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| ISSUE DATE July 2, 2018 | EFFECTIVE DATE July 2, 2018 | NUMBER 01-18-08, 08-18-09, 09-18-09, 24-18-06, 25-18-01, 28-18-02, 31-18-09, 33-18-09 |
| SUBJECT Updates to the Family Planning Services Program Fee Schedule | | BY  Sally A. Kozak, Deputy Secretary Office of Medical Assistance Programs |

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISE to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at:
http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

PURPOSE:

The purpose of this bulletin is to notify providers of updates to the Family Planning Services program fee schedule as a result of implementing the 2018 Healthcare Common Procedure Coding System (HCPCS), and to issue an updated Family Planning Services covered services chart.

SCOPE:

This bulletin applies to Medical Assistance (MA) enrolled family planning providers, including family planning clinics, outpatient hospital clinics, Certified Registered Nurse Practitioners, certified nurse midwives, federally qualified health centers, rural health clinics, laboratories, pharmacies, medical suppliers, independent medical/surgical clinics and physicians who render services to MA beneficiaries in the MA fee-for-service delivery system.

BACKGROUND/DISCUSSION:

The Department of Human Services (Department) issued MAB 01-15-15, "Family Planning Services", to announce the implementation of the Family Planning State Plan option known as Family Planning Services, on July 1, 2015. Family Planning Services provides coverage of family planning and certain family planning-related services, pharmaceuticals and supplies for men and women who are not otherwise eligible for MA and have income at or below 215% of the Federal Poverty Level.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type.

Visit the Office of Medical Assistance Programs Web site at:
<http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm>.

The Department issued MA Bulletin 99-18-07, "2018 Healthcare Common Procedure Coding System (HCPCS) Updates and Other Procedure Code Changes", to announce changes to the MA Program Fee Schedule, including changes resulting from the implementation of the 2018 HCPCS procedure code updates, effective July 2, 2018. These changes include the addition of a new procedure code, the removal of end-dated procedure codes, and updates to an existing procedure code for Family Planning Services.

New Procedure Code for Long-Acting Reversible Contraception (LARC)

The Department added the following procedure code, J7296 (Kyleena), for provider type 01/010 (acute care general hospital) as a result of the 2018 HCPCS procedure code updates. For information on how to bill for LARC in an inpatient setting, providers may refer to MA Bulletin 01-16-33, "MA Program Fee Schedule Updates for Certain Family Planning Services", effective December 1, 2016.

End-dated Procedure Codes

The Department end-dated the following procedure codes, 55450 and 86729, as a result of the 2018 HCPCS procedure code updates. No new authorizations will be issued for the procedure codes being end-dated on and after July 2, 2018.

Procedure Code Updates

Procedure code 85025 is currently open for certain Provider Type (PT)/Specialty (Spec)/Place of Service (POS) combinations for Family Planning Services. The Department added the QW (Clinical Laboratory Improvement Amendments (CLIA) waived test) informational modifier, FP (Family Planning) modifier and 91 (Repeat Clinical Diagnostic Laboratory Test) modifier to the PT/Spec/POS that may perform the CLIA-waived test. The Department also added PT/Spec/POS combinations as a result of the Centers for Medicare & Medicaid Services determining that procedure code 85025 is now a CLIA-waived test.

For additional information related to the above referenced procedure codes, providers should refer to MA Bulletin 99-18-07, "2018 Healthcare Common Procedure Coding System (HCPCS) Updates and Other Procedure Code Changes", effective July 2, 2018.

As a result of the above changes, the Department updated the "Family Planning Services: Covered Services Chart."

PROCEDURE:

Providers should refer to the updated "Family Planning Services: Covered Services Chart" attached to this bulletin for services rendered on and after July 2, 2018.

ATTACHMENT:

Family Planning Services: Covered Services Chart, effective July 2, 2018

FAMILY PLANNING SERVICES:
COVERED SERVICES CHART
Effective July 2, 2018

| Code | Code Description | Provider Type | Specialty | Place of Service | Pricing Modifier | Info Modifier | MA Fee | Prior Auth | MA units | Limits | Post op days | Comments |
|--------------------------|--|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|------------------------|--------------|---|
| FAMILY PLANNING SERVICES | | | | | | | | | | | | |
| 11976 | Removal, implantable contraceptive capsules | 01 | 183 | 22 | | FP | \$118.05 | No | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 11976 | Removal, implantable contraceptive capsules | 08 | 082 | 49 | | FP | \$118.05 | No | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 11976 | Removal, implantable contraceptive capsules | 08 | 083 | 22, 49 | | FP | \$118.05 | No | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 11976 | Removal, implantable contraceptive capsules | 31 | All | 11, 21, 99 | | FP | \$118.05 | No, but AUR and PSR process applies | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 11976 | Removal, implantable contraceptive capsules | 33 | 335 | 11, 21, 99 | | FP | \$118.05 | No, but AUR and PSR process applies | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 11981 | Insertion, non-biodegradable drug delivery implant | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11981 | Insertion, non-biodegradable drug delivery implant | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11981 | Insertion, non-biodegradable drug delivery implant | 01 | 183 | 22 | | FP | \$103.91 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11981 | Insertion, non-biodegradable drug delivery implant | 08 | 082 | 49 | | FP | \$103.91 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11981 | Insertion, non-biodegradable drug delivery implant | 08 | 083 | 22, 49 | | FP | \$103.91 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11981 | Insertion, non-biodegradable drug delivery implant | 31 | All | 11, 21, 24 | | FP | \$103.91 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11982 | Removal, non-biodegradable drug delivery implant | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11982 | Removal, non-biodegradable drug delivery implant | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11982 | Removal, non-biodegradable drug delivery implant | 01 | 183 | 22 | | FP | \$126.20 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11982 | Removal, non-biodegradable drug delivery implant | 08 | 082 | 49 | | FP | \$126.20 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11982 | Removal, non-biodegradable drug delivery implant | 08 | 083 | 22, 49 | | FP | \$126.20 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11982 | Removal, non-biodegradable drug delivery implant | 31 | All | 11, 21, 24 | | FP | \$126.20 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|-------------------|--------------|---|
| 11983 | Removal with reinsertion, non-biodegradable drug delivery implant | 01 | 021 | 24 | SG | | \$200.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11983 | Removal with reinsertion, non-biodegradable drug delivery implant | 02 | 020 | 24 | SG | | \$200.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11983 | Removal with reinsertion, non-biodegradable drug delivery implant | 01 | 183 | 22 | | FP | \$219.10 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11983 | Removal with reinsertion, non-biodegradable drug delivery implant | 08 | 082 | 49 | | FP | \$219.10 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11983 | Removal with reinsertion, non-biodegradable drug delivery implant | 08 | 083 | 22, 49 | | FP | \$219.10 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 11983 | Removal with reinsertion, non-biodegradable drug delivery implant | 31 | All | 11, 21, 24 | | FP | \$219.10 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 55200 | Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure) | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 55200 | Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure) | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 55200 | Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure) | 01 | 183 | 22 | | FP | \$115.00 | No | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 55200 | Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure) | 08 | 082 | 49 | | FP | \$115.00 | No | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 55200 | Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure) | 08 | 083 | 22, 49 | | FP | \$115.00 | No | per procedure | once per day | 90 days | |
| 55200 | Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure) | 31 | All | 11, 21, 24, 99 | | FP | \$115.00 | No, but AUR and PSR process applies | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 55250 | Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 55250 | Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 55250 | Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) | 01 | 183 | 22 | | FP | \$282.79 | No | per procedure | once per lifetime | 90 days | This provider type must bill with the FP modifier |
| 55250 | Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) | 08 | 082 | 49 | | FP | \$282.79 | No | per procedure | once per lifetime | 90 days | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|------------------------|--------------|---|
| 55250 | Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) | 08 | 083 | 22, 49 | | FP | \$282.79 | No | per procedure | once per lifetime | 90 days | This provider type must bill with the FP modifier |
| 55250 | Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) | 31 | All | 11, 21, 24, 99 | | FP | \$282.79 | No, but AUR and PSR process applies | per procedure | once per lifetime | 90 days | This provider type must bill with the FP modifier |
| 55250 | Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) | 31 | All | 11 | SU | FP | \$417.84 | No | per procedure | once per lifetime | 90 days | This provider type must bill with the FP modifier |
| 57170 | Diaphragm or cervical cap fitting with instructions | 01 | 183 | 22 | | FP | \$60.55 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57170 | Diaphragm or cervical cap fitting with instructions | 08 | 082 | 49 | | FP | \$60.55 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57170 | Diaphragm or cervical cap fitting with instructions | 08 | 083 | 22, 49 | | FP | \$60.55 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57170 | Diaphragm or cervical cap fitting with instructions | 31 | All | 11, 21, 99 | | FP | \$60.55 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57170 | Diaphragm or cervical cap fitting with instructions | 33 | 335 | 11, 21, 99 | | FP | \$60.55 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 58300 | Insertion of intrauterine device (IUD) | 01 | 183 | 22 | | FP | \$67.60 | No | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 58300 | Insertion of intrauterine device (IUD) | 08 | 082 | 49 | | FP | \$67.60 | No | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 58300 | Insertion of intrauterine device (IUD) | 08 | 083 | 22, 49 | | FP | \$67.60 | No | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 58300 | Insertion of intrauterine device (IUD) | 31 | All | 11, 21, 99 | | FP | \$67.60 | No, but AUR and PSR process applies | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 58300 | Insertion of intrauterine device (IUD) | 33 | 335 | 11, 21, 99 | | FP | \$67.60 | No, but AUR and PSR process applies | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 58301 | Removal of intrauterine device (IUD) | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58301 | Removal of intrauterine device (IUD) | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58301 | Removal of intrauterine device (IUD) | 01 | 183 | 22 | | FP | \$84.25 | No | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 58301 | Removal of intrauterine device (IUD) | 08 | 082 | 49 | | FP | \$84.25 | No | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|------------------------|--------------|---|
| 58301 | Removal of intrauterine device (IUD) | 08 | 083 | 22, 49 | | FP | \$84.25 | No | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 58301 | Removal of intrauterine device (IUD) | 31 | All | 11, 21, 24, 99 | | FP | \$84.25 | No, but AUR and PSR process applies | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 58301 | Removal of intrauterine device (IUD) | 33 | 335 | 11, 21, 99 | | FP | \$84.25 | No, but AUR and PSR process applies | per procedure | 1 per 3 calendar years | 0 days | This provider type must bill with the FP modifier |
| 58340 | Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58340 | Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58340 | Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography | 01 | 183 | 22 | | FP | \$52.00 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58340 | Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography | 08 | 082 | 49 | | FP | \$52.00 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58340 | Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography | 08 | 083 | 22, 49 | | FP | \$52.00 | No | per procedure | once per day | 0 days | |
| 58340 | Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography | 31 | All | 11, 21, 24 | | FP | \$52.00 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58565 | Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58565 | Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58565 | Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants | 01 | 183 | 22 | | FP | \$405.57 | No | per procedure | once per lifetime | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58565 | Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants | 08 | 082 | 49 | | FP | \$405.57 | No | per procedure | once per lifetime | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58565 | Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants | 08 | 083 | 22, 49 | | FP | \$405.57 | No | per procedure | once per lifetime | 90 days | |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|-------------------|--------------|---|
| 58565 | Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants | 31 | All | 11, 21, 24, 99 | | FP | \$405.57 | No, but AUR and PSR process applies | per procedure | once per lifetime | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58600 | Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral | 01 | 021 | 24 | SG | | \$736.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58600 | Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral | 02 | 020 | 24 | SG | | \$736.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58600 | Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral | 31 | All | 21, 24 | | FP | \$306.50 | No, but AUR and PSR process applies | per procedure | two per lifetime | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58600 | Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral | 31 | All | 21, 24 | 80 | FP | \$61.50 | No, but AUR and PSR process applies | per procedure | two per lifetime | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58615 | Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58615 | Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58615 | Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach | 31 | All | 21, 24 | | FP | \$230.31 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58670 | Laparoscopy, surgical; with fulguration of oviducts (with or without transection) | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58670 | Laparoscopy, surgical; with fulguration of oviducts (with or without transection) | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58670 | Laparoscopy, surgical; with fulguration of oviducts (with or without transection) | 31 | All | 21, 24 | | FP | \$316.82 | No, but AUR and PSR process applies | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58671 | Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring) | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58671 | Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring) | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |

