
0695	0697	Aspiration of uterus	0	9

6831	689	HYSTERECTOMY	0	9
6901	6902	D&C RELATED TO ABORTION OR DELIVERY	0	9
6951	6952	ASPIRATION CURETTAGE RELATED TO ABORTION	0	9
697	697	Insertion of iud	0	9
6992	6992	Artifical insemination	0	9
6993	6993	INSERTION OF LAMINARIA	0	9
6991	6991	Insert Uterine Device	0	9
7491	7491	HYSTEROTOMY TO TERMINATE PREGNANCY	0	9
750	750	INTRA-AMNIOTIC INJECTION FOR ABORTION	0	9
9617	9617	Vag Diaphragm Insertion	0	9
9649	9649	OTHER GENITOURINARY INSTILLATION	0	9
9724	9724	Replace Vag Diaphragm	0	9
9771	9771	Removal iud	0	9
9773	9773	Remov Vaginal Diaphragm	0	9
9996	9996	Sperm Collection	0	9
0JH60HZ	0JH60HZ	INSERTION CNTRACPT DEV CHEST SUBQ TISS & FASC OP	0	10
0JH63HZ	0JH63HZ	INSERT CNTRACPT DEV CHEST SUBQ TISS & FASC PERQ	0	10
0JH80HZ	0JH80HZ	INSERT CNTRACPT DEVC ABDOMEN SUBQ TISS & FASC OP	0	10
0JH83HZ	0JH83HZ	INSERT CNTRACPT DEV ABDOMEN SUBQ TISS FASC PERQ	0	10
0JHD0HZ	0JHD0HZ	INSERT CONTRACPT DEV RT UP ARM SQ TISS FASC OPN	0	10
0JHD3HZ	0JHD3HZ	INSERT CONTRACPT DEV RT UP ARM SQ TISS FASC PERQ	0	10
0JHF0HZ	0JHF0HZ	INSERT CNTRACPT DEV LT UP ARM SUBQ TISS FASC OPN	0	10
0JHF3HZ	0JHF3HZ	INSERT CNTRACPT DEVC LT UP ARM SQ TISS FASC PERQ	0	10
0JHG0HZ	0JHG0HZ	INSERT CNTRACPT DEV RT LOW ARM SUBQ TISS FASC OP	0	10
0JHG3HZ	0JHG3HZ	INSERTION CNTRACPT DEV RT LOW ARM SUBQ TISS PERQ	0	10
0JHH0HZ	0JHH0HZ	INSERT CNTRACPT DEVC LT LW ARM SUBQ TISS FASC OP	0	10
0JHH3HZ	0JHH3HZ	INSERTION CNTRACPT DEV LT LOW ARM SUBQ TISS PERQ	0	10
0JHL0HZ	0JHL0HZ	INSERT CNTRACPT DEV RT UP LEG SUBQ TISS FASC OPN	0	10
0JHL3HZ	0JHL3HZ	INSERT CNTRACPT DEVC RT UP LEG SQ TISS FASC PERQ	0	10
0JHM0HZ	0JHM0HZ	INSERT CNTRACPT DEV LT UP LEG SUBQ TISS FASC OPN	0	10
0JHM3HZ	0JHM3HZ	INSERT CNTRACPT DEVC LT UP LEG SQ TISS FASC PERQ	0	10

0JHN0HZ	0JHN0HZ	INSERTION CONTRACPT DEV RL LEG SQ TISS & FASC OP	0	10
0JHN3HZ	0JHN3HZ	INSERTION CONTRACPT DEV RL LEG SQ TISS & FASC PERQ	0	10
0JHP0HZ	0JHP0HZ	INSERT CNTRACPT DEV LT LW LEG SUBQ TISS FASC OP	0	10
0JHP3HZ	0JHP3HZ	INSERTION CNTRACPT DEV LL LEG SQ TISS FASC PERQ	0	10
0U2DXHZ	0U2DXHZ	CHANGE/CONTRACEPTIVE DEVICE/UTERUS/CERVIX	0	10
0U550ZZ	0U568ZZ	DESTRUCTION/UNILATERAL FALLOPIAN TUBE	0	10
0U570ZZ	0U578ZZ	DESTRUCTION/BILATERAL FALLOPIAN TUBES	0	10
0U9500Z	0U978ZZ	DRAINAGE/FALLOPIAN TUBE	0	10
0U9C00Z	0U9C8ZZ	DRAINAGE/CERVIX	0	10
0UB50ZX	0UB78ZZ	EXCISION/FALLOPIAN TUBE	0	10
0UB90ZX	0UB98ZZ	EXCISION UTERUS	0	10
0UBC0ZX	0UBC8ZZ	EXCISION/CERVIX	0	10
0UDB7ZX	0UDB8ZZ	EXCTRACTION/ENDOMETRIUM	0	10
0UH97HZ	0UH98HZ	INSERTION/CONTRACEPTIVE DEVICE/UTERUS	0	10
0UHC7HZ	0UHC8HZ	INSERTION/CONTRACEPTIVE DEVICE/CERVIX	0	10
0UHD03Z	0UHD83Z	INSERTION/INFUSION DEVICE/UTERUS/CERVIX	0	10
0UL50CZ	0UL68ZZ	OCCLUSION/UNILATERAL FALLOPIAN TUBE	0	10
0UL70CZ	0UL78ZZ	OCCLUSION/BILATERAL FALLOPIAN TUBES	0	10
0UM00ZZ	0UM24ZZ	REATTACHMENT/OVARY	0	10
0UPD7HZ	0UPD8HZ	REMOVAL/CONTRACEPTIVE DEVICE/UTERUS/CERVIX	0	10
0UQ20ZZ	0UQ78ZZ	REPAIR FEMALE REPRODUCTIVE SYSTEM	0	10
0US00ZZ	0US24ZZ	REPOSITION/OVARY	0	10
0UT50ZZ	0UT6FZZ	RESECTION/UNILATERAL FALLOPIAN TUBE	0	10
0UT70ZZ	0UT7FZZ	RESECTION/BILATERAL FALLOPIAN TUBES	0	10
0UT90ZZ	0UT9FZZ	RESECTION UTERUS	0	10
0V1N07J	0V1Q4ZP	BYPASS/VAS DEFERENS	0	10
0V510ZZ	0V534ZZ	DESTRUCTION/SEMINAL VESICLE	0	10
0V5F0ZZ	0V5H4ZZ	DESTRUCTION/SPERMATIC CORD	0	10
0V5N0ZZ	0V5Q4ZZ	DESTRUCTION/VAS DEFERENS	0	10
0V9100Z	0V9Q4ZZ	DRAINAGE/VESICLE/CORD/EPID/VAS DEFERENS	0	10
0V9S00Z	0V9TXZZ	DRAINAGE/PENIS/PREPUCE	0	10
0VB10ZX	0VB34ZZ	EXCISION/SEMINAL VESICLE	0	10
0VBC0ZX	0VBC4ZZ	EXCISION OF BILATERAL TESTES	0	10
0VBF0ZX	0VBH4ZZ	EXCISION/SPERMATIC CORD	0	10
0VBL0ZX	0VBL4ZZ	EXCISION OF BILATERAL EPIDIDYMIS	0	10
0VBN0ZX	0VBQ4ZZ	EXCISION/VAS DEFERENS	0	10
0VBS0ZX	0VBTXZZ	EXCISION/PENIS/PREPUCE	0	10
0VC10ZZ	0VCQ4ZZ	EXTIRPATION/VESICLE/CORD/EPID/VAS DEFERENS	0	10

0VLF0CZ	0VLQ4ZZ	OCCLUSION SPERMATIC CORD/VAS DEFERENS	0	10
0VN10ZZ	0VNQ4ZZ	RELEASE/VESICLE/CORD/EPID/VAS DEFERENS	0	10
0VP400Z	0VPRXDZ	DEVICE REMOVAL/SEMINAL VESICLE/SPERMATIC CORD/VAS DEFERENS	0	10
0VQ10ZZ	0VQ34ZZ	REPAIR/SEMINAL VESICLE	0	10
0VQF0ZZ	0VQH4ZZ	REPAIR/SPERMATIC CORD	0	10
0VQJ0ZZ	0VQL4ZZ	REPAIR OF EPIDIDYMIS	0	10
0VQN0ZZ	0VQQ4ZZ	REPAIR/VAS DEFERENS	0	10
0VT10ZZ	0VT34ZZ	RESECTION/SEMINAL VESICLE	0	10
0VTF0ZZ	0VTH4ZZ	RESECTION/SPERMATIC CORD	0	10
0VTN0ZZ	0VTQ4ZZ	RESECTION/VAS DEFERENS	0	10
0VU107Z	0VUQ4KZ	SUPPLEMENT/VESICLE/CORD/EPID/VAS DEFERENS	0	10
0VW400Z	0VWRXKZ	REVISION/VESICLE/CORD/EPID/VAS DEFERENS	0	10
10A00ZZ	10A08ZZ	ABORTION	0	10
10D17ZZ	10D28ZZ	EXCTRACTION/RETAINED PRODUCTS OF CONCEPTION	0	10
10J20ZZ	10J2XZZ	INSPECTION ECTOPIC PRODUCTS OF CONCEPTION	0	10
10S20ZZ	10T28ZZ	REPO/RESECTION ECTOPIC PRODUCTS OF CONCEPTION	0	10
3E0P7LZ	3E0P7LZ	INTRO SPERM FEMALE REPROD VIA NAT/ART OPENING	0	10
8E0VX63	8E0VX63	SPERM COLLECTION	0	10
		Sensitive SP codes for ages over 13 (SA/DMH)		
9402	9402	Psychologic Test Admins	1	9
9408	9408	Psych Eval & Test NEC	1	9
9409	9409	Psychol Mental Stat NOS	1	9
9411	9411	Psychiat Mental Determin	1	9
9412	9412	Routine Psychiat Visit	1	9
9413	9413	Psychia Commitment Eval	1	9
9419	9419	Psychia Interv/Eval NEC	1	9
9425	9425	Psychiat Drug Therap NEC	1	9
9429	9429	Psychiatr Somatother NEC	1	9
9431	9431	Psychoanalysis	1	9
9434	9434	Ind Therap Psychsex Dysf	1	9
9436	9436	Play Psychotherapy	1	9
9437	9437	Explor Verbal Psychother	1	9
9438	9438	Suppor Verbal Psychother	1	9
9439	9439	Individ Psychotherap NEC	1	9
9441	9441	GRP THERAP PSYCHSEX SYSF	1	9
9443	9443	Psychodrama	1	9
9445	9445	Drug Addict Counselling	1	9
9446	9446	Alcholism Counselling	1	9
9449	9449	Other Counselling	1	9

9451	9451	Referral for Psychother	1	9
9452	9452	Referral Psych Aftercare	1	9
9453	9453	Referral alcohol rehab	1	9
9454	9454	Referral for Drug Rehab	1	9
9455	9455	Referral vocation rehab	1	9
9459	9459	Referral Psych Rehab NEC	1	9
9461	9461	Alcohol Rehabilitation	1	9
9462	9462	Alcohol Detoxification	1	9
9463	9463	Alcohol Rehab/Detox	1	9
9464	9464	Drug Rehabilitation	1	9
9465	9465	Drug Rehabilitation	1	9
9466	9466	Drug Rehab/Detox	1	9
9467	9467	Comb Alcohol/Drug Rehab	1	9
9468	9468	Comb Alcohol/Drug Detox	1	9
9469	9469	Comb Alco/Drug Reha/Deto	1	9
9536	9536	Ophth Counsel & Instruct	1	9
GZ10ZZZ	GZJZZZZ	MENTAL HEALTH SERVICES	1	10
HZ2ZZZZ	HZ99ZZZ	SUBSTANCE ABUSE TREATMENT	1	10
		Sensitive SP codes for ages under 18		
720	7599	Delivery Codes	2	9
9998	9998	Milk extraction	2	9
102073Z	10908ZU	OBSTETRICS	2	10
10D00Z0	10D07Z8	PRODUCTS OF CONCEPTION EXTRACTION	2	10
10E0XZZ	10J1XZZ	OBSTETRICS	2	10
10P003Z	10S0XZZ	OBSTETRICS	2	10
10Y03ZE	10Y07ZY	OBSTETRICS	2	10

9 Appendix D – Selection Criteria used to assign EOB Caption

Service Caption	Procedure Codes	Claim Type	Other Criteria
TRANSPORTATION/ AMBULANCE	PC=A0021-A0999, S0209-S0215, T2001-T2007		Caption based on Procedure Code.
ANESTHESIA SERVICE	PC=00100-01999, 99100-99150		Caption based on Procedure Code.
CHIROPRACTIC SERVICE	PrvSpclty Code = B376 and PrvSubspclty code = C999		Caption based on PrvSpclty/Subspclty.
DIALYSIS	PC=90918-90999, G0257,G0308-G0327		Caption based on Procedure Code.
HEARING AID SERVICE	PC=V5010-V5267, V5275, V5298		Caption based on Procedure Code.
HEARING/SPEECH SERVICE	PC=V5008, V5268-V5274, V5281-V5290,V5299-V5364		Caption based on Procedure Code.
HOME HEALTH		23	Caption based on Claim Type.
HOSPITAL STAY		2	Caption based on Claim Type.
IMMUNIZATIONS/INJECTION	PC= 90281-90784, 95100-95199, 96300- 96549, G0008-G0010, G0332, G0345-G0362, G0377, J0120--J7399, J7501, J7504-J7505, J7511, J7513, J7516, J7525, J7608, J7648-J7649, J7658-J7659, J7674, J9000-J9999, Q0034, Q0138-Q0139, Q0515, Q2009-Q3011, Q3021-Q3030, Q4074--Q4199, Q5101, Q9970 - Q9980, S0010-S0191		Caption based on Procedure Code.

