

February 5, 2020



Healthfirst Reimbursement Policy Updates

Effective March 1, 2020 | For All Lines of Business

Healthfirst aims to ensure that our reimbursement policy standards are up to date and are compliant with state and national industry standards. Effective **March 1, 2020**, several changes will be made to our reimbursement policy to maintain compliance with industry-accepted coding and reimbursement practices as well as state and national regulatory requirements.

For more details, [click on the links below](#).

- [✔ Professional Services for Allergen Immunotherapy Not Including Provision of Allergenic Extracts](#)
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Should you have any questions, you may contact your network representative, or call Provider Services at **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm.

Professional Services for Allergen Immunotherapy Not Including Provision of Allergenic Extracts

Policy Overview

Effective March 1, 2020, consistent with the American Academy of Allergy, Asthma, and Immunology, Healthfirst will no longer reimburse any combination of “professional services for allergen immunotherapy not including provision of allergenic extracts” when billed with greater than three unique visits per week.

Rationale

According to the American Academy of Allergy, Asthma, and Immunology, the frequency of allergen immunotherapy administration is generally 1 to 3 injections per week.

Billing Information

This policy applies to the following service codes:

- 95115:** Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection.
- 95117:** Professional services for allergen immunotherapy not including provision of allergenic extracts, 2 or more injections.

Hospital Evaluation and Management Services

Policy Overview

Effective March 1, 2020, consistent with CMS policies, Healthfirst will recode an Initial Hospital Care service (99221-99223) to a Subsequent Hospital Care services (99231-99233), if an Initial Hospital Care service has been billed in the previous three days for the same diagnosis by the same Tax ID and subspecialty.

Rationale

Per CMS, both Initial Hospital Care (CPT codes 99221-99223) and Subsequent Hospital Care (99231-99233) codes are “per diem” services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.

Billing Information

This policy applies to the following service codes:

99221: Initial hospital care, per day, for the evaluation and management of a patient

99222: Initial hospital care, per day, for the evaluation and management of a patient

99223: Initial hospital care, per day, for the evaluation and management of a patient

99231: Subsequent hospital care, per day, for the evaluation and management of a patient

99232: Subsequent hospital care, per day, for the evaluation and management of a patient

99233: Subsequent hospital care, per day, for the evaluation and management of a patient

Allergy Studies

Policy Overview

Effective March 1, 2020, consistent with CMS Local Coverage Determinations (jurisdiction N), Healthfirst will no longer reimburse allergy studies when billed with more than 100 units for a single patient within a one-year (365 days) time frame.

Rationale

According to CMS, it would not be expected that:

- More than twenty (20) units be reported for percutaneous testing per year for food sensitivity.
- More than forty (40) units be reported for intracutaneous (intradermal) testing with allergenic extracts, immediate type reaction, per year for a patient.
- More than forty (40) units be reported for intracutaneous (intradermal), sequential and incremental testing with allergenic extracts for airborne allergens, immediate type reaction, per year for a patient.
- All patients would receive the same tests or the same number of sensitivity tests.

The number of tests performed must be judicious and related to the history, physical findings and clinical judgment specific to each individual patient.

Billing Information

This policy applies to the following service codes:

- 95004:** Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests.
- 95017:** Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests.
- 95018:** Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests.
- 95024:** Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests.
- 95027:** Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests.

Diabetic Management Services

Policy Overview

Effective March 1, 2020, consistent with the HCPCS Level II Manual, Healthfirst will no longer reimburse Diabetic management program, dietitian visit or Nutritional Counseling, dietitian visit when billed with a provider specialty that is not Nutritional Medicine, Diabetic Educator, or Hospital.

Rationale

According to the HCPCS Level II Manual, a dietitian services visit will only be covered when performed by a registered dietitian, nutrition professional, certified diabetic educator, registered nurse certified diabetic educator (CDE) or in the hospital setting. These services should not be reported by any other provider specialty.

Billing Information

This policy applies to the following service codes:

S9465: Diabetic management program, dietitian visit

S9470: Nutritional counseling, dietitian visit

Oncotype DX™ Breast Cancer Assay

Policy Overview

Effective March 1, 2020, consistent with CMS Local Coverage Article (jurisdiction 15), Healthfirst will no longer reimburse the Oncotype DX™ breast cancer assay without the secondary diagnosis indicating estrogen receptor positive status.

Rationale

Per CMS, Oncotype DX™ and reg Breast was developed for patients with the following findings:

- estrogen-receptor positive, node-negative carcinoma of the breast
- estrogen-receptor positive micro metastases of carcinoma of the breast, and
- estrogen-receptor positive breast carcinoma with 1-3 positive nodes

Billing Information

This policy applies to the following service codes:

81519: Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score

Z17.0: Estrogen receptor positive status [ER+]

Molecular Diagnostic Services

Policy Overview

Effective March 1, 2020, consistent with CMS Local Coverage Articles (jurisdiction 15), Healthfirst will no longer reimburse Molecular Diagnostic Services when billed.

Rationale

Per CMS, although the detection of elevated CTCs during therapy is a definitive indication of subsequent rapid disease progression and mortality in breast, colorectal and prostate cancer, no data has been forthcoming to demonstrate improved patient outcomes, or that the assay changes physician management to demonstrate improved patient outcomes.

Billing Information

This policy applies to the following service codes:

- 86152:** Cell enumeration using immunologic selection and identification in fluid specimen
- 86153:** Cell enumeration using immunologic selection and identification in fluid specimen; physician interpretation and report

Genetic Testing Frequency

Policy Overview

Effective March 1, 2020, consistent with CMS Local Coverage Article (jurisdiction L and H), Healthfirst will only reimburse certain genetic testing procedures for a disease once in a patient's lifetime.

Rationale

Per CMS, genetic testing procedures may only be eligible for coverage when the individual has not previously received genetic testing for the disease/condition. (In general, diagnostic genetic testing for a disease should be performed once in a lifetime.) Medically necessary exceptions may apply in rare cases.

Billing Information

Examples of genetic testing include, but are not limited to:

81220 – 81224: Cystic fibrosis transmembrane conductance regulator (CFTR) gene analysis

81162 and 81212: Breast cancer 1 and 2 (BRCA 1, BCRA 2) hereditary breast and ovarian cancer gene analysis

81298 – 81300: Hereditary nonpolyposis colorectal cancer, Lynch syndrome (MSH2) gene analysis

81545: Oncology (thyroid), gene expression analysis of 142 genes

MTHFR Genetic Testing

Policy Overview

Effective March 1, 2020, consistent with the American College of Medical Genetics and Genomics, Healthfirst will no longer reimburse MTHFR [5, 10-methylenetetrahydrofolate reductase] gene analysis, common variants (eg, 677T, 1298C) when billed with a diagnosis of thrombophilia or history of reoccurring pregnancy loss.

Rationale

According to the American College of Medical Genetics and Genomics, there is growing evidence that MTHFR polymorphism testing has minimal clinical utility and, therefore should not be ordered as part of a routine evaluation for thrombophilia. There is also currently no evidence of increased risk of venous thromboembolism or recurrent pregnancy loss related to MTHFR status.

Billing Information

This policy applies to the following service codes:

81291: MTHFR (5, 10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)