

# Healthcare Group of Arizona

## Preventive and Wellness Service Codes as of January 2009

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### **Purpose:**

To provide primary preventive screening and wellness services to Healthcare Group (HCG) members and facilitate early detection and appropriate education and management of disease.

### **Justification:**

Early identification of disease is a well-proven means to heighten member awareness, improve health, and reduce future medical care expenditures through early medical intervention.

### **Authorities:**

The HCG preventive and wellness benefit was developed based on the following authorities:

- Healthy People 2010
- Healthy Arizona
- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- U.S. Preventive Services Task Force (USPSTF)
- Centers for Medicare and Medicaid (CMS)

### **Coverage:**

Subject to benefit limitations and coding requirements, the following types of services are covered under the HCG Preventive and Wellness benefit:<sup>1</sup>

- Annual Wellness (Preventive) Exams
- Screening mammography
- Screening Pap test
- Prostate cancer screening
- Colorectal Cancer screening
- Diabetes Screening<sup>2</sup>
- Osteoporosis screening<sup>3</sup>
- Childhood and Adolescent Immunizations
- Adult Immunizations

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<sup>1</sup> Only those services included in this document are covered under the preventive and wellness benefit and excluded from a member's deductible. All other covered services fall under the member's general medical benefit and **may be** subject to the member's deductible.

<sup>2</sup> Limited to non-diabetic and non-pre-diabetic members, only.

<sup>3</sup> DEXA screening, only.

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### 1. Annual Wellness Exams

Preventive services are performed in the absence of complaints or symptoms for the purpose of detecting new diseases, as well as to protect by way of risk factor reduction against future disease.

If an abnormality is encountered or a pre-existing problem is addressed in the course of performing a preventive medicine service that is significant enough to require additional work to perform the key components of a problem-oriented evaluation and management service, then office visit code 99201-99215 may be reported additionally. Modifier –25 would be added to the office visit code to indicate a significant, separately identifiable service was provided by the same physician on the same day as the preventive medicine service. List the diagnoses that coincide with the condition(s) treated with the appropriate office visit code.

Office visit codes 99201-99215 will be subject to the member's standard medical benefit and may be subject to the annual deductible.

Initial comprehensive preventive medicine services include gender and age appropriate history, examination, counseling/anticipatory guidance/risk factor intervention, as well as the ordering of appropriate immunizations and lab/diagnostic procedures (reported separately).

- a. Limitations: Benefit limited to:
  - i. Age 1 year and under: up to 7 visit codes per year<sup>4</sup>
  - ii. Age 1 to 4: up to 4 visit codes per year
  - iii. Age 5 and over: one visit code per year
  
- b. Diagnosis Requirements: One of the following diagnosis codes must be billed:
  - i. V20.2 Routine infant and child exam
  - ii. V70.0 Routine physical exam
  - iii. V72.31 Gynecological exam

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<sup>4</sup> AAP recommends 6 ambulatory well child visits during the first 12 months of life assuming the newborn and 2-4 day check-up are performed in the hospital. A 7<sup>th</sup> ambulatory visit would be appropriate if the infant is released from the hospital within 48 hours of birth.

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c. Allowable Codes for Annual Wellness exams:

CPT Code	Description	Limit/Dx
99381	New patient, age <1 year	7 per year V20.2
99391	Established patient, age <1 year	
99382	New patient, age 1-4 years	4 per year V20.2
99392	Established patient, age 1-4 years	
99383	New patient, age 5-11 years	1 per year V20.2
99393	Established patient, age 5-11 years	
99384	New patient, age 12-17 years	1 per year V70.0 V72.31
99394	Established patient, age 12-17 years	
99385	New patient, age 18-39 years	
99395	Established patient, 18-39 years	
99386	New patient, age 40-64 years	
99396	Established patient, age 40-64 years	
99387	New patient, age 65+ years	
99397	Established patient, age 65+ years	

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**2. Mammogram**

- a. Limitations: Benefit limited to:
  - i. Females, age 35+
  - ii. Age 35-39: One baseline screening
  - iii. Age 40-49: One screening every 1-2 years
  - iv. Age 50+: One screening every year
  - v. Additional screenings at Medical Director’s discretion. This benefit will also cover a diagnostic mammogram performed as a result of a questionable screening mammogram, biopsy-proven benign breast disease, or when member has personal history of breast cancer or disease.
  
