# Mandated Benefits
## Data Collection Methodologies

## Background

In 2001, the Texas legislature passed a bill requiring TDI to collect and report data about mandated health benefits and mandated offers of coverage (Insurance Code Chapter 38, Subchapter F). In 2002, TDI adopted the rule (28 TAC Sections 21.3401 – 21.3409) creating the mandated benefits data call and amended the rule in 2003 to clarify the reporting periods and revise the reporting deadlines.

In 2015, TDI began the rule change process for the mandated benefits data call and adopted the amendments in June 2017. As part of the process, TDI added five mandated benefits and one mandated offer to the data call and removed five mandated benefits from the data call. The first table located in the appendix shows the mandated benefits and offers collected under the previous rule and under the recently adopted rule change.

This document lists the mandates that will be included in the data call and explains the methodology for each mandate.

## Mandated benefits data call code workbook

The mandated benefits data call instructions reference the code workbook. TDI provides lists of medical billing codes to help issuers identify claims data about the various mandated benefits and offers. The workbook is a general reference tool and may not include all of the applicable codes for each mandate. Also, the workbook does not include modifiers, but issuers will need to use them as necessary to report data accurately for professional and technical services. Issuers need to ensure they are using codes that will capture data within the scope of the mandates based on any parameters specified in the statutes. In addition, issuers are responsible for staying current with any changes in codes.

As part of the rule project, TDI updated the workbook using International Classification of Diseases (ICD) diagnosis and procedure codes, Current Procedural Terminology (CPT[1]) codes, and Healthcare Common Procedure Coding System (HCPCS) codes. The updated workbook includes the ICD-10 codes that went into effect in the fall of 2015. TDI staff, with limited knowledge of medical coding, performed the research and compiled the workbook. Staff asks that you report any discrepancies so we can make the necessary revisions.

[1] CPT is a registered trademark of the American Medical Association.

## Reporting methodologies

The mandates included in the data call are diverse, and each one will have a unique methodology to capture the cost and utilization data. The methodologies used by the issuers to report data need to be consistent for the information in our report to be accurate and meaningful. Some mandates are similar in nature, like those for preventive screenings so, the proposed methodologies for these mandates are similar. TDI realizes that some mandates will be relatively simple to report, while others deal with complex medical conditions and procedures. Issuers need to ensure they only report data that falls within the scope of each mandate, and at the same time, report all of the data for the mandate. Issuers are also responsible for reporting the costs of anesthesia, prescription drugs, and durable medical equipment if their use falls within the scope of the mandate.

## Reporting exceptions

The rule includes a section that describes exceptions to required reporting. An issuer is not required to report data that could reasonably be used to identify a specific enrollee or violates confidentiality requirements of state or federal law or regulation applicable to an enrollee. There are also exceptions for HMOs. An HMO is not required to report data for a particular benefit or coverage if the HMO does not directly process the claim because the services are prepaid under a capitated payment arrangement or does not receive complete and accurate encounter data.

## Reporting limitations

TDI acknowledges there are reporting limitations that affect the information submitted for the data call each year. In the annual report, TDI will address the limitations discussed below.

Some issuers will report the data necessary to meet the stipulations of each mandate, while others may include additional data for diagnosis and procedure codes beyond what is required. This is acceptable as long as the additional information falls within the scope of the mandate. Instances where this would not be acceptable would be including data for treatment for the mandates for screening only. For example, the prostate cancer mandate is for screening only and data for the treatment of prostate cancer would not be included for enrollees diagnosed because of the screening.

Sometimes the same procedure codes may be relevant for more than one mandate. To prevent duplicate data from being reported, some of the methodologies suggest using specific diagnosis codes with procedure codes, instead of just reporting the data based on procedure codes alone. For example, there is a separate mandate for autism spectrum disorder; however, the data could be included in the serious mental illness and developmental delays mandates. Issuers are specifically instructed not to include the autism-related diagnosis codes when capturing the data for serious mental illness and developmental delays to prevent reporting the data multiple times.

