Preventive Services Payment Policy

Policy

Plan members have no member cost-sharing for preventive services rendered by in-network providers. Members may be required to pay a copayment, deductible, or coinsurance for non-preventive services received in conjunction with a preventive service visit, or for PPO members who receive preventive care from out-of-network providers.

Definitions

Preventive care: Services, tests, and immunizations that are intended to screen for diseases or conditions and to improve early detection of disease when there is no diagnosis or symptoms present. This includes immunizations, health maintenance visits (routine physical exams) for adults and children, as well as mammograms, Pap tests and other tests associated with the health maintenance visit, prenatal maternity care, well child care (including vision and auditory screening), voluntary family planning, nutrition counseling, and health education.

Reimbursement

Claims for preventive services must be submitted with service and diagnosis codes indicating that the service is preventive. Preventive ICD-10 codes must be in the primary diagnosis position. If another diagnosis is in the primary position on the claims, the service may be subject to member cost-sharing.

Reimbursement will be made for a preventive code with a problem focused code when modifier 25 is applied to the problem-focused code. Reimbursement for the preventive service will be made at 100% of the contracted rate, and reimbursement for the problem focused service will be made at 50% of the contracted rate. This should only occur when a significant abnormality or pre-existing condition is addressed and additional work is required to perform the key components of a problem focused E&M service, and services should be submitted on the same claim. Members have no copayment and/or deductible for routine physical exams. Medicare Advantage plan members will be responsible for a copayment and/or deductible when a problem-focused code with modifier 25 is included on the claim. Therefore, the appropriate use of modifier 25 is critical since it will be transparent to members. Beginning October 1, 2014, the Plan will not calculate a copayment and/or deductible for E&M codes submitted with modifier 25 when billed with annual preventive services for members enrolled in a commercial plan. Those services coded with modifier 25 will be regularly reviewed for coding accuracy.

The Plan reimburses advance care planning including the explanation and discussion of advance directives (CPT codes 99497 and 99498) with no member cost-share when provided with an annual preventive visit. Member cost-share will be required when these services are provided outside of the annual preventive visit.

Billing/coding guidelines

In order for a service to be considered preventive care, a preventive diagnosis must be the primary diagnosis on the claim. In addition, each claim line should indicate the applicable diagnosis. In cases where the diagnosis is not preventive in nature, cost-sharing will apply. The below coding represents services and diagnose codes that the Plan considers preventive, while the below listed are considered preventive there may be other preventive benefits available based upon the member's plan type. As some CPT/HCPCS codes can be both preventive and diagnostic the appropriate preventive diagnostic code should be billed.

Abdominal Aortic Aneurysm

Code	Description	Guidance/Instructions
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal	Per USPSTF recommendation should be performed for men

	aortic aneurysm (AAA)	65-75 years with a history of smoking.

Alcohol Misuse Counseling

Code	Description	Guidance/Instructions
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	No specific diagnosis code required
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	

Behavioral health screening in primary care for MassHealth ACO members

Behavioral health screening using a standardized behavioral health screening tool is covered for MassHealth ACO members from birth to 21 years.

Behavioral health assessment should occur at every preventive visit, including initial and periodic visits, from newborn to 21 years, with standardized behavioral health screening performed if there are concerns. In performing behavioral health screening, providers should use one of the clinically appropriate tools listed in Appendix W (EPSDT Periodicity Schedule) of the MassHealth Provider Manual. Primary care providers who conduct behavioral health screenings according to Appendix W will receive separate payment for the behavioral health screening when billed with a preventive visit.

Behavioral health screening is billed using CPT 96110. Claims for CPT 96110 must be submitted with a U modifier (U1 through U8) to indicate whether a behavioral health need was identified. “Behavioral health need identified” means the provider administering the screening tool, in his or her professional judgment, identified a child with a potential behavioral health services need.

When the Edinburgh Postnatal Depression Scale (EPDS) is administered to caregivers of infants younger than six months, an additional, second modifier (UD) is required, signifying that the EPDS is the screening tool administered. Modifier UD must be used together with one of the U modifiers (U1 through U8).

Claims for CPT 96110 submitted for MassHealth ACO members 21 years of age and older will deny. Claims for CPT 96110 submitted without a U (U1 through U8) modifier will deny.