Service Caption	Procedure Codes	Claim Type	Other Criteria
LABORATORY SERVICE	PC=80047-89399, G0306-G0307, G0328, G0461 – G0462, G0464, G0471-G0472, G0477-G0483, G6030-G6058, Q0111-Q0115, Q3031, P2028-P9615, S3854 or PC has 8 in 1st position.		Caption based on Procedure Code.
LONG TERM CARE FACILITY		12	Caption based on Claim Type.
MATERNAL INFANT HEALTH	PrvSpclty/SubSpclty = B356-C999		Caption based on Provider Spclty/SubSpclty.
MEDICAL SUPPLIES	PC= A4206-A4640, A4648-A9300, A9900-A9999, B4034-B9999, C0000-C9999, G0333, E0100-E8002, J7500, J7503, J7512, J7506-J7510, J7515, J7517-J7520, J7527-J7607, J7609-J7647, J7650-J7657, J7660-J7672, J7675-J8999, K0001-K0902, L0100-L9900, Q0144-Q0514, Q1003-Q2004, Q4001-Q4051, S1001-S1090, S5000-S5001, S5199-S8490, S8999-S9007, S9325-S9381, S9490-S9504,S9537, T2048-T5999		Caption based on Procedure Code.
DENTAL SERVICES	PC=D0000-D9999		Caption based on Procedure Code beginning with D

Service Caption	Procedure Codes	Claim Type	Other Criteria
MISC SERVICES	PC= 98960-99091, 99172, 99605-99607, 0001M-0010M, G9008, H0001-H0017, H0019-H0033, H0035, H0037-H2014, H2016-H2021, H2023-H2037, S0194-S0208, S0220-S0316, S0320-S0400, S0601-S0618, S0622-S0830, S2900-S3853, S3855-S4995, S5002-S5036, S8930-S8990, S9015-S9310, S9395-S9444, S9447-S9465, S9472-S9485, S9524-S9535, S9538-S9999		Caption based on Procedure Code
OUTPATIENT VISIT		3	Caption based on Claim Type and Revenue Code exclusions: 051X, 0451, and 0456.
OUTPATIENT CLINIC VISIT		3	Caption based on Claim Type and Revenue Code Combination, 051x.
OUTPATIENT NON-EMERGENCY SERVICE		3	Caption based on Claim Type and Revenue Code Combination, 0451 or 0456.
PHYSICIAN SERVICES	PC=01996,10021-69990, 97810-98943, 99170, 99175-99199, 0001T-9999T,G0101-G0129, G0166-G0178, G0186, G0237-G0256, G0258-G0305, G0329, G0339-G0343, G6018-G6028, Q0035-Q0092, Q3014, G0363-G0376, G0389-G0460,G0473, G3001, M0075-M0301, S0317, S2050-S2411, 91000-91299, 92015-92072, 92100-95079, 95250-96155, 96567-97799		Caption based on Procedure Code.

Service Caption	Procedure Codes	Claim Type	Other Criteria
PHYSICIAN VISIT/EXAM	PC= 90785-90911, 92002-92014, 92081-92083, 99201-99499, G0378-G0384,G0463, G0466-G0470, M0064, S0592, S0620-S0621		Caption based on Procedure Code.
PODIATRIST SERVICE/VISIT	PrvSpclty-Code = B426		Caption based on Provider Specialty Code.
PRESCRIPTION		24	Caption based on Claim Type.
PRIVATE DUTY NURSING		52	Caption based on Claim Type.
SCHOOL BASED SERVICES		54	Caption based on Claim Type
VISION CARE	PrvSpclty/SubSpclty = B285-C999, B286-C999, B401-C551, B401-C999		Caption based on Provider Spclty/SubSpclty.
HOME AND COMMUNITY SERVICES	PC=97802-98704, 99506, 99510, H0018, H0034, H0036, H2015, H2022, S0209, S5100-S5199, S8990, S9445-S9446, S9470 T1001-T1999, T2010-T2041		Caption based on Procedure code.
RADIOLOGY PROCEDURE	PC= 70010-79999, A4641-A4647, A9500-A9700, G0130-G0132, G0202-G0235, G0330-G0331, G6001-G6017, Q9949-Q9969, R0070-R0076		Caption based on Procedure Code.
HOSPICE		22, 59	Caption based on Claim Type.
EXCLUDED CAPTION CLAIM TYPE		67, 69	These Claim Types are excluded from the EOB Process.

10 Appendix E – Reporting Codes to Suppress

0001F-9999F

G0908-G0922

G8006- G9007

G9009-G9999

MEDICAID HEALTH PLAN KEY CONTACTS

	Blue Cross Complete of Michigan	CoventryCares of Mich, Inc.
24hr Toll Free #	**(800) 228-8554**	**(866) 316-3784**
Web Page	**www.mibluecrosscomplete.com**	**www.CoventryCaresMI.com**
CEO	Nancy Wanchik	Beverly Allen
	Phone: 313-225-7297	Phone: (313) 465-1517
	FAX: 1-800-560-7306	FAX: (313) 465-1605
	E-Mail: nwanchik@bcbsm.com	E-Mail: baallen@cvty.com
CFO	Sue Kluge	Kenyata Rogers, CFO
	Phone: (248) 799-6730	Phone: (313) 465-1523
	FAX: (248) 223-5475	FAX: (313) 465-1605
	E-Mail: skluge@bcbsm.com	E-Mail: kjrogers@cvty.com
MIS Director	Paul Loffreda	Kim Williams
	Phone: (313) 225-7456	Phone: (313) 465-1514
	FAX: (866) 467-1271	FAX: (313) 465-1604
	E-Mail: ploffreda@bcbsm.com	E-Mail: krwilliams@cvty.com
Medical Director	Donald Beam, MD	Joseph Blount, MD
	Phone: (313) 225-7440	Phone: (313) 465-1538
	FAX: (877) 325-5972	FAX: (313) 465-1603
	E-Mail: DBeam@bcbsm.com	E-Mail: jlblount@cvty.com
Medicaid Liaison	Michele Lundberg	Donna West, Director of Operations
	Phone: (313) 225-7307	Phone: (313) 465-1552
	FAX: (855) 314-3055	FAX: (866) 602-1251
	E-Mail: mlundberg@bcbsm.com	E-Mail: djwest@cvty.com
Utilization Review	Julia Griffith	Karen Hammons, Director, Health Services
	Phone: (313) 225-7465	Phone: (313) 465-1516
	FAX: (866) 485-1061	FAX: (313) 465-1603
	E-Mail: jgriffith@bcbsm.com	E-Mail: klhammons@cvty.com
Quality Management	Julia Griffith	Rachel Godwin
	Phone: (313) 225-7465	Phone: (314) 465-1535
	FAX: (866) 485-1061	Fax: (866) 889-7597
	E-Mail: jgriffith@bcbsm.com	E-Mail: rvgodwin@cvty.com
Pharmacy	Vikki Columbus RPh	Donna Anderson
	Phone: (313) 225-8175	Phone: (313) 465-1541
	FAX: (866) 814-5274	FAX: (313) 465-1603
	E-Mail: vcolumbus@bcbsm.com	E-Mail: DMAnderson@cvty.com
PBM	PerformRX	Coventry Prescription Management Services, Inc.
Enrollment Services	Mike Tegler	Jeannette Gail, Manager, CSO
	Phone: (313) 225-7535	Phone: (302) 283-6838
	FAX: (866) 464-8003	FAX: (302) 283-6555
	E-Mail: mtegler@bcbsm.com	E-Mail: jgail@cvty.com
Member Services	Mike Tegler	Jeannette Gail, Manager, CSO
	Phone: (313) 225-7535	Phone: (302) 283-6838
	FAX: (866) 464-8003	FAX: (302) 283-6555
	E-Mail: mtegler@bcbsm.com	E-Mail: jgail@cvty.com
Provider Services	Brenda Lever	Donna West, Director of Operations
	Phone: (313) 225-7530	Phone: (313) 465-1552
	FAX: (866) 648-3106	FAX: (866) 602-1251
	E-Mail: blever@bcbsm.com	E-Mail: djwest@cvty.com
MIHP (MSS/ISS)	Jacquelyn Redding	Mary Washington, Complex Case Manager
	Phone: (313) 225-0610	Phone: (313) 465-1542
	FAX: (866) 647-5627	FAX: (866) 889-7597
	E-Mail: jredding@bcbsm.com	E-Mail: mewashington@cvty.com
Claims Manager	Mike Tegler	Rhonda Friday
	Phone: (313) 225-7535	Phone: (313) 465-1515
	FAX: (866) 464-8003	FAX: (313) 465-1604
	E-Mail: mtegler@bcbsm.com	E-Mail: rlfriday@cvty.com
Adm. Hearings	Kelsey LeMay 313-225-0101	Havard Cole (313) 465-1616
Behavioral Health	Jacquelyn Redding 313-225-0610	Joseph Blount, MD (313) 465-1538
Care Coordination-	Jacquelyn Redding Ph: 313-225-0610	Rochelle Tramble 313-465-1529 fx: 866-889-7572
Liaison	Fx: 866-597-8387	rytramble@cvty.com
Complaints	Ramia Kaji 313-225-7466	Donna West (members) (313) 465-1552 / Rachel Godwin (p
Compliance Officer	Patrick J. Haley 248-223-5164	Rhonda Fluker-Marshall (313) 465-1508
Contract Expediter	Michele Lundberg 313-225-7307	Beverly Allen, CEO (313) 465-1517
MI Enrolls	Ramia Kaji 313-225-7466	Donna West (313) 465-1552

MEDICAID HEALTH PLAN KEY CONTACTS

	HAP Midwest Health Plan, Inc.	Harbor Health Plan, Inc.
24hr Toll Free #	**(888) 654-2200**	**1(844) 427-2671**
Web Page	**http://www.midwesthealthplan.com**	**www.harborhealthplan.com**
CEO	Mark Saffer, DPM	Carrie Harris Muller, President, MBA, MHA
	Phone: (313) 581-3700	Phone: (313 745-7897
	FAX: (313) 581-6013	FAX: (313) 966-9697
	E-Mail: msaffer@midwesthealthplan.com	E-Mail: charris-@harborhealthplan.com
CFO	Allen Kessler	Chris Allen
	Phone: (313) 586-6064	Phone: (313) 966-2774
	FAX: (313) 581-8699	FAX : (313) 966-7520
	E-Mail: akessler@midwesthealthplan.com	E-Mail: callen@dmc.org
MIS Director	Refaat Shulaiba	Patrick Murrary
	Phone: (313) 586-6040	Phone: (313) 578-3740
	FAX: (313) 581-2780	FAX : (313) 966-7520
	E-Mail: rshulaiba@midwesthealthplan.com	E-Mail: pmurray@harborhealthplan.com
Medical Director	Mark Tucker, MD	Gregory Berger, MD
	Phone: (313) 586-6060	Phone: (313) 578-3750
	FAX: (313) 581-2780	FAX: (248) 262-7760
	E-Mail: mtucker@midwesthealthplan.com	E-Mail: gberger@harborhealthplan.com
Medicaid Liaison	Sudha Gadgil	Joyce Poole
	Phone: (313) 586-6001	Phone: (313) 578-3742
	FAX: (313) 582-3092	FAX : (313) 966-7520
	E-Mail: vgadgil@midwesthealthplan.com	E-Mail: jpoole@harborhealthplan.com
Utilization Review	Holly Davis, RN, MSN	Joan Valentine, RN
	Phone: (313) 586-6031	Phone: (313) 578-3752
	FAX: (313) 429-5231	FAX: (248) 262-7760
	E-Mail: hdavis@midwesthealthplan.com	E-Mail: jvalenti@harborhealthplan.com
Quality Management	Kimberly Weaver, RN, CCM	Denise Doede
	Phone: (313) 586-6077	Phone: (313) 578-3749
	FAX: (313) 429-5177	FAX: (248) 262-7760
	E-Mail: kweaver@midwesthealthplan.com	E-Mail: ddoede@harborhealthplan.com
Pharmacy	Brian Peltz, MS, RPh, FAHM, FACHE	Gregory Berger, MD
	Phone: (313) 827-5565	Phone: (313) 578-3750
	FAX: (313) 429-5231	FAX: (248) 262-7760
	E-Mail: bpeltz@midwesthealthplan.com	E-Mail: gberger@harborhealthplan.com
PBM	4-D Pharmacy Management Services	ScriptGuideRX
Enrollment Services	Sudha Gadgil	Veronica Rivera
	Phone: (313) 586-6001	Phone: (602) 824-3789
	FAX: (313) 429-5201	FAX : (602) 824-3789
	E-Mail: vgadgil@midwesthealthplan.com	E-Mail: vrivera@abrazohealth.com
Member Services	Patricia Madden	Ruth E. Evans
	Phone: (313) 586-6020	Phone: (313) 578-3761
	FAX: (313) 586-6043	FAX : (313) 966-7520
	E-Mail: pvier@midwesthealthplan.com	E-Mail: revans@harborhealthplan.com
Provider Services	Sudha Gadgil	Joyce Poole
	Phone: (313) 586-6001	Phone: (313) 578-3742
	FAX: (313) 429-5201	FAX : (313) 966-7520
	E-Mail: vgadgil@midwesthealthplan.com	E-Mail: jpoole@harborhealthplan.com
MIHP (MSS/ISS)	Andrea Fogarty	Joan Valentine, RN
	Phone: (313) 586-6071	Phone: (313) 578-3752
	FAX: (313) 827-5694	FAX: (248) 262-7760
	E-Mail: afogarty@midwesthealthplan.com	E-Mail: jvalenti@harborhealthplan.com
Claims Manager	Sudha Gadgil	Jay Belew
	Phone: (313) 586-6001	Phone: (602) 824-4094
	FAX: (313) 429-5201	FAX : N/A
	E-Mail: vgadgil@midwesthealthplan.com	E-Mail: jbelew@abrazohealth.com
Adm. Hearings	Patricia Madden 313-586-6020	Joan Valentine, RN, (313) 578-3752
Behavioral Health	Holly Davis 313-586-6031	Joan Valentine, RN, (313) 578-3752
Care Coordination-	Holly Davis 313-586-6031	Joan Valentine, RN, jvalenti@harborhealthplan.com
Liaison	hdavis@midwesthealthplan.com	Phone: (313) 578-3752 FAX: (248) 262-7760
Complaints	Patricia Madden 313-586-6020	Ruth E. Evans (313) 578-3761
Compliance Officer	Kathleen Harkness, RN, MS, CPHQ 313-586-6063	Vanessa Benavides Phone: 469-893-6285
Contract Expediter	Sudha Gadgil	Carrie Harris Muller, MBA, MHA (313) 745-7897
MI Enrolls	Sudha Gadgil	Joyce Poole (313) 578-3742 or Patrick Murray