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| 58671 | Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring) | 31 | All | 21, 24 | | FP | \$326.39 | No, but AUR and PSR process applies | per procedure | once per lifetime | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 74740 | Hysterosalpingography, radiological supervision and interpretation | 01 | 183 | 22 | TC | FP | \$26.50 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 74740 | Hysterosalpingography, radiological supervision and interpretation | 08 | 082 | 49 | TC | FP | \$26.50 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 74740 | Hysterosalpingography, radiological supervision and interpretation | 08 | 083 | 22, 49 | TC | FP | \$26.50 | No | per procedure | once per day | N/A | |
| 81025 | Urine pregnancy test, by visual color comparison methods | 01 | 183 | 22 | | FP | \$10.76 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81025 | Urine pregnancy test, by visual color comparison methods | 08 | 082 | 49 | | FP | \$10.76 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81025 | Urine pregnancy test, by visual color comparison methods | 08 | 083 | 22, 49 | | FP | \$10.76 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81025 | Urine pregnancy test, by visual color comparison methods | 09 | All | 11 | | FP | \$10.76 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81025 | Urine pregnancy test, by visual color comparison methods | 28 | 280 | 81 | | FP | \$10.76 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81025 | Urine pregnancy test, by visual color comparison methods | 31 | All | 11 | | FP | \$10.76 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81025 | Urine pregnancy test, by visual color comparison methods | 33 | 335 | 11 | | FP | \$10.76 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 84703 | Gonadotropin, chorionic (hCG); qualitative | 01 | 183 | 22 | | FP | \$10.26 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84703 | Gonadotropin, chorionic (hCG); qualitative | 01 | 183 | 22 | | QW, FP | \$10.26 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84703 | Gonadotropin, chorionic (hCG); qualitative | 08 | 083 | 22, 49 | | FP | \$10.26 | No | per test | once per day | N/A | |
| 84703 | Gonadotropin, chorionic (hCG); qualitative | 08 | 083 | 22, 49 | | QW, FP | \$10.26 | No | per test | once per day | N/A | |
| 84703 | Gonadotropin, chorionic (hCG); qualitative | 28 | 280 | 81 | | FP | \$10.26 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84703 | Gonadotropin, chorionic (hCG); qualitative | 28 | 280 | 81 | | QW, FP | \$10.26 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| Code | Code Description | Provider Type | Specialty | Place of Service | Pricing Modifier | Info Modifier | MA Fee | Prior Auth | MA units | Limits | Post op days | Comments |
|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|-----------|--------------|--------------|---|
| 99201 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. | 08 | 083 | 22, 49 | | FP | \$32.84 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99201 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. | 09 | All | 11, 99 | | FP | \$32.84 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99201 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. | 31 | All | 11, 99 | | FP | \$32.84 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99201 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. | 33 | 335 | 11, 99 | | FP | \$32.84 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family. | 08 | 083 | 22, 49 | | FP | \$62.20 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|-----------|--------------|--------------|---|
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family. | 09 | All | 11, 99 | | FP | \$62.20 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family. | 31 | All | 11, 99 | | FP | \$62.20 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family. | 33 | 335 | 11, 99 | | FP | \$62.20 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family. | 08 | 083 | 22, 49 | | FP | \$95.13 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family. | 09 | All | 11, 99 | | FP | \$95.13 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|------------|-----------|--------------|--------------|---|
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family. | 31 | All | 11, 99 | | FP | \$95.13 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99203 | management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family. | 33 | 335 | 11, 99 | | FP | \$95.13 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99204 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family. | 09 | All | 11, 99 | | FP | \$160.89 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99204 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family. | 31 | All | 11, 99 | | FP | \$160.89 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99204 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family. | 33 | 335 | 11, 99 | | FP | \$160.89 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|------------|-----------|--------------|--------------|---|
| 99205 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family. | 09 | All | 11, 99 | | FP | \$209.15 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99205 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family. | 31 | All | 11, 99 | | FP | \$209.15 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99205 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family. | 33 | 335 | 11, 99 | | FP | \$209.15 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | 08 | 083 | 22, 49 | | FP | \$20.00 | No | per visit | one per year | N/A | |
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | 09 | All | 11, 99 | | FP | \$20.00 | No | per visit | one per year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | 31 | All | 11, 99 | | FP | \$20.00 | No | per visit | one per year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|-----------|--------------|--------------|---|
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | 33 | 335 | 11, 99 | | FP | \$20.00 | No | per visit | one per year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. | 08 | 083 | 22, 49 | U7 | FP | \$31.15 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. | 09 | All | 11, 99 | | FP | \$31.15 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. | 31 | All | 11, 99 | | FP | \$31.15 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. | 33 | 335 | 11, 99 | | FP | \$31.15 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|-----------|--------------|--------------|---|
| 99213 | management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family. | 08 | 083 | 22, 49 | | FP | \$63.14 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family. | 09 | All | 11, 99 | | FP | \$63.14 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99213 | management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family. | 31 | All | 11, 99 | | FP | \$63.14 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family. | 33 | 335 | 11, 99 | | FP | \$63.14 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. | 08 | 083 | 22, 49 | | FP | \$96.91 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|------------|-----------|--------------|--------------|---|
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. | 09 | All | 11, 99 | | FP | \$96.91 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. | 31 | All | 11, 99 | | FP | \$96.91 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. | 33 | 335 | 11, 99 | | FP | \$96.91 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family. | 09 | All | 11, 99 | | FP | \$137.24 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family. | 31 | All | 11, 99 | | FP | \$137.24 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|------------|-----------|---|--------------|---|
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family. | 33 | 335 | 11, 99 | | FP | \$137.24 | No | per visit | once per day | N/A | This provider type must bill with the FP modifier |
| 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) | 08 | 083 | 22, 49 | | FP | \$126.41 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 08 | 083 | 22, 49 | | FP | \$121.14 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 09 | All | 11 | | FP | \$121.14 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |

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| 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 | 31 | All | 11 | | FP | \$121.14 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 33 | 335 | 11 | | FP | \$121.14 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 08 | 083 | 22, 49 | | FP | \$147.46 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 09 | All | 11 | | FP | \$147.46 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|------------|-----------|---|--------------|---|
| 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 | 31 | All | 11 | | FP | \$147.46 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 33 | 335 | 11 | | FP | \$147.46 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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) | 08 | 083 | 22, 49 | | FP | \$107.53 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 08 | 083 | 22, 49 | | FP | \$110.60 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|------------|-----------|---|--------------|---|
| 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 | 09 | All | 11 | | FP | \$110.60 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 31 | All | 11 | | FP | \$110.60 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 33 | 335 | 11 | | FP | \$110.60 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 08 | 083 | 22, 49 | | FP | \$120.25 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |

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|-------|--|---------------|-------------------------|------------------|------------------|---------------|------------|------------|----------------|---|--------------|---|
| 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 | 09 | All | 11 | | FP | \$120.25 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 31 | All | 11 | | FP | \$120.25 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 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 | 33 | 335 | 11 | | FP | \$120.25 | No | per visit | Maximum 4 visits per year of any combination of the following procedure codes: 99384, 99385, 99386, 99394, 99395 and 99396. | N/A | This provider type must bill with the FP modifier |
| 99401 | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes | 08 | 083 | 22, 49 | | FP | \$10.00 | No | per 15 minutes | once per lifetime | N/A | |
| A4264 | Permanent implantable contraceptive intratubal occlusion device(s) and delivery system | 24 | 240, 241, 242, 243, 245 | 11, 12 | | FP | \$1,300.00 | Yes | each device(s) | once per lifetime | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| A4264 | Permanent implantable contraceptive intratubal occlusion device(s) and delivery system | 25 | 250 | 11, 12 | | FP | \$1,300.00 | Yes | each device(s) | once per lifetime | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| A4266 | Diaphragm for contraceptive use | 01 | 183 | 22 | | FP | \$22.86 | No | each | two per 365 days | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| A4266 | Diaphragm for contraceptive use | 08 | 082 | 49 | | FP | \$22.86 | No | each | two per 365 days | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-------------------------|------------------|------------------|---------------|------------------------|------------|------------------|------------------|--------------|---|
| A4266 | Diaphragm for contraceptive use | 08 | 083 | 22, 49 | | FP | \$22.86 | No | each | two per 365 days | N/A | |
| A4266 | Diaphragm for contraceptive use | 31 | All | 11 | | FP | \$22.86 | No | each | two per 365 days | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| A4267 | Contraceptive supply, condom, male, each | 08 | 083 | 22, 49 | | FP | \$0.35 | No | each | 144 per 30 days | N/A | |
| A4267 | Contraceptive supply, condom, male, each | 24 | 240, 241, 242, 243, 245 | 11, 12 | | FP | \$0.35 | No | each | 144 per 30 days | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| A4267 | Contraceptive supply, condom, male, each | 25 | 250 | 11, 12 | | FP | \$0.35 | No | each | 144 per 30 days | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| A4268 | Contraceptive supply, condom, female, each | 08 | 083 | 22, 49 | | FP | \$2.25 | No | each | 144 per 30 days | N/A | |
| A4268 | Contraceptive supply, condom, female, each | 24 | 240, 241, 242, 243, 245 | 11, 12 | | FP | \$2.25 | No | each | 144 per 30 days | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| A4268 | Contraceptive supply, condom, female, each | 25 | 250 | 11, 12 | | FP | \$2.25 | No | each | 144 per 30 days | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| J7296 | Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg | 01 | 010 | 22 | | FP | \$938.06 | No | each | once per day | N/A | This provider type must bill with the FP modifier |
| J7297 | Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg | 01 | 010 | 22 | | FP | \$645.00 | No | each | once per day | N/A | This provider type must bill with the FP modifier |
| J7298 | Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg | 01 | 010 | 22 | | FP | \$885.80 | No | each | once per day | N/A | This provider type must bill with the FP modifier |
| J7300 | Intrauterine copper contraceptive | 01 | 010 | 22 | | FP | \$762.65 | No | each | once per day | N/A | This provider type must bill with the FP modifier |
| J7301 | Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg | 01 | 010 | 22 | | FP | \$737.57 | No | each | once per day | N/A | This provider type must bill with the FP modifier |
| J7307 | Etonogestrel (contraceptive) implant system, including implant and supplies | 01 | 010 | 22 | | FP | \$796.20 | No | each | once per day | N/A | This provider type must bill with the FP modifier |
| S4989 | Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies | 01 | 010 | 22 | | FP | \$800.00 | No | each | once per day | N/A | This provider type must bill with the FP modifier |
| T1015 | Clinic visit/encounter, all-inclusive | 01 | 183 | 22 | U4 | FP | Provider Specific Rate | No | per clinic visit | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| T1015 | Clinic visit/encounter, all-inclusive | 01 | 183 | 22 | U5 | FP | Provider Specific Rate | No | per clinic visit | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|----------------------------------|--|---------------|-----------|------------------|------------------|---------------|---|-------------------------------------|------------------|--------------|--------------|---|
| T1015 | Clinic visit/encounter, all-inclusive | 08 | 080 | 50 | | FP | Provider Specific Rate | No | per clinic visit | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| T1015 | Clinic visit/encounter, all-inclusive | 08 | 081 | 72 | | FP | Provider Specific Rate | No | per clinic visit | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| T1015 | Clinic visit/encounter, all-inclusive | 08 | 082 | 49 | U7 | FP | \$35.00 | No | per clinic visit | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| FAMILY PLANNING-RELATED SERVICES | | | | | | | | | | | | |
| 00400 | Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified | 31 | 311 | 21, 24 | | FP | (base units x conversion factor) + (time units x conversion factor) | No, but AUR and PSR process applies | | | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 00851 | Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection | 31 | 311 | 21, 24 | | FP | (base units x conversion factor) + (time units x conversion factor) | No, but AUR and PSR process applies | | | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 00902 | Anesthesia for; anorectal procedure | 31 | 311 | 24 | | FP | (base units x conversion factor) + (time units x conversion factor) | No, but AUR and PSR process applies | | | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 00920 | Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified | 31 | 311 | 21, 24 | | FP | (base units x conversion factor) + (time units x conversion factor) | No, but AUR and PSR process applies | | | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 00921 | Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral | 31 | 311 | 21, 24 | | FP | (base units x conversion factor) + (time units x conversion factor) | No, but AUR and PSR process applies | | | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---|-------------------------------------|---------------|---------------|--------------|---|
| 00940 | Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified | 31 | 311 | 21, 24 | | FP | (base units x conversion factor) + (time units x conversion factor) | No, but AUR and PSR process applies | | | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 00952 | Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography | 31 | 311 | 21, 24 | | FP | (base units x conversion factor) + (time units x conversion factor) | No, but AUR and PSR process applies | | | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11420 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less | 01 | 021 | 24 | SG | | \$572.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11420 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less | 02 | 020 | 24 | SG | | \$572.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11420 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less | 01 | 183 | 22 | | FP | \$40.00 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11420 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less | 08 | 082 | 49 | | FP | \$40.00 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11420 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less | 08 | 083 | 22, 49 | | FP | \$40.00 | No | per procedure | twice per day | 10 days | |
| 11420 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less | 31 | All | 11, 24, 99 | | FP | \$40.00 | No, but AUR and PSR process applies | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11421 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm | 01 | 021 | 24 | SG | | \$678.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11421 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm | 02 | 020 | 24 | SG | | \$678.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11421 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm | 01 | 183 | 22 | | FP | \$42.50 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11421 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm | 08 | 082 | 49 | | FP | \$42.50 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|---------------|--------------|---|
| 11421 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm | 08 | 083 | 22, 49 | | FP | \$42.50 | No | per procedure | twice per day | 10 days | |
| 11421 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm | 31 | All | 11, 24, 99 | | FP | \$42.50 | No, but AUR and PSR process applies | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11422 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm | 01 | 021 | 24 | SG | | \$741.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11422 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm | 02 | 020 | 24 | SG | | \$741.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11422 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm | 01 | 183 | 22 | | FP | \$37.50 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11422 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm | 08 | 082 | 49 | | FP | \$37.50 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11422 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm | 08 | 083 | 22, 49 | | FP | \$37.50 | No | per procedure | twice per day | 10 days | |
| 11422 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm | 31 | All | 11, 24, 99 | | FP | \$37.50 | No, but AUR and PSR process applies | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11423 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm | 01 | 021 | 24 | SG | | \$691.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11423 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm | 02 | 020 | 24 | SG | | \$691.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11423 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm | 01 | 183 | 22 | | FP | \$36.00 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11423 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm | 08 | 082 | 49 | | FP | \$36.00 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11423 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm | 08 | 083 | 22, 49 | | FP | \$36.00 | No | per procedure | twice per day | 10 days | |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|---------------|--------------|---|
| 11423 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm | 31 | All | 11, 24, 99 | | FP | \$36.00 | No, but AUR and PSR process applies | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11424 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11424 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11424 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm | 01 | 183 | 22 | | FP | \$86.50 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11424 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm | 08 | 082 | 49 | | FP | \$86.50 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11424 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm | 08 | 083 | 22, 49 | | FP | \$86.50 | No | per procedure | twice per day | 10 days | |
| 11424 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm | 31 | All | 11, 24, 99 | | FP | \$86.50 | No, but AUR and PSR process applies | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11426 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm | 01 | 021 | 24 | SG | | \$846.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11426 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm | 02 | 020 | 24 | SG | | \$846.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 11426 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm | 01 | 183 | 22 | | FP | \$121.00 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11426 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm | 08 | 082 | 49 | | FP | \$121.00 | No | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 11426 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm | 08 | 083 | 22, 49 | | FP | \$121.00 | No | per procedure | twice per day | 10 days | |
| 11426 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm | 31 | All | 11, 24, 99 | | FP | \$121.00 | No, but AUR and PSR process applies | per procedure | twice per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| Code | Code Description | Provider Type | Specialty | Place of Service | Pricing Modifier | Info Modifier | MA Fee | Prior Auth | MA units | Limits | Post op days | Comments |
|-------|--|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|--------------|--------------|---|
| 17000 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion | 01 | 021 | 24 | SG | | \$923.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 17000 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion | 02 | 020 | 24 | SG | | \$923.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 17000 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion | 01 | 183 | 22 | | FP | \$20.00 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 17000 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion | 08 | 082 | 49 | | FP | \$20.00 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 17000 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion | 08 | 083 | 22, 49 | | FP | \$20.00 | No | per procedure | once per day | 10 days | |
| 17000 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion | 31 | All | 11, 24, 99 | | FP | \$20.00 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 17003 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion) | 01 | 183 | 22 | | FP | \$4.25 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 17003 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion) | 08 | 082 | 49 | | FP | \$4.25 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 17003 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion) | 08 | 083 | 22, 49 | | FP | \$4.25 | No | per procedure | once per day | 0 days | |
| 17003 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion) | 31 | All | 11, 24, 99 | | FP | \$4.25 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 17004 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions | 01 | 183 | 22 | | FP | \$116.39 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 17004 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions | 08 | 082 | 49 | | FP | \$116.39 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 17004 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions | 08 | 083 | 22, 49 | | FP | \$116.39 | No | per procedure | once per day | 10 days | |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|--------------|--------------|---|
| 17004 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions | 31 | All | 11 | | FP | \$116.39 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 17110 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions | 01 | 021 | 24 | SG | | \$645.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 17110 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions | 02 | 020 | 24 | SG | | \$645.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 17110 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions | 01 | 183 | 22 | | FP | \$85.20 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 17110 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions | 08 | 082 | 49 | | FP | \$85.20 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 17110 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions | 08 | 083 | 22, 49 | | FP | \$85.20 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 17110 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions | 31 | All | 11, 24, 99 | | FP | \$85.20 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 17111 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 17111 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 17111 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions | 01 | 183 | 22 | | FP | \$105.29 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 17111 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions | 08 | 082 | 49 | | FP | \$105.29 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 17111 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions | 08 | 083 | 22, 49 | | FP | \$105.29 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 17111 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions | 31 | All | 11, 24 | | FP | \$105.29 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|--------------|--------------|---|
| 46900 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46900 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46900 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 01 | 183 | 22 | | FP | \$171.03 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46900 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 08 | 082 | 49 | | FP | \$171.03 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46900 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 08 | 083 | 22, 49 | | FP | \$171.03 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46900 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 31 | All | 11, 24, 99 | | FP | \$171.03 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46910 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 01 | 021 | 24 | SG | | \$773.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46910 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 02 | 020 | 24 | SG | | \$773.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46910 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 01 | 183 | 22 | | FP | \$107.44 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 46910 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 08 | 082 | 49 | | FP | \$107.44 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 46910 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 08 | 083 | 22, 49 | | FP | \$107.44 | No | per procedure | once per day | 10 days | |
| 46910 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 31 | All | 11, 24, 99 | | FP | \$107.44 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 46916 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 01 | 183 | 22 | | FP | \$178.05 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46916 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 08 | 082 | 49 | | FP | \$178.05 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46916 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 08 | 083 | 22, 49 | | FP | \$178.05 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|--------------|--------------|---|
| 46916 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 31 | All | 11, 99 | | FP | \$178.05 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46917 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46917 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46917 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 01 | 183 | 22 | | FP | \$109.41 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 46917 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 08 | 082 | 49 | | FP | \$109.41 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 46917 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 08 | 083 | 22, 49 | | FP | \$109.41 | No | per procedure | once per day | 10 days | |
| 46917 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 31 | All | 11, 24, 99 | | FP | \$109.41 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 46922 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46922 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46922 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 01 | 183 | 22 | | FP | \$108.34 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 46922 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 08 | 082 | 49 | | FP | \$108.34 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 46922 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 08 | 083 | 22, 49 | | FP | \$108.34 | No | per procedure | once per day | 10 days | |
| 46922 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 31 | All | 11, 24, 99 | | FP | \$108.34 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 46924 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electro-surgery, cryosurgery, chemosurgery) | 01 | 021 | 24 | SG | | \$752.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46924 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electro-surgery, cryosurgery, chemosurgery) | 02 | 020 | 24 | SG | | \$752.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 46924 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electro-surgery, cryosurgery, chemosurgery) | 01 | 183 | 22 | | FP | \$230.08 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46924 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electro-surgery, cryosurgery, chemosurgery) | 08 | 082 | 49 | | FP | \$230.08 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46924 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electro-surgery, cryosurgery, chemosurgery) | 08 | 083 | 22, 49 | | FP | \$230.08 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 46924 | Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electro-surgery, cryosurgery, chemosurgery) | 31 | All | 11, 24, 99 | | FP | \$230.08 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54050 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54050 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54050 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 01 | 183 | 22 | | FP | \$129.69 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54050 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 08 | 082 | 49 | | FP | \$129.69 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54050 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 08 | 083 | 22, 49 | | FP | \$129.69 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54050 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical | 31 | All | 11, 24, 99 | | FP | \$129.69 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54055 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54055 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54055 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 01 | 183 | 22 | | FP | \$38.50 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|--------------|--------------|---|
| 54055 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 08 | 082 | 49 | | FP | \$38.50 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 54055 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 08 | 083 | 22, 49 | | FP | \$38.50 | No | per procedure | once per day | 10 days | |
| 54055 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation | 31 | All | 11, 24, 99 | | FP | \$38.50 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 54056 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54056 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54056 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 01 | 183 | 22 | | FP | \$136.79 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54056 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 08 | 082 | 49 | | FP | \$136.79 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54056 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 08 | 083 | 22, 49 | | FP | \$136.79 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54056 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery | 31 | All | 11, 24, 99 | | FP | \$136.79 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54057 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54057 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54057 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 01 | 183 | 22 | | FP | \$28.00 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 54057 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 08 | 082 | 49 | | FP | \$28.00 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 54057 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 08 | 083 | 22, 49 | | FP | \$28.00 | No | per procedure | once per day | 10 days | |