Code	Description	Guidance/Instructions
96110	Developmental testing (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation	Claims for CPT 96110 must be submitted with a U modifier (U1 through U8) to indicate whether a behavioral health need was identified.

Modifiers for use with CPT 96110:

Servicing Provider	Modifier for Use When No Behavioral Health Need Is Identified	Modifier for Use When Behavioral Health Need Is Identified
Physician, Certified Nurse Midwife, Independent Nurse Practitioner, Physician Assistant, Acute Outpatient Hospital; Physician Employed by a Community Health Center	U1	U2

Certified Nurse Midwife employed by a Community Health Center	U3	U4
Nurse Practitioner employed by a Physician or Community Health Center	U5	U6
Physician Assistant employed by a Community Health Center	U7	U8

Birth Control

Code	Description	Guidance/ Instructions
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection	The Plan covers Birth Control as preventative based upon the FDA Approved Categories Pharmacy related benefits can be located Here Please bill with the appropriate encounter code range encounters for contraceptive management Z30.0- Z30.9
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography	
11976	Removal, implantable contraceptive capsules	
11981	Insertion, non-biodegradable drug delivery implant	
11982	Removal, non-biodegradable drug delivery implant	
11983	Removal with reinsertion, non-biodegradable drug delivery implant	
57170	Diaphragm or cervical cap fitting with instructions	
58300	Insertion of intrauterine device (IUD)	
58301	Removal of intrauterine device (IUD)	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	
58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	
A4261	Cervical cap for contraceptive use	
A4266	Diaphragm for contraceptive use	
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg	
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg	
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg	
J7300	Intrauterine copper contraceptive	
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	
J7303	Contraceptive supply, hormone containing vaginal ring, each	
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	

BRCA

Code	Description	Guidance/Instructions
81212	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	Prior Authorization is required Considered preventive only when meeting the USPSTF B level recommendation here: Recommendation Use a below diagnoses code to indicate preventative Z80.0: Family history of malignant neoplasm of digestive organs Z80.3: Family history of malignant neoplasm of breast Z80.41: Family history of malignant neoplasm of ovary Z80.49: Family history of malignant neoplasm of other genital organs
81215	BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	
81216	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	
81217	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	

Breast Cancer Screening

Code	Description	Guidance/Instructions
77053	Mammary ductogram or galactogram, single duct, radiological supervision and interpretation	Use appropriate screening diagnostic codes Z12.31: Encounter for screening mammogram for malignant neoplasm of breast Z12.39 : Encounter for other screening for malignant neoplasm of breast
77054	Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation	
77061	Digital breast tomosynthesis; unilateral	
77062	Digital breast tomosynthesis; bilateral	
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	

Cervical Cancer Screening

Code	Description	Guidance/Instructions
88141-88175	Cytopath codes	Cervical Cancer Screening should be performed in accordance with the USPSTF recommendation Diagnosis codes: Z01.411: Encounter for gynecological examination (general) (routine) with abnormal findings Z01.419: Encounter for gynecological examination

		(general) (routine) without abnormal findings Z12.4: Encounter for screening for malignant neoplasm of cervix

Chlamydia and Gonorrhea Screening for Women

Code	Description	Guidance/Instructions
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	Chlamydia and Gonorrhea screenings are appropriate for woman as outlined by USPSTF Recommendation
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique	

Colorectal Cancer Screening

Commercial and MassHealth members

What's new: Effective May 18, 2021, the USPSTF has expanded the recommended ages for colorectal cancer screening to 45 to 75 years of age (previously it was 50 to 75 years). Recommended screening strategies include:

- High-sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year
- Stool DNA-FIT every 1 to 3 years
- Computed tomography colonography every 5 years
- Flexible sigmoidoscopy every 5 years
- Flexible sigmoidoscopy every 10 years + annual FIT
- Colonoscopy screening every 10 years

Code	**Description**	**Guidance/Instructions**
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	For commercial and MassHealth members, colorectal cancer screening is covered in accordance with the USPSTF A and B Recommendations in effect at the time the service is rendered (Colorectal Cancer: Screening, updated May 18, 2021). ICD-10 Codes Z12.11: Encounter for screening for malignant neoplasm of colon Z80.0: Family history of malignant neoplasm of digestive organs
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	
45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination	
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	