MEDICAID HEALTH PLAN KEY CONTACTS

	HealthPlus Partners, Inc.	Meridian Health Plan
24hr Toll Free #	**(800) 332-9161**	**(888) 437-0606**
Web Page	**http://www.healthplus.org**	**http://www.mhplan.com**
CEO	Nancy Jenkins	Jon Cotton
	Phone: (810) 230-2183	Phone: (313) 324-3705
	FAX: (810) 496-8444	FAX: (313) 202-0075
	E-Mail: njenkins@healthplus.org	E-Mail:jon.cotton@mhplan.com
CFO	Jim Phillips	Janice Torosian
	Phone: (810) 230-2184	Phone: (313) 324-3704
	FAX: (810) 733-8966	FAX: (313) 202-0074
	E-Mail: jphillips@healthplus.org	E-Mail: janice.torosian@mhplan.com
MIS Director	Julie Boyer	Teresa (Teri) Takai
	Phone: (810) 230-2061	Phone: (313) 324-9100
	FAX: (810) 230-2093	FAX: (313) 202-0072
	E-Mail: jboyer@healthplus.org	E-Mail: teri.takai@mhplan.com
Medical Director	Michael A. Genord, M.D.	Elzbieta Rozmiej
	Phone: (810) 496-8478	Phone: (313) 324-3700 ext. 1919
	FAX: (810) 496-8488	FAX: (313) 463-4805
	E-Mail: mgenord@healthplus.org	E-Mail: elzbieta.rozmiej@mhplan.com
Medicaid Liaison	Tiffany Stone	Kellie Rice
	Phone: (810) 733-1929	Phone: (313) 324-3700 ext. 1485
	FAX: (810) 733-1958	FAX: (313) 463-6895
	E-Mail: tstone@healthplus.org	E-Mail: kellie.rice@mhplan.com
Utilization Review	Deborah McCormick	Catherine Smith, RN
	Phone: (810) 733-1955	Phone: (313) 324-3714
	FAX: (810) 230-2002	FAX: (313) 202-0081
	E-Mail: dmccormi@healthplus.org	E-Mail: catherine.smith@mhplan.com
Quality Management	Margaret Kokoszka	Diane Lecerf
	Phone: (810) 230-2074	Phone: (313) 324-3754
	FAX: (810) 230-2106	FAX: (313) 463-6886
	E-Mail: mkokoszk@healthplus.org	E-Mail: diane.lecerf@mhplan.com
Pharmacy	Carrie Germain	Rene Acker, RPh, R.P.h.,
	Phone: (810) 230-2299	Phone: (313) 324-3738 cell: 313-550-4180
	FAX: (810) 720-2757	FAX: (313) 202-1274
	E-Mail: cgermain@healthplus.org	E-Mail: rene.acker@meridianrx.com
PBM	None	Meridian RX
Enrollment Services	Mary Gramke	James Voss
	Phone: (810) 230-2066	Phone: (313) 324-9086
	FAX: (810) 733-1925	FAX: (313) 324-9087
	E-Mail: mgramke@healthplus.org	E-Mail: james.voss@mhplan.com
Member Services	Venus Pope	Christina Brandon
	Phone: (810) 230-2780	Phone: (313) 324-3732
	FAX: (810) 496-8440	FAX: (313) 202-5778
	E-Mail: vpope@healthplus.org	E-Mail: christina.brandon@mhplan.com
Provider Services	Jeanne Visuri	Kellie Rice
	Phone: (989) 797-4007	Phone: (313) 324-3700 ext. 1485
	FAX: (989) 799-8494	FAX: (313) 463-6895
	E-Mail: jvisuri@healthplus.org	E-Mail: kellie.rice@mhplan.com
MIHP (MSS/ISS)	Tiffany Stone	Nicole Felix
	Phone: (810) 733-1929	Phone: (313)-324-9065
	FAX: (810) 733-1958	FAX: (313)-463-5262
	E-Mail: tstone@healthplus.org	E-Mail: nicole.felix@mhplan.com
Claims Manager	Kelly Sherrill	Bruce Wegner
	Phone: (810) 230-2082	Phone: (313) 324-3730
	FAX: (810) 230-2289	FAX: (313) 202-0066
	E-Mail: ksherril@healthplus.org	E-Mail: bruce.wegner@mhplan.com
Adm. Hearings	Cynthia Lamb (810) 230-2125	Maria Moubadder, LPN (313) 324-9165
Behavioral Health	Karen Borruso (810) 230-2143	Mary Roberts, MD (313-202-3943)
Care Coordination-	Tiffany Stone (810)-733-1929	Jenette Ferguson, RN (313) 324-9165
Liaison	tstone@healthplus.org	jeanette.ferguson@mhplan.com
Complaints	Tiffany Stone	Maria Moubadder, LPN (313) 324-9165
Compliance Officer	Theresa Schurman (810) 720-8199	Jane Goldsmith, RN (313) 463-4835
Contract Expediter	Bruce Hill	Mike Stines, Esq. (313) 324-3746
MI Enrolls	Tiffany Stone	Kellie Rice (313) 324-3700 ext. 1485

MEDICAID HEALTH PLAN KEY CONTACTS

	McLaren Health Plan	Molina Healthcare of Michigan
24hr Toll Free #	**(888) 327-0671**	**(888) 898-7969**
Web Page	**www.mclarenhealthplan.org**	**http://www.molinahealthcare.com/**
CEO	Kathy Kendall	Stephen Harris, President
	Phone: (810) 733-9700	Phone: 248-925-1710
	FAX: (810) 733-5788	FAX: 248-925-1721
	E-Mail: kathy.kendall@mclaren.org	E-Mail: stephen.harris@molinahealthcare.com
CFO	Carol Solomon	Stephen Whiting
	Phone: (810) 733-9705	Phone: (248) 925-1730
	FAX: (810) 733-5788	FAX: (248) 925-1722
	E-Mail: carol.solomon@mclaren.org	E-Mail: stephen.whiting@molinahealthcare.com
MIS Director	Sara Mavredes	Tonya Wardena
	Phone: (810) 733-9725	Phone: (248) 925-1737
	FAX: (810) 733-9653	FAX: (248) 925-1721
	E-Mail: sara.mavredes@mclaren.org	E-Mail: tonya.wardena@molinahealthcare.com
Medical Director	Kathleen Kudray, DO	James D. Forshee, MD, MBA, Chief Medical Officer
	Phone: (810) 733-9711	Phone: (248) 925-1702
	FAX: (810) 733-5788	FAX: (248) 925-1729
	kathleen.kudray@mclaren.org	E-Mail: james.forshee@molinahealthcare.com
Medicaid Liaison	Sue Bayer	Pam Gourwitz
	Phone: (517) 913-2622	Phone: 248-925-1701
	FAX: (517) 913-2659	FAX: (248) 925-1721
	E-Mail: sue.bayer@mclaren.org	E-Mail: pamela.gourwitz@molinahealthcare.com
Utilization Review	MaryLynn Clark, RN	Kim English, RN
	Phone: (810) 733-9642	Phone: (248) 729-0827
	FAX: (810) 733-9645	FAX: (248) 925-1740
	E-Mail: marylynn.clark@mclaren.org	E-Mail: kim.english@molinahealthcare.com
Quality Management	Beth Caughlin	Hagy Wegener
	Phone: (810) 733-9710	Phone: (248) 729-0840
	FAX: (810) 733-5788	FAX: (248) 925-1732
	E-Mail: beth.caughlin@mclaren.org	E-Mail: hagy.wegener@molinahealthcare.com
Pharmacy	4-D Pharmacy Management Services	Jennifer Walters
	Phone: (248) 540-8066 ext. 122 (Sue Syoen)	Phone: (248) 729-0839
	FAX: (248) 540-9811	FAX: (248) 925-1771
	Prior Authorization FAX: (248) 282-0471	E-Mail: jennifer.walters@molinahealthcare.com
PBM	4-D Pharmacy Management Services	CVS/Caremark
Enrollment Services	Rhonda Hayes	Patricia Barnett
	Phone: (810) 733-9566	Phone: (248) 925-1743
	FAX: (810) 733-9665	FAX: (248) 925-1767
	E-Mail: rhonda.hayes@mclaren.org	E-Mail: patricia.barnett@molinahealthcare.com
Member Services	Jody Landon	Patricia Barnett
	Phone: (810) 733-9507	Phone: (248) 925- 1743
	FAX: (810) 733-9651	FAX: (248) 925- 1767
	E-Mail: jody.landon@mclaren.org	E-Mail: patricia.barnett@molinahealthcare.com
Provider Services	Beth Caughlin	Dawn Carreri
	Phone: (810) 733-9710	Phone: (248) 925-1745
	FAX: (810) 733-5788	FAX: (248) 925-1784
	E-Mail: beth.caughlin@mclaren.org	E-Mail: dawn.carreri@molinahealthcare.com
MIHP (MSS/ISS)	MaryLynn Clark, RN	Patricia Fenn, RN
	Phone: (810) 733-9642	Phone: (866) 449-6828 ext. 155428
	FAX: (810) 733-9645	FAX: (248) 925-1732
	E-Mail: marylynn.clark@mclaren.org	E-Mail: Patricia.Fenn@molinahealthcare.com
Claims Manager	Vicki Laney	Annette Nicolosi
	Phone: (810) 733-9724	Phone: 248-925-1748
	FAX: (810) 733-9660	FAX: 248-925-1768
	E-Mail: vicki.laney@mclaren.org	E-Mail: annette.nicolosi@molinahealthcare.com
Adm. Hearings	Beth Caughlin 810-733-9710	Eugenia Phillips 248-925-1819
Behavioral Health	Carmen McGlinchey 810-733-9524	Kim English 248-729-0827
Care Coordination-	MaryLynn Clark, RN Ph: (810) 733-9645	Kim English, RN 248-729-0827 fx: 248-925-1740
Liaison	E-Mail: marylynn.clark@mclaren.org	kim.english@molinahealthcare.com
Complaints	Carmen McGlinchey 810-733-9524	Eugenia Phillips Eugenia.Phillips@MolinaHealthCare.Com
Compliance Officer	Sue Bayer (517) 913-2622	Michael von Arx 248-729-0837 Michael.vonarx@molinahealthcare.com
Contract Expediter	Kathy Kendall 810-733-9701	Stephen Harris 248-925-1710
MI Enrolls	Rhonda Hayes 810-733-9566	Renee Atkinson 248-925-1707 renee.atkinson@molinahealthca