Several of the mandates allow for annual screenings, and double reporting may occur when enrollees change plans or issuers. In addition, other screening mandates allow for screening every five or 10 years depending on the mandate and type of procedure performed. It may be difficult

for issuers to filter the data to only account for one screening per enrollee every five or 10 years, so double reporting may occur if some enrollees have multiple screenings performed. Because there is no way to prevent this type of double reporting from happening, TDI recognizes it as a limitation in the annual report.

Issuers will report data for claims incurred rather than claims paid. Because claims incurred include claims that have been reported and an estimate of claims that were incurred that have not yet been reported to the company (IBNR), they provide a more comprehensive measure of the overall claims costs than simply collecting claims paid. IBNR is an estimate based on the company's experience in prior years of the amount of claims they will still have to pay as of a certain date in time. Since data call information will not be due until June following the calendar year reporting period, we expect IBNR to be low at the time the data is prepared for submission. However, there may be claims settled later than June that affect the final claims paid amount once all are resolved (that is, cases where the insurance company is a secondary payer), but this is an acceptable limitation.

## Wellness exams

TDI recommends not using wellness exam codes to capture report data for any of the mandates. These preventive examinations include multiple screenings and procedures that would inflate the costs of the specific mandates. In addition, sometimes a health care provider recommends screenings at a wellness exam, but the enrollee chooses not to do them.

The preventive examination codes are not gender specific—they are based on patient age and whether they are a new or established patient. Also, the ages do not always correspond to the age parameters of the mandates. For example, the mammography mandate applies to women 35 years of age and older. The age range for preventive exam code 99385 is 18–39, so it would include women who are younger than the age specified in the mandate, thus potentially capturing data not relevant to the mandate.

In the annual report, TDI will explain that preventive codes are not being used and will result in the full costs of some mandates not being captured. By not using the preventive codes, TDI will not receive all of the data for mandated preventive screenings. On the other hand, the data reported by the issuers will not be inflated due to including information that does not fall within the scope of the mandates.

## Evaluation and management codes

TDI recommends using evaluation and management codes as necessary to capture data for any of the mandated benefits and mandated offers. The code lists for at least three of the mandates include evaluation and management codes—acquired brain injury, serious mental illness, and chemical dependency; however, issuers should use these codes as applicable to capture and report data for any of the mandates.

# Methodologies

## Acquired brain injury (ABI)

### Insurance Code Chapter 1352

As defined in 28 TAC Section 21.3102, an ABI is a neurological insult to the brain that is not hereditary, congenital, or degenerative. The injury to the brain happened after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Because of the nature of ABI, there is not a specific diagnosis code for ABI. TDI recommends capturing the data for this mandate using ABI-related ICD-10 diagnosis codes in conjunction with ICD-10 procedure codes, CPT, and HCPCS codes for the services covered by the mandate. The mandate requires coverage of specific therapy and intervention services, as well as post-acute care. The mandate does not include medical services for acute treatment of the actual head injury or illness that caused acquired brain injury. Issuers will need to ensure that these costs are not included in the data they report.

## Autism spectrum disorder

### Insurance Code Chapter 1355, Subchapter A

TDI added this mandate to the data call as part of the rule change project. The mandate defines autism spectrum disorder as a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder—Not Otherwise Specified. The mandate also defines neurobiological disorder as an illness of the nervous system caused by genetic, metabolic, or other biological factors.

TDI recommends capturing the screening data based on CPT screening codes, and treatment data based on ICD-10 diagnosis codes with CPT and HCPCS codes. The mandate stipulates screening at 18 and 24 months of age, and issuers need to report screening data regardless of the results. Because of possible timing issues of doing the screenings when a child is exactly 18 and 24 months old, issuers will report data for no more than two screenings per enrolled child up to their second birthday, if possible. The mandate also requires coverage for treatment for enrollees diagnosed before their 10th birthday. Issuers will need to ensure they only report treatment data based on this parameter. The mandate includes an annual cap for applied behavior analysis of $36,000 per enrollee once they reach 10 years of age; however, the cap does not apply to enrollees under 10 years of age. Issuers will need to ensure the data reported reflects the actual annual cost for applied behavior analysis for each enrollee regardless of their age, and not limit the data to $36,000 per enrollee. Because of the long-term nature of an autism-related diagnosis, issuers will not report the costs for any treatment or services that are not associated with an autism-related diagnosis. For example, in the event a person with autism has medical treatment for an unrelated condition, like a broken arm, we do not want to capture the cost associated with treatment of the broken arm. Issuers will need to ensure that the procedure codes used to capture treatment data

only apply to enrollees with an autism-related diagnosis. In addition, issuers will need to use pharmacy claims to get data for any medications prescribed to treat an autism-related diagnosis.