45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	
45379	Colonoscopy, flexible; with removal of foreign body(s)	
45380	Colonoscopy, flexible; with biopsy, single or multiple	
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	
45382	Colonoscopy, flexible; with control of bleeding, any method	
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	
45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	
45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	
81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result Use for Cologuard™ multitarget stool DNA (sDNA) test	
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection) Use for HSgFOBT	
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations Use for Fecal Immunochemical Test (FIT), such as InSure®	
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness	

	and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age	
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age	
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older	
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	

Colorectal Cancer Screening

Medicare members

What's new: Effective for dates on service on or after January 19, 2021, a blood-based biomarker test is covered as a colorectal cancer screening test once every 3 years for Medicare members when all of the following criteria are met:

- The member is age 50-85 years of age, and is
  - Asymptomatic (no signs or symptoms of colorectal cancer including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immuochemical test), and
  - At average risk of developing colorectal cancer (i.e., (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

- The blood-based biomarker screening test has FDA approval with an indication for colorectal cancer screening, and the test has both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in the detection of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), based on the pivotal studies included in the FDA labeling.

Code	Description	Guidance/Instructions
81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result Use for Cologuard™ multitarget stool DNA (sDNA) test	For Medicare members, colorectal cancer screening for is covered in accordance with National Coverage Determination (NCD) for Colorectal Cancer Screening Tests (210.3) ICD-10 Codes Z86.004 For multitarget sDNA testing and blood-based testing, use ICD-10 codes Z12.11 and Z12.12 For additional information on coverage for colorectal cancer screening services, refer to Medicare Preventive Services Chart[1]
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection) Use for HSgFOBT	
G0104	Colorectal cancer screening; flexible sigmoidoscopy	
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	
G0106	Colorectal cancer screening; alternative to g0104, screening sigmoidoscopy, barium enema	
G0120	Colorectal cancer screening; alternative to g0105, screening colonoscopy, barium enema	
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	
G0327	Colorectal cancer screening; blood-based biomarker The currently available Epi proColon® (Epigenomics) and ColoVantage (Quest Diagnostics) blood-based biomarker colorectal cancer screening tests do not meet Medicare criteria. At this time, Epi proColon® test and Colovantage are not covered tests.	
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous Use for Fecal Immunochemical Test (FIT), such as InSure®	
G0500	Moderate sedation services provided by the same physician or other qualified health-care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older.	

[1] Medicare Preventive Services Chart available at: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html.

	Report G0500 for all endoscopic procedures where moderate sedation is inherent to the procedure. Additional time may be reported with 99153, as appropriate.	
99153	Moderate sedation services provided by the same physician or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intra- service time (List separately in addition to code for primary service).	
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	

Depression Screening

Code	Description	Guidance/Instructions
G0444	Annual depression screening, 15 minutes	Bill with a screening code if billed with part of other preventative services. Specific Diagnosis Code Z13.3: Encounter for screening examination for mental health and behavioral disorders

Fluoride Varnish

Code	Description	Guidance/Instructions
99188	Application of topical fluoride varnish by a physician or other qualified health care professional	Appropriate for children in accordance with the USPSTF Recommendation Bill with an appropriate encounter code related to a newborn Z00.1 range or child Z00.12 range
D1206	Topical application of fluoride varnish D1206 should only be used by dentists to bill for topical application of fluoride varnish for plan members with preventive dental coverage.	

Hearing Screening in Children

American Academy of Audiology Childhood Hearing Screening Guidelines[2] recommendations for hearing screening:

1. Screen children age 3 (chronologically and developmentally) and older using pure tone screening.
2. Otoacoustic emissions (OAE) should be used only when screening preschool and school age children for whom pure tone screening is not developmentally appropriate (ability levels < 3 years).
3. Tympanometry should be used as a second-stage screening method following failure of pure tone or otoacoustic emissions screening.

Code	**Description**	**Guidance/Instructions**
92551	Screening test, pure tone, air only	ICD-10 Codes Z00.121

[2] Available at: https://www.cdc.gov/ncbddd/hearingloss/recommendations.html.

92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	Routine child health exam with abnormal findings Z00.129 Routine child health exam without abnormal findings
92567	Tympanometry (impedance testing)	

Note: ICD-10 codes Z01.10 (encounter for examination of ears and hearing without abnormal findings) and Z01.118 (encounter for examination of ears and hearing with other abnormal findings) are reported only when a child presents for an encounter specific to ears and hearing, not for a routine well-child examination at which a hearing screening is performed.

