Rule Category:
Billing

Ref: No:
2013-BR-0010

Version Control:
Version No.1.1

Effective Date:
December 2013

Revision Date:
December 2014

V Codes

Adjudication Rule

Table of content

Abstract	Scope	Adjudication Policy	Adjudication examples	Denial codes	Appendices
Page 1	Page 2	Page 2	Page 2	Page 2	Page 2

Approved by:
Daman

Responsible:
Medical Strategy & Development Department

Related Adjudication Rules:
None

Abstract

For Members

V codes are used to describe encounters with circumstances other than disease or injury. They are used either as a first listed (primary) or contributing (secondary) code depending on the situation. There are four primary situations for which V codes are used:

1. A person who is not currently sick or injured encounters the healthcare system for a specific reason (e.g., exposure to an infectious disease)
2. A person with a resolving injury/disease or a chronic condition requires aftercare specifically for that condition (e.g., suture removal, dressing change)
3. Circumstances or problems influence a person's health status, but are not themselves a current illness or injury (e.g., asymptomatic HIV status.
4. Newborns, to indicate birth status

For Medical Professionals

V codes can be reported in any healthcare setting. These codes can be claimed either as a first listed (outpatient) or principal diagnosis (inpatient) or secondary diagnosis codes (both outpatient and inpatient).

There are three groups of V codes based on ICD 9 CM sequencing rule, which are as following:

- First listed/Principal only
- Secondary only
- First listed/Principal or Secondary

Coverage depends on the proper sequencing of these V codes and whether the service for which V codes stands for is covered by the individual plan. E.g.; Vaccination V codes will be covered only for plans for which vaccines are covered.

Disclaimer

By accessing these Daman Adjudication Rules (the "AR"), you acknowledge that you have read and understood the terms of use set out in the disclaimer below:
The information contained in this AR is intended to outline the procedures of adjudication of medical claims as applied by the National Health Insurance Company – Daman PJSC (hereinafter "Daman"). The AR is not intended to be comprehensive, should not be used as treatment guidelines and should only be used for the purpose of reference or guidance for adjudication procedures and shall not be construed as conclusive. Daman in no way interferes with the treatment of patient and will not bear any responsibility for treatment decisions interpreted through Daman AR. Treatment of patient is and remains at all times the sole responsibility of the treating Healthcare Provider. This AR does not grant any rights or impose obligations on Daman.
The AR and all of the information it contains are provided "as is" without warranties of any kind, whether express or implied which are hereby expressly disclaimed.
Under no circumstances will Daman be liable to any person or business entity for any direct, indirect, special, incidental, consequential, or other damages arising out of any use of, access to, or inability to use or access to, or reliance on this AR, including but without limitation to, any loss of profits, business interruption, or loss of programs or information, even if Daman has been specifically advised of the possibility of such damages. Daman also disclaims all liability for any material contained in other websites linked to Daman website.
This AR is subject to the laws, decrees, circulars and regulations of Abu Dhabi and UAE. Any information provided herein is general and is not intended to replace or supersede any laws or regulations related to the AR as enforced in the UAE issued by any governmental entity or regulatory authority, or any other written document governing the relationship between Daman and its contracting parties.
This AR is developed by Daman and is the property of Daman and may not be copied, reproduced, distributed or displayed by any third party without Daman's express written consent.
This AR incorporates the Current Procedural Terminology and Current Dental Terminology (CPT® and CDT®, which is a registered trademark of the American Medical Association ("AMA"), and the American Dental Association ("ADA") respectively), and the CPT and CDT codes and descriptions belong to the AMA. Daman reserves the right to modify, alter, amend or obsolete the AR at any time by providing one month prior notice.

Scope

This adjudication rule describes the coverage & billing requirements of V codes.

There are four primary circumstances for the use of V codes as given below:

1) A person who is not currently sick encounters the health services for some specific reason, such as to act as an organ donor, to receive prophylactic care, such as inoculations or health screenings, or to receive counseling on health related issues.
2) A person with a resolving disease or injury, or a chronic, long-term condition requiring continuous care, encounters the health care system for specific aftercare of that disease or injury (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change). A diagnosis/symptom code should be used whenever a current, acute, diagnosis is being treated or a sign or symptom is being studied.
3) Circumstances or problems influence a person's health status but are not in themselves a current illness or injury.
4) Newborns, to indicate birth status

Adjudication Policy

Eligibility / Coverage Criteria

V codes can be reported in any healthcare setting. These codes can be claimed either as a first listed (outpatient) or principal diagnosis (inpatient) or secondary diagnosis codes (both outpatient and inpatient).

