Appendix XIV — Codes, Claims and Reimbursable Services

Appendix XIV-A — Appropriate Codes for Claims/Encounter Data

Reminder ICD10 is here and should be used for all dates of service from October 1, 2015 forward. Visit www.healthfirst.org/ICD10 for resources to ensure your practice is using the correct ICD-10 codes.

Providers should follow all guidelines outlined in Provider Manual Section 16 – Provider Compensation and the Billing and Reimbursement Policies. Adhering to these guidelines ensures prompt and accurate claims payments.

Obstetrical Care: Healthfirst reimburses for obstetrical care on a fee-for-service basis or based on specific contractual arrangements. In all cases, the provider must submit claims for each service rendered. Claims should be submitted for payment of prenatal and postpartum visits, as well as for delivery. The following CPT-4 codes should be used:

- 59409 – Vaginal Delivery Only
- 59514 – Cesarean Delivery Only
- 59612 – Vaginal Delivery after Previous Cesarean Delivery
- 59620 – Cesarean Delivery after Previous Cesarean Delivery
- 59430 – Postpartum Care (in conjunction with the appropriate pregnancy diagnosis ICD10 code; e.g., Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2)

Cases requiring more than seven (7) prenatal visits or more than one (1) postpartum visit may be subject to retrospective medical record review by the Healthfirst Medical Management department.

Type of Care	Appropriate CPT-4 Codes	Appropriate ICD-10 Codes
PRENATAL CARE (Initial visit must be made in the 1st trimester or within 42 days of enrollment with Healthfirst)	59425 and 59426 (itemize each date of service), 99201–99205, 99211–99215, 99241–99245 with a pregnancy-related diagnosis code	Series 009-016, Series 020-026, Series 020-030, Series 040-048 Z codes-Z33.2-Z34.93
POSTPARTUM VISITS (Visit must be made between 21 to 56 days after delivery)	59430	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.

Please verify that the codes you are currently using match those shown above. If you have a billing service, please make them aware that they should use these codes to report prenatal and postpartum services.
To report gestational diabetes, use the appropriate ICD10 codes O24.011- O24.919

Family Planning Services: Healthfirst reimburses for family planning services provided to Healthfirst members.

- The following CPT/HCPCS/ICD9CM codes are **acceptable** for billing family planning services: A4260, 11975, 11976, 11977, 55450, 56301, 56302, 57170, 58300, 58301, 58600, 58605, 58611, 58700, 58770, 81025, 84703, 86406, Z30.02, Z31.61, J1050, J1055, J7300.
- The following codes are likely to be deemed **unacceptable** according to New York State's definition of family planning services: 84235, 89310, 54900, 54901, 55250, 55400, 57700, 57720, 58760, 58321, 58322, 58345, 58740, 58750, 58752, 59000, 59012, 59015, 59320, 59325, 74740, 74742, 76857, 84165 V26.0–V26.9.

Please note:

- Healthfirst's Medicaid members may obtain family planning and reproductive services without a PCP referral from either in-network or out-of-network Medicaid providers.
- Healthfirst's CHPlus and members may obtain family planning and reproductive health services through

any in-network CHPlus provider without approval from or notification to Healthfirst or their PCP.
- Healthfirst will not pay claims for Healthfirst CHPlus members seeking family planning and reproductive health services from out-of-network providers.

Chlamydia Testing: In accordance with the requirements of the NYSDOH, tests for chlamydia must be coded according to the DNA tests specific for chlamydia. Healthfirst will deny all claims coded with -ICD 10 CM diagnostic code 87797 – DETECT AGENT NOS, DNA, DIR when used for chlamydia testing. Use CPT4 code 87491 for chlamydia screening using urine specimen.

Providers must use these codes for chlamydia testing:
- 87110 – Chlamydia culture
- Chlamydia trachomatis detection by:
- 87270 – immunofluorescence microscopy
- 87320 – enzyme immunoassay technique
- Chlamydia trachomatis detection by nucleic acid:
    - 87490 – direct probe technique
    - 87491 – amplified probe technique
    - 87492 – quantification
    - 87810 – Chlamydia trachomatis detection by immunoassay with direct optical observation

Venipuncture: Venipuncture for the collection of specimens is considered a bundled service and is NOT separately reimbursable. Venipuncture is the insertion of a needle into a vein in order to obtain a blood sample, start an intravenous infusion, or to give medication. A bundled service is any service essential to the primary procedure and is included in the fee for the primary procedure. Bundled services are not reimbursed separately.
Venipuncture for the collection of specimens shall NOT be reimbursed separately if submitted with a charge for an office visit, hospital or emergency room visit, or in addition to a laboratory test. The reimbursement is considered included in the office visit, or the surgical or laboratory procedure. **Healthfirst will automatically deny payment for the venipuncture procedure codes listed below. "ZE"-"Procedure Rebundled" will appear on the EOP**.