Hepatitis B Virus Screening

Code	**Description**	**Guidance/Instructions**
87340	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)	The USPSTF recommends screening for those at high risk and for pregnant women Please utilize these diagnoses for high risk Z11.3 (Encounter for screening for infections with a predominantly sexual mode of transmission) Z11.59 (Encounter for screening for other viral diseases) Please utilize an appropriate encounter code related to pregnancy for pregnant woman
87341	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization	
G0499	Hepatitis B screening in non-pregnant, high risk individual includes hepatitis B surface antigen (HBSAG) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to HBSAG (anti-HBS) and hepatitis B core antigen (anti-HBC)	

Hepatitis C Virus Screening for Commercial and MassHealth Members

What's new: Effective March 2, 2020, the USPSTF expanded the population that should be screened for Hepatitis C virus to include asymptomatic adults aged 18 to 79 years (including pregnant women) without known liver disease. Previously the USPSTF recommended Hepatitis C virus screening in adults born between 1945 and 1965 and others at high risk.

Most adults should only be screened once per lifetime. Persons with continued risk for HCV infection (e.g., past or current injected drug use) should be screened periodically.

Note: A positive screening Hepatitis C antibody test result may be followed by diagnostic PCR (polymerase chain reaction) testing (e.g., CPT 87522). Diagnostic lab testing for commercial members is subject to member cost-sharing.

Code	Description	Guidance/Instructions
86803	Hepatitis C antibody;	For commercial and MassHealth members, Hepatits C virus screening is covered in accordance with the USPSTF A and B Recommendations in effect at the time the service is rendered: Hepatitis C Virus

		Infection in Adolescents and Adults: Screening (Updated March 2, 2020). Please utilize these diagnoses for high risk Z11.3 (Encounter for screening for infections with a predominantly sexual mode of transmission) Z11.59 (Encounter for screening for other viral diseases)

Hepatitis C Virus Screening for Medicare Members

Code	Description	Guidance/Instructions
G0472	Hepatitis C antibody screening, for individual at high risk and other covered indication(s) Please note: G0472 is the only code that should be reported for Hepatitis C screening under Medicare NCD 210.13 (MM9200).	For Medicare members, Hepatitis C screening is covered in accordance with the Medicare NCD for Screening for Hepatitis C Virus (HCV) in Adults (210.13) ICD-10 Codes Z72.89, F19.20

HPV Screening

Code	Description	Guidance/Instructions
87623	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)	Screenings will be covered based upon the USPSTF Recommendation Please utilize these diagnoses for high risk Z11.3 (Encounter for screening for infections with a predominantly sexual mode of transmission) Z11.59 (Encounter for screening for other viral diseases)
87624	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	
87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	

HIV Preexposure Prophylaxis (PrEP) for commercial and MassHealth ACO members

On June 11, 2019, the USPSTF released a recommendation that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. See Clinical Considerations on pages 2205-2206 of the USPSTF Recommendation Statement[3] for information about the identification of persons at high risk of HIV acquisition.

Accordingly, the Plan covers PrEP consistent with the USPSTF recommendation without cost sharing for plan years (in the individual market, policy years) beginning on or after one year from the issue date of the recommendation (in this case, plan or policy years beginning on or after June 30, 2020.

[3] The full USPSTF Recommendation Statement is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis.

Currently, two medications have been approved for use as PrEP by the US Food and Drug Administration (FDA).[4] Each consists of two drugs combined in a single oral tablet taken daily:

- Emtricitabine (F) 200 mg in combination with tenofovir disoproxil fumarate (TDF) 300 mg (F/TDF – brand name Truvada or generic equivalent).
- Emtricitabine (F) 200 mg in combination with tenofovir alafenamide (TAF) 25 mg (F/TAF – brand name Descovy)

To be effective, PrEP requires high levels of adherence. When taken as prescribed, oral PrEP is extremely effective in preventing HIV.

HIV PrEP medications are covered under the pharmacy (prescription drug) benefit. For additional information on pharmacy benefits, go to: https://www.fchp.org/members/commercial/Pharmacy/online-drug-formulary.aspx.