## Serious mental illness

### Insurance Code Chapter 1355, Subchapter A

TDI recommends capturing the data for serious mental illness based on ICD-10 diagnosis codes with CPT and HCPCS codes. The mandate states that a health benefit plan must provide coverage, based on medical necessity, for not less than 45 days of inpatient treatment, and not less than 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year. In addition, the mandate states that the plan may not include a lifetime limitation on the number of days of inpatient treatment or the number visits for outpatient treatment covered under the plan. Also, the plan must include the same amount limitations, deductibles, copayments, and coinsurance factors for serious mental illness as the plan includes for physical illness, which may require treatment coverage in excess of the 45 days and 60 visits requirement. Issuers will report data regardless of the number of days of inpatient treatment or visits of outpatient treatment enrollees received during the calendar year. Issuers should not report data associated with autism-related diagnosis codes (F84.0 - F84.9) under this mandate since they will report that data under the autism spectrum disorder mandate. Because of the long-term nature of serious mental illness, issuers will not report the costs for any treatment or services that are not associated with a serious mental illness diagnosis. For example, in the event a person with a serious mental illness has medical treatment for an unrelated condition, like a broken arm, we do not want to capture the cost associated with treatment of the broken arm. There are no age parameters associated with this mandate, and issuers need to ensure they are reporting all costs for serious mental illness treatment for all enrollees regardless of their age. In addition, issuers will need to use pharmacy claims to obtain data for any medications prescribed to treat serious mental illness.

## Mammography cancer screening

### Insurance Code Chapter 1356, HMO 28 TAC Section 11.508 (a)(1)(H)(iv)

**UPDATE:** The 85th Legislature passed HB 1036 that requires a health benefit plan to include digital mammography and breast tomosynthesis as forms of low-dose mammography in their coverage to females 35 years of age or older for an annual screening for the presence of occult breast cancer. The bill took effect September 1, 2017, and applies to health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2018.

TDI recommends capturing the data for screening mammograms based on either the ICD-10 diagnosis code for screening or CPT codes. The mandate limits this to an annual screening for females 35 years of age or older. Issuers will need to filter the data based on these parameters and, if possible, limit the data reported to one annual screening mammogram per enrollee. The mandate is for screening only, so issuers need to ensure they are not including data for diagnostic mammograms or for the treatment of breast cancer.

## Reconstructive surgery following mastectomy

### Insurance Code Chapter 1357, Subchapter A

TDI recommends capturing the data for reconstructive surgery following mastectomy based on ICD-10 diagnosis codes with CPT and HCPCS codes. The mandate requires coverage for breast reconstruction, prostheses, and treatment of physical complications, including lymphedemas, at all stages of mastectomy. Because the mandate is not gender specific, issuers must capture and report data for both male and female enrollees. The code workbook previously provided by TDI included diagnosis codes for malignant neoplasms of the female and male breast and the code for a personal history of malignant neoplasm of the breast. These codes should not be used to capture data because not all enrollees with these codes undergo a mastectomy. In addition, enrollees who do undergo a mastectomy may decide against reconstructive surgery or the use of a prosthesis, and issuers would not report information for these enrollees unless they change their mind later. Issuers need to ensure they are reporting all data within the scope of the mandate.

