wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
- Ambulatory Surgery Centers
- Family Planning Clinics
- Independent Labs
- Nurse Midwives
- Nurse Practitioners
- Optometrists
- Physician Assistants
- Physician Clinics
- Physicians
- Rural Health Clinics
- HMOs and Other Managed Care Programs

HCPCS screening procedure codes policy

Effective for dates of service (DOS) on and after July 1, 2002, Wisconsin Medicaid reimburses specific Health Care Procedure Coding System* (HCPCS) screening procedure codes. Previously, providers were instructed to submit claims with Current Procedural Terminology (CPT) procedure codes along with the appropriate diagnosis code for screening services. Providers were notified of Wisconsin Medicaid's acceptance of these HCPCS procedure codes in the October 2002 Wisconsin Medicaid and BadgerCare Update (2002-56), titled "Procedure code updates." This Update explains Wisconsin Medicaid's policy for submitting claims for screening and diagnostic procedures.

Wisconsin Medicaid adopted HCPCS screening codes

Effective for dates of service (DOS) on and after July 1, 2002, Wisconsin Medicaid reimburses Health Care Procedure Coding System* (HCPCS) screening procedure codes. This *Wisconsin Medicaid and BadgerCare Update* explains Wisconsin Medicaid's policy for submitting claims for screening and diagnostic procedures. Providers are required to use these HCPCS procedure codes when submitting claims for the following screening procedures:

- Breast cancer — mammography.
- Colorectal cancer.
- Glaucoma.
- Pap smears.
- Pelvic and breast exams.
- Prostate cancer.

Refer to the Attachment of this *Update* for a list of allowable screening procedure codes. Previously, Wisconsin Medicaid did not reimburse for most HCPCS screening procedure codes. Instead, providers were instructed to submit claims for screenings using diagnostic *Current Procedural Terminology* (CPT) procedure codes, regardless of whether the procedure was for screening or diagnostic purposes.

General principles

The following are general principles for Medicaid coverage of screening and diagnostic procedures:

- Wisconsin Medicaid covers both screening and diagnostic tests and procedures under the appropriate procedure codes.
- Office visits are included in the reimbursement for surgical procedures, whether diagnostic or screening (e.g., colonoscopy, flexible sigmoidoscopy). Providers should not submit claims for office visits when performing surgical procedures (procedure codes listed with type of service [TOS] "2") listed in the Attachment performed on the same DOS.
- Laboratory and radiology screening and diagnostic procedures (procedure codes listed with TOS "4," "5," "Q," or "U") listed in the Attachment are separately reimbursable when submitted with an

*Formerly known as "HCFA Common Procedure Coding System."

office visit procedure code on the same DOS.

Screenings

Providers should use the screening procedure codes when submitting claims in the following instances:

- For routine tests or procedures performed to identify recipients at increased risk for diseases.
- When a recipient is asymptomatic or does not have a personal history of the disease (or related conditions) for which the screening test is being performed.

Wisconsin Medicaid does not limit the frequency, age criteria, or reasons for screening; rather, this is left to best medical judgement based on standard medical practice and the patient's individual circumstances.

Claims for screenings must have the diagnosis code field completed (e.g., a preventive code). For example, a claim for a glaucoma screening could indicate *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code V80.1 (Special screening for neurological, eye, and ear diseases; Glaucoma).

Diagnostic procedures

Providers should use the diagnostic procedure codes when submitting claims in the following instances:

- There are symptoms or other indications of a medical problem or to confirm a previous diagnosis.
- There is a personal history of a medical problem or related condition.
- During a screening, a problem or medical condition is found and a biopsy or other sample is taken for further study and analysis.

Service-specific information

The following information gives details about each kind of screening and/or when to bill services as diagnostic services. Refer to the Attachment for screening procedure codes. Refer to CPT for diagnostic procedure codes.

Breast cancer — mammography

Wisconsin Medicaid does not have limitations on the frequency of mammography. Providers may be reimbursed for both a screening mammography and a diagnostic mammography for the same patient on the same DOS if they are performed as separate films. Reasons for the separate procedures must be documented in the recipient's medical record.

Claims for screenings must have the diagnosis code field completed (e.g., a preventive code).

Wisconsin Medicaid does not recognize HCPCS modifiers "-GG" or "-GH" which are used by *Medicare* to indicate mammograms performed for the same patient on the same DOS.

Colorectal cancer

Providers may submit claims for a variety of colorectal cancer screening or diagnostic tests, including laboratory tests, flexible sigmoidoscopy, proctosigmoidoscopy, barium enema, and colonoscopy. Providers should use the HCPCS or CPT procedure code that best reflects the nature of the procedure. If during a screening colonoscopy or sigmoidoscopy abnormalities (e.g., polyps) are found and biopsies taken or other coverage criteria are met (e.g., personal history of colon cancer), then the CPT diagnostic procedure code should be used.

