ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid
To: All Providers, HMOs and Other Managed Care Programs

2017 CPT and HCPCS Procedure Code Changes

Effective for dates of service on and after January 1, 2017, ForwardHealth has updated covered services, policies, and service limitations to reflect the 2017 *Current Procedural Terminology* and Healthcare Common Procedure Coding System procedure code changes.

Effective for dates of service (DOS) on and after January 1, 2017, ForwardHealth has updated covered services, policies, and service limitations to reflect the 2017 *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure code changes. These changes include the following:

- Enddated, added, and revised CPT and HCPCS procedure codes for BadgerCare Plus and Medicaid
- Added *Current Dental Terminology* (CDT) codes
- Added HCPCS codes to the Provider-Administered Drugs Carve-Out Procedure Codes table
- Added new revenue code for allogeneic stem cell acquisition services
- Added new covered services based on provider recommendations

Procedure Code Changes for BadgerCare Plus and Medicaid

ForwardHealth has updated CPT and HCPCS procedure codes for BadgerCare Plus and Medicaid. These changes include the following:

- Enddated discontinued CPT and HCPCS procedure codes
- Added new CPT and HCPCS procedure codes
- Revised existing CPT and HCPCS procedure codes, when applicable

This *ForwardHealth Update* provides information regarding new policy for certain new procedure codes. Providers should refer to the 2017 CPT and HCPCS code books for complete information on newly added, deleted, and revised procedure codes.

Information on coverage, policy, and maximum allowable fees related to the new CPT and HCPCS procedure codes, including the applicable rendering provider types, is available via the interactive maximum allowable fee schedules on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*. To access the fee schedules, click the Fee Schedules link in the Providers quick links box of the Portal home page, and then click the Interactive Max Fee Search link in the Quicklinks box. Policy information for CPT and HCPCS procedure codes is subject to change; providers should refer to the interactive fee schedules and the Online Handbook for the most current policy and coverage information.

Changes for Durable Medical Equipment

Discontinued Procedure Codes

The following HCPCS procedure codes for durable medical equipment (DME) have been discontinued:

- K0901 (Knee orthosis [KO], single upright, thigh and calf, with adjustable flexion and extension joint [unicentric or polycentric], medial-lateral and rotation

control, with or without varus/valgus adjustment, prefabricated, off-the-shelf)
- K0902 (Knee orthosis [KO], double upright, thigh and calf, with adjustable flexion and extension joint [unicentric or polycentric], medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf)

New Procedure Codes

The following HCPCS procedure codes for DME have replaced procedure codes K0901 and K0902:

- L1851 (Knee orthosis [KO], single upright, thigh and calf, with adjustable flexion and extension joint [unicentric or polycentric], medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf)
- L1852 (Knee orthosis [KO], double upright, thigh and calf, with adjustable flexion and extension joint [unicentric or polycentric], medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf)

Prior authorization (PA) is not required for these procedure codes.

Revised Definitions

The following HCPCS procedure code definitions have changed. These codes are appropriate for replacement only and may no longer be requested with PA for a wheelchair purchase or billed with a wheelchair purchase:

- E0967 (Manual wheelchair accessory, hand rim with projections, any type, replacement only, each)
- E0995 (Wheelchair accessory, calf rest/pad, replacement only, each)
- E2206 (Manual wheelchair accessory, wheel lock assembly, complete, replacement only, each)
- E2220 (Manual wheelchair accessory, solid [rubber/plastic] propulsion tire, any size, replacement only, each)
- E2221 (Manual wheelchair accessory, solid [rubber/plastic] caster tire [removable], any size, replacement only, each)
- E2222 (Manual wheelchair accessory, solid [rubber/plastic] caster tire with integrated wheel, any size, replacement only, each)
- E2224 (Manual wheelchair accessory, propulsion wheel excludes tire, any size, replacement only, each)
- K0015 (Detachable, non-adjustable height armrest, each)
- K0019 (Arm pad, replacement only, each)
- K0037 (High mount flip-up footrest, replacement only, replacement only, each)
- K0042 (Standard size footplate, replacement only, each)
- K0043 (Footrest, lower extension tube, replacement only, each)
- K0044 (Footrest, upper hanger bracket, replacement only, each)
- K0045 (Footrest, complete assembly, replacement only, each)
- K0046 (Elevating legrest, lower extension tube, replacement only, each)
- K0047 (Elevating legrest, upper hanger bracket, replacement only, each)
- K0050 (Ratchet assembly, replacement only)
- K0051 (Cam release assembly, footrest or legrest, replacement only, each)
- K0052 (Swingaway, detachable footrests, replacement only, each)
- K0069 (Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only, each)
- K0070 (Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only, each)
- K0071 (Front caster assembly, complete, with pneumatic tire, replacement only, each)
- K0072 (Front caster assembly, complete, with semi-pneumatic tire, replacement only, each)
- K0077 (Front caster assembly, complete, with solid tire, replacement only, each)
- K0098 (Drive belt for power wheelchair, replacement only)

Procedure codes approved with PA before January 1, 2017, which are dispensed on and after January 1, 2017, will not be reimbursed with the purchase of a wheelchair.

Changes for Emerging Molecular Pathology and Diagnostic Genetic Testing

New Procedure Codes

Several new codes have been added to the CPT code set for emerging molecular pathology and diagnostic genetic testing. The new procedure codes for emerging molecular pathology and diagnostic genetic testing may be covered by ForwardHealth.

Refer to Attachment 1 of this *Update* for a list of molecular pathology and diagnostic genetic testing procedure codes that are covered with PA. Providers are reminded to refer to the fee schedules for information on coverage, as coverage status has changed for many procedure codes.

Fetal Aneuploidy Testing Using Cell-Free Fetal DNA

ForwardHealth covers fetal aneuploidy testing using cell-free fetal DNA in maternal blood tests without PA in cases that meet the guidelines published by the American Congress of Obstetricians and Gynecologists (ACOG). DNA-based noninvasive prenatal tests of fetal aneuploidy are proven and medically necessary as screening tools for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome), and trisomy 13 (Patau syndrome) in **any one** of the following circumstances:

- The member is 35 years of age or older at delivery.
- Fetal ultrasound findings indicate an increased risk of aneuploidy.
- The member has a history of a prior pregnancy with a trisomy.
- The member had positive first- or second-trimester screening test results for aneuploidy.
- There is parental balanced Robertsonian translocation with an increased risk of fetal trisomy 13 or trisomy 21.

DNA-based noninvasive prenatal tests of fetal aneuploidy are unproven and not medically necessary for pregnant women who do not meet the above criteria or women with multiple gestations. The use of the test for the general obstetric population or women with multiple gestations as a first line testing is not covered.

ForwardHealth will cover fetal aneuploidy testing using cell-free fetal nucleic acids in maternal blood for the general obstetric population if they have had a positive result from traditional screening methods in the first or second trimester.

The use of expanded noninvasive prenatal testing panels, which includes additional testing for some micro-deletion syndromes, is not reimbursable.

Reminders

Full Genome and Exome Sequencing

ForwardHealth does not cover full genome and exome sequencing.

Panel Versus Component Coding

In adherence with correct coding guidelines, it is not appropriate to report two or more procedures to describe a service when a single, comprehensive procedure exists that more accurately describes the complete service performed by a provider. ForwardHealth expects providers who perform all components of a genomic sequencing procedure and other molecular multianalyte assays to request PA and submit claims only for the associated panel code.