## Diabetes equipment, supplies, and self-management training

### Insurance Code Chapter 1358, Subchapter B

TDI recommends capturing the data for diabetes equipment, supplies, and self-management training based on ICD-10 diagnosis codes with CPT and HCPCS codes. The mandate requires health benefit plans that provide coverage for the treatment of diabetes and conditions associated with diabetes to also provide coverage for diabetes equipment, supplies, and self-management training. A qualified enrollee is an individual eligible for coverage diagnosed with the following: insulin dependent or noninsulin dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels. Information about equipment, supplies, and self-management training is in 28 TAC Sections 21.2605 and 21.2606. Issuers will need to use pharmacy claims to get data for supplies obtained through a pharmacy.

## Formulas for phenylketonuria (PKU) or other heritable diseases

### Insurance Code Chapter 1359

TDI recommends capturing the data for the formulas necessary to treat PKU or other heritable diseases based on ICD-10 diagnosis codes with CPT and HCPCS codes. The mandate defines a heritable disease as an inherited disease that may result in mental or physical retardation or death. The updated code workbook includes the ICD-10 diagnosis codes for PKU and other heritable disorders. The list may not include all possible diagnosis codes, so issuers will need to ensure they report data for any other heritable diseases as defined in the mandate treated with formulas. Issuers should not include data for the screening, evaluation, and any other treatment since the mandate is specifically for formulas. Issuers will need to use pharmacy claims to get formula data.

## Temporomandibular joint (TMJ) diagnosis and treatment

### Insurance Code Chapter 1360

TDI recommends capturing the data for TMJ diagnosis and treatment based on the ICD-10 diagnosis codes with CPT codes. The mandate requires coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is medically necessary because of: an accident, a trauma, a congenital defect, a developmental defect, or a pathology. Issuers need to capture and report the full cost of treatment from start to finish.

## Osteoporosis detection and prevention

### Insurance Code Chapter 1361

TDI recommends capturing the data for osteoporosis detection and prevention based on the ICD-10 diagnosis code or CPT and HCPCS codes. Because the mandate is not gender specific, issuers must capture and report data for both male and female enrollees. We will assume that if a doctor is ordering bone density tests for an enrollee that it is medically necessary and one or more of the qualifying conditions applies. The issuers will not need to filter for these conditions. Issuers will not include codes for family history or general medical exams. Family history is not included as a stipulation in the mandate and general medical exams will capture additional costs not associated with the mandate. The mandate is for detection and prevention only and issuers should not report data for the treatment of osteoporosis.

## Prostate cancer screening

### Insurance Code Chapter 1362

TDI recommends capturing the data for prostate cancer screening based on the ICD-10 diagnosis codes for screening and family history with CPT and HCPCS codes. The mandate limits this screening to an annual physical examination for the detection of prostate cancer for all males. In addition, males who are at least 50 years of age and are asymptomatic, or at least 40 years of age and with a family history of prostate cancer or another prostate cancer risk factor can also get an annual prostate-specific antigen (PSA) test. Issuers will need to filter the data based on these parameters and, if possible, limit the data reported to one annual physical prostate examination per enrollee and one annual PSA test per enrollee who meet the age and risk parameters. The mandate is for screening only and issuers should not report data for the treatment of prostate cancer.

## Colorectal cancer screening

### Insurance Code Chapter 1363

TDI recommends capturing the data for colorectal cancer screening based on the ICD-10 diagnosis codes for screening with CPT and HCPCS codes. The mandate limits this screening to enrollees 50 years of age or older and at normal risk for developing colon cancer. The statute also limits the screening frequency based on the type of screening performed. An enrollee may get an annual fecal occult blood test and a flexible sigmoidoscopy performed every five years or a colonoscopy performed every 10 years. Issuers will need to filter the data based on these

parameters and, if possible, limit the data reported per enrollee to one fecal occult blood test annually and one sigmoidoscopy every five years or one colonoscopy every 10 years. The mandate is for screening only and issuers should not report data for the treatment of colorectal cancer.