- b. Diagnosis Requirements: One of the following diagnosis codes must be billed:
  - i. V76.11 Screening mammogram for high risk patient
  - ii. V76.12 Screening mammography
  - iii. V16.3 Family History
  - iv. V10.3 Personal History
  - v. 793.80 Abnormal findings – mammogram - without diagnosis
  
- c. Allowable Codes for Mammography’s:

CPT Code	Description	Diagnosis
+77051	Diagnostic mammography, CAD –use in addition to 77055 or 77056	V76.11 V76.12 V16.3 V10.3 793.80
+77052	Screening mammography, CAD –use in addition to 77057	
77055	Mammography; unilateral	
77056	Mammography; bilateral	
77057	Screening mammography, bilateral	
G0202	Screening mammography, bilateral	
G0204	Diagnostic mammography, bilateral	
G0206	Diagnostic mammography, unilateral	

- d. Benefit includes physician interpretation.

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**3. Screening Pap Tests**

- a. Limitations: Benefit limited to:
  - i. Females
  - ii. One screening test every year, to include physician interpretation.
  
- b. Diagnosis Requirements: One of the following diagnosis codes must be billed:<sup>5</sup>
  - i. V76.2 Special screening for malignant neoplasm
  - ii. V76.47 Special screening for malignant neoplasm
  - iii. V76.49 Special screening for malignant neoplasm
  - iv. V15.89 Other personal history presenting hazards to health
  - v. **V72.31 Routine gynecological exam**
  
- c. Allowable Codes for Pap Tests:<sup>6</sup>

CPT Code	Description	Diagnosis
88141	Cytopathology, cervical or vaginal - requiring interpretation by physician. Use in conjunction with 88142-88154, 88164-88167, 88174-88175.	V76.2 V76.47 V76.49 V15.89 <b>V72.31</b>
88142	Cytopathology, cervical or vaginal	
88143	Cytopathology, cervical or vaginal	
88147	Cytopathology, cervical or vaginal	
88150	Cytopathology, cervical or vaginal	
88152	Cytopathology, cervical or vaginal	
88153	Cytopathology, cervical or vaginal	
88154	Cytopathology, cervical or vaginal	
+88155	Cytopathology, cervical or vaginal – definitive hormonal evaluation. List separately in conjunction with 88142-88154, 88164-88167, 88174-88175.	
88164	Cytopathology, cervical or vaginal	
88165	Cytopathology, cervical or vaginal	
88166	Cytopathology, cervical or vaginal	
88167	Cytopathology, cervical or vaginal	
88172	Cytopathology, cervical or vaginal	
88173	Cytopathology, cervical or vaginal	
88174	Cytopathology, cervical or vaginal	
88175	Cytopathology, cervical or vaginal	

<sup>5</sup> CMS Pub 100-4, 18, 30.6

<sup>6</sup> CMS Pub 100-4, 18, 30.5

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Allowable Codes for Pap Tests Continued ...

CPT Code	Description	Diagnosis
G0123	Screening cytopathology	V76.2 V76.47 V76.49 V15.89 V72.31
G0124	Screening cytopathology	
G0141	Screening cytopathology	
G0143	Screening cytopathology	
G0144	Screening cytopathology	
G0145	Screening cytopathology	
G0147	Screening cytopathology smears	
G0148	Screening cytopathology smears	
P3000	Screening cytopathology	
P3001	Screening Papanicolaou smear	
Q0091	Screening cytopathology, preparation	

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**4. PSA Screening**

- a. Limitations: Benefit limited to:
  - i. Male, age 50+
  - ii. One screening per year
  
- b. Diagnosis Requirements: One of the following diagnosis codes must be billed<sup>7</sup>:
  - i. V76.44 Screening for malignant neoplasm, prostate
  
- c. Allowable Codes for PSA screening:

CPT Code	Description	Diagnosis
84152	PSA, complexed	V76.44
84153	PSA, total	
84154	PSA, free	
G0102	Prostate cancer screening, DRE	
G0103	Prostate cancer screening, PSA total	

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<sup>7</sup> CMS Pub 100-4, 18, 50.5

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**5. Colorectal Cancer Screening**