MEDICAID HEALTH PLAN KEY CONTACTS

	Priority Health Choice	Sparrow PHP	
24hr Toll Free #	**(888) 975-8102**	**(800) 661-8299**	
Web Page	**http://www.priorityhealth.com**	**http://www.PHPMichigan.com**	
CEO	Michael P. Freed	Dennis Reese	
	Phone: (616) 464-8119	Phone: 517-364-8379	
	FAX: (616) 464-8905	FAX: 517-364-8416	
	E-Mail: mike.freed@priorityhealth.com	E-Mail: dennis.reese@phpmm.org	
CFO	Mary Anne Jones	Dennis Reese	
	Phone: (616) 464-8695	Phone: 517-364-8379	
	FAX: (616) 464-8905	FAX: 517-364-8416	
	E-Mail: maryanne.jones@priorityhealth.com	E-Mail: dennis.reese@phpmm.org	
MIS Director	Krischa Winright	Nick Smith	
	Phone: (616) 464-8318	Phone: 517-364-8476	
	FAX: (616) 464-8905	FAX: (517) 364-8460	
	E-Mail: krischa.winright@priorityhealth.com	E-Mail: nick.smith@phpsso.com	
Medical Director	Jay LaBine, MD	Peter Graham, MD	
	Phone: (616) 464-8971	Phone: (517) 364-8479	
	FAX: (616) 464-8905	FAX: (517) 364-8479	
	E-Mail: jay.labine@priorityhealth.com	E-Mail: Peter.graham@sparrow.org	
Medicaid Liaison	Nancy Busch	Mary Anne Sesti, MMA, RN	
	Phone: (616) 464-8739	Phone: (517) 364-8498	
	FAX: (616) 464.8905	FAX: (517) 364-8416	
	E-Mail: nancy.busch@priorityhealth.com	E-Mail: maryanne.sesti@phpmm.org	
Utilization Review	Sheila Wilson	Linda Dickinson, RN, BSN	
	Phone: (616) 464-4145	Phone: (517) 517-364-8324	
	FAX: (616) 464-7494	FAX: (517) 364-8412	
	E-Mail: sheila.wilson@priorityhealth.com	E-Mail: Linda.Dickinson@phpmm.org	
Quality Management	Gina Schutter	Linda Dickinson, RN, BSN	
	Phone: (616) 464-8976	Phone: (517) 517-364-8324	
	FAX: (616) 464-8905	FAX: (517) 364-8412	
	E-Mail: gina.schutter@priorityhealth.com	E-Mail: Linda.Dickinson@phpmm.org	
Pharmacy	Nancy Busch	Ann Hunt-Fugate, PharD	
	Phone: (616) 464-8739	Phone: (517) 364-8428	
	FAX: (616) 464.8905	FAX: (517) 364-8413	
	E-Mail: nancy.busch@priorityhealth.com	E-Mail: ann.hunt-fugate@phpmm.org	
PBM	Express Scripts	Express Scripts, Incorporated	
Enrollment Services	Eleanor DeMatteis	Annabel Diaz	
	Phone: (616) 464-8504	Phone: (517) 364-8493	
	FAX: (616) 464-8905	FAX: (517) 364-8416	
	E-Mail: eleanor.dematteis@priorityhealth.com	E-Mail: annabel.diaz@phpmm.org	
Member Services	Carol Nowak	Phyllis M. Fisher	
	Phone: (616) 575-4914	Phone: (517) 364-8212	
	FAX: (616) 464-8905	FAX: (517) 364-8411	
	E-Mail: carol.nowak@priorityhealth.com	E-Mail: phyllis.fisher@phpmm.org	
Provider Services	Nancy Busch	Robin Classens	
	Phone: (616) 464-8739	Phone: (517) 364-8461	
	FAX: (616) 464.8905	FAX: (517) 364-8412	
	E-Mail: nancy.busch@priorityhealth.com	E-Mail: robin.classens@phpmm.org	
MIHP (MSS/ISS)	Stacey Arambula	Karen Wrzesinski RN, BSN	
	Phone: (616) 464-8334	Phone: (517)364-8393	
	FAX: (616) 464-8905	FAX: (517) 364-8412	
	E-Mail: stacey.arambula@priorityhealth.com	E-Mail: karen.wrzesinski@phpmm.org	
Claims Manager	Laura Sterkenburg	Kim Larner	
	Phone: (616) 464-8688	Phone: (517) 364-8485	
	FAX: (616) 464-8905	FAX: (517) 364-8485	
	E-Mail: laura.sterkenburg@priorityhealth.com	E-Mail: kim.larner@phpmm.org	
Adm. Hearings	Jeffrey Greshak (616) 464-8260	Lauri Omans (517) 364-8224	
Behavioral Health	Angela Smith-Hietikko 616-464-8460	Linda Dickinson, RN, BSN (517) 364-8324	
Care Coordination-	Sheila Wilson (616) 464-4145 Fx: (616) 464-7494	Karen Wrzesinski RN, BSN (517) 364-8393	
Liaison	sheila.wilson@priorityhealth.com	Email: karen.wrzesinski@phpmm.org	
Complaints	Nancy Busch (616) 464.8739	Annabel Diaz (517) 364-8493	
Compliance Officer	Terry Somerville 616-464-8424	Lynda Patriarche 517-364-8290	
Contract Expediter	Guy Gauthier 616-464-8088	Dennis Reese 517-364-8379	
MI Enrolls	Nancy Busch (616) 464.8739	Annabel Diaz (517) 364-8493	

MEDICAID HEALTH PLAN KEY CONTACTS

	Total Health Care	UnitedHealthcare Community Plan, Inc.
24hr Toll Free #	**(800) 826-2862**	**(800) 903-5253**
Web Page	**www.THCmi.com**	**http://www.uhccommunityplan.com**
CEO	Randy Narowitz	Dennis J. Mouras
	Phone: (313) 871-7878	Phone: (248) 331-4269
	FAX: (313) 871-6400	Fax:
	E-Mail: ran@thcmi.com	E-Mail: dmouras@uhc.com
CFO	Nicole Roush	Carol Gothard
	Phone: (313) 871-6402	Phone: (248) 331-4389
	FAX: (313) 871-4762	FAX: (248) 331-4330
	E-Mail: nroush@thcmi.com	E-Mail: cgothard@uhc.com
MIS Director	Noah Monro	Cybele Kanin
	Phone: (313) 871-7889	Phone: (303)627-3847
	FAX: (313) 748-1399	FAX: (248) 331-4330
	E-Mail: nmonro@thcmi.com	E-Mail: cybele_kanin@uhc.com
Medical Director	R.J. Arrington, Jr., MD	Dr. Brian Kennedy
	Phone: (313) 871-7801	Phone: 248-331-4488
	FAX: (313) 871-6400	FAX: 866-291-2773
	E-Mail: jmorris@thcmi.com	E-Mail: bkennedy@uhc.com
Medicaid Liaison	Jacqueline Jackson	Rose Myers
	Phone: (313) 871-6582	Phone: (248) 331-4357
	FAX: (586) 461-2540	FAX: (855) 387-7237
	E-Mail: jsjackson@thcmi.com	E-Mail: rmyers@uhc.com
Utilization Review	Linda Alexander	Laurie Salswedel, RN
	Phone: (313) 871-5260	Phone: (248) 331-4463
	FAX: (313) 871-1391	FAX: (248) 331-8038
	E-Mail: lalexander@thcmi.com	E-Mail: lsalswedel@uhc.com
Quality Management	Nancy Williams	Laurie Salswedel, RN
	Phone: (313) 871-5263	Phone: (248) 331-4463
	FAX: (313) 871-3104	FAX: (248) 331-8038
	E-Mail: nwilliams@thcmi.com	E-Mail: lsalswedel@uhc.com
Pharmacy	Karen Bunio	Janine Kudla, Pharmacy Coordinator
	Phone: (313) 871-7827	Phone: (517) 852-0842
	FAX: (313) 748-1327	FAX: (855) 387-7237
	E-Mail: kbunio@thcmi.com	E-Mail: jkudla@uhc.com
PBM	EnvisionRx Options	Prescription Solutions
Enrollment Services	Noah Monro	Sharon Theut
	Phone: 313-871-6583	Phone: (248) 331-4348
	FAX: 313-748-1399	FAX: (248) 331-4519
	E-Mail: nmonro@thcmi.com	E-Mail: stheut@uhc.com
Member Services	Angela Counsman	Theresa Hayes-Aiken
	Phone: 313/871-6596	Phone: (248)331-4217
	FAX: 313/871-6406	FAX: (248)331-5222
	E-Mail: acounsman@thcmi.com	E-Mail: thayes-aiken@uhc.com
Provider Services	Susan Ryan	Lisa Gray
	Phone: (313) 871-6589	Phone: (248)331-4322
	FAX: (313) 748-1324	FAX: (248)331-4330
	E-Mail: sryan@thcmi.com	E-Mail: lgray@uhc.com
MIHP (MSS/ISS)	Kyra Lawrence	Stephanie Esters
	Phone: (313) 871-7815	Phone: (248) 331-4369
	FAX: (313) 748-1368	FAX: (248) 331-4519
	E-Mail: klawrence@thcmi.com	E-Mail: sesters@uhc.com
Claims Manager	LaDawn Wyatt	Henrietta Edge
	Phone: (313) 871-7877	Phone: (248) 331-4319
	FAX: (313) 748-1377	FAX: (248) 331-5222
	E-Mail: lwyatt@thcmi.com	E-Mail: hedge@uhc.com
Adm. Hearings	Annmarie Kowalski (313) 871-6583	Eric Wexler 248-331-4264
Behavioral Health	Linda Alexander 313-871-5260	Pamela Coin 248-331-4362
Care Coordination-	Linda Alexander 313-871-5260	Laurie Salswedel ph: 248-331-4463 fx: 248-331-8038
Liaison	Email: lalexander@THCmi.com	lsalswedel@uhc.com
Complaints	Annmarie Kowalski 313-871-6583	Joshua Wennmacher - 309-798-2459
Compliance Officer	Marcie Johnson 313-871-7876	Rose Myers 248-331-4357
Contract Expediter	Marcie Johnson 313-871-7876	Jeff Nohl (248) 331-4269
MI Enrolls	Angela Counsman 313-871-6596	Rose Myers 248-331-4357

MEDICAID HEALTH PLAN KEY CONTACTS

	Upper Peninsula Health Plan
24hr Toll Free #	**1-800-835-2556**
Web Page	**http://www.uphp.com**
CEO	Dennis Smith
	Phone: (906) 225-7500 / (888) 904-7526
	FAX: (906) 225-7690
	E-Mail: dhsmith@uphp.com
CFO	Regina M. Bergh
	Phone: (906) 225-7491
	FAX: (906) 225-8687
	E-Mail: rmbergh@uphp.com
MIS Director	Paula Johnson
	Phone: (906) 225-7831
	FAX: (906) 225-7690
	E-Mail: pjohnson@uphp.com
Medical Director	Michael M. Mlsna, MD
	Phone: (906) 225-7720
	FAX: (906) 225-7690
	E-Mail: mmlsna@uphp.com
Medicaid Liaison	Melissa Holmquist
	Phone: (906) 225-7157
	FAX: (906) 225-8778
	E-Mail: mholmquist@uphp.com
Utilization Review	Nicole Sandstrom, RN
	Phone: (906) 225-7784
	FAX: (906) 225-9269
	E-Mail: nsandstrom@uphp.com
Quality Management	Anne Levandoski, RN., B.S.N.
	Phone: (906) 225-7723
	FAX: (906) 225-8761
	E-Mail: ablevandoski@uphp.com
Pharmacy	Sheryl Waudby, RPH
	Phone: (906) 225-7876
	FAX: (906) 225-7690
	E-Mail: sdwaudby@uphp.com
PBM	Catamaran
Enrollment Services	Leslie Lacosse
	Phone: (906) 225-7503
	FAX: (906) 225-8751
	E-Mail: llacosse@uphp.com
Member Services	Melissa Holmquist
	Phone: (906) 225-7157
	FAX: (906) 225-8778
	E-Mail: mholmquist@uphp.com
Provider Services	Roni Bur
	Phone: (906) 225-7843
	FAX: (906) 225-8781
	E-Mail: rlbur@uphp.com
MIHP (MSS/ISS)	Anne Levandoski
	Phone: (906) 225-7723
	FAX: (906) 225-8761
	E-Mail: ablevandoski@uphp.com
Claims Manager	Leslie Lacosse
	Phone: (906) 225-7503
	FAX: (906) 225-8751
	E-Mail: llacosse@uphp.com
Adm. Hearings	Melissa Holmquist 906-225-7517
Behavioral Health	Anne Levandoski, RN BSN 906-225-7723
Care Coordination-	Nicole Sandstrom 906-225-7784
Liaison	fx: 906-225-9269
Complaints	Melissa Holmquist 906-225-7157
Compliance Officer	Melanie Bicigo 906-225-7749
Contract Expediter	Dennis H. Smith 906-225-7833
MI Enrolls	Leslie Lacosse 906-225-7503

Name of Clinc
Address Line 1
Address Line 2

Date of Service:	*Insurance* Provider:
Patient ID:	*Insurance* ID:
Patient Name:	Provider:
Patient Date of Birth:	
Patient Gender (circle one): M / F	

Evaluation and Management Codes (Time in Minutes)		**Codes**	**CPT**	**$**
New Patient Office Visit	Problem Focused-Straightforward (10 min)		99201	
	Expanded Problem Focused-Straightforward (20 min)		99202	
	Detailed-Low Complexity (30 min)		99203	
	Comprehensive-Moderate Complexity (45 min)		99204	
Established patient visit	Follow-up (presenting problems minimal) (5 min)		99211	
	Problem Focused-Straightforward (10 min)		99212	
	Expanded Problem Focused-Low Complexity (15 min)		99213	
	Detailed-Moderate Complexity (25 min)		99214	
	Detailed - High Complexity (40 min)		99215	
Procedure Codes				
Injection Administration-Medication	Subcutaneous or Intramuscular		96372	
Other Procedures				
Wart Removal (Simple vs Extensive: Provide judgement based on time, effort, complexity and number and size of lessions.)	Vulva; simple		56501	
	Vulva; extensive		56515	
	Vagina; simple		57061	
	Vagina; extensive		57065	
	Anal; simple		46900	
	Anal; extensive		46924	
	Penis; simple (cryosurgery)		54056	
	Penis; extensive		54065	
Preventative Medicine Counseling	~15 mins		99401	
	~30 mins		99402	
	~45 mins		99403	
	~60 mins		99404	

Modifiers	
22	For when a procedure was more **complicated** or **took more time than usual** (i.e., passing out during blood draw)
24	For a service performed during **post-op period (10 days)** and **unrelated** to original op
25	For a significant, separately identifiable service on **same day** as original procedure
33	For a visit **preventative** in nature
58	For **staged procedure** within **10 days of original procedure** (same problem with diff't stages to address fully)
92	For use with rapid HIV tests; "alternative lab platform testing"

Hold for Future Use				

*When counseling and/or coordination of care comprise more than 50% of the typical time for a vist, it is permissible to use time as the driving factor to report CPT code.