Glaucoma

Wisconsin Medicaid covers glaucoma screening examinations when they are performed by or under the direct supervision of an ophthalmologist or optometrist. If a recipient has a previous history of glaucoma, use the CPT diagnostic procedure code when submitting a claim for services. In either case, Wisconsin Medicaid will not separately reimburse a provider for a glaucoma screening if an ophthalmological exam is provided to a recipient on the same DOS. Glaucoma screening and diagnostic examinations are

included in the reimbursement for the ophthalmological exam.

Pap smears

Wisconsin Medicaid reimburses both screening and diagnostic Pap smears. Wisconsin Medicaid will reimburse for both screening and diagnostic Pap smears for the same DOS if abnormalities are found during a screening procedure and a subsequent diagnostic procedure is done as follow-up. Providers are required to document this in the recipient's medical record.

Pelvic and breast exams

Wisconsin Medicaid will cover a screening pelvic and breast exam if it is the only procedure performed on that DOS. A pelvic and breast exam (HCPCS procedure code G0101) performed during a routine physical examination or a problem-oriented office visit is not separately reimbursable but is included in the reimbursement for the physical examination or office visit. When using an Evaluation and Management (E&M) office visit procedure code, the time and resources for the pelvic and breast exam should be factored into the determination of the appropriate level for the office visit.

Providers are not required to submit adjustments to paid claims for screening services performed on and after July 1, 2002.

Prostate cancer

Wisconsin Medicaid reimburses the following tests and procedures provided to an individual for the early detection and monitoring of prostate cancer and related conditions:

- Screening Digital Rectal Examination (DRE) — This test is a routine clinical examination of an asymptomatic individual's prostate for nodules or other abnormalities of the prostate.
- Screening Prostate Specific Antigen (PSA) Blood Test — This test detects the marker for adenocarcinoma of the prostate.
- Diagnostic PSA Blood Test — This test is used when there is a diagnosis or history of prostate cancer or other prostate conditions for which the test is a reliable indicator.

Reimbursement for a DRE is included in the payment for a covered E&M or preventive medical examination when the services are furnished to a recipient on the same day. If the DRE is the only service provided, the applicable procedure code may be reimbursed. The screening and diagnostic PSA tests are separately reimbursable when performed on the same DOS as an E&M or preventive medical exam.

Adjustments are not required

Providers are not required to submit adjustments to paid claims for screening services performed on and after July 1, 2002.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

ATTACHMENT
Wisconsin Medicaid-allowable cancer screening procedure codes

Refer to the October 2002 *Wisconsin Medicaid and BadgerCare Update* (2002-56), titled "Procedure code updates," for maximum allowable fee and recipient copayment information for these procedures. Refer to *Current Procedural Terminology* (CPT) for appropriate diagnostic procedure codes.

Type of screening	Code	Description	Type of service*
Colorectal cancer	G0104	Colorectal cancer screening; flexible sigmoidoscopy	2, F
	G0105	colonoscopy on individual at high risk	2, F
	G0106	alternative to G0104, screening sigmoidoscopy, barium enema	2, F
	G0107	fecal-occult blood test, 1-3 simultaneous determinations	5
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema	2, F
	G0121	colonoscopy on individual not meeting criteria for high risk	2, F
	G0122	barium enema	2, F
Glaucoma	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	1, J
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist	1, J
Mammograms	76085	Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography	4,Q,U
	76092	Screening mammography, bilateral (two view film study of each breast)	4,Q,U
	G0202	Screening mammography, producing direct digital image, bilateral, all views	4,Q,U
Pelvic and breast examinations and pap smears	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	1
	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by cytotechnologist under physician supervision	5
	G0124	requiring interpretation by physician	5
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	5
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening by cytotechnologist under physician supervision	5

Type of screening	Code	Description	Type of service*
Pelvic and breast examinations and pap smears (continued)	G0144	with manual screening and computer-assisted rescreening by cytotechnologist under physician supervision	5
	G0145	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	5
	G0147	Screening cytopathology smears, cervical or vaginal; performed by automated system under physician supervision	5
	G0148	performed by automated system with manual rescreening	5
Prostate cancer	G0102	Prostate cancer screening; digital rectal examination	1
	G0103	Prostate cancer screening; prostate specific antigen test (PSA), total	5

*Type of Service — Description

1	Medical
2	Surgery
4	Diagnostic X-ray-Total charge/Ultrasound-Total charge
5	Diagnostic Lab
F	Free-Standing Ambulatory Surgery Center
J	Vision Care
Q	Diagnostic X-ray-Professional/Ultrasound-Professional
U	Diagnostic X-ray-Medical-Technical/Ultrasound-Technical