Testing for Drugs of Abuse

Discontinued Procedure Codes

The following HCPCS procedure codes for testing for drugs of abuse have been discontinued:

- G0477 (Drug test[s], presumptive, any number of drug classes; any number of devices or procedures, [e.g., immunoassay] capable of being read by direct optical observation only [eg, dipsticks, cups, cards, cartridges], includes sample validation when performed, per date of service)
- G0478 (Drug test[s], presumptive, any number of drug classes; any number of devices or procedures, [e.g., immunoassay] read by instrument-assisted direct optical observation [eg, dipsticks, cups, cards, cartridges], includes sample validation when performed, per date of service)

- G0479 (Drug test[s], presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers [eg, utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry], includes sample validation when performed, per date of service)

New Procedure Codes

The following procedure codes for testing for drugs of abuse have been added:

- 80305 (Drug tests[s], presumptive, any number of drug classes, any number of devices or procedures [eg, immunoassay]; capable of being read by direct optical observation only [eg, dipsticks, cups, cards, cartridges] includes sample validation when performed, per date of service)
- 80306 (Drug test[s], presumptive, any number of drug classes, any number of devices or procedures [eg, immunoassay]; read by instrument assisted direct optical observation [eg, dipsticks, cups, cards, cartridges], includes sample validation when performed, per date of service)
- 80307 (Drug test[s], presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers [eg, utilizing immunoassay [eg, EIA, ELISA, EMIT FPIA, IA, KIMS, RIA]], chromatography [eg, GC, HPLC], and mass spectrometry either with or without chromatography, [eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF] includes sample validation when performed, per date of service)
- G0659 (Drug test[s], definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers [but not necessarily stereoisomers], including but not limited to GC/MS [any type, single or tandem] and LC/MS [any type, single or tandem], excluding immunoassays [e.g., IA, EIA, ELISA, EMIT, FPIA] and enzymatic methods [e.g., alcohol dehydrogenase], performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard[s] for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes.

Revised Procedure Codes

The following HCPCS procedure codes for testing for drugs of abuse have been revised:

- G0480 (Drug test[s], definitive, utilizing [1] drug identification methods able to identify individual drugs and distinguish between structural isomers [but not necessarily stereoisomers], including, but not limited to GC/MS [any type, single or tandem] and LC/MS [any type, single or tandem and excluding immunoassays [e.g., IA, EIA, ELISA, EMIT, FPIA] and enzymatic methods [e.g., alcohol dehydrogenase]]; [2] stable isotope or other universally recognized internal standards in all samples [e.g., to control for matrix effects, interferences and variations in signal strength], and [3] method or drug-specific calibration and matrix-matched quality control material [e.g., to control for instrument variations and mass spectral drift]; qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class[es], including metabolite[s] if performed)
- G0481 (Drug test[s] definitive, utilizing [1] drug identification methods able to identify individual drugs and distinguish between structural isomers [but not necessarily stereoisomers], including, but not limited to GC/MS [any type, single or tandem] and LC/MS [any type, single or tandem and excluding immunoassays [e.g., IA, EIA, ELISA, EMIT, FPIA] and enzymatic methods [e.g., alcohol dehydrogenase]]; [2] stable isotope or other universally recognized internal standards in all samples [e.g., to control for matrix effects, interferences and variations in signal strength], and [3] method or drug-specific calibration and matrix-matched quality control material [e.g., to control for instrument variations and mass spectral drift]; qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class[es], including metabolite[s] if performed)
- G0482 (Drug test[s] definitive, utilizing [1] drug identification methods able to identify individual drugs

and distinguish between structural isomers [but not necessarily stereoisomers], including, but not limited to GC/MS [any type, single or tandem] and LC/MS [any type, single or tandem and excluding immunoassays [e.g., IA, EIA, ELISA, EMIT, FPIA] and enzymatic methods [e.g., alcohol dehydrogenase]]; [2] stable isotope or other universally recognized internal standards in all samples [e.g., to control for matrix effects, interferences and variations in signal strength], and [3] method or drug-specific calibration and matrix-matched quality control material [e.g., to control for instrument variations and mass spectral drift]; qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class[es], including metabolites[s] if performed)

- G0483 (Drug test[s] definitive, utilizing [1] drug identification methods able to identify individual drugs and distinguish between structural isomers [but not necessarily stereoisomers], including, but not limited to GC/MS [any type, single or tandem] and LC/MS [any type, single or tandem and excluding immunoassays [e.g., IA, EIA, ELISA, EMIT, FPIA] and enzymatic methods [e.g., alcohol dehydrogenase]]; [2] stable isotope or other universally recognized internal standards in all samples [e.g., to control for matrix effects, interferences and variations in signal strength], and [3] method or drug-specific calibration and matrix-matched quality control material [e.g., to control for instrument variations and mass spectral drift]; qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class[es], including metabolites[s] if performed)

Providers are required to submit claims for presumptive drug tests (when testing for drugs of abuse) with CPT procedure codes 80305-80307. ForwardHealth's coverage policy of presumptive drug tests remains unchanged.