The USPSTF recommendation cites CDC guidelines[5] which advise that PrEP is a comprehensive intervention comprised of antiretroviral medication and essential support services (including medication self-management/adherence counseling, risk reduction strategies, and mental health counseling, etc.) that ensure PrEP is administered safely and effectively to plan members who need it.

All persons whose sexual or drug injection history indicates consideration of PrEP and who are interested in taking PrEP must undergo laboratory testing to identify those for whom this intervention would be harmful or for whom it would present specific health risks that would require close monitoring. Tests include HIV testing, Hepatitis B and C testing, pregnancy testing (if applicable), testing for renal insufficiency (creatinine testing and calculated estimated creatinine clearance (eCrCl) or glomerular filtration rate (eGFR)) and screening for sexually transmitted infections (STIs).

Who should not be prescribed PrEP?

- People with HIV – Plan members must be confirmed as HIV negative before initiating PrEP. Excluding people with acute HIV infection is critically important, as there is a risk of developing resistant HIV if they are inadvertently started on PrEP.
- People with renal insufficiency - Providers should confirm that the plan member's estimated creatinine clearance is ≥60 mL/minute (Cockcroft-Gault formula) before initiating F/TDF as PrEP or ≥30 mL/minute before initiating F/TAF as PrEP.

Recommended ICD-10-CM codes

Office visits must include a principal diagnosis/first-listed condition to be billable. Z20.6 (Contact with and (suspected) exposure to HIV), is classified as an acceptable principal diagnosis in the ICD-10-CM system. Use Z20.6 when coding PrEP office visits.

Lab tests prior to initiation use screening codes:

- Z11.4 - Encounter for screening for HIV
- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission

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[4] According to a September 28, 2021 press release (https://viivhealthcare.com/hiv-news-and-media/news/), ViiV Healthcare submitted a New Drug Application (NDA) to the U.S. Food and Drug Administration (FDA) for injectable cabotegravir. If approved, cabotegravir would be the first, long-acting injectable therapy for the prevention of HIV for individuals at risk of sexually acquired HIV-1 infection, who have a negative HIV-1 test prior to initiation.

[5] Comprehensive guidelines for prescribing PrEP have been published by the Centers for Disease Control and Prevention (CDC) in Preexposure Prophylaxis For The Prevention Of Hiv Infection In The United States – 2017 Update, A Clinical Practice Guideline. The CDC Clinical Practice Guideline is available at: https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf. An updated version of the CDC Clinical Practice Guideline is being developed for 2021.

- Z11.59 - Encounter for screening for other viral diseases

Subsequent lab tests (related to the ongoing risk of HIV, STD or HCV infection while taking PrEP) use contact with codes:

- Z20.6 - Contact with and (suspected) exposure to HIV
- Z20.2 - Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
- Z20.5 – Contact with and (suspected) exposed to viral hepatitis

Use Z71.7 (HIV counseling) for adherence/preventive counseling (99401-99404).

Lab tests ordered to evaluate conditions potentially associated with long-term use of PrEP medication (i.e., creatinine to assess for potential kidney injury) should include Z79.899 (Other long term (current) drug therapy).

Recommended CPT codes

Code(s)	Description	Guidance/Instructions
99202-99205	Office visit or other outpatient visit for the evaluation and management of a new patient	Office visits - Office visits are covered when the primary purpose of the office visit is the delivery of a component of the USPSTF recommendation that is not billed separately,
99211-99215	Office visit or other outpatient visit for the evaluation and management of an established patient	
86701	HIV-1	HIV testing - Plan members must be tested and confirmed to be uninfected before starting PrEP and tested again for HIV every three months while taking PrEP
86702	HIV-2	
86703	HIV-1 and HIV-2, single result	
87389	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	
86704	Hepatitis B core antibody (HBc-Ab); total	Baselline Hepatitis B testing – Hepatitis B virus infection is not a contraindication to PrEP, but plan members being considered for PrEP must be screened so that when the PrEP medication, which suppresses HBV replication in the liver, is stopped, the plan member can be monitored to ensure safety and to rapidly identify any potential injury.
86706	Hepatitis B surface antibody (HBsAb)	
87340	Hepatitis B surface antigen (HBsAG)	
87341	Hepatitis B surface antigen (HBsAG) neutralization	
86803	Hepatitis C antibody	Hepatitis C testing – Plan members should be screened at baseline for hepatitis C virus infection. Plan members with ongoing risk of contracting hepatitis C should be screened periodically consistent with CDC guidelines for hepatitis C screening.
86804	Hepatitis C antibody; confirmatory test (e.g., immunoblot	
82565	Creatinine; blood	Creatinine testing with calculation of estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR) – The estimated eCrCl