- a. Limitations: Benefit limited to:<sup>8</sup>
  - i. Age 50+
  - ii. Fecal-occult: Annual (1 to 3 simultaneous determinations)
  - iii. Flexible sigmoidoscopy: One test every 5 years
  - iv. Colonoscopy: One test every 10 years
  
- b. Diagnosis Requirements: One of the following diagnosis codes must be billed for preventive screening:<sup>9</sup>
  - i. V10.05, V10.06, V12.72, V16.0, V19.8
  - ii. V76.41, V76.49, V76.51
  - iii. 555.0-555.9, 556.0-556.9, 558.2, 558.3, 558.9
  
- c. Allowable Codes for Colorectal Screening:

CPT Code	Description	Diagnosis
82270	Fecal-occult blood test	See list, above.
82272	Fecal-occult blood test, single specimen	See list, above.
82274	Fecal-occult immunoassay	See list, above.
G0107	Fecal-occult blood test	See list, above.
G0328	Fecal-occult immunoassay	See list, above.
45330	Screening sigmoidoscopy	See list, above.
45331	Biopsy/removal during sigmoidoscopy	See list, above.
G0104	Screening sigmoidoscopy	See list, above.
G0106	Barium enema, alt to G0104	See list, above.
45378	Screening colonoscopy – high risk	See list, above.
45380	Biopsy/removal during colonoscopy	See list, above.
G0105	Screening colonoscopy – high risk	See list, above.
G0120	Barium enema, alt to G0105	See list, above.
74270	Barium enema	See list, above.

- d. Benefit includes physician and facility charges.

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<sup>8</sup> CMS Pub 100-4, 18, 60

<sup>9</sup> CMS Pub 100-4, 18, 60.3

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- e. Anesthesia: In Maricopa County, anesthesia claims are being received from Anesthesiologists billing 00810 for screening colonoscopies. Since the anesthesia charges are being billed separately, deductibles are being applied to these claims. HCG can not add code 00810 to the preventive code list without affecting payments for non-preventive surgery codes as well. Instead, if a member complains or appeals a deductible being applied to an anesthesia claim for a preventive colonoscopy, HCG requests its contracted health plans to refund or reverse any deductible applied provided the colonoscopy procedure performed in among those included in the preventive benefit.

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**6. Diabetes Screening**

- a. Limitations: Benefit limited to:
  - i. Non-diabetic and non pre-diabetic members only
  - ii. Lipid profile: every 5 years
  - iii. Fasting glucose: every 3 years

b. Diagnosis Requirements: None

c. Allowable Codes for Diabetes Screening:

CPT Code	Description	Diagnosis
80061	Lipid profile	V77.91
82947	Fasting glucose	V77.1

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**7. Osteoporosis Screening**

- a. Limitations: Benefit limited to:
  - i. All women aged 65 and older regardless of risk factors.
  - ii. Younger postmenopausal women with one or more risk factors (other than being white, postmenopausal and female).
    - 1. Estrogen deficient women at clinical risk for osteoporosis (256.39).
    - 2. Individuals with vertebral abnormalities as demonstrated by an x-ray (793.7).
    - 3. Individuals receiving, or planning to receive, long-term glucocorticoid (steroid) therapy (V58.65).
    - 4. Individuals with primary hyperparathyroidism (252.01).
    - 5. Individuals being monitored to assess the response or efficacy of an approved osteoporosis drug therapy (V58.69).
  - iii. One screening every 5 years
  
- b. Diagnosis Requirements:
  - i. V49.81 Asymptomatic postmenopausal status
  - ii. V82.81 Special screening for osteoporosis - use additional code to indicate risk factor from list above.
  - iii. V07.4 Hormone replacement therapy (postmenopausal)
  
- c. Allowable Codes for Osteoporosis Screening:

CPT Code	Description	Diagnosis
77080	DEXA, 1 or more sites, axial skeleton	V49.81 V82.81 V07.4
77081	DEXA; appendicular skeleton	
77082	DEXA; vertebral fracture assessment	
G0130	SEXA; 1 or more sites <sup>10</sup>	

- d. Benefit includes physician and facility charges.