Laboratory Codes		**Codes**	**CPT**	**$**
	UHCG-Urine Pregnancy		81025	
	Wet mount		87210	
	Venipuncture		36415	
	PPD Plant TB		86580	
	Gram Stain		87205	
	Urinalysis (Dip stick)		81003	
	Glucose-Fingerstick		82962	
	Total Cholesterol Screening (HDL, LDL +TRG)		80061	
	Rapid HIV-1/Initial CMS test		86701	
	Rapid HIV-1/2		86703	
	Hep C-Rapid		87902	
STD Tests	**Labs sent to State Lab for Processing-Use for Tracking Only**			
	VDRL - Syphilis			
	Gonnorrhea			
	Chlamydia			
	Hepatitis			
	Herpes Culture			
Medication Codes				
	Zithromax - per 500mg		J0456	
	Ceftriaxone - per 250 mg		J0696	
	Bicillin - LA per 100,00 units		J0561	
	Other Medication			
Hepatitis	HAV/HBV Combo (Twinrix)		90636	
	HAV (Teen/pediatric; 2 dose sched)		90633	
	HAV (Teen/pediatric; 3 dose sched)		90634	
	HAV (Adult)		90632	
	HBV (Teen; 2 dose sched)		90743	
	HBV (Adult) (3 dose sched)		90746	
	HBV (Immunosupp or dialysis pt; 3 dose sched)		90740	
	HBV (Immunosupp or dialysis pt; 4 dose sched)		90747	
	HBV (Teen/pediatric; 3 dose sched)		90744	
HPV	Gardasil (3 dose sched) *Requires NDC# from package		90649	
	Unclassified drug (use for Aldara)		J3490	
Diagnosis Code(s) :				
Previous Balance				
Total Charges				
Payments				
Balance Due				

EMERGENCY CONTRACEPTION	ICD-10
Consulting & supply	Z30.012

FAMILY PLANNING	ICD-10
FP RELATED DIAGNOSIS	
High risk sexual behavior (heterosexual)	Z72.51
High risk sexual behavior (homosexual)	Z72.52
High risk sexual behavior (bisexual)	Z72.53
Problems regarding life-style (self damaging behavior)	Z72.89
Feared complaint, no problem	Z71.1
Observation disease or condition ruled out	Z03.89
Worried well	Z71.1
Noncompliance w/med tx	Z91.19

WELL WOMAN/GYN/ PAP	ICD-10
Female Pelvic exam with or w/o Pap without abnormal findings	Z01.419
Female Pelvic exam with or w/o Pap with abnormal findings	Z01.411

CARDIOVASCULAR	ICD-10
Elevated Blood Pressure - w/o dx HTN	R03.0

CONTRACEPTION	ICD-10
Contraceptive Counseling & Advice	Z30.09
Preconception Counseling/Procreative management	Z31.9
Prescription of Oral Contraceptives (initial)	Z30.011
Removal of any FB in Vagina (1st encounter)	T19.2XXA
Unspecified Contraceptive Management	Z30.9

METABOLIC	ICD-10
Obesity NOS	E66.9
Obesity, Morbid due to excess calories	E66.01
Overweight	E66.3

DX: SCREENING (no sign/sym)	ICD-10
Screening for STI	Z11.3
Screening for chlamydia	Z11.8
Screening for HPV	Z11.51
Screening for HIV	Z11.4
Screening for any virus	Z11.59

FEMALE/GYN	ICD-10
Amenorrhea (uspecified)	N91.2
Pregnancy, Normal 1st	Z34.00
Bacterial Vaginosis	N76.0
Bartholin's Cyst	N75.0
Cervicitis	N72
Dysmenorrhea	N94.6
Dyspareunia	N94.1
Irregular menstrual Cycles, unspecified	N92.6
Pelvic Inflammatory Disease, unspecified	N73.9
Pelvic Pain and/or perineal	R10.2
Premenstral tension/Prememstrual Dysphoric Disorder	N94.3
Trichomonas Vulovaginits	A59.01
Trichomoniasis, NOS	A59.9
Vulvovaginitis, NOS	N76.0
Vaginitis/Vulvitis-Candida	B37.3

GENITOURINARY SYSTEM	ICD-10
Dysuria	R30.0
Epididymitis/Orchitis	N45.3
Exposure to STD	Z20.2
Prostatitis, acute	N41.9
Urethritis	N34.2
Urinary Frequency	R35.0
Urinary retention	R33.9
Urinary Tract Infection	N39.0

GASTROINTESTINAL	ICD-10
Abdominal Pain	R10.9
Nausea with vomiting	R11.2

INFECTIOUS & PARASITIC DISEASES	ICD-10
AIDS (Only confirmed cases)	B20
Bacteremia	R78.81
Balanitis	N48.1
Candidiasis, oral thrush	B37.0
Candidiasis, esophageal	B37.81
Candidiasis, vulvovaginal	B37.3
Chlamydia unspecified	A74.9
Chlamydial trachomatis	A71.9
Genital wart Condyloma	A63.0
Gonococcal infection, cervix	A54.03
Gonorrhea, acute infection	A54.00
Hepatitis C chronic	B18.2
Herpes, Genital- NOS	A60.9
Herpetic Ulceration Uvlva	A60.04
Herpes Vulvovaginitis	A60.04
Herpes Penis	A60.01
Herpes, Simplex, Oral	B00.2
Herpes Zoster, w/ out complication	B02.9
HIV Infection (+), Asymptomatic	Z21
Syphilis	
Syphilis – unspecified	A53.9
Syphilis – primary	A51.0
Syphilis – secondary	A51.41
Syphilis – neurosyphilis	A52.3
Syphilis – latent	A53.0

NEUROLOGICAL	ICD-10
Migraine	G43.909

DX: PREGNANCY TESTS	ICD-10
Preg test positive	Z32.01
Preg test negative	Z32.02
Preg Test result unknown (ex.send out H	Z32.00

DX: OTHERS FOR FP/CM	ICD-10
Natural FP advice to avoid pregnancy	Z30.02

PREVENTIVE / WELLNESS CODE	ICD-10
GYN only with or w/o Pap without abnormal findings	Z01.419
GYN only with or w/o Pap with abnormal findings	Z01.411
Encounter for cervical pap smear only	Z12.4

SKIN/SUBCUTANEOUS	ICD-10
Rash	R21
Eczema	L25.9
Dermatitis, NOS	L25.9
Dry skin (xerosis)	L85.3
Folliculitis	L73.9
Fungal Rash / Candidiasis of skin or nails	B37.2
Herpes Simplex	B00.9
Herpes Zoster (without complications)	B02.9
Molluscum contagiosum	B08.1
Pruritus	L29.9
Psoriasis	L40.9
Scabies	B86
Sebaceous Cyst	L72.3
Skin tags	L91.9
Tinea, versicolor	B36.0
Ulcer, chronic	L98.499
Urticaria/Hives	L50.9
Viral Warts unspecified	B07.9
Wound Infection- cellultis or abcess of skin unspecified site	L03.90

SYMPTOMS, ILL-DEFINED CONDITION	ICD-10
Allergic Reaction NOS - first encounter	T78.40XA
Fatigue/Malaise	R53.83
Ulceration of vulva	N76.6
Nausea alone	R11.0
Vomitting alone	R11.10
Tension headache	G44.209
High risk sexual behavior (heterosexual)	Z72.51
High risk behavior (homosexual)	Z72.52
High risk behavior (bisexual)	Z72.53

EXPOSURE TO:	ICD-10
Exposed to STI/STD	Z20.2
Exposed to HIV (or other virus)	Z20.6

Superbill Printing Instructions:

1. Select: File > Print.
2. On Print Page under Settings select:

i. Print Entire Workbook
ii. Pages: 1 to 2
iii. Print on Both Sides
iv. Fit All Columns on One Page

3. Then Print.

Note: This should be set up automatically in the file.

FOR MORE TOOLS AND RESOURCES, VISIT STDTAC.ORG/BILLING-TOOLKIT

**STDTAC/Jan. 2014. Thank you to Roberta Moss, Moss Healthcare Consulting, for her contributions to this document.*

Building Sustainability for HIV, STD and Related Services

A Coding Guide for Programs and Providers

2015

Building Sustainability for HIV, STD and Related Services

A Coding Guide for Programs and Providers

University of Washington
Public Health Capacity Building Center

The University of Washington Public Health Capacity Building Center (UWPHCBC) is one of 21 capacity building assistance (CBA) providers supported by the Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention, to provide CBA for High Impact Prevention (HIP). UWPHCBC is funded to provide CBA to state, local, tribal and territorial health departments. UWPHCBC can provide CBA to directly and indirectly funded health departments; indirectly funded health departments must request CBA via the directly funded health department.

There are six focus areas for CBA: 1) HIV testing; 2) prevention with positives; 3) organizational development & management; 4) prevention with negatives; 5) condom distribution; and 6) policy.

UWPHCBC is funded for three focus areas: 1) HIV testing; 2) prevention with HIV-positive persons, with an emphasis on Data to Care; and 3) organizational development & management, including third-party billing. Cardea's work with UWPHCBC focuses on organizational development & management.

In addition to Cardea, the University of Washington's partners include Public Health—Seattle & King County, Northwest AIDS Education and Training Center, California STD/HIV Prevention Training Center, New York State STD/HIV Prevention Training Center, and Rietmeijer Consulting.

Contact us for more information:
Becca Hutcheson, Assistant Director, UWPHCBC,
hutchbec@uw.edu, 206-897-5814

Funding for this guide was made possible (in part) by the Centers for Disease Control and Prevention (CDC). The views expressed do not necessarily reflect the official policies of the Department of Health and Human Services (DHHS), nor does the mention of trade names, commercial practices, or organizations imply endorsement by the US Government.

Funded by Centers for Disease Control and Prevention

Cbaproviders.org

ACKNOWLEDGEMENTS

This guide was adapted from the *Texas Billing and Coding Guide*, developed by Cardea in partnership with the Texas/Oklahoma AIDS Education and Training Center as part of the work of the STD-related Reproductive Health Training and Technical Assistance Centers (STDRHTTAC) for U.S. Public Health Regions VI, IX, and X.

CARDEA
Training, Organizational Development and Research

Cardeaservices.org

Texas/Oklahoma
AIDS Education & Training Center

Aidseducation.org

DISCLAIMER

This guide was prepared as a service to the public and is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. Specific coding and payer guidelines should be reviewed prior to the submission of claims for reimbursement.

OVERVIEW

This guide is designed to be a resource for programs providing HIV, STD and related services and to assist in the transition from ICD-9 to ICD-10 coding. It includes basic information about HIV and STD screening and testing, an overview of coding guidelines, and common ICD-9, ICD-10, and CPT codes. Several coding scenarios are included along with accompanying resources and references. While this is not an exhaustive list of codes for HIV, STD and related services and diagnoses, these common codes offer a quick reference to help improve coding efficiency. Always follow current legal guidelines and standards of practice when providing medical services.

Coding for HIV, STD and related services is an essential practice for programs that are preparing for billing third party payers. Beginning to properly code for services is a critical step in improving revenue cycle management and developing sustainable systems.

SCREENING RECOMMENDATIONS

Third-party payer coverage for CDC recommended screening services may vary. Contact payers to determine billing eligibility.

HIV Recommendations

The objectives of the following recommendations are to: increase HIV screening of patients, including pregnant women, in health care settings; foster earlier detection of HIV infection; identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and further reduce perinatal transmission of HIV in the United States.

The Centers for Disease Control and Prevention (CDC) makes the following recommendations for patients in all health care settings:

- HIV screening is recommended for patients in all health care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Persons at high-risk for HIV infection should be screened for HIV at least annually.
- Separate written consent for HIV testing should not be required. General consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health care settings.

Why provide routine screening for HIV/AIDS?

- Twenty percent (20%) of people living in the U.S. with HIV do not know they are infected.
- HIV is a serious health condition that can be reliably diagnosed prior to symptoms development, and patients are more likely to be tested if it is suggested by a clinician.
- Routine screening helps to de-stigmatize HIV.
- Early entry into care increases the likelihood of a longer, healthier life. Unfortunately, an estimated 39% of people with HIV in the U.S are not diagnosed until they are in the later stages of the disease.
- Transmission rates are higher in people who do not know they have HIV. Individuals who know that they are HIV positive are more likely to engage in risk reduction efforts.
- Appropriate treatment during pregnancy can reduce the perinatal transmission rate to < 2%. Pregnant women who know they are infected are better able to make critical decisions about care for themselves and their infants.

Source: Centers for Disease Control and Prevention

STD Recommendations

The Centers for Disease Control and Prevention makes the following recommendations for STD screening:

- Chlamydia—screen women under age 25 and others, including men, at increased risk
- Gonorrhea—screen women at increased risk
- Syphilis—screen women exposed to syphilis
- Hepatitis B—provide prevaccination screening for women at increased risk
- Hepatitis C—screen women at risk
- Herpes Simplex Virus—do not screen general population

Other health organizations also provide screening recommendations for STD that may vary slightly.

Why provide screening for STDs?