There are three groups of V codes based on ICD 9 CM sequencing rule

V codes which can be listed as

- First listed/Principal only
- Secondary only
- First listed/Principal or Secondary

Coverage depends on the proper sequencing of these V codes and whether the service for which V codes stands for, is covered by the individual plan.

E.g.; Vaccination V codes will be covered only for plans for which vaccines are covered.

Requirements for Coverage

ICD and CPT codes must be coded to the highest level of specificity.

Non-Coverage

Claims with V codes reported as primary or secondary may be denied if noncompliant with the sequencing or payment and coding rules.

Payment and Coding Rules

Please apply HAAD payment rules and regulations and relevant coding manuals for ICD, CPT, etc.
There are 15 different categories of V codes (please refer page no. 3 and 4)

Adjudication Examples

Example 1

Question: Provider reports only V 67.9-Unspecified follow up examination as principal diagnosis, and claims for some procedures. How will you adjudicate this?

Answer: Procedures billed, should be rejected as not compliant with the ICD coding rules.

Example 2

Question: Provider reports V code for follow-up examination as principal diagnosis and Diabetes Mellitus as Secondary diagnosis and claims for services for DM. How would you adjudicate this?

Answer: All services related to follow-up for DM can be covered.

Denial codes

Code	Code description
CLAI-012	Submission not compliant with contractual agreement
NCOV-003	Services are not covered
MNEC-004	Services not clinically indicated

Appendices

A. References

1. ICD -9 -CM Official Guidelines for Coding and Reporting 2011
2. CCSC coding manual 2012

B. Revision History

Date	Change(s)
01-11-13	N.A
15-07-14	1. V 1.1 2. Disclaimer updated as per system requirements

15 different categories of V codes

Description	ICD codes	Coverage
Contact /Exposure to communicable diseases	V01, V15.84 – V15.86 V87.0 – V87.3	Medical justification of performed CPT codes
Inoculations & vaccination	V03-V06	Plan wise coverage
Status-these codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition	V02, V07.5x, V08, V09, V21, V22.2, V26.5x, V42, V43, V44, V45, V46, V49.6, V49.7, V49.81-V49.87,V58.6x, V83-V86,V88,V90	Medical justification of performed CPT codes
History codes : Personal- past medical condition that no longer exists and is not receiving any treatment, but had the potential for recurrence and therefore requires monitoring	V10, V 12 - V15 (except 15.7, V15.84, V15-86)	Medical justification of performed CPT codes
History codes : Family history-codes for use when a patient has a family member who had a particular disease that causes the patient to be at higher risk of also contracting the disease	V16-V19, V87 (Except V87.0-V87.3)	Medical justification of performed CPT codes
Screening-is testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease. A V code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed	V28, V73 - V82	Plan wise coverage
Observation-there are three observation v code categories, for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out	V29, V71, V89	Medical justification of performed CPT codes
Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for long term consequences of the disease	V51.0, V52-V57, V58.0, V58.11, V58.12, V58.3x, V58.41,-V58.49, V58.7x, V58.81-V58.83, V58.89	Medical justification of performed CPT codes
Follow-up-used to explain continuing surveillance following completed treatment of a disease, condition or injury	V24, V67	Medical justification of performed CPT codes
Donor category codes are used for living individuals who are donating blood or other body tissue.	V59	Plan wise coverage
Counselling V codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems	V25.0, V26.3, V26.4, V61.x, V65.1, V65.3, V65.4	Plan wise coverage
Obstetrics or related conditions-V codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the obstetrics chapter exists	V22-V28, V91	Medical justification of performed CPT codes
New-born, infant and child-to indicate birth status	V20, V29, V30-V39	Medical justification of performed CPT codes
Routine & admin exam-V codes allow for the description of encounters for routine examinations, such as, general check-up, pre-employment physical, etc.	V20.2, V70, V72	Medical justification of performed CPT codes
Miscellaneous V codes-capture a number of other health-care encounters that do not fall into one of the other categories	V07, V40.31, V50, V58.5, V60, V62-64, V66, V68, V69	Medical justification of performed CPT codes
Prophylactic organ removal for encounters especially for prophylactic removal of breasts, ovaries, or another organ due to a genetic susceptibility to cancer or a family history of cancer, the principal or the first listed codes should be a code from subcategory V50.4	V50.4	Plan wise coverage
Non-specific V codes-Certain V codes are so non-specific, or potentially redundant, that there can be little justification for their use in the inpatient setting. In outpatient setting, their use should be limited to those instances when there is no further documentation to permit more precise coding.	V11, V13.4, V13.6, V15.7, V23.2, V40, V41, V47-V49 (except V49.6, V49.7, V49.81, V49.82, V49.83, V49.86, V49.87), V51.8, V58.2, V58.9	Medical justification of performed CPT codes