## Loss or impairment of speech or hearing – Offer

### Insurance Code Chapter 1365

TDI recommends capturing the data for the necessary care and treatment of loss or impairment of speech or hearing based on CPT and HCPCS codes. The updated list does not include diagnosis codes because the procedures listed are for the treatment of loss or impairment of speech or hearing. In the past, the code list provided by TDI included a diagnosis code for ear and hearing examinations. These diagnosis codes should not be used because we only want to capture the cost of necessary care and treatment and not the initial examinations. This offer of coverage does not include an age parameter; however, the hearing screening mandated benefit requires coverage for newborn screening and diagnostic follow-up care until a child is 24 months old. Accordingly, issuers should filter the data for this offer and limit the data reported to enrollees 24 months of age and older. This should prevent duplicate data from being reported for enrollees younger than two years of age.

## In vitro fertilization – Offer

### Insurance Code Chapter 1366, Subchapter A

TDI recommends capturing the data for in vitro fertilization based on the ICD-10 procedure code or CPT and HCPCS codes. We will assume the conditions applicable to coverage listed in the mandate are being met when issuers report this information for enrollees for this procedure. Thus, the issuers will not need to filter for these conditions.

## Childhood immunizations

### Insurance Code Chapter 1367, Subchapter B

TDI recommends capturing the data for childhood immunizations based on the ICD-10 diagnosis code for immunization with CPT codes for vaccines and immunization administration. The mandate requires immunization coverage for each covered child from birth until the child's sixth birthday. Issuers will report immunization data for children five years of age and younger. The required immunizations include diphtheria, haemophilus influenzae type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and rotovirus (HMO only), and any other immunization required by law. Issuers will need to filter the data based on the age parameter and ensure they are not reporting data for vaccines not included in the mandate or adult dosages of vaccines.

## Hearing screening for children

### Insurance Code Chapter 1367, Subchapter C

We recommend capturing the data for hearing screening for children based on ICD-10 diagnosis codes with CPT and HCPCS codes. The mandate provides for a screening test for hearing loss from birth until the child is 30 days old and for necessary diagnostic follow-up care related to the

screening test from birth until the child is 24 months old. Issuers will need to filter the data based on the age parameters and report newborn enrollee screening tests and diagnostic follow-up care related to the screening through 23 months of age. Issuers will report data for children 23 months old and younger. Issuers may include data for multiple screening tests whenever rescreening was necessary.

## Developmental delays in children – Offer

### Insurance Code Chapter 1367, Subchapter E

TDI added this mandate to the data call as part of the rule change project. TDI recommends capturing the data for developmental delays in children based on ICD-10 diagnosis codes with CPT and HCPCS codes for the services covered by the mandate. The mandate requires a health benefit plan issuer to offer coverage for rehabilitative and habilitative therapies for children under three years of age with developmental delays. Chapter 73 of the Human Resources Code is the source of the age parameter for this mandate. The rehabilitative and habilitative therapies include evaluations and services for occupational therapy, physical therapy, speech therapy, and dietary or nutritional evaluations. Issuers should not report data associated with autism-related diagnosis codes (F84.0 - F84.9) under this mandate since they will report that data under the autism spectrum disorder mandate. Issuers will need to filter the data based on the age parameter and ensure they are only reporting data within the scope of the mandate for children two years of age and younger identified as having developmental delays.

## Chemical dependency – Inpatient and outpatient

### Insurance Code Chapter 1368

TDI recommends capturing the data for both inpatient and outpatient chemical dependency treatment based on ICD-10 diagnosis codes with ICD-10 procedure codes, CPT, and HCPCS codes for the services covered by the mandate. Issuers will continue to report data separately for inpatient and outpatient treatment. The statute defines chemical dependency as the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance. Because of the long-term nature of chemical dependency, issuers will not report the costs for any treatment or services that are not associated with a chemical dependency diagnosis. For example, in the event a person with chemical dependency has medical treatment for an unrelated condition, like a broken arm, TDI does not want to capture the cost associated with treatment of the broken arm. Issuers will need to ensure that the CPT codes used to capture data only apply to enrollees with a chemical dependency diagnosis. In addition, issuers will need to use pharmacy claims to get data for any medications prescribed to treat chemical dependency.

