wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Federally Qualified Health Centers

Optometrists

Physician Clinics

Physicians

Rural Health Clinics

HMOs and Other Managed Care Programs

Wisconsin Medicaid Coverage for Postoperative Management for Cataract Surgery

Effective for dates of service on and after July 1, 2004, separate reimbursement is allowed for postoperative management for cataract surgery when it is performed by a provider other than the surgeon or shared with the surgeon performing the surgery. This *Wisconsin Medicaid and BadgerCare Update* provides coverage information on postoperative management and surgical care for cataract surgery.

Separate Reimbursement for Postoperative Management and Surgical Care

Effective for dates of service (DOS) on and after July 1, 2004, separate reimbursement is allowed for postoperative management when it is performed by a provider other than the surgeon or shared with the surgeon following cataract surgery. Separate reimbursement is allowed when the surgeon performs only the surgical component.

Modifier "55" for Postoperative Management

Postoperative management for cataract surgery is allowed only when a physician or other qualified provider performs the postoperative management during the postoperative period after a different physician has performed the surgical procedure.

Modifier "55" (Postoperative management only) should be used with the appropriate cataract surgery procedure code when another provider delivers all or part of the postoperative management or when the surgeon provides a portion of the postoperative management. Refer to the Attachment of this *Wisconsin Medicaid and BadgerCare Update* for a list of applicable cataract surgery procedure codes that can be reimbursed with modifier "55." Wisconsin Medicaid does not separately reimburse postoperative management (modifier "55") for any procedure codes other than what is specified in this *Update*.

The following criteria apply when using modifier "55":

- Modifier "55" includes all postoperative visits performed by a provider. Quantity is limited to "1" per provider during the entire postoperative period.
- Wisconsin Medicaid will not reimburse more than the global maximum allowable fee for a given surgery, including postoperative management. The sum of reimbursement for separately performed "postoperative management only" and "surgical care only" will not exceed the global fee for cataract surgery, regardless of the number of providers involved. Reimbursement may be reconciled in post-pay audit.

- The provider is reimbursed at 20 percent of the global maximum allowable fee for providing postoperative management for major surgery.
- When two or more provider types (i.e., ophthalmologists, optometrists, or other qualified providers) split postoperative management, reimbursement will be reduced proportionately following post-pay review of the claims and/or medical records.
- The surgeon *and* all postoperative management providers are required to keep a copy of the written transfer agreement with the dates of relinquishment and assumption of care in their recipient's medical record.
- The dates that the postoperative management was provided as indicated on the claim must occur on and after those indicated on the transfer agreement. A claim with a DOS prior to what was indicated on the transfer agreement will be denied during post-pay review and the reimbursement will be recouped.
- Wisconsin Medicaid does not require providers to submit additional supporting clinical documentation as part of the claims submission process for cataract surgery.

Modifier "54" for Surgical Care Only

Submitting claims for surgical care only is allowed when one surgeon performs the cataract surgery and another provider delivers postoperative management. Surgical care only is identified by adding modifier "54" (Surgical care only) to the appropriate procedure code on the claim. Refer to the Attachment for a list of applicable cataract surgery procedure codes that can be reimbursed with modifier "54." Wisconsin Medicaid does not separately reimburse surgical care (modifier "54") for any procedure codes other than what is specified in this *Update*.

Submitting claims for surgical care only is allowed when one surgeon performs the cataract surgery and another provider delivers postoperative management.

The following criteria apply when using modifier "54":

- The modifier is allowable only for the surgeon who performed the surgery.
- The surgeon is reimbursed at 80 percent of the global maximum allowable fee for performing the surgery.
- Wisconsin Medicaid will not reimburse more than what the global period allows for a given surgery. The sum of reimbursement for separately performed "surgical care only" and "postoperative management only" will not exceed the global maximum allowable fee for cataract surgery, regardless of the number of providers involved. Reimbursement may be reconciled in post-pay audit.
- Hospital inpatients: If cataract surgery is performed on a hospital inpatient, only the surgeon may submit claims for the appropriate cataract procedure codes with modifier "54." Any other provider who sees the recipient during the inpatient stay will be reimbursed only for medically necessary evaluation and management procedures (e.g., 99232 [subsequent hospital care]).

Preoperative Management

Preoperative management is included in the reimbursement rate for surgical care and is not separately reimbursable. Wisconsin Medicaid does not separately reimburse modifier "56" (preoperative management only) when submitting claims for preoperative management.

Information on Late Billing

For DOS that are beyond the 365-day timely filing deadline, providers are required to submit the claim or adjustment to Timely Filing Appeals. Along with the claim or adjustment, include a Timely Filing Appeals Request, HCF 13047 (Rev. 08/05) and a copy of this *Update* to the following address:

Wisconsin Medicaid
Timely Filing
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Late claims must be received by Wisconsin Medicaid before September 1, 2005.

Obtaining the Timely Filing Appeals Request

The Timely Filing Appeals Request may be downloaded and printed from the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

Questions about the form or requests for paper copies of the form may be directed to 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/*.

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ATTACHMENT
Cataract Surgery Procedure Codes

The following procedure codes may be used with or without modifiers "54" (Surgical care only) and/or "55" (Postoperative management only).

Procedure Code	Description
66820	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)
66821	laser surgery (eg, YAG laser) (one or more stages)
66830	Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
66840	Removal of lens material; aspiration technique, one or more stages
66850	phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration
66852	pars plana approach, with or without vitrectomy
66920	intracapsular
66930	intracapsular for dislocated lens
66940	extracapsular (other than 66840, 66850, 66852)
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)