- Chlamydia and gonorrhea prevalence is highest among adolescents and young adults under 25
- STDs can have severe effects for pregnant women, their partners and fetuses
- STDs can increase the risk of contracting HIV

HIV/STD Recommendations for Pregnant Women

For pregnant women, the CDC recommends the following screening:

- STD and HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women in the first trimester or prenatal appointment.
- STD screening for pregnant women should include the following: syphilis, hepatitis B, hepatitis C (increased risk patients only), chlamydia, and gonorrhea (increased risk patients only).
- STD and HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Repeat screening in the third trimester is recommended in certain jurisdictions with elevated rates of HIV infection among pregnant women. Women at increased risk for HIV and STDs should also be screened for syphilis, HIV, chlamydia and gonorrhea in the third trimester.

Source: Centers for Disease Control and Prevention

CODING GUIDELINES

What is documentation and why is it important?

According to the Centers for Medicare and Medicaid Services (CMS), medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to better manage the patient's care over time
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations and
- Collection of data that may be useful for research and education

Document every step you take. Remember, if it's not documented in the record, it did not happen.

Source: Centers for Medicare and Medicaid Services

International Classification of Diseases Diagnosis Codes

The International Classification of Diseases (ICD) is a system of coding maintained by the World Health Organization that is used to describe diseases, symptoms, abnormal findings, and external causes of injury. Standardizing codes improves consistency among clinicians in recording patient symptoms and diagnoses for the purposes of payer claims reimbursement and clinical research.

On October 1, 2015, the ICD-9-CM code sets used to report medical diagnoses are to be replaced by ICD-10 codes. The transition is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA). The ICD-10-CM code set expands from 13,000 to over 68,000 codes, offering many new code choices and combinations. Crosswalks are guides meant to help translate forward and backward between ICD-9 and ICD-10 codes but should not replace becoming familiar with the entire expanded code selection applicable to your practice. Learning to code ICD-10 fully is essential for accurate coding and reimbursement.

Included below are common ICD diagnosis codes that are used for coding STD and HIV services (partial listings). The "Direct" indicator implies a 1:1 match between the existing and new codes. "Approximate" conversions between ICD-9-CM codes and ICD-10-CM codes may require clinical interpretation in order to determine the most appropriate conversion code(s) for your specific coding situation. ICD coding guidelines, including specific rules for coding HIV, should always be consulted for accurate coding purposes.

ICD-9 TO ICD-10 CROSSWALK

ICD-9	Description	Direct/ Approx.	ICD-10	Description
HIV Specific Codes				
V01.79	Contact with or exposure to venereal diseases	Approx.	**Z20.6** **Z20.828**	Contact with and (suspected) exposure to human immunodeficiency virus (HIV) Contact with and (suspected) exposure to other viral communicable diseases
V65.44	Human immunodeficiency virus (HIV) counseling	Direct	**Z71.7**	Human immunodeficiency virus (HIV) counseling
V70.0	Routine general medical examination at a health care facility	Approx.	**Z00.00** **Z00.01**	Encounter for general adult medical examination without abnormal findings Encounter for general adult medical examination abnormal findings* *Use additional code to identify abnormal findings (R70-R94)
V73.89	Special screening examination for other specified viral diseases (e.g. HIV, HSV)	Approx.	**Z11.4** **Z11.59**	Encounter for screening for human immunodeficiency virus (HIV) Encounter for screening for other viral diseases
042	HIV disease	Direct	**B20**	HIV disease *Code first HIV disease complicating pregnancy, childbirth and the puerperium, if applicable (098.7-) **Use additional code(s) to identify all manifestations of HIV infection
079.53	HIV, type 2 (HIV-2) * Report as secondary diagnosis code only (when applicable)	Direct	**B97.35**	HIV, type 2 (HIV-2) as the cause of diseases classified elsewhere Note: Provided for use as supplementary or additional code to identify the infectious agent(s) in diseases classified elsewhere
V08	Asymptomatic HIV infection status	Direct	**Z21**	Asymptomatic HIV infection status. * Code first HIV disease complicating pregnancy, childbirth and the puerperium, if applicable (098.7-)
Screening Tests: Increased Risk of Infection				
V01.1	Contact with or exposure to tuberculosis	Direct	**Z20.1**	Contact with and (suspected) exposure to tuberculosis
V01.6	Contact with or exposure to venereal diseases	Direct	**Z20.2**	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
V01.79	Contact with or exposure to other venereal diseases (e.g. Hep, HIV)	Approx.	**Z20.6** **Z20.828**	Contact with and (suspected) exposure to human immunodeficiency virus (HIV) Contact with and (suspected) exposure to other viral communicable diseases

ICD-9	Description	Direct/ Approx.	ICD-10	Description
V02.7 **V02.8**	Carrier or suspected carrier of gonorrhea Carrier or suspected carrier of other venereal diseases	Approx.	**Z22.4**	Carrier of infections with a predominantly sexual mode of transmission
V03.89 **V05.3** **V05.8**	Other specified vaccination Need for prophylactic vaccination and inoculation against viral hepatitis Need for prophylactic vaccination and inoculation against other specified disease	Approx.	**Z23**	Encounter for immunization *Procedure codes are required to identify the types of immunizations given
V15.85	Personal history of contact with and (suspected) exposure to potentially hazardous body fluids (e.g. needle stick)	Approx.	**Z77.21**	Contact with and (suspected) exposure to potentially hazardous body fluids Code Also: any follow-up examination (Z08-Z09)
V65.42	Counseling on substance use and abuse	Approx.	**Z71.41**	Alcohol abuse counseling and surveillance of alcoholic
V69.2	High-risk sexual behavior	Approx.	**Z72.51** **Z72.52** **Z72.53**	High-risk heterosexual behavior High-risk homosexual behavior High-risk bisexual behavior
V69.8	Other problems related to lifestyle	Approx.	**Z72.89**	Other problems related to lifestyle (Self-damaging behavior)
V72.40	Pregnancy examination or test, pregnancy unconfirmed	Direct	**Z32.00**	Encounter for pregnancy test, result unknown
V72.41	Pregnancy exam or test, negative result	Direct	**Z32.02**	Encounter for pregnancy test, result negative
V72.42	Pregnancy exam or test, positive result	Direct	**Z32.01**	Encounter for pregnancy test, result positive
V73.81	Special screening examination for human papillomavirus (HPV)	Direct	**Z11.51**	Encounter for screening for HPV
V73.88 **V73.98**	Special screening examination for other specified chlamydial diseases Special screening examination for unspecified chlamydial disease	Approx.	**Z11.8**	Encounter for screening for other infectious and parasitic diseases (Encounter for screening for chlamydia, rickettsial, spirochetal or mycoses)
V73.89	Special screening examination for other specified viral diseases	Approx.	**Z11.59**	Encounter for screening for other viral diseases
V74.1	Screening examination for pulmonary tuberculosis	Direct	**Z11.1**	Encounter for screening for respiratory tuberculosis
V74.5	Screening examination for venereal disease	Direct	**Z11.3**	Encounter for screening for infections with a predominantly sexual mode of transmission
V75.8	Screening examination for other specified parasitic infections	Approx.	**Z11.0** **Z11.8**	Encounter for screening for intestinal infectious diseases Encounter for screening for other infectious and parasitic diseases
Diagnostic Testing				
053.9	Herpes zoster without mention of complication	Direct	**B02.9**	Zoster without complications (Shingles, zona)
054.10	Genital herpes, unspecified	Approx.	**A60.9**	Anogenital herpesviral infection, unspecified

ICD-9	Description	Direct/ Approx.	ICD-10	Description
054.11 **054.12**	Herpetic vulvovaginitis Herpetic ulceration of vulva	Approx.	**A60.04**	Herpesviral vulvovaginitis (Herpesviral (herpes simplex) ulceration, vaginitis, vulvitis)
054.13	Herpetic infection of penis	Direct	**A60.01**	Herpesviral infection of penis
054.19	Other genital herpes	Direct	**A60.09**	Herpesviral infection of other urogenital tract
054.2	Herpetic gingivostomatitis	Direct	**B00.2**	Herpesviral gingivostomatitis and pharyngotonsillitis
054.8 **054.9**	Herpes simplex with unspecified complication Herpes simplex without mention of complication	Approx.	**B00.9**	Herpesviral infection, unspecified (Herpes simplex infection NOS)
078.0	Molluscum contagiosum	Direct	**B08.1**	Molluscum contagiosum
078.10	Viral wart, unspecified	Direct	**B07.9**	Viral wart, unspecified
078.11	Condyloma acuminatum	Direct	**A63.0**	Anogenital (venereal) warts (Anogenital warts due to HPV, Condyloma acuminatum)
078.88	Other specified diseases due to chlamydia	Approx.	**A74.89**	Other chlamydial diseases
079.4	Human papillomavirus in conditions classified elsewhere and of unspecified site (HPV infection, unspecified)	Direct	**B97.7**	Papillomavirus as the cause of diseases classified elsewhere
079.98	Unspecified chlamydial infection	Approx.	**A74.9**	Chlamydial infection, unspecified (Chlamydiosis NOS)
091.0	Genital syphilis (primary)	Direct	**A51.0**	Primary genital syphilis (Syphilitic chancre NOS)
091.1	Primary anal syphilis	Direct	**A51.1**	Primary anal syphilis
092.0 **092.9**	Early syphilis, latent, serological relapse after treatment. Early syphilis, latent, unspecified	Approx.	**A51.5**	Early syphilis, latent (Syphilis (acquired) without clinical manifestations, with positive serological reaction and negative spinal fluid test, less than 2 years after infection.)
096	Late syphilis, latent	Direct	**A52.8**	Late syphilis, latent (Syphilis (acquired) without clinical manifestations, with positive serological reaction and negative spinal fluid test, 2 years or more after infection.)
097.9	Syphilis, unspecified	Direct	**A53.9**	Syphilis, unspecified (Infection due to Treponema pallidum NOS, Syphilis (acquired) NOS)
098.0 **098.2**	Gonococcal infection (acute) of lower genitourinary tract (urethritis) Gonococcal infection, chronic, of lower genitourinary tract	Approx.	**A54.00**	Gonococcal infection of lower genitourinary tract, unspecified
098.10	Gonococcal infection (acute) of upper genitourinary tract, site unspecified	Approx.	**A54.29**	Other gonococcal genitourinary infections
098.12 **098.32**	Gonococcal prostatitis acute Gonococcal prostatitis, chronic	Approx.	**A54.22**	Gonococcal prostatitis
098.13 **098.14** **098.33** **098.34**	Gonococcal epididymoorchitis (acute) Gonococcal seminal vesiculitis (acute) Gonococcal orchitis (chronic) Gonococcal seminal vesiculitis (chronic)	Approx.	**A54.23**	Gonococcal infection of other male genital organs (Gonococcal epididymitis, Gonococcal orchitis)

ICD-9	Description	Direct/ Approx.	ICD-10	Description
098.15 **098.35**	Gonococcal cervicitis (acute) Gonococcal cervicitis (chronic)	Approx.	**A54.03**	Gonococcal cervicitis, unspecified
098.16 **098.36**	Gonococcal endometritis (acute) Gonococcal endometritis (chronic)	Approx.	**A54.24**	Gonococcal female pelvic inflammatory disease
098.6	Gonococcal infection of pharynx	Direct	**A54.5**	Gonococcal pharyngitis
098.7	Gonococcal infection of anus and rectum	Direct	**A54.6**	Gonococcal infection of anus and rectum
099.0	Chancroid	Direct	**A57**	Chancroid (Ulcus molle)
099.1	Lymphogranuloma venereum	Direct	**A55**	Chlamydial lymphogranuloma (venereum)
099.2	Granuloma inguinale	Direct	**A58**	Granuloma inguinale
099.40 **099.41**	Other nongonococcal urethritis, unspecified Other nongonococcal urethritis, chlamydia trachomatis	Approx.	**N34.1**	Nonspecific urethritis (Nongonococcal urethritis, Nonvenereal urethritis)
099.50 **099.54**	Other venereal diseases due to chlamydia trachomatis, unspecified site Other venereal diseases due to chlamydia trachomatis, other genitourinary sites	Approx.	**A56.19**	Other chlamydial genitourinary infection
099.51	Other venereal diseases due to chlamydia trachomatis, pharynx	Direct	**A54.5**	Chlamydial infection of pharynx
099.52	Other venereal diseases due to chlamydia trachomatis, anus and rectum	Direct	**A56.3**	Chlamydial infection of anus and rectum
099.53	Other venereal diseases due to chlamydia trachomatis, lower genitourinary sites (cervicitis)	Approx.	**A56.00**	Other venereal diseases due to chlamydia trachomatis, lower genitourinary sites
099.56	Other venereal diseases due to chlamydia trachomatis, peritoneum	Approx.	**A56.8**	Sexually transmitted chlamydial infection of other sites
110.3	Dermatophytosis of groin and perianal area	Direct	**B35.6**	Tinea cruris (DHOBI Itch, Groin ringworm, jock itch)
112.0	Candidiasis of mouth (Thrush Oral)	Approx.	**B37.0** **B37.83**	Candidal stomatitis Candidal cheilitis
112.1	Candidiasis of vulva and vagina	Direct	**B37.3**	Candidiasis of vulva and vagina
112.2	Candidiasis of other urogenital sites	Approx.	**B37.42** **B37.49**	Candidal balanitis Other urogenital candidiasis
131.01	Trichomonal vulvovaginitis	Direct	**A59.01**	Trichomonal vulvovaginitis
132.2	Phthirus pubis (pubic louse)	Direct	**B85.3**	Phthiriasis
133.0	Scabies	Direct	**B86**	Scabies
599.0	Urinary tract infection (UTI), site not specified	Direct	**N39.0**	Urinary tract infection, site not specified *Use Additional code (B95-B97), to identify infectious agent
614.3	Acute parametritis and pelvic cellulitis	Direct	**N73.0**	Acute parametritis and pelvic cellulitis *Use Additional code (B95-B97), to identify infectious agent