## Prescription contraceptive drugs, devices, and related services

### Insurance Code Chapter 1369, Subchapter C

We recommend capturing the data for prescription contraceptive drugs, devices, and related services based on ICD-10 diagnosis codes with CPT and HCPCS codes. Issuers should not report information about sterilization procedures or contraceptive methods that are available over-the-counter. Issuers will need to use pharmacy claims to get prescription drug data.

## Human papillomavirus (HPV) and cervical cancer screening

### Insurance Code Chapter 1370

TDI added this mandate to the data call as part of the rule change project. We recommend capturing the data for HPV and cervical cancer screening based on the ICD-10 diagnosis codes for screening with CPT and HCPCS codes. The mandate limits this to an annual screening for females 18 years of age or older. The statute states that coverage must include at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the U.S. Food and Drug Administration (FDA), alone or with a test approved by the FDA for the detection of HPV. Issuers will need to filter the data based on the gender and age parameters and, if possible, limit the data reported per enrollee to one HPV and one cervical cancer screening annually. The mandate is for screening only and issuers should not report data for the treatment of HPV or cervical cancer.

## Ovarian cancer screening

### Insurance Code Chapter 1370

TDI added this mandate to the data call as part of the rule change project. We recommend capturing the data for ovarian cancer screening based on the ICD-10 diagnosis code for screening with the CPT code for a CA 125 blood test. The mandate limits this to an annual screening for females 18 years of age or older. Issuers will need to filter the data based on the gender and age parameters and, if possible, limit the data reported to one annual ovarian cancer screening per enrollee. The mandate is for screening only and issuers should not report data for the treatment of ovarian cancer.

## Cardiovascular disease – Early detection

### Insurance Code Chapter 1376

TDI added this mandate to the data call as part of the rule change project. We recommend capturing the data for cardiovascular disease screening based on ICD-10 procedure codes and CPT codes. The mandate limits this to males older than 45 years of age and younger than 76 years of age, and females older than 55 years of age and younger than 76 years of age. Enrollees must also be diabetic or have a risk of developing coronary heart disease, based on an intermediate or higher score derived using the Framingham Heart Study coronary prediction algorithm. The mandate also has a minimum coverage amount of up to $200 for one of two noninvasive screening tests for atherosclerosis and abnormal artery structure every five years. The two tests are computed tomography (CT) scanning measuring coronary artery calcification or ultrasonography measuring carotid intima-media thickness and plaque. TDI will assume that if a doctor is ordering one of these tests for an enrollee that it is medically necessary and one of the qualifying conditions applies. Thus, the issuers will not need to filter for these conditions. The issuers will need to filter the data based on the gender and age (46–75 males and 56–75 females) parameters, and, if possible, limit the data reported to one cardiovascular disease screening per enrollee every five years. Additionally, issuers will need to ensure the data reported reflects the

actual cost of each claim, and not limit the data to $200 per claim. The mandate is for screening only and issuers should not report data for the treatment of cardiovascular disease.

### Amino acid-based elemental formulas

#### Insurance Code Chapter 1377

TDI added this mandate to the data call as part of the rule change project. TDI recommends capturing the data for amino acid-based elemental formulas based on ICD-10 diagnosis codes with CPT and HCPCS codes. The mandate requires coverage for amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of a disease or disorder listed in the statute. The coverage must include any medically necessary services associated with the administration of the formula. Furthermore, the treating physician must issue a written order stating that the amino acid-based elemental formula is medically necessary for the treatment of an enrollee diagnosed with one of the listed diseases or disorders. Issuers should not include data for the screening, evaluation, and any other treatment since the mandate is specifically for amino acid-based elemental formulas and any medically necessary services associated with the administration of the formula. Issuers will need to use pharmacy claims to get formula data.

## Questions?

Send questions about the mandated benefits data call to MBSurvey@tdi.texas.gov.