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<sup>10</sup> CMS NCD 150.3

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**8. Immunizations (Childhood, Adolescent, Adult)**

a. Limitations: Benefit limited to preventive vaccinations only for the following:

1. DTAP/DTTP/DT/Td
2. Hepatitis A
3. Hepatitis B
4. Hib
5. Influenza
6. Measles, Mumps, Rubella
7. Meningococcal
8. Pneumonia
9. Polio
10. Chicken Pox
11. Combined Vaccines
12. Human Papilloma Virus (HPV)<sup>11</sup>
13. Pentavalent Rotavirus

b. Diagnosis Requirements: See table below. For childhood immunizations, may use appropriate vaccine V code or V20.2.

c. Allowable Codes for Administration:

CPT Code	Description	Diagnosis
90465	Immunization, age <8 years	Link to specific vaccine V code.
90466	Immunization, age <8 years	
90467	Immunization, nasal, age <8 years	
90468	Immunization, nasal, age <8 years	
90471	Immunization	
90472	Immunization	
90473	Immunization oral/nasal	
90474	Immunization oral/nasal	
G0008	Admin influenza vaccine (adult)	
G0009	Admin pneumococcal vaccine (adult)	
G0010	Admin hepatitis B vaccine (adult)	

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<sup>11</sup> HPV vaccination is only covered for adolescent females aged 11-12.

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d. Allowable Codes for DTAP/DTP/DT/Td:

CPT Code	Description	Diagnosis
90696	DTAP-IPV, IM use	V06.1
90698	DTAP-HIB-IP	V06.1
90700	DTAP, Pediatric	V06.1
90701	DTP, Pediatric	V06.1
90702	DT, Pediatric	V06.5
90703	Tetanus	V03.7
90714	Td, Preserv Free	V06.5
90715	Tdap	V06.8
90718	Td	V06.5
90719	Diphtheria	V03.5

e. Allowable Codes for Hepatitis A:

CPT Code	Description	Diagnosis
90632	Hep A, 2 dose, Adult	V05.3
90633	Hep A, 2 dose, Ped/Adol	
90634	Hep A, 3 dose, Ped/Adol	

f. Allowable Codes for Hepatitis B:

CPT Code	Description	Diagnosis
90740	Hep B	V05.3 (Adult)
90743	Hep B, Adol	
90744	Hep B, Ped/Adol Preserv Free	
90746	Hep B, Adult	
90747	Hep B	
90748	Heb/Hib	V06.8

g. Allowable Codes for Hib:

CPT Code	Description	Diagnosis
90648	Hib-PRP-T	V03.81
90647	Hib-PRP-OMP	
90645	Hib-Hboc	
90646	Hib-PRP-D	

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h. Allowable Codes for Influenza:

CPT Code	Description	Diagnosis
90655	Influenza split, 6-35 months	V04.81
90658	Influenza split, 36 months +	
90657	Influenza split, 6-35 months	V04.81
90656	Influenza split pre free, 36 months +	
90660	Influenza Nasal Spray	

i. Allowable Codes for Measles, Mumps, Rubella:

CPT Code	Description	Diagnosis
90704	Mumps	V04.6
90705	Measles	V04.2
90707	MMR	V06.4
90708	Measles-Rubella	V06.8
90710	MMRV	V06.8

j. Allowable Codes for Meningococcal:

CPT Code	Description	Diagnosis
90733	MPSV4	V03.89
90734	MCV4	

k. Allowable Codes for Pneumonia:

CPT Code	Description	Diagnosis
90669	PCV7 (<5 years)	V03.82
90732	PPV23	

l. Allowable Codes for Polio:

CPT Code	Description	Diagnosis
90712	OPV	V04.0
90713	IPV	

m. Allowable Codes for Chicken Pox:

CPT Code	Description	Diagnosis
90716	Varicella vaccine	V05.4

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n. Allowable Codes for Combined Vaccines:

CPT Code	Description	Diagnosis
90748	Hep B / Hib	V06.8
90723	HDTAP / Hep B/IPV	
90636	Hep A / Hep B	
90720	DTP / Hib	
90721	DTAP / Hib	

o. Allowable Codes for HPV:<sup>12</sup>

CPT Code	Description	Diagnosis
90649	Human Papilloma virus	V04.89

p. Allowable Codes for Pentavalent Rotavirus Vaccine:

CPT Code	Description	Diagnosis
90680	Pentavalent Rotavirus	V04.89
90681	Pentavalent Rotavirus	

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<sup>12</sup> CPT 90650 for HPV vaccine still awaiting FDA approval. Code will be added once approved.