ICD-9	Description	Direct/ Approx.	ICD-10	Description
616.0	Cervicitis and endocervicitis	Direct	**N72**	Inflammatory disease of cervix uteri *Use Additional code (B95-B97), to identify infectious agent
616.10	Vaginitis and vulvovaginitis, unspecified	Approx.	**N76.0** **N76.1** **N76.2** **N76.3**	Acute vaginitis Subacute and chronic vaginitis Acute vulvitis Subacute and chronic vulvitis *Use Additional code (B95-B97), to identify infectious agent
623.5	Leukorrhea, not specified as infective	Approx.	**N89.8**	Other specified non-inflammatory disorders of vagina
625.0	Dyspareunia	Direct	**N94.1**	Dyspareunia
782.1	Rash and other nonspecific skin eruption	Direct	**R21**	Rash and other nonspecific skin eruption
788.1	Dysuria	Approx.	**R30.0** **R30.9**	Dysuria Painful micturition, unspecified
788.7	Urethral discharge	Approx.	**R36.0** **R36.9**	Urethral discharge without blood Urethral discharge, unspecified
795.00	Abnormal glandular Papanicolaou smear of cervix	Approx.	**R87.619**	Unspecified abnormal cytological findings in specimens from cervix uteri
795.01 **795.02**	Papanicolaou smear of cervix with atypical squamous cells of undetermined significance ASC-US Papanicolaou smear of cervix with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)	Direct	**R87.610**	Atypical squamous cells of undetermined significance on cytologic smear of cervix (ASC-US) Atypical squamous cells cannot exclude high grade squamous intraepithelial lesion on cytologic smear of cervix (ASC-H)
795.03	Papanicolaou smear of cervix with low grade squamous intraepithelial lesion (LGSIL)	Direct	**R87.612**	Low grade squamous intraepithelial lesion on cytologic smear of cervix (LGSIL)
795.04	Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL)	Direct	**R86.613**	High grade squamous intraepithelial lesion on cytologic smear of cervix (HGSIL)
795.09	Other abnormal Papanicolaou smear of cervix and cervical HPV	Approx.	**R87.820**	Cervical low risk human papillomavirus (HPV) DNA test positive
795.10 **795.19**	Abnormal glandular Papanicolaou smear of vagina Other abnormal Papanicolaou smear of vagina and vaginal HPV	Approx.	**R87.628**	Other abnormal cytological findings on specimens from vagina * Use additional code to identify acquired absence of the uterus and cervix, if applicable (Z90.71-)

ICD-9	Description	Direct/ Approx.	ICD-10	Description
Contraceptive Related Codes				
V25.01	General counseling on prescription of oral contraceptives	Direct	**Z30.011**	Encounter for initial prescription of contraceptive pills
V25.02	General counseling on initiation of other contraceptive measures	Approx.	**Z30.013** **Z30.014** **Z30.018** **Z30.019**	Encounter for initial prescription of injectable contraceptive Encounter for initial prescription of intrauterine contraceptive device Encounter for initial prescription of other contraceptives General counseling on initiation of other contraceptive measures
V25.03	Encounter for emergency contraceptive (EC) counseling and prescription	Direct	**Z30.012**	Encounter for prescription of emergency contraception (EC)
V25.09	Other general counseling and advice on contraceptive management	Direct	**Z30.09**	Encounter for other general counseling and advice on contraception
V25.11	Encounter for insertion of IUD	Direct	**Z30.430**	Encounter for insertion of IUD
V25.12	Encounter for removal of IUD	Direct	**Z30.432**	Encounter for removal of IUD
V25.13	Encounter for removal and reinsertion of IUD	Direct	**Z30.433**	Encounter for removal and reinsertion of IUD
V25.40	Contraceptive surveillance, unspecified	Direct	**Z30.40**	Encounter for surveillance of contraceptives, unspecified
V25.41	Surveillance of contraceptive pill	Direct	**Z30.41**	Encounter for surveillance of contraceptive pills
V25.42	Surveillance of IUD	Direct	**Z30.431**	Encounter for routine checking of IUD
V25.43 **V25.49** **V25.5**	Surveillance of implantable subdermal contraceptive (Nexplanon) Surveillance of other contraceptive method Insertion of implantable subdermal contraceptive	Approx.	**Z30.49**	Encounter for surveillance of other contraceptives
V25.8	Other specified contraceptive management	Approx.	**Z30.8**	Encounter for other contraceptive management
V25.9	Unspecified contraceptive management	Approx.	**Z30.9**	Encounter for contraceptive management, unspecified
Pregnancy Related Codes				
V22.0	Supervision of normal first pregnancy		**Z34.0** **Z34.00** **Z34.01** **Z34.02** **Z34.03**	Encounter for supervision of normal first pregnancy …… unspecified trimester …… first trimester …… second trimester …… third trimester
V22.1	Supervision of other normal pregnancy		**Z34.8** **Z34.80** **Z34.81** **Z34.82** **Z34.83**	Encounter for supervision of other normal pregnancy …… unspecified trimester …… first trimester …… second trimester …… third trimester
V23.8	Other high-risk pregnancy		**009**	Supervision of high-risk pregnancy (requires 4th and 5th digits)

ICD-9	Description	Direct/ Approx.	ICD-10	Description
V23.8	Other high-risk pregnancy (continued)		**009.0**	Supervision of pregnancy with history of infertility
			009.00	…… unspecified trimester
			009.01	…… first trimester
			009.02	…… second trimester
			009.03	…… third trimester
			009.1	Supervision of pregnancy with history of ectopic or molar pregnancy
			009.10	…… unspecified trimester
			009.11	…… first trimester
			009.12	…… second trimester
			009.13	…… third trimester
			009.2	Supervision of pregnancy with other poor reproductive or obstetric history
			009.21	Supervision of pregnancy with history of pre-term labor
			009.211	…… first trimester
			009.212	…… second trimester
			009.213	…… third trimester
			009.219	…… unspecified trimester
			009.29	Supervision of pregnancy with other poor reproductive or obstetric history
			009.291	…… first trimester
			009.292	…… second trimester
			009.293	…… third trimester
			009.299	…… unspecified trimester
			009.3	Supervision of pregnancy with insufficient antenatal care
			009.30	…… unspecified trimester
			009.31	…… first trimester
			009.32	…… second trimester
			009.33	…… third trimester
			009.4	Supervision of pregnancy with grand multiparity
			009.40	…… unspecified trimester
			009.41	…… first trimester
			009.42	…… second trimester
			009.43	…… third trimester
			009.5	Supervision of elderly primigravida and multigravida
			009.51	Supervision of elderly primigravida
			009.511	…… first trimester
			009.512	…… second trimester
			009.513	…… third trimester
			009.519	…… unspecified trimester
			009.52	Supervision of elderly multigravida
			009.521	…… first trimester
			009.522	…… second trimester
			009.523	…… third trimester
			009.529	…… unspecified trimester

ICD-9	Description	Direct/ Approx.	ICD-10	Description
V23.8	Other high-risk pregnancy (continued)		**009.6**	Supervision of young primigravida and multigravida
			009.61	Supervision of young primigravida
			009.611	…… first trimester
			009.612	…… second trimester
			009.613	…… third trimester
			009.619	…… unspecified trimester
			009.62	Supervision of young multigravida
			09.621	…… first trimester
			009.622	…… second trimester
			009.623	…… third trimester
			009.629	…… unspecified trimester
			009.7	Supervision of high-risk pregnancy due to social problems
			009.70	…… unspecified trimester
			009.71	…… first trimester
			009.72	…… second trimester
			009.73	…… third trimester
			009.8	Supervision of other high-risk pregnancies
			009.81	Supervision of pregnancy resulting from assisted reproductive technology
			009.811	…… first trimester
			009.812	…… second trimester
			009.813	…… third trimester
			009.819	…… unspecified trimester
			009.82	Supervision of pregnancy with history of inutero procedure during previous pregnancy
			009.821	…… first trimester
			009.822	…… second trimester
			009.823	…… third trimester
			009.829	…… unspecified trimester
			009.89	Supervision of other high-risk pregnancies
			009.891	…… first trimester
			009.892	…… second trimester
			009.893	…… third trimester
			009.899	…… unspecified trimester
			009.9	Supervision of high-risk pregnancy, unspecified
			009.90	…… unspecified trimester
			009.91	…… first trimester
			009.92	…… second trimester
			009.93	…… third trimester

Current Procedural Terminology (CPT) Codes

Current Procedural Terminology (CPT®) codes were developed and are maintained by the American Medical Association (AMA). They are alphanumeric codes that medical coders and billers use to report health care services and procedures to payers for reimbursement. The purpose of CPT® is to provide a uniform language accurately describing medical, surgical and diagnostic services. Level II HCPCS codes are used to capture supplies such as drugs, devices and other supplies used for treating the patient. Together, the codes serve as an effective means for reliable nationwide communication within the health care industry. CPT codes and guidelines should be reviewed prior to billing of services using the official AMA CPT guide. Please direct any questions regarding codes to the payer being billed. The following is a subset of common codes that describes STD and HIV related diagnostic services and supplies:

COMMON CPT CODES

CPT/HCPCS	Type	Description
HIV Related Diagnostic Lab Tests		
86689	Lab - HIV	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86701	Lab - HIV	Antibody; HIV-1
86702	Lab – HIV	Antibody; HIV-2
86703	Lab - HIV	Antibody; HIV-1 and HIV-2, single result
87389	Lab - HIV	EIA HIV 1 antibody with HIV 1 & HIV2 antigens: qualitative or semi-quantitative; single step
87390	Lab - HIV	EIA HIV 1; qualitative or semi-quantitative; multi-step
87391	Lab - HIV	EIA HIV 2; qualitative or semi-quantitative; multi-step
87534	Lab - HIV	DNA/RNA; HIV 1; direct probe
87535	Lab - HIV	DNA/RNA; HIV 1; amplified probe
87536	Lab - HIV	DNA/RNA; HIV 1; quantification
87537	Lab - HIV	DNA/RNA; HIV 2; direct probe
87538	Lab - HIV	DNA/RNA; HIV 2; amplified probe
87539	Lab - HIV	DNA/RNA; HIV 2 quantification
87900	Lab - HIV	HIV phenotype testing for prediction using (regularly updated) genotype biochemical and biological analysis
87901	Lab - HIV	HIV genotype testing (mutation analysis) for resistance
87903	Lab - HIV	HIV phenotype testing (resistance testing) - first 10 drugs

CPT/HCPCS	Type	Description
87904+	Lab - HIV	HIV phenotype testing (resistance testing) - for each additional drug (list separately in addition to primary procedure)
87906	Lab - HIV	HIV Genotype DNA/RNA
87999	Lab - HIV	Trofile Co-Receptor Tropism Assay
G0432	Lab - HIV	EIA HIV-1/HIV-2 screen *(Use for Medicare and some commercial payers)*
G0433	Lab - HIV	ELISA HIV-1/HIV-2 screen *(Use for Medicare and some commercial payers)*
G0435	Lab - HIV	Oral HIV-1/HIV-2 screen *(Use for Medicare and some commercial payers)*
S3645	Lab - HIV	HIV-1 antibody testing of oral mucosal transudate *(Use for Medicare and some commercial payers)*
Other STD Related Diagnostic Lab Tests		
Chlamydia (CT)		
86631	Lab - CT	Chlamydia antibody
86632	Lab - CT	Chlamydia igm antibody
87110	Lab - CT	Chlamydia culture, any source
87270	Lab - CT	Chlamydia antigen detection by immunofluorescent technique
87320	Lab - CT	Chlamydia antigen detection by enzyme immunoassay technique
87490	Lab - CT	Chlamydia trachomatis dna direct probe technique
87491	Lab - CT	Chlamydia trachomatis, amplified probe technique
87492	Lab - CT	Chlamydia trachomatis, quantification
87810	Lab - CT	Chlamydia antigen detection by immunoassay with direct optical observation
Gonorrhea (GC)		
87081	Lab - GC	Culture, presumptive, pathogenic organisms, screening only
87590	Lab - GC	Neisseria gonorrhea, direct probe technique
87591	Lab - GC	Neisseria Gonorrhea, amplified probe technique
87592	Lab - GC	Neisseria gonorrhea, quantification
87850	Lab - GC	Neisseria gonorrhea antigen detection by immunoassay with direct optical observation
Hepatitis A (HAV), Hepatitis B (HBV), Hepatitis C (HCV)		
86708	Lab - HAV	Hepatitis A antibody (HAAb); total
86709	Lab - HAV	Hepatitis A antibody (HAAb); IgM antibody
86704	Lab - HBV	Hepatitis B core antibody (HBcAb); total
86705	Lab - HBV	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Lab - HBV	Hepatitis B surface antibody (HBsAb)
87340	Lab - HBV	Hepatitis B surface antigen detection by EIA (HBsAg)
87341	Lab - HBV	Hepatitis B surface, ag, eia