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| 54057 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery | 31 | All | 11, 24, 99 | | FP | \$28.00 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 54060 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54060 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54060 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 01 | 183 | 22 | | FP | \$64.50 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 54060 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 08 | 082 | 49 | | FP | \$64.50 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 54060 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 08 | 083 | 22, 49 | | FP | \$64.50 | No | per procedure | once per day | 10 days | |
| 54060 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision | 31 | All | 11, 24, 99 | | FP | \$64.50 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 54065 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 01 | 021 | 24 | SG | | \$769.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54065 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 02 | 020 | 24 | SG | | \$769.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 54065 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 01 | 183 | 22 | | FP | \$215.35 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54065 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 08 | 082 | 49 | | FP | \$215.35 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54065 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 08 | 083 | 22, 49 | | FP | \$215.35 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 54065 | Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 31 | All | 11, 24, 99 | | FP | \$215.35 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56405 | Incision and drainage of vulva or perineal abscess | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |

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| 56405 | Incision and drainage of vulva or perineal abscess | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56405 | Incision and drainage of vulva or perineal abscess | 01 | 183 | 22 | | FP | \$93.81 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56405 | Incision and drainage of vulva or perineal abscess | 08 | 082 | 49 | | FP | \$93.81 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56405 | Incision and drainage of vulva or perineal abscess | 08 | 083 | 22, 49 | | FP | \$93.81 | No | per procedure | once per day | 10 days | |
| 56405 | Incision and drainage of vulva or perineal abscess | 31 | All | 11, 24, 99 | | FP | \$93.81 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56420 | Incision and drainage of Bartholin's gland abscess | 01 | 021 | 24 | SG | | \$675.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56420 | Incision and drainage of Bartholin's gland abscess | 02 | 020 | 24 | SG | | \$675.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56420 | Incision and drainage of Bartholin's gland abscess | 01 | 183 | 22 | | FP | \$112.73 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56420 | Incision and drainage of Bartholin's gland abscess | 08 | 082 | 49 | | FP | \$112.73 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56420 | Incision and drainage of Bartholin's gland abscess | 08 | 083 | 22, 49 | | FP | \$112.73 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56420 | Incision and drainage of Bartholin's gland abscess | 31 | All | 11, 24, 99 | | FP | \$112.73 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56440 | Marsupialization of Bartholin's gland cyst | 01 | 021 | 24 | SG | | \$748.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56440 | Marsupialization of Bartholin's gland cyst | 02 | 020 | 24 | SG | | \$748.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56440 | Marsupialization of Bartholin's gland cyst | 01 | 183 | 22 | | FP | \$225.08 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56440 | Marsupialization of Bartholin's gland cyst | 08 | 082 | 49 | | FP | \$225.08 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56440 | Marsupialization of Bartholin's gland cyst | 08 | 083 | 22, 49 | | FP | \$225.08 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |

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| 56440 | Marsupialization of Bartholin's gland cyst | 31 | All | 11, 24, 99 | | FP | \$225.08 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56501 | Destruction of lesion(s), vulva; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 01 | 021 | 24 | SG | | \$552.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56501 | Destruction of lesion(s), vulva; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 02 | 020 | 24 | SG | | \$552.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56501 | Destruction of lesion(s), vulva; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 01 | 183 | 22 | | FP | \$141.09 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56501 | Destruction of lesion(s), vulva; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 08 | 082 | 49 | | FP | \$141.09 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56501 | Destruction of lesion(s), vulva; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 08 | 083 | 22, 49 | | FP | \$141.09 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56501 | Destruction of lesion(s), vulva; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 31 | All | 11, 24, 99 | | FP | \$141.09 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56501 | Destruction of lesion(s), vulva; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 33 | 335 | 11, 99 | | FP | \$141.09 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56515 | Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 01 | 021 | 24 | SG | | \$804.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56515 | Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 02 | 020 | 24 | SG | | \$804.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56515 | Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 01 | 183 | 22 | | FP | \$249.18 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56515 | Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 08 | 082 | 49 | | FP | \$249.18 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56515 | Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 08 | 083 | 22, 49 | | FP | \$249.18 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56515 | Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 31 | All | 11, 24, 99 | | FP | \$249.18 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56515 | Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 33 | 335 | 11, 99 | | FP | \$249.18 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 56605 | Biopsy of vulva or perineum (separate procedure); 1 lesion | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56605 | Biopsy of vulva or perineum (separate procedure); 1 lesion | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |

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| 56605 | Biopsy of vulva or perineum (separate procedure); 1 lesion | 01 | 183 | 22 | | FP | \$75.38 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 56605 | Biopsy of vulva or perineum (separate procedure); 1 lesion | 08 | 082 | 49 | | FP | \$75.38 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 56605 | Biopsy of vulva or perineum (separate procedure); 1 lesion | 08 | 083 | 22, 49 | | FP | \$75.38 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 56605 | Biopsy of vulva or perineum (separate procedure); 1 lesion | 31 | All | 11, 24, 99 | | FP | \$75.38 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 56606 | Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure) | 01 | 183 | 22 | | FP | \$37.30 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 56606 | Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure) | 08 | 082 | 49 | | FP | \$37.30 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 56606 | Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure) | 08 | 083 | 22, 49 | | FP | \$37.30 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 56606 | Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure) | 31 | All | 11, 24, 99 | | FP | \$37.30 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 56820 | Colposcopy of the vulva | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56820 | Colposcopy of the vulva | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56820 | Colposcopy of the vulva | 01 | 183 | 22 | | FP | \$77.24 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56820 | Colposcopy of the vulva | 08 | 082 | 49 | | FP | \$77.24 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56820 | Colposcopy of the vulva | 08 | 083 | 22, 49 | | FP | \$77.24 | No | per procedure | once per day | 0 days | |
| 56820 | Colposcopy of the vulva | 09 | All | 11 | | FP | \$77.24 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56820 | Colposcopy of the vulva | 31 | All | 11, 24, 99 | | FP | \$77.24 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56820 | Colposcopy of the vulva | 33 | 335 | 11, 99 | | FP | \$77.24 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 56821 | Colposcopy of the vulva; with biopsy(s) | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56821 | Colposcopy of the vulva; with biopsy(s) | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 56821 | Colposcopy of the vulva; with biopsy(s) | 01 | 183 | 22 | | FP | \$105.72 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56821 | Colposcopy of the vulva; with biopsy(s) | 08 | 082 | 49 | | FP | \$105.72 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56821 | Colposcopy of the vulva; with biopsy(s) | 08 | 083 | 22, 49 | | FP | \$105.72 | No | per procedure | once per day | 0 days | |
| 56821 | Colposcopy of the vulva; with biopsy(s) | 09 | All | 11 | | FP | \$105.72 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56821 | Colposcopy of the vulva; with biopsy(s) | 31 | All | 11, 24, 99 | | FP | \$105.72 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 56821 | Colposcopy of the vulva; with biopsy(s) | 33 | 335 | 11, 99 | | FP | \$105.72 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57061 | Destruction of vaginal lesion(s); simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 01 | 021 | 24 | SG | | \$607.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57061 | Destruction of vaginal lesion(s); simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 02 | 020 | 24 | SG | | \$607.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57061 | Destruction of vaginal lesion(s); simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 01 | 183 | 22 | | FP | \$120.58 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57061 | Destruction of vaginal lesion(s); simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 08 | 082 | 49 | | FP | \$120.58 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57061 | Destruction of vaginal lesion(s); simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 08 | 083 | 22, 49 | | FP | \$120.58 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57061 | Destruction of vaginal lesion(s); simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 31 | All | 11, 24, 99 | | FP | \$120.58 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57061 | Destruction of vaginal lesion(s); simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery) | 33 | 335 | 11, 99 | | FP | \$120.58 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |

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| 57065 | Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57065 | Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57065 | Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 01 | 183 | 22 | | FP | \$216.16 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57065 | Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 08 | 082 | 49 | | FP | \$216.16 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57065 | Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 08 | 083 | 22, 49 | | FP | \$216.16 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57065 | Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) | 31 | All | 11, 24, 99 | | FP | \$216.16 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57100 | Biopsy of vaginal mucosa; simple (separate procedure) | 01 | 021 | 24 | SG | | \$607.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57100 | Biopsy of vaginal mucosa; simple (separate procedure) | 02 | 020 | 24 | SG | | \$607.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57100 | Biopsy of vaginal mucosa; simple (separate procedure) | 01 | 183 | 22 | | FP | \$59.99 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57100 | Biopsy of vaginal mucosa; simple (separate procedure) | 08 | 082 | 49 | | FP | \$59.99 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57100 | Biopsy of vaginal mucosa; simple (separate procedure) | 08 | 083 | 22, 49 | | FP | \$59.99 | No | per procedure | once per day | 0 days | |
| 57100 | Biopsy of vaginal mucosa; simple (separate procedure) | 31 | All | 11, 24, 99 | | FP | \$59.99 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57105 | Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) | 01 | 021 | 24 | SG | | \$607.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57105 | Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) | 02 | 020 | 24 | SG | | \$607.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57105 | Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) | 01 | 183 | 22 | | FP | \$70.00 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|--------------|--------------|---|
| 57105 | Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) | 08 | 082 | 49 | | FP | \$70.00 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57105 | Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) | 08 | 083 | 22, 49 | | FP | \$70.00 | No | per procedure | once per day | 10 days | |
| 57105 | Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) | 31 | All | 11, 24, 99 | | FP | \$70.00 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57150 | Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease | 01 | 183 | 22 | | FP | \$27.05 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57150 | Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease | 08 | 082 | 49 | | FP | \$27.05 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57150 | Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease | 08 | 083 | 22, 49 | | FP | \$27.05 | No | per procedure | once per day | 0 days | |
| 57150 | Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease | 31 | All | 11, 99 | | FP | \$27.05 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57150 | Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease | 33 | 335 | 11 | | FP | \$27.05 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57420 | Colposcopy of the entire vagina, with cervix if present | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | n/a | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57420 | Colposcopy of the entire vagina, with cervix if present | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | n/a | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57420 | Colposcopy of the entire vagina, with cervix if present | 01 | 183 | 22 | | FP | \$81.73 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57420 | Colposcopy of the entire vagina, with cervix if present | 08 | 082 | 49 | | FP | \$81.73 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57420 | Colposcopy of the entire vagina, with cervix if present | 08 | 083 | 22, 49 | | FP | \$81.73 | No | per procedure | once per day | 0 days | |
| 57420 | Colposcopy of the entire vagina, with cervix if present | 09 | All | 11 | | FP | \$81.73 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|-----------------|--------------|---|
| 57420 | Colposcopy of the entire vagina, with cervix if present | 31 | All | 11, 24, 99 | | FP | \$81.73 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57420 | Colposcopy of the entire vagina, with cervix if present | 33 | 335 | 11, 99 | | FP | \$81.73 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57421 | Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57421 | Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57421 | Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix | 01 | 183 | 22 | | FP | \$155.89 | No | per procedure | one per 90 days | 0 days | This provider type must bill with the FP modifier |
| 57421 | Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix | 08 | 082 | 49 | | FP | \$155.89 | No | per procedure | one per 90 days | 0 days | This provider type must bill with the FP modifier |
| 57421 | Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix | 08 | 083 | 22, 49 | | FP | \$155.89 | No | per procedure | one per 90 days | 0 days | This provider type must bill with the FP modifier |
| 57421 | Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix | 09 | All | 11 | | FP | \$155.89 | No | per procedure | one per 90 days | 0 days | This provider type must bill with the FP modifier |
| 57421 | Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix | 31 | All | 11, 24, 99 | | FP | \$155.89 | No, but AUR and PSR process applies | per procedure | one per 90 days | 0 days | This provider type must bill with the FP modifier |
| 57421 | Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix | 33 | 335 | 11, 99 | | FP | \$155.89 | No | per procedure | one per 90 days | 0 days | This provider type must bill with the FP modifier |
| 57452 | Colposcopy of the cervix including upper/adjacent vagina; | 01 | 021 | 24 | SG | | \$584.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57452 | Colposcopy of the cervix including upper/adjacent vagina; | 02 | 020 | 24 | SG | | \$584.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57452 | Colposcopy of the cervix including upper/adjacent vagina; | 01 | 183 | 22 | | FP | \$114.64 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57452 | Colposcopy of the cervix including upper/adjacent vagina; | 08 | 082 | 49 | | FP | \$114.64 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57452 | Colposcopy of the cervix including upper/adjacent vagina; | 08 | 083 | 22, 49 | | FP | \$114.64 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57452 | Colposcopy of the cervix including upper/adjacent vagina; | 09 | All | 11 | | FP | \$114.64 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57452 | Colposcopy of the cervix including upper/adjacent vagina; | 31 | All | 11, 24 | | FP | \$114.64 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57452 | Colposcopy of the cervix including upper/adjacent vagina; | 33 | 335 | 11 | | FP | \$114.64 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |

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| 57454 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57454 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57454 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage | 01 | 183 | 22 | | FP | \$168.63 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57454 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage | 08 | 082 | 49 | | FP | \$168.63 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57454 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage | 08 | 083 | 22, 49 | | FP | \$168.63 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57454 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage | 31 | All | 11, 24, 99 | | FP | \$168.63 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57454 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage | 33 | 335 | 11, 99 | | FP | \$168.63 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57455 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57455 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57455 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | 01 | 183 | 22 | | FP | \$137.94 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57455 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | 08 | 082 | 49 | | FP | \$137.94 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57455 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | 08 | 083 | 22, 49 | | FP | \$137.94 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57455 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | 09 | All | 11 | | FP | \$137.94 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57455 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | 31 | All | 11, 24, 99 | | FP | \$137.94 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57455 | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | 33 | 335 | 11, 99 | | FP | \$137.94 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57456 | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57456 | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57456 | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | 01 | 183 | 22 | | FP | \$128.30 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |

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| 57456 | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | 08 | 082 | 49 | | FP | \$128.30 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57456 | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | 08 | 083 | 22, 49 | | FP | \$128.30 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57456 | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | 09 | All | 11 | | FP | \$128.30 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57456 | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | 31 | All | 11, 24, 99 | | FP | \$128.30 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57456 | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | 33 | 335 | 11, 99 | | FP | \$128.30 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57460 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57460 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57460 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix | 01 | 183 | 22 | | FP | \$202.40 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57460 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix | 08 | 082 | 49 | | FP | \$202.40 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57460 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix | 08 | 083 | 22, 49 | | FP | \$202.40 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57460 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix | 31 | All | 11, 24, 99 | | FP | \$202.40 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57461 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57461 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57461 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix | 01 | 183 | 22 | | FP | \$234.04 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57461 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix | 08 | 082 | 49 | | FP | \$234.04 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57461 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix | 08 | 083 | 22, 49 | | FP | \$234.04 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57461 | Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix | 31 | All | 11, 24, 99 | | FP | \$234.04 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57500 | Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) | 01 | 021 | 24 | SG | | \$779.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |

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| 57500 | Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) | 02 | 020 | 24 | SG | | \$779.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57500 | Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) | 01 | 183 | 22 | | FP | \$94.01 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57500 | Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) | 08 | 082 | 49 | | FP | \$94.01 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57500 | Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) | 08 | 083 | 22, 49 | | FP | \$94.01 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57500 | Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) | 31 | All | 11, 24, 99 | | FP | \$94.01 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57505 | Endocervical curettage (not done as part of a dilation and curettage) | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57505 | Endocervical curettage (not done as part of a dilation and curettage) | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57505 | Endocervical curettage (not done as part of a dilation and curettage) | 01 | 183 | 22 | | FP | \$113.13 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57505 | Endocervical curettage (not done as part of a dilation and curettage) | 08 | 082 | 49 | | FP | \$113.13 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57505 | Endocervical curettage (not done as part of a dilation and curettage) | 08 | 083 | 22, 49 | | FP | \$113.13 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57505 | Endocervical curettage (not done as part of a dilation and curettage) | 31 | All | 11, 24, 99 | | FP | \$113.13 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57510 | Cautery of cervix; electro or thermal | 01 | 021 | 24 | SG | | \$738.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57510 | Cautery of cervix; electro or thermal | 02 | 020 | 24 | SG | | \$738.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57510 | Cautery of cervix; electro or thermal | 01 | 183 | 22 | | FP | \$32.00 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57510 | Cautery of cervix; electro or thermal | 08 | 082 | 49 | | FP | \$32.00 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57510 | Cautery of cervix; electro or thermal | 08 | 083 | 22, 49 | | FP | \$32.00 | No | per procedure | once per day | 10 days | |

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| 57510 | Cautery of cervix; electro or thermal | 31 | All | 11, 24, 99 | | FP | \$32.00 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57511 | Cautery of cervix; cryocautery, initial or repeat | 01 | 021 | 24 | SG | | \$785.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57511 | Cautery of cervix; cryocautery, initial or repeat | 02 | 020 | 24 | SG | | \$785.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57511 | Cautery of cervix; cryocautery, initial or repeat | 01 | 183 | 22 | | FP | \$162.30 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57511 | Cautery of cervix; cryocautery, initial or repeat | 08 | 082 | 49 | | FP | \$162.30 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57511 | Cautery of cervix; cryocautery, initial or repeat | 08 | 083 | 22, 49 | | FP | \$162.30 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57511 | Cautery of cervix; cryocautery, initial or repeat | 31 | All | 11, 24, 99 | | FP | \$162.30 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier |
| 57513 | Cautery of cervix; laser ablation | 01 | 021 | 24 | SG | | \$785.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57513 | Cautery of cervix; laser ablation | 02 | 020 | 24 | SG | | \$785.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57513 | Cautery of cervix; laser ablation | 01 | 183 | 22 | | FP | \$51.50 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57513 | Cautery of cervix; laser ablation | 08 | 082 | 49 | | FP | \$51.50 | No | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57513 | Cautery of cervix; laser ablation | 08 | 083 | 22, 49 | | FP | \$51.50 | No | per procedure | once per day | 10 days | |
| 57513 | Cautery of cervix; laser ablation | 31 | All | 11, 24, 99 | | FP | \$51.50 | No, but AUR and PSR process applies | per procedure | once per day | 10 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57520 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser | 01 | 021 | 24 | SG | | \$796.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57520 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser | 02 | 020 | 24 | SG | | \$796.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|--------------|--------------|---|
| 57520 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser | 01 | 183 | 22 | | FP | \$211.50 | No | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57520 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser | 08 | 082 | 49 | | FP | \$211.50 | No | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57520 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser | 08 | 083 | 22, 49 | | FP | \$211.50 | No | per procedure | once per day | 90 days | |
| 57520 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser | 31 | All | 11, 24, 99 | | FP | \$211.50 | No, but AUR and PSR process applies | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57522 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57522 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57522 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision | 01 | 183 | 22 | | FP | \$217.95 | No | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57522 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision | 08 | 082 | 49 | | FP | \$217.95 | No | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57522 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision | 08 | 083 | 22, 49 | | FP | \$217.95 | No | per procedure | once per day | 90 days | |
| 57522 | Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision | 31 | All | 11, 24, 99 | | FP | \$217.95 | No, but AUR and PSR process applies | per procedure | once per day | 90 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 57800 | Dilation of cervical canal, instrumental (separate procedure) | 01 | 021 | 24 | SG | | \$817.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57800 | Dilation of cervical canal, instrumental (separate procedure) | 02 | 020 | 24 | SG | | \$817.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 57800 | Dilation of cervical canal, instrumental (separate procedure) | 01 | 183 | 22 | | FP | \$60.09 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57800 | Dilation of cervical canal, instrumental (separate procedure) | 08 | 082 | 49 | | FP | \$60.09 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 57800 | Dilation of cervical canal, instrumental (separate procedure) | 08 | 083 | 22, 49 | | FP | \$60.09 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |

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| 57800 | Dilation of cervical canal, instrumental (separate procedure) | 31 | All | 11, 24, 99 | | FP | \$60.09 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 58100 | Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) | 01 | 021 | 24 | SG | | \$730.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58100 | Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) | 02 | 020 | 24 | SG | | \$730.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58100 | Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) | 01 | 183 | 22 | | FP | \$108.89 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 58100 | Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) | 08 | 082 | 49 | | FP | \$108.89 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 58100 | Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) | 08 | 083 | 22, 49 | | FP | \$108.89 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 58100 | Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) | 31 | All | 11, 24, 99 | | FP | \$108.89 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 58110 | Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure) | 01 | 183 | 22 | | FP | \$32.05 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58110 | Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure) | 08 | 082 | 49 | | FP | \$32.05 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58110 | Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure) | 08 | 083 | 22, 49 | | FP | \$32.05 | No | per procedure | once per day | 0 days | |
| 58110 | Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure) | 09 | All | 11 | | FP | \$32.05 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58110 | Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure) | 31 | All | 11, 24, 99 | | FP | \$32.05 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58110 | Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure) | 33 | 335 | 11, 99 | | FP | \$32.05 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 58562 | Hysteroscopy, surgical; with removal of impacted foreign body | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|----------|-------------------------------------|---------------|--------------|--------------|---|
| 58562 | Hysteroscopy, surgical; with removal of impacted foreign body | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 58562 | Hysteroscopy, surgical; with removal of impacted foreign body | 31 | All | 24 | | FP | \$359.51 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 64435 | Injection, anesthetic agent; paracervical (uterine) nerve | 01 | 021 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 64435 | Injection, anesthetic agent; paracervical (uterine) nerve | 02 | 020 | 24 | SG | | \$776.00 | No, but AUR and PSR process applies | | N/A | N/A | This provider type must bill with the ICD-10 DX Z30.011 through Z30.9 |
| 64435 | Injection, anesthetic agent; paracervical (uterine) nerve | 01 | 183 | 22 | | FP | \$104.43 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 64435 | Injection, anesthetic agent; paracervical (uterine) nerve | 08 | 082 | 49 | | FP | \$104.43 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 64435 | Injection, anesthetic agent; paracervical (uterine) nerve | 08 | 083 | 22, 49 | | FP | \$104.43 | No | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 64435 | Injection, anesthetic agent; paracervical (uterine) nerve | 31 | All | 11, 24, 99 | | FP | \$104.43 | No, but AUR and PSR process applies | per procedure | once per day | 0 days | This provider type must bill with the FP modifier |
| 76830 | Ultrasound, transvaginal | 01 | 183 | 22 | | FP | \$76.50 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 76830 | Ultrasound, transvaginal | 01 | 183 | 22 | TC | FP | \$46.50 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 76830 | Ultrasound, transvaginal | 08 | 082 | 49 | | FP | \$76.50 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 76830 | Ultrasound, transvaginal | 08 | 082 | 49 | TC | FP | \$46.50 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 76830 | Ultrasound, transvaginal | 08 | 083 | 22, 49 | | FP | \$76.50 | No | per procedure | once per day | N/A | |
| 76830 | Ultrasound, transvaginal | 08 | 083 | 22, 49 | TC | FP | \$46.50 | No | per procedure | once per day | N/A | |
| 76830 | Ultrasound, transvaginal | 31 | All | 11 | | FP | \$76.50 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 76830 | Ultrasound, transvaginal | 31 | All | 11 | TC | FP | \$46.50 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|----------|------------|---------------|--------------|--------------|---|
| 76830 | Ultrasound, transvaginal | 31 | All | 11, 22, 49 | 26 | FP | \$30.00 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 01 | 183 | 22 | | FP | \$131.63 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 01 | 183 | 22 | TC | FP | \$88.59 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 08 | 082 | 49 | | FP | \$131.63 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 08 | 082 | 49 | TC | FP | \$88.59 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 08 | 083 | 22, 49 | | FP | \$131.63 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 08 | 083 | 22, 49 | TC | FP | \$88.59 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 31 | All | 11 | | FP | \$131.63 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 31 | All | 11 | TC | FP | \$88.59 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76856 | Ultrasound, pelvic (nonobstetric), real time with image documentation; complete | 31 | All | 11, 22, 49 | 26 | FP | \$43.04 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 01 | 183 | 22 | | FP | \$57.83 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 01 | 183 | 22 | TC | FP | \$26.64 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 08 | 082 | 49 | | FP | \$57.83 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 08 | 082 | 49 | TC | FP | \$26.64 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 08 | 083 | 22, 49 | | FP | \$57.83 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 08 | 083 | 22, 49 | TC | FP | \$26.64 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 31 | All | 11 | | FP | \$57.83 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 31 | All | 11 | TC | FP | \$26.64 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 76857 | Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles) | 31 | All | 11, 22, 49 | 26 | FP | \$31.19 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier |
| 80048 | Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520) | 01 | 183 | 22 | | FP | \$9.36 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80048 | Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520) | 01 | 183 | 22 | | QW, FP | \$9.36 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 80048 | Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520) | 28 | 280 | 81 | | FP | \$9.36 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80048 | Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520) | 28 | 280 | 81 | | QW, FP | \$9.36 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80053 | Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520) | 01 | 183 | 22 | | FP | \$11.69 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80053 | Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520) | 01 | 183 | 22 | | QW, FP | \$11.69 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80053 | Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520) | 28 | 280 | 81 | | FP | \$11.69 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80053 | Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520) | 28 | 280 | 81 | | QW, FP | \$11.69 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 01 | 183 | 22 | | FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 01 | 183 | 22 | | QW, FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 08 | 082 | 49 | | FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 08 | 082 | 49 | | QW, FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 08 | 083 | 22, 49 | | FP | \$14.00 | No | per test | once per day | N/A | |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 08 | 083 | 22, 49 | | QW, FP | \$14.00 | No | per test | once per day | N/A | |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 09 | All | 11 | | FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 09 | All | 11 | | QW, FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 28 | 280 | 81 | | FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 28 | 280 | 81 | | QW, FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 31 | All | 11 | | FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 31 | All | 11 | | QW, FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 33 | 335 | 11 | | FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) | 33 | 335 | 11 | | QW, FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80076 | Hepatic function panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Bilirubin, direct (82248) Phosphatase, alkaline (84075) Protein, total (84155) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) | 01 | 183 | 22 | | FP | \$9.03 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 80076 | Hepatic function panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Bilirubin, direct (82248) Phosphatase, alkaline (84075) Protein, total (84155) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) | 28 | 280 | 81 | | FP | \$9.03 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|--------|------------|----------|--------------|--------------|---|
| 81000 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy | 01 | 183 | 22 | | FP | \$4.32 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81000 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy | 08 | 083 | 22, 49 | | FP | \$4.32 | No | per test | once per day | N/A | |
| 81000 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy | 28 | 280 | 81 | | FP | \$4.32 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81001 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy | 01 | 183 | 22 | | FP | \$3.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81001 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy | 08 | 083 | 22, 49 | U7 | FP | \$4.37 | No | per test | once per day | N/A | |
| 81001 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy | 28 | 280 | 81 | | FP | \$3.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81002 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy | 01 | 183 | 22 | | FP | \$4.35 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81002 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy | 08 | 082 | 49 | | FP | \$4.35 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81002 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy | 08 | 083 | 22, 49 | | FP | \$4.35 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81002 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy | 09 | All | 11 | | FP | \$4.35 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81002 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy | 28 | 280 | 81 | | FP | \$4.35 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81002 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy | 31 | All | 11 | | FP | \$4.35 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 81002 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy | 33 | 335 | 11 | | FP | \$4.35 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|--------|------------|----------|--------------|--------------|---|
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 01 | 183 | 22 | | FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 01 | 183 | 22 | | QW, FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 08 | 082 | 49 | | FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 08 | 082 | 49 | | QW, FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 08 | 083 | 22, 49 | | FP | \$3.10 | No | per test | once per day | N/A | |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 08 | 083 | 22, 49 | | QW, FP | \$3.10 | No | per test | once per day | N/A | |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 09 | All | 11 | | FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 09 | All | 11 | | QW, FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 28 | 280 | 81 | | FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 28 | 280 | 81 | | QW, FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 31 | All | 11 | | FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 31 | All | 11 | | QW, FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 33 | 335 | 11 | | FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | 33 | 335 | 11 | | QW, FP | \$3.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82105 | Alpha-fetoprotein (AFP); serum | 01 | 183 | 22 | | FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82105 | Alpha-fetoprotein (AFP); serum | 08 | 083 | 22, 49 | | FP | \$20.00 | No | per test | once per day | N/A | |
| 82105 | Alpha-fetoprotein (AFP); serum | 28 | 280 | 81 | | FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82465 | Cholesterol, serum or whole blood, total | 01 | 183 | 22 | | FP | \$6.01 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82465 | Cholesterol, serum or whole blood, total | 01 | 183 | 22 | | QW, FP | \$6.01 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82465 | Cholesterol, serum or whole blood, total | 08 | 083 | 22, 49 | | FP | \$6.01 | No | per test | once per day | N/A | |
| 82465 | Cholesterol, serum or whole blood, total | 08 | 083 | 22, 49 | | QW, FP | \$6.01 | No | per test | once per day | N/A | |
| 82465 | Cholesterol, serum or whole blood, total | 28 | 280 | 81 | | FP | \$6.01 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82465 | Cholesterol, serum or whole blood, total | 28 | 280 | 81 | | QW, FP | \$6.01 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82533 | Cortisol; total | 01 | 183 | 22 | | FP | \$12.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82533 | Cortisol; total | 08 | 083 | 22, 49 | | FP | \$12.00 | No | per test | once per day | N/A | |
| 82533 | Cortisol; total | 28 | 280 | 81 | | FP | \$12.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82626 | Dehydroepiandrosterone (DHEA) | 01 | 183 | 22 | | FP | \$21.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82626 | Dehydroepiandrosterone (DHEA) | 08 | 083 | 22, 49 | | FP | \$21.00 | No | per test | once per day | N/A | |
| 82626 | Dehydroepiandrosterone (DHEA) | 28 | 280 | 81 | | FP | \$21.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 82627 | Dehydroepiandrosterone-sulfate (DHEA-S) | 01 | 183 | 22 | | FP | \$21.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82627 | Dehydroepiandrosterone-sulfate (DHEA-S) | 28 | 280 | 81 | | FP | \$21.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82670 | Estradiol | 01 | 183 | 22 | | FP | \$21.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82670 | Estradiol | 28 | 280 | 81 | | FP | \$21.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82671 | Estrogens; fractionated | 01 | 183 | 22 | | FP | \$22.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82671 | Estrogens; fractionated | 08 | 083 | 22, 49 | | FP | \$22.00 | No | per test | once per day | N/A | |
| 82671 | Estrogens; fractionated | 28 | 280 | 81 | | FP | \$22.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82672 | Estrogens; total | 01 | 183 | 22 | | FP | \$13.92 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82672 | Estrogens; total | 28 | 280 | 81 | | FP | \$13.92 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82948 | Glucose; blood, reagent strip | 01 | 183 | 22 | | FP | \$2.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82948 | Glucose; blood, reagent strip | 08 | 083 | 22, 49 | | FP | \$2.00 | No | per test | once per day | N/A | |
| 82948 | Glucose; blood, reagent strip | 28 | 280 | 81 | | FP | \$2.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82951 | Glucose; tolerance test (GTT), 3 specimens (includes glucose) | 01 | 183 | 22 | | FP | \$12.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82951 | Glucose; tolerance test (GTT), 3 specimens (includes glucose) | 01 | 183 | 22 | | QW, FP | \$12.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82951 | Glucose; tolerance test (GTT), 3 specimens (includes glucose) | 08 | 083 | 22, 49 | | FP | \$12.50 | No | per test | once per day | N/A | |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 82951 | Glucose; tolerance test (GTT), 3 specimens (includes glucose) | 08 | 083 | 22, 49 | | QW, FP | \$12.50 | No | per test | once per day | N/A | |
| 82951 | Glucose; tolerance test (GTT), 3 specimens (includes glucose) | 28 | 280 | 81 | | FP | \$12.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 82951 | Glucose; tolerance test (GTT), 3 specimens (includes glucose) | 28 | 280 | 81 | | QW, FP | \$12.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83001 | Gonadotropin; follicle stimulating hormone (FSH) | 01 | 183 | 22 | | FP | \$17.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83001 | Gonadotropin; follicle stimulating hormone (FSH) | 01 | 183 | 22 | | QW, FP | \$17.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83001 | Gonadotropin; follicle stimulating hormone (FSH) | 08 | 083 | 22, 49 | | FP | \$17.50 | No | per test | once per day | N/A | |
| 83001 | Gonadotropin; follicle stimulating hormone (FSH) | 08 | 083 | 22, 49 | | QW, FP | \$17.50 | No | per test | once per day | N/A | |
| 83001 | Gonadotropin; follicle stimulating hormone (FSH) | 28 | 280 | 81 | | FP | \$17.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83001 | Gonadotropin; follicle stimulating hormone (FSH) | 28 | 280 | 81 | | QW, FP | \$17.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83002 | Gonadotropin; luteinizing hormone (LH) | 01 | 183 | 22 | | FP | \$17.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83002 | Gonadotropin; luteinizing hormone (LH) | 01 | 183 | 22 | | QW, FP | \$17.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83002 | Gonadotropin; luteinizing hormone (LH) | 08 | 083 | 22, 49 | | FP | \$17.00 | No | per test | once per day | N/A | |
| 83002 | Gonadotropin; luteinizing hormone (LH) | 08 | 083 | 22, 49 | | QW, FP | \$17.00 | No | per test | once per day | N/A | |
| 83002 | Gonadotropin; luteinizing hormone (LH) | 28 | 280 | 81 | | FP | \$17.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83002 | Gonadotropin; luteinizing hormone (LH) | 28 | 280 | 81 | | QW, FP | \$17.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83491 | Hydroxycorticosteroids, 17- (17-OHCS) | 01 | 183 | 22 | | FP | \$7.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---------------------------------------|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 83491 | Hydroxycorticosteroids, 17- (17-OHCS) | 08 | 083 | 22, 49 | | FP | \$7.00 | No | per test | once per day | N/A | |
| 83491 | Hydroxycorticosteroids, 17- (17-OHCS) | 28 | 280 | 81 | | FP | \$7.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83586 | Ketosteroids, 17- (17-KS); total | 01 | 183 | 22 | | FP | \$17.69 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83586 | Ketosteroids, 17- (17-KS); total | 08 | 083 | 22, 49 | | FP | \$17.69 | No | per test | once per day | N/A | |
| 83586 | Ketosteroids, 17- (17-KS); total | 28 | 280 | 81 | | FP | \$17.69 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83727 | Luteinizing releasing factor (LRH) | 01 | 183 | 22 | | FP | \$23.76 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 83727 | Luteinizing releasing factor (LRH) | 08 | 083 | 22, 49 | | FP | \$23.76 | No | per test | once per day | N/A | |
| 83727 | Luteinizing releasing factor (LRH) | 28 | 280 | 81 | | FP | \$23.76 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84138 | Pregnanetriol | 01 | 183 | 22 | | FP | \$23.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84138 | Pregnanetriol | 08 | 083 | 22, 49 | | FP | \$23.00 | No | per test | once per day | N/A | |
| 84138 | Pregnanetriol | 28 | 280 | 81 | | FP | \$23.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84144 | Progesterone | 01 | 183 | 22 | | FP | \$17.00 | No | per test | 2 per 7 days | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84144 | Progesterone | 08 | 083 | 22, 49 | | FP | \$17.00 | No | per test | 2 per 7 days | N/A | |
| 84144 | Progesterone | 28 | 280 | 81 | | FP | \$17.00 | No | per test | 2 per 7 days | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84146 | Prolactin | 01 | 183 | 22 | | FP | \$24.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84146 | Prolactin | 08 | 083 | 22, 49 | | FP | \$24.00 | No | per test | once per day | N/A | |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 84146 | Prolactin | 28 | 280 | 81 | | FP | \$24.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84233 | Receptor assay; estrogen | 01 | 183 | 22 | | FP | \$48.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84233 | Receptor assay; estrogen | 08 | 083 | 22, 49 | | FP | \$48.00 | No | per test | once per day | N/A | |
| 84233 | Receptor assay; estrogen | 28 | 280 | 81 | | FP | \$48.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84234 | Receptor assay; progesterone | 01 | 183 | 22 | | FP | \$82.32 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84234 | Receptor assay; progesterone | 08 | 083 | 22, 49 | | FP | \$82.32 | No | per test | once per day | N/A | |
| 84234 | Receptor assay; progesterone | 28 | 280 | 81 | | FP | \$82.32 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84235 | Receptor assay; endocrine, other than estrogen or progesterone (specify hormone) | 01 | 183 | 22 | | FP | \$72.31 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84235 | Receptor assay; endocrine, other than estrogen or progesterone (specify hormone) | 08 | 083 | 22, 49 | | FP | \$72.31 | No | per test | once per day | N/A | |
| 84235 | Receptor assay; endocrine, other than estrogen or progesterone (specify hormone) | 28 | 280 | 81 | | FP | \$72.31 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84270 | Sex hormone binding globulin (SHBG) | 01 | 183 | 22 | | FP | \$25.82 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84270 | Sex hormone binding globulin (SHBG) | 08 | 083 | 22, 49 | | FP | \$25.82 | No | per test | once per day | N/A | |
| 84270 | Sex hormone binding globulin (SHBG) | 28 | 280 | 81 | | FP | \$25.82 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84402 | Testosterone; free | 01 | 183 | 22 | | FP | \$27.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84402 | Testosterone; free | 28 | 280 | 81 | | FP | \$27.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 84403 | Testosterone; total | 01 | 183 | 22 | | FP | \$27.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84403 | Testosterone; total | 28 | 280 | 81 | | FP | \$27.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84410 | Testosterone; bioavailable, direct measurement (eg, differential precipitation) | 01 | 183 | 22 | | FP | \$58.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84410 | Testosterone; bioavailable, direct measurement (eg, differential precipitation) | 28 | 280 | 81 | | FP | \$58.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84443 | Thyroid stimulating hormone (TSH) | 01 | 183 | 22 | | FP | \$23.21 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84443 | Thyroid stimulating hormone (TSH) | 01 | 183 | 22 | | QW, FP | \$23.21 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84443 | Thyroid stimulating hormone (TSH) | 28 | 280 | 81 | | FP | \$23.21 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84443 | Thyroid stimulating hormone (TSH) | 28 | 280 | 81 | | QW, FP | \$23.21 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84481 | Triiodothyronine T3; free | 01 | 183 | 22 | | FP | \$23.41 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84481 | Triiodothyronine T3; free | 08 | 083 | 22, 49 | | FP | \$23.41 | No | per test | once per day | N/A | |
| 84481 | Triiodothyronine T3; free | 28 | 280 | 81 | | FP | \$23.41 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84702 | Gonadotropin, chorionic (hCG); quantitative | 01 | 183 | 22 | | FP | \$16.42 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84702 | Gonadotropin, chorionic (hCG); quantitative | 08 | 083 | 22, 49 | | FP | \$16.42 | No | per test | once per day | N/A | |
| 84702 | Gonadotropin, chorionic (hCG); quantitative | 28 | 280 | 81 | | FP | \$16.42 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 84704 | Gonadotropin, chorionic (hCG); free beta chain | 01 | 183 | 22 | | FP | \$16.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 84704 | Gonadotropin, chorionic (hCG); free beta chain | 08 | 083 | 22, 49 | | FP | \$16.22 | No | per test | once per day | N/A | |
| 84704 | Gonadotropin, chorionic (hCG); free beta chain | 28 | 280 | 81 | | FP | \$16.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 01 | 183 | 22 | | FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 01 | 183 | 22 | | QW, FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 08 | 082 | 49 | | FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 08 | 082 | 49 | | QW, FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 08 | 083 | 22, 49 | | FP | \$3.23 | No | per test | once per day | N/A | |
| 85014 | Blood count; hematocrit (Hct) | 08 | 083 | 22, 49 | | QW, FP | \$3.23 | No | per test | once per day | N/A | |
| 85014 | Blood count; hematocrit (Hct) | 09 | All | 11 | | FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 09 | All | 11 | | QW, FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 28 | 280 | 81 | | FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 28 | 280 | 81 | | QW, FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 31 | All | 11 | | FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 31 | All | 11 | | QW, FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 85014 | Blood count; hematocrit (Hct) | 33 | 335 | 11 | | FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85014 | Blood count; hematocrit (Hct) | 33 | 335 | 11 | | QW, FP | \$3.23 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85018 | Blood count; hemoglobin (Hgb) | 01 | 183 | 22 | | FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 01 | 183 | 22 | | QW, FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 08 | 082 | 49 | | FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 08 | 082 | 49 | | QW, FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 08 | 083 | 22, 49 | | FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 08 | 083 | 22, 49 | | QW, FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 09 | All | 11 | | FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 09 | All | 11 | | QW, FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 28 | 280 | 81 | | FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 28 | 280 | 81 | | QW, FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 31 | All | 11 | | FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 31 | All | 11 | | QW, FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 33 | 335 | 11 | | FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85018 | Blood count; hemoglobin (Hgb) | 33 | 335 | 11 | | QW, FP | \$4.04 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 01 | 183 | 22 | | FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 01 | 183 | 22 | | QW, FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 01 | 183 | 22 | | FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|--------|------------|----------|----------------------------|--------------|---|
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 01 | 183 | 22 | | QW, FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 08 | 082 | 49 | | FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 08 | 082 | 49 | | FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 08 | 082 | 49 | | QW, FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 08 | 082 | 49 | | QW, FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 08 | 083 | 22, 49 | | FP | \$6.00 | No | per test | total of two tests per day | N/A | |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 08 | 083 | 22, 49 | | QW, FP | \$6.00 | No | per test | total of two tests per day | N/A | |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 08 | 083 | 22, 49 | | FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 08 | 083 | 22, 49 | | QW, FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 09 | All | 11 | | FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 09 | All | 11 | | FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 09 | All | 11 | | QW, FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 09 | All | 11 | | QW, FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 28 | 280 | 81 | | FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 28 | 280 | 81 | | QW, FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 28 | 280 | 81 | | FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 28 | 280 | 81 | | QW, FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 31 | All | 11 | | FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 31 | All | 11 | | FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 31 | All | 11 | | QW, FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 31 | All | 11 | | QW, FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 33 | 335 | 11 | | FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 33 | 335 | 11 | | FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 33 | 335 | 11 | | QW, FP | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | 33 | 335 | 11 | | QW, FP, 91 | \$6.00 | No | per test | total of two tests per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85027 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) | 01 | 183 | 22 | | FP | \$7.52 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85027 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) | 28 | 280 | 81 | | FP | \$7.52 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85652 | Sedimentation rate, erythrocyte; automated | 01 | 183 | 22 | | FP | \$3.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85652 | Sedimentation rate, erythrocyte; automated | 08 | 083 | 22, 49 | | FP | \$3.00 | No | per test | once per day | N/A | |