		or eGFR must be measured and calculated before beginning PrEP to assess if kidney function is in the range for safe prescribing of PrEP medication. Creatinine and eCrCL or eGFR should be checked periodically consistent with CDC guidelines while on PrEP medication to assess for potential kidney injury and to ensure that it is safe to continue PrEP medication.
87491	Chlamydia trachomatis, amplified probe technique	Testing for sexually transmitted infections (STIs) – Persons must be screened for STIs at baseline and should be screened periodically thereafter consistent with CDC guidelines, which may require multiple anatomic site testing (i.e., genital, oropharyngeal, and rectal) for gonorrhea and chlamydia, and testing for syphilis, together with behavioral counseling, which are recommended to reduce the risk of STIs, the presence of which may increase the likelihood of acquiring HIV sexually.
87591	Neisseria gonorrhoeae, amplified probe technique	
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe technique Use when performing combined chlamydia and gonorrhea testing	
86592	Syphilis test, non-treponemal antibody; qualitative	
86593	Syphilis test, non-treponemal antibody; quantitative	
86780	Treponema pallidum	
84702	Pregnancy test; hCG, total, quantitative	Persons with childbearing potential must be tested for pregnancy at baseline and should be tested again periodically thereafter consistent with CDC guidelines until PrEP is stopped so that pregnant patients, together with their health care providers, can make a fully informed and individualized decision about taking PrEP.
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)* * Any E&M service reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E&M selection	Adherence counseling – Persons taking PrEP must be offered regular counseling for assessment of behavior and adherence consistent with CDC guidelines to ensure that PrEP is used as prescribed and to maximize PrEP's effectiveness.

HIV Screening

Code	Description	Guidance/Instructions
86703	Antibody; HIV-1 and HIV-2, single result	Screenings will be covered in accordance with the USPSTF Recommendation

Lactation

Code	Description	Guidance/Instructions
S9443	Lactation classes, nonphysician provider, per session	Lactation counseling services performed within the scope of an office visit will not separately be reimbursed. Services may require member reimbursement.
E0603	Breast pump, electric (AC and/or DC), any type	Prior authorization may be required based on plan type.

Lung Cancer Screening

What's new: CMS reconsidered the NCD for lung cancer screening with low dose computed tomography (LDCT) (210.14) and determined that the evidence is sufficient to expand eligibility, effective February 10, 2022, to include Medicare beneficiaries who meet all of the following criteria:

- Age 50 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receive an order for lung cancer screening with LDCT.

Per NCD 210.14, before a Medicare beneficiary's first LDCT screening, the beneficiary must receive a counseling and shared decision-making visit that is appropriately documented in the beneficiary's medical records (see **Counseling and Shared Decision-Making Visit Prior to First Lung Cancer Screening for Medicare plan members** below).

What's new: Effective March 9, 2021, the USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Previously the USPFTS recommended screening in adults aged 55 to 80 years with a 30 pack-year smoking history. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

Code	Description	Guidance/Instructions
71271	Computed tomography (CT), thorax, low dose for lung cancer screening, without contrast material(s) Note: Effective January 1, 2021 HCPCS code G0297 has been replaced by new CPT code 71271.	Prior authorization is required for LDCT for lung cancer screening (CPT 71271) for commercial and MassHealth ACO plan members. Effective September 1, 2021, prior authorization is not required for CPT 71271 for Medicare Advantage, NaviCare and PACE plan

		members. For commercial and MassHealth members, annual lung cancer screening using LDCT is covered in accordance with the USPSTF Recommendation for Lung Cancer Screening (updated March 9, 2021). For Medicare members, annual lung cancer screening using LDCT is covered in accordance with the Medicare NCD for Lung Cancer Screening with Low Dose Computed Tomography (210.14).[6] ICD-10-CM Diagnosis Codes: F17.210, F17.211, F17.213, F17.218, F17.219, Z87.891