# Appendix

The first table shows the mandated benefits and offers collected under the previous rule and under the rule change adopted in 2017. The second table shows the recommended types of medical billing codes for each mandate to capture the information for the data call.

| Mandated Benefits Data Call | Previous | Current |
|---|---|---|
| **Benefits** | | |
| Acquired Brain Injury | ✓ | ✓ |
| Autism Spectrum Disorder | | ✓ |
| Serious Mental Illness - 45/60 | ✓ | ✓ |
| Mammography Cancer Screening | ✓ | ✓ |
| Reconstructive Surgery Following Mastectomy | ✓ | ✓ |
| Diabetes Equipment, Supplies, and Self-Management Training | ✓ | ✓ |
| Formulas for PKU or Other Heritable Diseases | ✓ | ✓ |
| Temporomandibular Joint (TMJ) Diagnosis and Treatment | ✓ | ✓ |
| Osteoporosis Detection and Prevention | ✓ | ✓ |
| Prostate Cancer Screening | ✓ | ✓ |
| Colorectal Cancer Screening | ✓ | ✓ |
| Childhood Immunizations | ✓ | ✓ |
| Hearing Screening for Children | ✓ | ✓ |
| Chemical Dependency – Inpatient Only | ✓ | ✓ |
| Chemical Dependency – Outpatient Only | ✓ | ✓ |
| Prescription Contraceptive Drugs, Devices, and Related Services | ✓ | ✓ |
| HPV and Cervical Cancer Screening | | ✓ |
| Ovarian Cancer Screening | | ✓ |
| Cardiovascular Disease - Early Detection | | ✓ |
| Amino Acid-Based Elemental Formulas | | ✓ |
| HIV, AIDS, or HIV-Related Illnesses | ✓ | |
| Reconstructive Surgery for Craniofacial Abnormalities in Children | ✓ | |
| Serious Mental Illness - Full Parity (large employer plans) | ✓ | |
| Psychiatric Day Treatment | ✓ | |
| Telemedicine/Telehealth | ✓ | |
| **Offers** | | |
| Loss or Impairment of Speech or Hearing | ✓ | ✓ |
| In Vitro Fertilization | ✓ | ✓ |
| Developmental Delays in Children | | ✓ |

| Mandated Benefits and Offers | ICD-10 Diagnosis Codes | ICD-10 Procedure Codes | CPT Codes | HCPCS Codes |
|---|---|---|---|---|
| **Benefits** | | | | |
| Acquired Brain Injury | ✓ | ✓ | ✓ | ✓ |
| Autism Spectrum Disorder | ✓ | | ✓ | ✓ |
| Serious Mental Illness - 45/60 | ✓ | | ✓ | ✓ |
| Mammography Cancer Screening | ✓ | | ✓ | |
| Reconstructive Surgery Following Mastectomy | ✓ | | ✓ | ✓ |
| Diabetes Equipment, Supplies, and Self-Management Training | ✓ | | ✓ | ✓ |
| Formulas for PKU or Other Heritable Diseases | ✓ | | ✓ | ✓ |
| Temporomandibular Joint (TMJ) Diagnosis and Treatment | ✓ | | ✓ | |
| Osteoporosis Detection and Prevention | ✓ | | ✓ | ✓ |
| Prostate Cancer Screening | ✓ | | ✓ | ✓ |
| Colorectal Cancer Screening | ✓ | | ✓ | ✓ |
| Childhood Immunizations | ✓ | | ✓ | |
| Hearing Screening for Children | ✓ | | ✓ | ✓ |
| Chemical Dependency – Inpatient Only | ✓ | ✓ | ✓ | ✓ |
| Chemical Dependency – Outpatient Only | ✓ | ✓ | ✓ | ✓ |
| Prescription Contraceptive Drugs, Devices, and Related Services | ✓ | | ✓ | ✓ |
| HPV and Cervical Cancer Screening | ✓ | | ✓ | ✓ |
| Ovarian Cancer Screening | ✓ | | ✓ | |
| Cardiovascular Disease - Early Detection | | ✓ | ✓ | |
| Amino Acid-Based Elemental Formulas | ✓ | | ✓ | ✓ |
| **Offers** | | | | |
| Loss or Impairment of Speech or Hearing | | | ✓ | ✓ |
| In Vitro Fertilization | | ✓ | ✓ | ✓ |
| Developmental Delays in Children | ✓ | | ✓ | ✓ |