Providers are required to submit claims for definitive drug tests (when testing for drugs of abuse) using newly revised codes G0480–G0483 or code G0659. Procedure code G0659 should be submitted when a simple definitive drug test(s) is performed (refer to HCPCS for the definition of a simple definitive drug test).

For current policy, refer to the Testing for Drugs of Abuse topic (topic #17959) of the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Physician service area of the ForwardHealth Online Handbook.

Dental

New Procedure Codes

The following CDT procedure codes for dental services have been added:

- D1575 (Distal shoe space maintainer – fixed – unilateral)
- D4346 (Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation)

Prior authorization is not required for these procedure codes.

Note: Procedure codes D4346 and D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis) cannot be reported on the same day.

New Policy for Apexification/Recalcification

Apexification/recalcification is a method of inducing a calcified barrier at the apex of a tooth with incomplete root formation.

New Procedure Codes

ForwardHealth will cover two additional apexification/recalcification CDT procedure codes in addition to CDT procedure code D3351 (apexification/recalcification-initial visit [apical closure/calcific repair of perforations, root resorption, etc.]):

- D3352 (apexification/recalcification - interim medication replacement [apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.])

- D3353 (apexification/recalcification - final visit [includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.])

Coverage Policy

ForwardHealth will cover apexification/recalcification without PA when the service is rendered by a provider practicing within his or her scope of licensure and training. The following policies will apply:

- Coverage of apexification/recalcification under CDT procedure code D3352 will be limited to one unit per day with a two-unit maximum per lifetime, per tooth. The service will be allowable for permanent teeth only (tooth numbers 2–15, 18–31).
- Coverage of apexification/recalcification under CDT procedure code D3353 will be limited to one unit per day with a one-unit maximum per lifetime, per tooth. The service will be allowable for permanent teeth only (tooth numbers 2–15, 18–31).
- Following reimbursement of an apexification procedure (initial visit, interim visit, or final visit), ForwardHealth will not reimburse any of the following procedures for a lifetime on the same tooth: pulpal debridement of permanent tooth, partial pulpotomy for apexogenesis, or endodontic therapy of an anterior, bicuspid, or molar tooth.

Physical and Occupational Therapy Evaluations

Discontinued Procedure Codes

The following CPT procedure codes for physical therapy (PT) and occupational therapy (OT) have been discontinued:

- 97001 (Physical therapy evaluation)
- 97002 (Physical therapy re-evaluation)
- 97003 (Occupational therapy evaluation)
- 97004 (Occupational therapy re-evaluation)

New Procedure Codes

New CPT procedure codes for physical medicine and rehabilitation have been introduced. ForwardHealth will cover these new codes following CPT guidelines:

- 97161 (Physical therapy evaluation: low complexity, requiring these components:
  - ✓ A history with no personal factors and/or comorbidities that impact the plan of care;
  - ✓ An examination of body system[s] using standardized tests and measures addressing 1–2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;
  - ✓ A clinical presentation with stable and/or uncomplicated characteristics; and
  - ✓ Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.

  Typically, 20 minutes are spent face to face with the patient and/or family.)

- 97162 (Physical therapy evaluation: moderate complexity, requiring these components:
  - ✓ A history of present problem with 1–2 personal factors and/or comorbidities that impact the plan of care;
  - ✓ An examination of body system[s] using standardized tests and measures addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;
  - ✓ An evolving clinical presentation with changing characteristics; and
  - ✓ Clinical decision making of moderate complexity using measurable assessment of functional outcome.