CPT/HCPCS	Type	Description
87912	Lab - HBV	Hepatitis B virus; Infectious agent genotype analysis by nucleic acid (DNA or RNA)
86803	Lab - HCV	Hepatitis C antibody
86804	Lab - HCV	Hepatitis C antibody; confirmatory test (eg, immunoblot)
87520	Lab - HCV	Hepatitis C, direct probe technique
87521	Lab - HCV	Hepatitis C, amplified probe technique
87522	Lab - HCV	Hepatitis C, quantification
87902	Lab - HCV	Hepatitis C virus; Infectious agent genotype analysis by nucleic acid (DNA or RNA)
G0472	Lab - HCV	Hepatitis C antibody screening for individual at high risk and other covered indication(s) *(Use for Medicare and some commercial payers)*
Herpes (HSV)		
86695	Lab - HSV	AB, Herpes Simplex Type 1
86696	Lab - HSV	AB, Herpes Simplex Type 2
87252	Lab - HSV	Culture, Herpes Simplex Virus
HPV		
87623	Lab - HPV	Human Papillomavirus (HPV), low-risk types (e.g., 6, 11, 42, 43, 44) – ***NEW 2015***
87624	Lab - HPV	Human Papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) – ***NEW 2015***
87625	Lab - HPV	Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed – ***NEW 2015***
Syphilis		
86592	Lab - Syph	Syphilis test, Qualitative (e.g., VDRL, RPR)
86593	Lab - Syph	Syphilis test, Quantitative (e.g., VDRL, RPR)
87164	Lab - Syph	Dark field exam for Syphillis, Treponema pallidum exam, Spirochetes
Other Commonly Used Codes		
81002	Lab	Dipstick or tablet reagent urinalysis (non-automated)
81003	Lab	Dipstick or tablet reagent urinalysis (automated, without microscopy)
81025	Lab	Urine pregnancy test
86380	Lab	CD4 County
86580	Lab	Purified protein derivative (PPD) skin test
87205	Lab	Smear Primary Source, Gram
87210	Lab	Smear, wet mount, (eg, saline, India ink, KOH preps)
87220	Lab	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi
88142	Lab	Cytopath, c/v, thin layer (Pap smear)

CPT/HCPCS	Type	Description
Vaccines—Common		
90632	HAV	Hepatitis A adult dosage)
90633	HAV	Hepatitis A Pedi/adolescent dosage - 2 dose schedule
90634	HAV	Hepatitis A Pedi/adolescent dosage - 3 dose schedule
90636	HAV/HBV	HAV/HBV Combo (Twinrix)
90739	HBV	Hepatitis B adult dosage - 2 dose schedule
90740	HBV	Hepatitis B for immunosuppressed - 3 dose schedule
90743	HBV	Hepatitis B Adolescent dosage - 2 dose schedule
90744	HBV	Hepatitis A Pedi/adolescent dosage - 3 dose schedule
90746	HBV	Hepatitis B Adult dosage – 2 dose schedule
90747	HBV	Hepatitis B for immunosuppressed - 4 dose schedule
90649; 90650	Toxoid	HPV – Gardasil; Cervarix
Administrations		
36415	Admin	Collection of venous blood by venipuncture
36416	Admin	Collection of capillary blood specimen (e.g., finger, heel, ear stick)
90465-90474	Admin	Administration of vaccines
96372	Admin	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular
Contraceptive / Drug Supplies—Common		
A4267	Supply	Contraceptive supply, condom, male, each
A4268	Supply	Contraceptive supply, condom, female, each
J0456	Drug	Injection, azithromycin, 500 mg
J0561	Drug	Injection, penicillin g benzathine, 100,000 unit
J0696	Drug	Injection, ceftriaxone sodium, per 250 mg
J1050	Drug	Injection, medroxyprogesterone acetate, 1 mg (Depo Provera)
J7300 **J7301** **J7302**	LARC LARC LARC	IUD - Copper Paragard IUD - Skyla IUD - Mirena
J7303	Supply	Contraceptive supply, hormone containing vaginal ring, each
J7304	Supply	Contraceptive supply, hormone containing patch, each
J7307	LARC	Etonogestrel (contraceptive) implant system, including implant and supplies (Nexplanon, Implanon)
J3490	Drug	Emergency Contraception – *Check with Payer for appropriate code*
S4994	Drug	Contraceptive pills for birth control

CPT/HCPCS	Type	Description
Procedures, Medical Visits and Other Services		
17110/17111	Procedure	Molluscum Destruction (1-14/15+)
46900/46924	Procedure	Destruction of lesions, anus (simple/extensive)
54050/54065	Procedure	Destruction of lesions, penis (simple/extensive)
56501/56515	Procedure	Destruction of lesions, vulva (simple/extensive)
57061/57065	Procedure	Destruction of lesions, vaginal (simple/extensive)
57454	Procedure	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
99384; 99385; 99386, 99387	E/M	Initial comprehensive preventive medicine evaluation and management, new patient; 12-17 years of age; 18-39 years of age; 40-64 years of age; 65 years and older
99394; 99395; 99396; 99397	E/M	Periodic comprehensive preventive medicine reevaluation and management, established patient; 12-17 years of age; 18-39 years of age; 40-64 years of age; 65 years and older
99201 - 99205	E/M	Office or other outpatient visit for the evaluation and management of a new patient (Brief, Focused, Expanded, Detailed, Comprehensive based on 3 key components: History, Exam and Medical-decision-making OR counseling time documented)
99211 - 99215	E/M	Office or other outpatient visit for the evaluation and management of an established patient (Brief, Focused, Expanded, Detailed, Comprehensive based on 3 key components: History, Exam and Medical-decision-making OR counseling time documented)
99401-99404	Counseling	Preventive counseling (*Time-based codes)
99406; 99407	Counseling	Smoking and tobacco-use cessation counseling visit (Intermediate > 3 minutes, <= 10 minutes; Intensive > 10 minutes)
G0436; G0437	Counseling	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes; Intensive, greater than 10 minutes); *(Use for Medicare and some commercial payers)*
G0445	Counseling	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; *(Use for Medicare and some commercial payers)*
99408; 99409	Counseling	Alcohol and/or substance abuse structured screening and brief intervention services; (15 to 30 minutes; >30 minutes)
G0442; G0443	Counseling	Annual alcohol misuse screening, 15 minutes; Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) *(Use for Medicare and some commercial payers)*
T1013	Other	Interpreter Services
99051	Other	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service (Also see 99050 – 99060)

Modifiers

The use of modifiers is an important part of coding and billing for health care services. Modifiers are two-digit codes (numeric or alphanumeric) appended to CPT and/or HCPCS codes to indicate that a procedure or service has been altered by a specific circumstance, but has not changed the code's definition. Third-party payers will also specify which modifiers you can use. In some cases, adding a modifier may directly alter reimbursement.

Modifier 92—Alternative Laboratory Platform Testing: With current CDC recommendations on routine testing and the move toward HIV testing as a routine part of care, more providers may use rapid test kits. Several of these are CLIA-waived and suitable for use in physician offices. The following is the CPT guidance for use of this modifier: "When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703)." Only report with Path/Lab test codes (86701-86703, G0433-G0435).*

Modifier QW—CLIA waived test: In accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), a laboratory provider must have: a Certificate of Compliance, a Certificate of Accreditation or a Certificate of Registration in order to perform clinical diagnostic laboratory procedures of high or moderate complexity. Waived tests include test systems cleared by the FDA designated as simple, have a low risk for error and are approved for waiver under the CLIA criteria. Only report with Path/Lab test codes (86701-86703, G0433-G0435)*

*Source: http://www.healthhiv.org/modules/info/files/files_5152a897e-a12e.pdf

CODING SCENARIOS

A **20-year-old single male** returns to your clinic for HIV screening. He declines other STD testing. He has had recent multiple sexual partners, both male and female. The clinician meets with the patient and counsels him on HIV and risk reduction. Face-to-face counseling is documented as greater than 50% of the 15-minute visit with the clinician. Patient is given an HIV rapid test. Test results are negative. What codes do we need for this visit?

CPT/HCPCS Codes:
99213 for problem focused E/M for an established patient, 86701 with modifier 92 for antibody HIV-1 test *or* 86703 with modifier 92 for antibody HIV-1 and HIV-2 single assay. Append Modifier 92 to indicate rapid test, Alternative Laboratory Platform Testing.

Related ICD-9 Codes:
V73.89 Special screening for other specified viral diseases (HIV), V69.2 High risk sexual behavior, V65.44 HIV Counseling**.**

Related ICD-10 Codes:
Z11.4 Encounter for screening for human immunodeficiency virus (HIV), Z72.53 High risk bisexual behavior, Z71.7 Human immunodeficiency virus (HIV) counseling.

A **25-year-old female** returns to your clinic for her HIV results as a follow-up to an earlier exam. The clinician advises the patient she is HIV+ (asymptomatic HIV). The clinician counsels her about what it means to be HIV+, reviews risk factors, and refers her to an HIV specialist. Face-to-face counseling with the clinician is 15 of the minutes of the 20-minute encounter. What codes do we need for this visit?

CPT/HCPCS Codes:
99213 for established patient problem focused E/M.

Related ICD-9 Codes:
V08 Asymptomatic human immunodeficiency virus (HIV) infection status, V65.44 HIV Counseling**.**

Related ICD-10 Codes:
Z21 Asymptomatic human immunodeficiency virus (HIV) infection status, Z71.7 Human immunodeficiency virus (HIV) counseling.

An **18-year-old female** patient returns to your clinic Wednesday evening at 7 p.m. to have extensive genital warts on her vulva removed that were diagnosed at her previous visit. The clinician treats the lesions using cryosurgery. What codes do we need for this visit?

CPT/HCPCS Codes:
56515 for destruction of vulvar warts, extensive, 99051 for regularly scheduled office evening hours after 6 pm.

Note: Do not bill for an E/M unless the documentation clearly supports it being separate and distinct from the lesion removal procedure.

Related ICD-9 Codes:
078.11 Condyloma accuminatum.

Related ICD-10 Codes:
A63.0 Anogenital (venereal) warts.

A **26-year-old male** presents to your clinic for the first time. He meets with the clinician and expresses concern over his partner having a vaginal discharge and "wants to be checked". Genital exam is negative. Specimens are obtained for gonorrhea (GC) and chlamydia (CT) testing, and blood draw is performed for syphilis, HSV, HPV and HIV serologies. Patient is given condoms x 12 and counseled on safe sex practices. Face-to-face counseling time is documented as > 50% of the 20 minute encounter with the clinician. What codes do we need for this visit?

CPT/HCPCS Codes:
99202 for problem-focused E/M for a new patient based on time, 36415 for venipuncture for blood draw; Outside lab will bill for ordered tests. A4267 for contraceptive supply, condom, male, each. Check with payers regarding reimbursement for condoms.

Related ICD-9 Codes:
V01.6 Contact with or exposure to venereal diseases, V74.5 Screening Venereal Disease, V73.89 Special screening for other specified viral diseases (HIV), V73.98 Special screening examination for unspecified chlamydial disease, V73.81 Special screening examination for Human papillomavirus (HPV).

Related ICD-10 Codes:
Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission, Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission, Z11.4 Encounter for screening for human immunodeficiency virus (HIV), Z11.8 Encounter for screening for other infectious and parasitic diseases, Z11.51 Encounter for screening for human papillomavirus (HPV).

A **32-year-old established female patient** presents seeking GC treatment. Her male partner of 1 year was treated 2 days prior after coming to the center for STI testing. She has been monogamous in the relationship. Using DMPA as contraception; condom use is described as "sporadic". Vitals taken and general appearance noted. GC /CT NAAT test ordered. Patient will be treated presumptively for GC. Ceftriaxone 250 mg IM injection given in right deltoid. Medications dispensed: Azithromycin 1GM po stat. Patient is counseled face-to-face by the clinician for more than 50% of this 20-minute visit in regards to STI and safe sex practices. Time is documented. Patient will call for results. What codes do we need for this visit?

CPT/HCPCS Codes:
99213 for problem-focused E/M for an established patient based on time, J0696 for the injection, ceftriaxone sodium, per 250 mg, 96372 therapeutic prophylactic, or diagnostic injection; subcutaneous or intramuscular and Q0144 for Azithromycin dehydrate, oral, capsules/powder, 1 gram. Outside lab will bill for ordered tests. Append a Modifier 25 to the E/M to show it is separate and distinct from the injection.

Related ICD-9 Codes:
V01.6 Contact with or exposure to venereal diseases, V74.5 screening examination for venereal disease, V73.98 Special screening examination for unspecified chlamydial disease, 098.0 Gonococcal infection (acute) of lower genitourinary tract. Note diagnosis codes for screening and testing are assigned until disease is confirmed by lab testing.

Related ICD-10 Codes:
Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission, Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission), Z11.8 Encounter for screening for other infectious and parasitic diseases, A54.00 Gonococcal infection of lower genitourinary tract, unspecified (review A54 codes for further specificity).

RESOURCES

- American Medical Association, CPT. www.ama-assn.org/go/cpt
- Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2010. MMWR 2010; 59 (No. RR-12). (Note: updated guidelines anticipated in 2015) http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm
- Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 2006; 55 (No. RR-14); 1-17. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm
- Centers for Medicare and Medicaid (CMS). Evaluation and Management Services Guide. November 2014. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf
- HCPCS codes, Centers for Medicare and Medicaid services. www.cms.gov/medhcpcsgeninfo
- ICD-9 Diagnosis Coding, ICD-9-CM Professional for Physicians—Volumes 1 & 2. OPTUM 2013.
- ICD-10-CM, The Complete Official Draft Code Set. OPTUM 2013.
- CMS Medicare Learning Network. Preventive Services Codes and Billing Information. January 2015 [click button for "HIV Screening"] https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
- US Preventive Task Force. Recommendations for STI Screening. http://www.uspreventiveservicestaskforce.org/uspstf08/methods/stinfections.htm