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| 85652 | Sedimentation rate, erythrocyte; automated | 28 | 280 | 81 | | FP | \$3.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85660 | Sickling of RBC, reduction | 01 | 183 | 22 | | FP | \$3.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 85660 | Sickling of RBC, reduction | 08 | 083 | 22, 49 | | FP | \$3.00 | No | per test | once per day | N/A | |
| 85660 | Sickling of RBC, reduction | 28 | 280 | 81 | | FP | \$3.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86255 | Fluorescent noninfectious agent antibody; screen, each antibody | 01 | 183 | 22 | | FP | \$16.44 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86255 | Fluorescent noninfectious agent antibody; screen, each antibody | 08 | 083 | 22, 49 | | FP | \$16.44 | No | per test | once per day | N/A | |
| 86255 | Fluorescent noninfectious agent antibody; screen, each antibody | 28 | 280 | 81 | | FP | \$16.44 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86255 | Fluorescent noninfectious agent antibody; screen, each antibody | 31 | 333 | 22, 49 | 26 | FP | \$15.21 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86317 | Immunoassay for infectious agent antibody, quantitative, not otherwise specified | 01 | 183 | 22 | | FP | \$20.49 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86317 | Immunoassay for infectious agent antibody, quantitative, not otherwise specified | 08 | 083 | 22, 49 | | FP | \$20.49 | No | per test | twice per day | N/A | |
| 86317 | Immunoassay for infectious agent antibody, quantitative, not otherwise specified | 28 | 280 | 81 | | FP | \$20.49 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86592 | Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) | 01 | 183 | 22 | | FP | \$4.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86592 | Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) | 08 | 083 | 22, 49 | | FP | \$4.00 | No | per test | once per day | N/A | |
| 86592 | Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) | 28 | 280 | 81 | | FP | \$4.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86593 | Syphilis test, non-treponemal antibody; quantitative | 01 | 183 | 22 | | FP | \$6.09 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 86593 | Syphilis test, non-treponemal antibody; quantitative | 28 | 280 | 81 | | FP | \$6.09 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86631 | Antibody; Chlamydia | 01 | 183 | 22 | | FP | \$9.88 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86631 | Antibody; Chlamydia | 28 | 280 | 81 | | FP | \$9.88 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86632 | Antibody; Chlamydia, IgM | 01 | 183 | 22 | | FP | \$17.55 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86632 | Antibody; Chlamydia, IgM | 28 | 280 | 81 | | FP | \$17.55 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86689 | Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot) | 01 | 183 | 22 | | FP | \$26.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86689 | Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot) | 28 | 280 | 81 | | FP | \$26.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86694 | Antibody; herpes simplex, non-specific type test | 01 | 183 | 22 | | FP | \$19.83 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86694 | Antibody; herpes simplex, non-specific type test | 28 | 280 | 81 | | FP | \$19.83 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86695 | Antibody; herpes simplex, type 1 | 01 | 183 | 22 | | FP | \$18.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86695 | Antibody; herpes simplex, type 1 | 28 | 280 | 81 | | FP | \$18.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86696 | Antibody; herpes simplex, type 2 | 01 | 183 | 22 | | FP | \$21.40 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86696 | Antibody; herpes simplex, type 2 | 28 | 280 | 81 | | FP | \$21.40 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 86701 | Antibody; HIV-1 | 01 | 183 | 22 | | FP | \$12.12 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86701 | Antibody; HIV-1 | 01 | 183 | 22 | | QW, FP | \$12.12 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86701 | Antibody; HIV-1 | 08 | 083 | 22, 49 | | FP | \$12.12 | No | per test | once per day | N/A | |
| 86701 | Antibody; HIV-1 | 08 | 083 | 22, 49 | | QW, FP | \$12.12 | No | per test | once per day | N/A | |
| 86701 | Antibody; HIV-1 | 28 | 280 | 81 | | FP | \$12.12 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86701 | Antibody; HIV-1 | 28 | 280 | 81 | | QW, FP | \$12.12 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86702 | Antibody; HIV-2 | 01 | 183 | 22 | | FP | \$13.83 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86702 | Antibody; HIV-2 | 08 | 083 | 22, 49 | | FP | \$13.83 | No | per test | once per day | N/A | |
| 86702 | Antibody; HIV-2 | 28 | 280 | 81 | | FP | \$13.83 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86703 | Antibody; HIV-1 and HIV-2, single result | 01 | 183 | 22 | | FP | \$23.34 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 86703 | Antibody; HIV-1 and HIV-2, single result | 08 | 082 | 49 | | FP | \$23.34 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 86703 | Antibody; HIV-1 and HIV-2, single result | 08 | 083 | 22, 49 | | FP | \$23.34 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 86703 | Antibody; HIV-1 and HIV-2, single result | 09 | All | 11 | | FP | \$23.34 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 86703 | Antibody; HIV-1 and HIV-2, single result | 28 | 280 | 81 | | FP | \$23.34 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 86703 | Antibody; HIV-1 and HIV-2, single result | 31 | All | 11 | | FP | \$23.34 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 86703 | Antibody; HIV-1 and HIV-2, single result | 33 | 335 | 11 | | FP | \$23.34 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 86704 | Hepatitis B core antibody (HBcAb); total | 01 | 183 | 22 | | FP | \$15.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86704 | Hepatitis B core antibody (HBcAb); total | 28 | 280 | 81 | | FP | \$15.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 86705 | Hepatitis B core antibody (HBcAb); IgM antibody | 01 | 183 | 22 | | FP | \$16.25 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86705 | Hepatitis B core antibody (HBcAb); IgM antibody | 28 | 280 | 81 | | FP | \$16.25 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86706 | Hepatitis B surface antibody (HBsAb) | 01 | 183 | 22 | | FP | \$13.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86706 | Hepatitis B surface antibody (HBsAb) | 28 | 280 | 81 | | FP | \$13.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86762 | Antibody; rubella | 01 | 183 | 22 | | FP | \$19.64 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86762 | Antibody; rubella | 08 | 083 | 22, 49 | | FP | \$19.64 | No | per test | once per day | N/A | |
| 86762 | Antibody; rubella | 28 | 280 | 81 | | FP | \$19.64 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 01 | 183 | 22 | | FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 01 | 183 | 22 | | QW, FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 08 | 082 | 49 | | FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 08 | 082 | 49 | | QW, FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 08 | 083 | 22, 49 | | FP | \$15.18 | No | per test | once per day | N/A | |
| 86780 | Antibody; Treponema pallidum | 08 | 083 | 22, 49 | | QW, FP | \$15.18 | No | per test | once per day | N/A | |
| 86780 | Antibody; Treponema pallidum | 09 | All | 11 | | FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 09 | All | 11 | | QW, FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|------------------------------|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 86780 | Antibody; Treponema pallidum | 28 | 280 | 81 | | FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 28 | 280 | 81 | | QW, FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 31 | All | 11 | | FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 31 | All | 11 | | QW, FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 33 | 335 | 11 | | FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86780 | Antibody; Treponema pallidum | 33 | 335 | 11 | | QW, FP | \$15.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 01 | 183 | 22 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 01 | 183 | 22 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 08 | 082 | 49 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 08 | 082 | 49 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 08 | 083 | 22, 49 | | FP | \$19.00 | No | per test | once per day | N/A | |
| 86803 | Hepatitis C antibody; | 08 | 083 | 22, 49 | | QW, FP | \$19.00 | No | per test | once per day | N/A | |
| 86803 | Hepatitis C antibody; | 09 | All | 11 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 09 | All | 11 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 86803 | Hepatitis C antibody; | 28 | 280 | 81 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 28 | 280 | 81 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 31 | All | 11 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 31 | All | 11 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 33 | 335 | 11 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86803 | Hepatitis C antibody; | 33 | 335 | 11 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86804 | Hepatitis C antibody; confirmatory test (eg, immunoblot) | 01 | 183 | 22 | | FP | \$21.40 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 86804 | Hepatitis C antibody; confirmatory test (eg, immunoblot) | 28 | 280 | 81 | | FP | \$21.40 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87040 | Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate) | 01 | 183 | 22 | | FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87040 | Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate) | 28 | 280 | 81 | | FP | \$14.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87070 | Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates | 01 | 183 | 22 | | FP | \$6.90 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87070 | Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates | 08 | 083 | 22, 49 | | FP | \$6.90 | No | per test | once per day | N/A | |
| 87070 | Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates | 28 | 280 | 81 | | FP | \$6.90 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87075 | Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates | 01 | 183 | 22 | | FP | \$10.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|---------------|--------------|---|
| 87075 | Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates | 08 | 083 | 22, 49 | | FP | \$10.00 | No | per test | once per day | N/A | |
| 87075 | Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates | 28 | 280 | 81 | | FP | \$10.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87076 | Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate | 01 | 183 | 22 | | FP | \$8.75 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87076 | Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate | 08 | 083 | 22, 49 | | FP | \$8.75 | No | per test | twice per day | N/A | |
| 87076 | Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate | 28 | 280 | 81 | | FP | \$8.75 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87077 | Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate | 01 | 183 | 22 | | FP | \$7.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87077 | Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate | 01 | 183 | 22 | | QW, FP | \$7.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87077 | Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate | 28 | 280 | 81 | | FP | \$7.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87077 | Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate | 28 | 280 | 81 | | QW, FP | \$7.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87081 | Culture, presumptive, pathogenic organisms, screening only; | 01 | 183 | 22 | | FP | \$5.20 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87081 | Culture, presumptive, pathogenic organisms, screening only; | 28 | 280 | 81 | | FP | \$5.20 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87086 | Culture, bacterial; quantitative colony count, urine | 01 | 183 | 22 | | FP | \$13.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87086 | Culture, bacterial; quantitative colony count, urine | 08 | 083 | 22, 49 | | FP | \$13.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87086 | Culture, bacterial; quantitative colony count, urine | 28 | 280 | 81 | | FP | \$13.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87088 | Culture, bacterial; with isolation and presumptive identification of each isolate, urine | 01 | 183 | 22 | | FP | \$8.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87088 | Culture, bacterial; with isolation and presumptive identification of each isolate, urine | 28 | 280 | 81 | | FP | \$8.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 87110 | Culture, chlamydia, any source | 01 | 183 | 22 | | FP | \$26.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87110 | Culture, chlamydia, any source | 08 | 083 | 22, 49 | | FP | \$26.10 | No | per test | once per day | N/A | |
| 87110 | Culture, chlamydia, any source | 28 | 280 | 81 | | FP | \$26.10 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87149 | Culture, typing; identification by nucleic acid (DNA or RNA) probe, direct probe technique, per culture or isolate, each organism probed | 01 | 183 | 22 | | FP | \$22.17 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87149 | Culture, typing; identification by nucleic acid (DNA or RNA) probe, direct probe technique, per culture or isolate, each organism probed | 28 | 280 | 81 | | FP | \$22.17 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87150 | Culture, typing; identification by nucleic acid (DNA or RNA) probe, amplified probe technique, per culture or isolate, each organism probed | 01 | 183 | 22 | | FP | \$40.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87150 | Culture, typing; identification by nucleic acid (DNA or RNA) probe, amplified probe technique, per culture or isolate, each organism probed | 28 | 280 | 81 | | FP | \$40.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87164 | Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection | 01 | 183 | 22 | | FP | \$8.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87164 | Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection | 28 | 280 | 81 | | FP | \$8.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87164 | Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection | 31 | 333 | 22 | 26 | FP | \$15.21 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87166 | Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection | 01 | 183 | 22 | | FP | \$8.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87166 | Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection | 08 | 083 | 22, 49 | | FP | \$8.00 | No | per test | once per day | N/A | |
| 87166 | Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection | 28 | 280 | 81 | | FP | \$8.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87205 | Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types | 01 | 183 | 22 | | FP | \$4.50 | No | per test | five per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87205 | Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types | 08 | 083 | 22, 49 | | FP | \$4.50 | No | per test | five per day | N/A | |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 87205 | Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types | 28 | 280 | 81 | | FP | \$4.50 | No | per test | five per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87206 | Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types | 01 | 183 | 22 | | FP | \$3.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87206 | Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types | 28 | 280 | 81 | | FP | \$3.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87207 | Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses) | 01 | 183 | 22 | | FP | \$10.20 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87207 | Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses) | 08 | 083 | 22, 49 | | FP | \$10.20 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87207 | Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses) | 28 | 280 | 81 | | FP | \$10.20 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87207 | Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses) | 31 | 333 | 22, 49 | 26 | FP | \$22.83 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87210 | Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps) | 01 | 183 | 22 | | FP | \$7.28 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87210 | Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps) | 01 | 183 | 22 | | QW, FP | \$7.28 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87210 | Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps) | 08 | 083 | 22, 49 | | FP | \$7.28 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87210 | Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps) | 08 | 083 | 22, 49 | | QW, FP | \$7.28 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87210 | Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps) | 28 | 280 | 81 | | FP | \$7.28 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87210 | Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps) | 28 | 280 | 81 | | QW, FP | \$7.28 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87220 | Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies) | 01 | 183 | 22 | | FP | \$3.90 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87220 | Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies) | 28 | 280 | 81 | | FP | \$3.90 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87252 | Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect | 01 | 183 | 22 | | FP | \$36.02 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87252 | Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect | 28 | 280 | 81 | | FP | \$36.02 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 87253 | Virus isolation; tissue culture, additional studies or definitive identification (eg, hemabsorption, neutralization, immunofluorescence stain), each isolate | 01 | 183 | 22 | | FP | \$26.48 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87253 | Virus isolation; tissue culture, additional studies or definitive identification (eg, hemabsorption, neutralization, immunofluorescence stain), each isolate | 28 | 280 | 81 | | FP | \$26.48 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87254 | Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus | 01 | 183 | 22 | | FP | \$5.41 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87254 | Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus | 28 | 280 | 81 | | FP | \$5.41 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87255 | Virus isolation; including identification by non-immunologic method, other than by cytopathic effect (eg, virus specific enzymatic activity) | 01 | 183 | 22 | | FP | \$37.85 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87255 | Virus isolation; including identification by non-immunologic method, other than by cytopathic effect (eg, virus specific enzymatic activity) | 28 | 280 | 81 | | FP | \$37.85 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87273 | Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 2 | 01 | 183 | 22 | | FP | \$12.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87273 | Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 2 | 28 | 280 | 81 | | FP | \$12.18 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87389 | 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; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result | 01 | 183 | 22 | | FP | \$27.30 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87389 | 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; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result | 28 | 280 | 81 | | FP | \$27.30 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87390 | 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; HIV-1 | 01 | 183 | 22 | | FP | \$10.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87390 | 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; HIV-1 | 28 | 280 | 81 | | FP | \$10.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 87391 | 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; HIV-2 | 01 | 183 | 22 | | FP | \$10.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87391 | 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; HIV-2 | 28 | 280 | 81 | | FP | \$10.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87490 | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique | 01 | 183 | 22 | | FP | \$22.72 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87490 | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique | 28 | 280 | 81 | | FP | \$22.72 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87491 | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique | 01 | 183 | 22 | | FP | \$23.19 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87491 | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique | 08 | 083 | 22, 49 | | FP | \$23.19 | No | per test | once per day | N/A | |
| 87491 | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique | 28 | 280 | 81 | | FP | \$23.19 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87492 | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification | 01 | 183 | 22 | | FP | \$39.61 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87492 | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification | 28 | 280 | 81 | | FP | \$39.61 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87522 | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, quantification, includes reverse transcription when performed | 01 | 183 | 22 | | FP | \$39.65 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87522 | Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, quantification, includes reverse transcription when performed | 28 | 280 | 81 | | FP | \$39.65 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87536 | Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed | 01 | 183 | 22 | | FP | \$116.09 | No | per test | 6 per calendar year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87536 | Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed | 08 | 083 | 22, 49 | | FP | \$116.09 | No | per test | 6 per calendar year | N/A | |
| 87536 | Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed | 28 | 280 | 81 | | FP | \$116.09 | No | per test | 6 per calendar year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 87591 | Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique | 01 | 183 | 22 | | FP | \$23.19 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87591 | Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique | 08 | 083 | 22, 49 | | FP | \$23.19 | No | per test | once per day | N/A | |
| 87591 | Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique | 28 | 280 | 81 | | FP | \$23.19 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87623 | Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44) | 01 | 183 | 22 | | FP | \$59.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87623 | Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44) | 08 | 083 | 22, 49 | | FP | \$59.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87623 | Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44) | 28 | 280 | 81 | | FP | \$59.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 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) | 01 | 183 | 22 | | FP | \$59.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 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) | 08 | 083 | 22, 49 | | FP | \$59.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 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) | 28 | 280 | 81 | | FP | \$59.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87625 | Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed | 01 | 183 | 22 | | FP | \$59.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87625 | Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed | 08 | 083 | 22, 49 | | FP | \$59.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87625 | Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed | 28 | 280 | 81 | | FP | \$59.75 | No | per test | once per day | N/A | This provider type must bill with the FP modifier |
| 87660 | Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique | 01 | 183 | 22 | | FP | \$22.42 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87660 | Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique | 28 | 280 | 81 | | FP | \$22.42 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87661 | Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique | 01 | 183 | 22 | | FP | \$38.30 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87661 | Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique | 28 | 280 | 81 | | FP | \$38.30 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 87797 | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism | 01 | 183 | 22 | | FP | \$22.97 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87797 | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism | 08 | 083 | 22, 49 | | FP | \$22.97 | No | per test | once per day | N/A | |
| 87797 | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism | 28 | 280 | 81 | | FP | \$22.97 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87798 | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism | 01 | 183 | 22 | | FP | \$23.19 | No | per test | 36 per calendar year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87798 | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism | 08 | 083 | 22, 49 | | FP | \$23.19 | No | per test | 36 per calendar year | N/A | |
| 87798 | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism | 28 | 280 | 81 | | FP | \$23.19 | No | per test | 36 per calendar year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 01 | 183 | 22 | | FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 01 | 183 | 22 | | QW, FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 08 | 082 | 49 | | FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 08 | 082 | 49 | | QW, FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 08 | 083 | 22, 49 | | FP | \$26.22 | No | per test | once per day | N/A | |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 08 | 083 | 22, 49 | | QW, FP | \$26.22 | No | per test | once per day | N/A | |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 09 | All | 11 | | FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 09 | All | 11 | | QW, FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 28 | 280 | 81 | | FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 28 | 280 | 81 | | QW, FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 31 | All | 11 | | FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 31 | All | 11 | | QW, FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 33 | 335 | 11 | | FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87806 | Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies | 33 | 335 | 11 | | QW, FP | \$26.22 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87808 | Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis | 01 | 183 | 22 | | FP | \$12.31 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87808 | Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis | 01 | 183 | 22 | | QW, FP | \$12.31 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87808 | Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis | 08 | 083 | 22, 49 | | FP | \$12.31 | No | per test | once per day | N/A | |
| 87808 | Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis | 08 | 083 | 22, 49 | | QW, FP | \$12.31 | No | per test | once per day | N/A | |
| 87808 | Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis | 28 | 280 | 81 | | FP | \$12.31 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 87808 | Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis | 28 | 280 | 81 | | QW, FP | \$12.31 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88141 | Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician | 01 | 183 | 22 | | FP | \$6.53 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88141 | Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician | 08 | 083 | 22, 49 | | FP | \$6.53 | No | per test | once per day | N/A | |
| 88141 | Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician | 28 | 280 | 81 | | FP | \$6.53 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88141 | Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician | 31 | All | 11 | | FP | \$6.53 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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| Code | Code Description | Provider Type | Specialty | Place of Service | Pricing Modifier | Info Modifier | MA Fee | Prior Auth | MA units | Limits | Post op days | Comments |
|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 88142 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision | 01 | 183 | 22 | | FP | \$16.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88142 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision | 08 | 083 | 22, 49 | | FP | \$16.00 | No | per test | once per day | N/A | |
| 88142 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision | 28 | 280 | 81 | | FP | \$16.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88160 | Cytopathology, smears, any other source; screening and interpretation | 01 | 183 | 22 | | FP | \$12.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88160 | Cytopathology, smears, any other source; screening and interpretation | 01 | 183 | 22 | TC | FP | \$2.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88160 | Cytopathology, smears, any other source; screening and interpretation | 28 | 280 | 81 | | FP | \$12.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88160 | Cytopathology, smears, any other source; screening and interpretation | 31 | All | 22 | 26 | FP | \$10.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88161 | Cytopathology, smears, any other source; preparation, screening and interpretation | 01 | 183 | 22 | | FP | \$16.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88161 | Cytopathology, smears, any other source; preparation, screening and interpretation | 01 | 183 | 22 | TC | FP | \$8.80 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88161 | Cytopathology, smears, any other source; preparation, screening and interpretation | 08 | 083 | 22, 49 | | FP | \$16.00 | No | per test | once per day | N/A | |
| 88161 | Cytopathology, smears, any other source; preparation, screening and interpretation | 08 | 083 | 22, 49 | TC | FP | \$8.80 | No | per test | once per day | N/A | |
| 88161 | Cytopathology, smears, any other source; preparation, screening and interpretation | 28 | 280 | 81 | | FP | \$16.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88161 | Cytopathology, smears, any other source; preparation, screening and interpretation | 31 | 333 | 22, 49 | 26 | FP | \$7.20 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88164 | Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision | 01 | 183 | 22 | | FP | \$7.15 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88164 | Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision | 08 | 083 | 22, 49 | | FP | \$7.15 | No | per test | once per day | N/A | |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 88164 | Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision | 28 | 280 | 81 | | FP | \$7.15 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88165 | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision | 01 | 183 | 22 | | FP | \$5.72 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88165 | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision | 28 | 280 | 81 | | FP | \$5.72 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88166 | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision | 01 | 183 | 22 | | FP | \$5.72 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88166 | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision | 28 | 280 | 81 | | FP | \$5.72 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88167 | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision | 01 | 183 | 22 | | FP | \$5.72 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88167 | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision | 28 | 280 | 81 | | FP | \$5.72 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88174 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision | 01 | 183 | 22 | | FP | \$23.88 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88174 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision | 28 | 280 | 81 | | FP | \$23.88 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88175 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision | 01 | 183 | 22 | | FP | \$29.55 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88175 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision | 08 | 083 | 22, 49 | | FP | \$29.55 | No | per test | once per day | N/A | |
| 88175 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision | 28 | 280 | 81 | | FP | \$29.55 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88300 | Level I - Surgical pathology, gross examination only | 01 | 183 | 22 | | FP | \$5.48 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88300 | Level I - Surgical pathology, gross examination only | 01 | 183 | 22 | TC | FP | \$1.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 88300 | Level I - Surgical pathology, gross examination only | 28 | 280 | 81 | | FP | \$5.48 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88300 | Level I - Surgical pathology, gross examination only | 31 | All | 11, 22 | 26 | FP | \$3.98 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88302 | Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization | 01 | 183 | 22 | | FP | \$11.29 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88302 | Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization | 01 | 183 | 22 | TC | FP | \$5.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88302 | Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization | 28 | 280 | 81 | | FP | \$11.29 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88302 | Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization | 31 | All | 11, 22 | 26 | FP | \$6.29 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88304 | Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocoele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity | 01 | 183 | 22 | | FP | \$16.53 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| 88304 | Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocoele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity | 01 | 183 | 22 | TC | FP | \$6.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88304 | Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocoele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity | 28 | 280 | 81 | | FP | \$16.53 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88304 | Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocoele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity | 31 | All | 11, 22 | 26 | FP | \$10.03 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|---------------|--------------|---|
| 88305 | <p>Level IV - Surgical pathology, gross and microscopic examination</p> <p>Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy</p> | 01 | 183 | 22 | | FP | \$88.53 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|---------------|--------------|---|
| 88305 | <p>Level IV - Surgical pathology, gross and microscopic examination</p> <p>Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy</p> | 01 | 183 | 22 | TC | FP | \$39.94 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|---------------|--------------|---|
| 88305 | <p>Level IV - Surgical pathology, gross and microscopic examination</p> <p>Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy</p> | 08 | 083 | 22, 49 | | FP | \$88.53 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|---------------|--------------|---|
| 88305 | Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy | 08 | 083 | 22, 49 | TC | FP | \$39.94 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|---------------|--------------|---|
| 88305 | Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy | 28 | 280 | 81 | | | \$88.53 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier |

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| Code | Code Description | Provider Type | Specialty | Place of Service | Pricing Modifier | Info Modifier | MA Fee | Prior Auth | MA units | Limits | Post op days | Comments |
|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|---------------|--------------|---|
| 88305 | Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy | 31 | All | 11, 22, 49 | 26 | FP | \$48.59 | No | per test | twice per day | N/A | This provider type must bill with the FP modifier |
| 88307 | Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse | 01 | 183 | 22 | | FP | \$45.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|--|
| 88307 | Level v - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curetings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse | 01 | 183 | 22 | TC | FP | \$11.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88307 | Level v - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curetings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse | 28 | 280 | 81 | | FP | \$45.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|--|
| 88307 | Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse | 31 | All | 11, 22 | 26 | FP | \$34.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88309 | Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection | 01 | 183 | 22 | | FP | \$67.60 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88309 | Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection | 01 | 183 | 22 | TC | FP | \$17.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|--------------------|--------------------|--------------|---|
| 88309 | Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection | 28 | 280 | 81 | | FP | \$67.60 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 88309 | Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection | 31 | All | 11, 22 | 26 | FP | \$50.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90649 | Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use | 01 | 183 | 22 | | FP | \$10.00 | No | per administration | three per lifetime | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90649 | Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use | 08 | 082 | 49 | | FP | \$10.00 | No | per administration | three per lifetime | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90649 | Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use | 08 | 083 | 22, 49 | | FP | \$10.00 | No | per administration | three per lifetime | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90649 | Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use | 09 | All | 11 | | FP | \$10.00 | No | per administration | three per lifetime | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90649 | Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use | 31 | All | 11 | | FP | \$10.00 | No | per administration | three per lifetime | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90649 | Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use | 33 | 335 | 11 | | FP | \$10.00 | No | per administration | three per lifetime | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90650 | Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use | 01 | 183 | 22 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|--------------------|--------------|--------------|---|
| 90650 | Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use | 08 | 082 | 49 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90650 | Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use | 08 | 083 | 22, 49 | | FP | \$10.00 | No | per administration | once per day | N/A | |
| 90650 | Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use | 09 | All | 11 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90650 | Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use | 31 | All | 11 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90650 | Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use | 33 | 335 | 11 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90651 | Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use | 01 | 183 | 22 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90651 | Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use | 08 | 082 | 49 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90651 | Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use | 08 | 083 | 22, 49 | | FP | \$10.00 | No | per administration | once per day | N/A | |
| 90651 | Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use | 09 | All | 11 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90651 | Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use | 31 | All | 11 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 90651 | Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use | 33 | 335 | 11 | | FP | \$10.00 | No | per administration | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 96160 | Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument | 01 | 183 | 22 | | FP | \$3.48 | No | per evaluation | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 96160 | Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument | 08 | 082 | 49 | | FP | \$3.48 | No | per evaluation | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 96160 | Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument | 08 | 083 | 22, 49 | | FP | \$3.48 | No | per evaluation | once per day | N/A | |

