wisconsin Medicaid update
and BadgerCare

January 2005 ● No. 2005-07

Wisconsin Medicaid and BadgerCare Information for Providers

To:

- Ambulatory Surgery Centers
- Anesthesiologist Assistants
- Audiologists
- Certified Registered Nurse Anesthetists
- Family Planning Clinics
- Federally Qualified Health Centers
- Independent Labs
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Physical Therapists
- Physician Assistants
- Physician Clinics
- Physicians
- Portable X-ray Providers
- Rehabilitation Agencies
- Rural Health Clinics
- Therapy Groups
- HMOs and Other Managed Care Programs

Procedure Code Updates

Wisconsin Medicaid is adopting 2005 *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes effective for dates of service (DOS) on and after January 1, 2005. Refer to the CPT or HCPCS books for new procedure codes, deleted procedure codes, and procedure codes with description changes in 2005.

Unlike previous years, there will not be a grace period to allow the continued reimbursement of obsolete procedure codes. Obsolete procedure codes submitted for DOS on and after January 1, 2005, will be denied.

Refer to the appropriate maximum allowable fee schedule for more information about Wisconsin Medicaid adopting the new CPT and HCPCS procedure codes, including the applicable performing provider types and pricing policy. Fee schedules incorporating new CPT and HCPCS procedure codes will be published in early January 2005. Fee schedules are updated on a quarterly basis and posted on the Wisconsin Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

The attachments of this *Wisconsin Medicaid and BadgerCare Update* contain new procedure codes, restrictions, and prior authorization requirements. The attachments include:

- Attachment 1 — New procedure codes with restrictions for physician services.
- Attachment 2 — New procedure codes and restrictions for therapy services.
- Attachment 3 — New procedure codes for audiologists.
- Attachment 4 — New procedure code for optometrists.

For More Information

Providers with questions regarding the procedure codes in this *Update* may call Provider Services at (800) 947-9627 or (608) 221-9883.

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 *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
New Procedure Codes with Restrictions for Physician Services

The following new procedure codes are reimbursed by Wisconsin Medicaid with certain restrictions.

Procedure code G0351 (Therapeutic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) is to be used only when the drug or substance is provided by the recipient or is separately billed by a pharmacy. It should not be used with procedure code 90782 for the same drug or substance. Providers should review the physician services max fee schedule to identify any changes in reimbursement policy for these codes and other infusion/injection codes.

In addition, the following digestive system/surgery procedure codes require prior authorization:

- 43644 (Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy [Roux limb 150 cm or less]).
- 43645 (Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption).
- 44137 (Removal of transplanted intestinal allograft, complete).

Note: Wisconsin Medicaid will not reimburse procedure code 43845, which is also a gastric restrictive procedure. Prior authorization requests submitted with this procedure code will not be approved.

ATTACHMENT 2
New Procedure Codes and Restrictions for Therapy Services

The following new therapy procedure codes require prior authorization (PA).

Procedure Code	Description	Allowable Modifiers*	Allowable Provider Types**	Max Fee
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface are less than or equal to 20 square centimeters	GO, GP	34, 35, 38	$27.25
			65	***
97598	total wound(s) surface area greater than 20 square centimeters	GO, GP	34, 35, 38	$34.79
			65	***

*Allowable modifiers
GO = Services delivered under an outpatient occupational therapy plan of care
GP = Services delivered under an outpatient physical therapy plan of care

**Allowable Provider Types

Code	Description
34	Physical Therapists
35	Occupational Therapists
38	Therapy Groups
65	Rehabilitation Agencies

***To be priced individually.

Note: Procedure code 97601 has been discontinued. For approved and modified PAs for procedure code 97601 currently in effect with grant dates prior to January 1, 2005, and expiration dates on and after January 1, 2005, Wisconsin Medicaid will identify and convert procedure code 97601 to 97598.

Since the procedure codes and modifiers will be converted on these requests for PA, providers are required to submit claims using the new codes that replace the discontinued codes for dates of service (DOS) on and after January 1, 2005. For DOS prior to January 1, 2005, providers are required to use the discontinued procedure codes.

Requests for PA that are returned by Wisconsin Medicaid to the provider for more information on and after January 1, 2005, will not be converted by Wisconsin Medicaid. For returned requests that are received by Wisconsin Medicaid on and after January 1, 2005, providers are required to use the new procedure codes for DOS on and after January 1, 2005.

ATTACHMENT 3
New Procedure Codes for Audiologists

Wisconsin Medicaid reimburses the following new procedure codes when a certified audiologist provides the service.

Procedure Code	Description	Max Fee	Restrictions
92620	Evaluation of central auditory function, with report; initial 60 minutes	$37.55	
92621	each additional 15 minutes	$9.50	Procedure code 92621 is allowable only when billed in conjunction with code 92620. A maximum of 2 units may be billed.
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	$36.92	

ATTACHMENT 4
New Procedure Code for Optometrists

Wisconsin Medicaid reimburses the following new procedure code when a certified optometrist provides the service.

Procedure Code	Description	Copay	Max Fee
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	$3.00	$37.55