Counseling and Shared Decision-Making Visit Prior to First Lung Cancer Screening for Medicare plan members

Code	Description	Guidance/Instructions
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)	Covered for Medicare plan members only. This counseling visit is required prior to the first lung cancer screening using LDCT per Medicare NCD for Lung Cancer Screening with Low Dose Computed Tomography (210.14). The counseling and shared decision–making visit must be appropriately documented in the plan member's medical records. ICD-10-CM Diagnosis Codes: F17.210, F17.211, F17.213, F17.218, F17.219, Z87.891

Osteoporosis Screening

[6] LDCT lung cancer screening for Medicare members must be furnished in a radiology imaging facility that utilizes a standardized lung nodule identification, classification and reporting system per Medicare NCD 210.14. Additionally, the reading radiologist must must have board certification or board eligibility with the American Board of Radiology or equivalent organization..

Code	Description	Guidance/Instructions
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Only considered preventative if billed within the USPSTF Recommendation for woman 65 years and older or those with an increased risk below 65 as outlined in a formal clinical risk assessment tool

Other Preventive wellness screenings

Code	Description	Guidance/Instructions
80048	Basic metabolic panel (Calcium, total)	No specific billing instructions
80061	Lipid panel	
82043	Albumin; urine (eg, microalbumin), quantitative	
83036	Hemoglobin; glycosylated (A1C)	

Preventive Exams

Code	Description	Guidance/Instructions
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)	No specific billing instructions. Coverage is subject to the code being on the provider's contract.
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)	
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)	
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years	
99386	Initial comprehensive preventive medicine evaluation and management of an individual	

	including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years	
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older	
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)	
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)	
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)	
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years	
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years	
99397	Periodic comprehensive preventive medicine	

	reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older	
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	
S0610	Annual gynecological examination, new patient	
S0612	Annual gynecological examination, established patient	
S0613	Annual gynecological examination; clinical breast examination without pelvic evaluation	

Syphilis Screening

Code	Description	Guidance/Instructions
86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)	The USPSTF has recommends screening for Pregnant Women and those with Those with Increased Risk Use an appropriate pregnancy screening code or for those with increased risk Z11.3: Encounter for screening for infections with a predominantly sexual mode of transmission
86593	Syphilis test, non-treponemal antibody; quantitative	

Tobacco Cessation Counseling

Code	Description	Guidance/Instructions
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	Use diagnosis code Z78.871(Personal history of nicotine dependence) Pharmacy benefits are also available for smoking cessation please consult the Plan's website here Services for non-pregnant adults and pregnant woman should be performed based upon the USPTF Recommendation
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes Not covered for MassHealth ACO plan members)	
S9453	Smoking cessation classes, nonphysician provider, per session	

Vaccines: Please see the Plan’s Vaccination Payment Policy.

Vision Screening

<table>
<tr><th>Code</th><th>Description</th><th>Guidance/Instructions</th></tr>
<tr><td>99172</td><td>Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination[s] for contrast sensitivity, vision under glare)</td><td rowspan="2">The UPSTF indicates screening should be done for children 3-5 years.
Recommendation
Utilize an encounter code for in the Z00.1 (Encounter for newborn, infant and child health examinations) range.</td></tr>
<tr><td>99173</td><td>Screening test of visual acuity, quantitative, bilateral</td></tr>
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Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	01/01/2012
Previous revision date(s):	11/01/2014 - Updated discussion of preventive services with evaluation and management codes and moved to Fallon Health template. 11/01/2015 - Annual review and moved to new plan template. 07/01/2016 - Added codes 99497 and 99498.
Connection date & details:	May 2017 – Annual review. July 2018 – Annual review, no updates. January 2019 – Added coding to billing/coding section. January 2020 – Annual review, no updates. July 2021 – Updated Billing/coding guidelines for colorectal cancer screening, hearing screening in children, Hepatitis C virus screening and lung cancer screening. October 2021 - Updated to reflect that prior authorization is not required for LDCT for lung cancer screening (CPT 71271) for Medicare members. January 2022 - Updated to include coverage and billing and coding instructions for HIV Preexposure Prophylaxis (PrEP); and billing and coding instructions for screening for behavioral health conditions for MassHealth ACO members from birth to 21 years. April 2022 – Updated to include new lung cancer screening with low dose computed tomography eligibility criteria for Medicare plan members.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.