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|-------|--|---------------|-----------|------------------|------------------|---------------|--------|------------|----------------|--------------|--------------|---|
| 96160 | Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument | 09 | All | 11 | | FP | \$3.48 | No | per evaluation | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 96160 | Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument | 31 | All | 11 | | FP | \$3.48 | No | per evaluation | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 96160 | Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument | 33 | 335 | 11 | | FP | \$3.48 | No | per evaluation | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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 | 01 | 183 | 22 | | FP | \$9.90 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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 | 08 | 082 | 49 | | FP | \$9.90 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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 | 08 | 083 | 22, 49 | | FP | \$9.90 | No | per procedure | once per day | N/A | |
| 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 | 09 | All | 11 | | FP | \$9.90 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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 | 31 | All | 11 | | FP | \$9.90 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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 | 33 | 335 | 11 | | FP | \$9.90 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|---------------|--------------|--------------|---|
| 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) | 01 | 183 | 22 | | FP | \$8.33 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 08 | 082 | 49 | | FP | \$8.33 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 08 | 083 | 22, 49 | | FP | \$8.33 | No | per procedure | once per day | N/A | |
| 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) | 09 | All | 11 | | FP | \$8.33 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 31 | All | 11 | | FP | \$8.33 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 33 | 335 | 11 | | FP | \$8.33 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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 | 01 | 183 | 22 | | FP | \$61.10 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|---------------|--------------|--------------|---|
| 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 | 08 | 082 | 49 | | FP | \$61.10 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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 | 08 | 083 | 22, 49 | | FP | \$61.10 | No | per procedure | once per day | N/A | |
| 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 | 09 | All | 11 | | FP | \$61.10 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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 | 31 | All | 11, 99 | | FP | \$61.10 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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 | 33 | 335 | 11, 99 | | FP | \$61.10 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 01 | 183 | 22 | | FP | \$46.31 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 08 | 082 | 49 | | FP | \$46.31 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 08 | 083 | 22, 49 | | FP | \$46.31 | No | per procedure | once per day | N/A | |
| 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) | 09 | All | 11 | | FP | \$46.31 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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COVERED SERVICES CHART
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| Code | Code Description | Provider Type | Specialty | Place of Service | Pricing Modifier | Info Modifier | MA Fee | Prior Auth | MA units | Limits | Post op days | Comments |
|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|---|--|--------------|---|
| 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) | 31 | All | 11, 99 | | FP | \$46.31 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 33 | 335 | 11, 99 | | FP | \$46.31 | No | per procedure | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 99407 | Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes | 01 | 370 | 22 | | FP | \$19.33 | No | greater than 10 minutes; face-to-face encounter | 1 unit per day, and 70 units per calendar year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 99407 | Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes | 08 | 370 | 22, 49 | | FP | \$19.33 | No | greater than 10 minutes; face-to-face encounter | 1 unit per day, and 70 units per calendar year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 99407 | Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes | 09 | 370 | 11, 99 | | FP | \$19.33 | No | greater than 10 minutes; face-to-face encounter | 1 unit per day, and 70 units per calendar year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 01 | 183 | 22 | | FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 01 | 183 | 22 | | QW, FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 08 | 082 | 49 | | FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 08 | 082 | 49 | | QW, FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 08 | 083 | 22, 49 | | FP | \$14.94 | No | per test | once per day | N/A | |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 08 | 083 | 22, 49 | | QW, FP | \$14.94 | No | per test | once per day | N/A | |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 09 | All | 11 | | FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 09 | All | 11 | | QW, FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 28 | 280 | 81 | | FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 28 | 280 | 81 | | QW, FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 31 | All | 11 | | FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 31 | All | 11 | | QW, FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 33 | 335 | 11 | | FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening | 33 | 335 | 11 | | QW, FP | \$14.94 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 01 | 183 | 22 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 01 | 183 | 22 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 08 | 082 | 49 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 08 | 082 | 49 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 08 | 083 | 22, 49 | | FP | \$19.00 | No | per test | once per day | N/A | |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 08 | 083 | 22, 49 | | QW, FP | \$19.00 | No | per test | once per day | N/A | |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 09 | All | 11 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 09 | All | 11 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|---------------|--------------|--------------|---|
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 28 | 280 | 81 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 28 | 280 | 81 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 31 | All | 11 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 31 | All | 11 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 33 | 335 | 11 | | FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0472 | Hepatitis C antibody screening for individual at high risk and other covered indication(s) | 33 | 335 | 11 | | QW, FP | \$19.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0476 | Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test | 01 | 183 | 22 | | FP | \$38.21 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| G0476 | Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test | 08 | 083 | 22, 49 | | FP | \$38.21 | No | per test | once per day | N/A | |
| G0476 | Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test | 28 | 280 | 81 | | FP | \$38.21 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 01 | 183 | 22 | | FP | \$19.00 | No | per screening | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 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) | 28 | 280 | 81 | | FP | \$19.00 | No | per screening | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| Q0111 | Wet mounts, including preparations of vaginal, cervical or skin specimens | 01 | 183 | 22 | | FP | \$5.96 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| Q0111 | Wet mounts, including preparations of vaginal, cervical or skin specimens | 28 | 280 | 81 | | FP | \$5.96 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|---|---------------|-----------|------------------|------------------|---------------|---------|------------|----------|--------------|--------------|---|
| Q0112 | All potassium hydroxide (KOH) preparations | 01 | 183 | 22 | | FP | \$4.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| Q0112 | All potassium hydroxide (KOH) preparations | 28 | 280 | 81 | | FP | \$4.50 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 01 | 183 | 22 | | FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 01 | 183 | 22 | | QW, FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 08 | 082 | 49 | | FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 08 | 082 | 49 | | QW, FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 08 | 083 | 22, 49 | | FP | \$20.00 | No | per test | once per day | N/A | |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 08 | 083 | 22, 49 | | QW, FP | \$20.00 | No | per test | once per day | N/A | |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 09 | All | 11 | | FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 09 | All | 11 | | QW, FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 28 | 280 | 81 | | FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 28 | 280 | 81 | | QW, FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 31 | All | 11 | | FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 31 | All | 11 | | QW, FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |

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|-------|--|---------------|-----------|------------------|------------------|---------------|---------|------------|---|--|--------------|---|
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 33 | 335 | 11 | | FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| S3645 | HIV-1 antibody testing of oral mucosal transudate | 33 | 335 | 11 | | QW, FP | \$20.00 | No | per test | once per day | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |
| 99407 | Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes | 31 | 370 | 11, 99 | | FP | \$19.33 | No | greater than 10 minutes; face-to-face encounter | 1 unit per day, and 70 units per calendar year | N/A | This provider type must bill with the FP modifier or with the ICD-10 DX Z30.011 through Z30.9 |