Procedure Code	Description
36400	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture; femoral or jugular vein
36405	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein
36406	Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture; other vein
36410	Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)
36420	Venipuncture, cutdown; under age 1 year
36425	Venipuncture, cutdown; age 1 or over
G0001	Routine venipuncture for collection of specimen(s)

Modifier – 25: Modifier – 25 indicates that on the day a procedure or service was performed, the patient required a significant, separately identifiable evaluation and management (E&M) service. The service must have been above and beyond the initial service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.
In these instances the provider should bill the E&M code with Modifier – 25. E&M codes should not be billed separately in addition to a CPT-4 procedure code that has been assigned a global period. Medical records

should support the use of Modifier – 25. Healthfirst will review E&M codes and will deny such codes billed in addition to procedure codes assigned a global period.

ICD-10: The ICD-10-CM code set has expanded the length of characters (formerly referred to as "digits") to a maximum of seven (7) characters, as opposed to five characters (digits) in ICD-9-CM. The code structure contains categories, subcategories and codes. All categories are three characters, and the first character of a category is a letter. The second and third characters may be either numbers or alpha categories. A three character category that has no further subdivision is equivalent to a code (I10 – Essential [primary] hypertension). Subcategories are either four (4) or five (5) characters. Subcategory characters may be either letters or numbers. Codes are four, five or six characters and the final character may be either a letter or number. The four (4) character subcategory further defines the site, etiology, and manifestation(s) or state (s) of the disease or condition. The fifth (5th) or sixth (6th) character sub-classification represents the most precise level of specificity. Certain ICD-10-CM categories have applicable seven (7) characters. The seventh (7th) character must always be the 7th character in the data field. Example: T50.B96A – Underdosing of other viral vaccines, initial encounter

If a code that requires a 7th character is not 6 characters, a placeholder **X (dummy placeholder)** must be used to fill in the empty characters. Example: T15.12XS Foreign body in conjunctival sac, left eye, sequela.

As mentioned above, medical records **must** contain the information to substantiate and support the reported codes**.**

Sexually Transmitted Diseases

STD	Minimum Required Visits	Appropriate CPT-4 Codes	Appropriate ICD-10 Codes
Chlamydia	Once per year	87110, 87270, 87320, 87490–87492, 87810	Z00.00, **Z11.3**, **Z11.8**, Z11.9, Z20.2
Gonorrhea	Once per year	87590–87592, 87850	Z00.00, **Z11.3**, **Z11.8**, Z11.9, Z20.2
Syphilis	Once per year	86592, 86593	Z11.3
Trichomoniasis	Once per year	88141–88158, 87177, 87210, 87211	Z00.00, **Z11.3**, **Z11.8**, Z11.9, Z20.2

Well-Child/Adolescent Care

Member's Age	Minimum Required Visits	Appropriate CPT-4 Codes	Appropriate ICD-10 Codes
0 to 15 months	6 or more	99381, 99382, 99391, 99392, 99432, 99461, and one of the ICD-9 codes listed in the next column	Z00.00-Z02.9
3 to 6 years old	Once per year	99382, 99383, 99392, 99393, and one of the ICD-9 codes listed in the next column	Z00.00-Z02.9
12 to 21 years old	Once per year	99383–99385, 99393–99395, and one of the ICD-9 codes listed in the next column	Z00.00-Z02.9

Childhood and Adolescent Immunizations

Required Service	CPT Codes
DTaP (4)	90700

Diphtheria and tetanus	90702
Diphtheria	90719
Tdap	90715
Td	90714, 90718
Tetanus	90703
IPV (3)	90713
DTaP-Hib-IPV	90698
DtaP-HepB-IPV	90723
DtaP-Hib	90721
MMR (1)	90707
Measles	90705
Measles & Rubella	90708
Mumps	90704
Rubella	90706
MMRV (Measles/Mumps/Rubella/Varicella)	90710
HiB (3)	90645, 90646, 90647, 90648
Hepatitis A	90633
Hepatitis B	90740, 90744, 90747
HepB-Hib	90748
VZV (1)	90716
Rotavirus (2 doses)	90681
Rotavirus	90680
Human Pappilomavirus Vaccine (HPV)	90650
PCV Pneumococcal (4)	90669
Meningococcal	90733, 90734
Influenza	90655, 90657, 90661, 90662

Please click here for a complete list of HEDIS eligible codes