  Typically, 30 minutes are spent face to face with the patient and/or family.)

- 97163 (Physical therapy evaluation: high complexity, requiring these components:
  - ✓ A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care;

- ✓ An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;
- ✓ A clinical presentation with unstable and unpredictable characteristics; and
- ✓ Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.

Typically, 45 minutes are spent face to face with the patient and/or family.)

- 97164 (Re-evaluation of physical therapy established plan of care, requiring these components:
  - ✓ An examination including a review of history and use of standardized tests and measures is required; and
  - ✓ Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome

  Typically, 20 minutes are spent face-to-face with the patient and/or family.)

- 97165 (Occupational therapy evaluation, low complexity, requiring these components:
  - ✓ An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem;
  - ✓ An assessment[s] that identifies 1–3 performance deficits [ie, relating to physical, cognitive, or psychosocial skills] that result in activity limitations and/or participation restrictions; and
  - ✓ Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment[s], and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance [eg, physical or verbal] with assessment[s] is not necessary to enable completion of evaluation component.

  Typically, 30 minutes are spent face to face with the patient and/or family.)

- 97166 (Occupational therapy evaluation, moderate complexity, requiring these components:
  - ✓ An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance;
  - ✓ An assessment[s] that identifies 3–5 performance deficits [ie, relating to physical, cognitive, or psychosocial skills] that result in activity limitations and/or participation restrictions; and
  - ✓ Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment[s], and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance [eg, physical or verbal] with assessment[s] is necessary to enable patient to complete evaluation component.

  Typically, 45 minutes are spent face to face with the patient and/or family.)

- 97167 (Occupational therapy evaluation, high complexity, requiring these components:
  - ✓ An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive review of physical, cognitive, or psychosocial history related to current functional performance;
  - ✓ An assessment[s] that identifies 5 or more performance deficits [ie, relating to physical, cognitive, or psychosocial skills] that result in

activity limitations and/or participation restrictions; and

- ✓ Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment[s], and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance [eg, physical or verbal] with assessment[s] is necessary to enable patient to complete evaluation component.

Typically, 60 minutes are spent face to face with the patient and/or family.)

- 97168 (Re-evaluation of occupational therapy established plan of care, requiring these components:
  - ✓ An assessment of changes in patient functional or medical status with revised plan of care;
  - ✓ An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and
  - ✓ A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required.

  Typically, 30 minutes are spent face to face with the patient and/or family.)

Note: Procedure codes 97164 and 97168 do not apply to the school-based services benefit.

Prior Authorization

Physical and Occupational Therapy

If a current valid PA request has a procedure code for re-evaluation that will be used on a DOS on or after January 1, 2017, the provider will need to submit a Prior Authorization Amendment Request form, F-11042 (07/12), requesting a change of the old re-evaluation code to the new procedure code. It is the provider's responsibility to submit this request to change codes.

Prior authorizations spanning 2016 and 2017 in which the evaluation/re-evaluation was performed before January 1, 2017, do not require an amendment. The 2016 procedure codes should be billed on claims in these cases.

Providers should continue to use appropriate modifiers on PA requests and claims submissions.

Birth to 3

Prior authorization requests for physical and occupational therapy that were approved through the Birth to 3 PA process, including procedure codes 97001–97004, and were for DOS on or after January 1, 2017, will be converted to add procedure codes 97161–97168. Providers will receive a decision notice when the PAs have been converted. No action is required by providers.

Mammography

Current Procedural Terminology procedure codes and Healthcare Common Procedure Coding System procedure codes now have separate and distinct code sets to describe breast mammography. To align with CPT policy, providers who submit professional claims are required to submit claims for breast mammography with new CPT procedure codes 77065–77067.

Discontinued Procedure Codes

The following CPT procedure codes for mammography have been discontinued:

- 77051 (Computer-aided detection [computer algorithm analysis of digital image data for lesion detection] with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography [List separately in addition to code for primary procedure])
- 77052 (Computer-aided detection [computer algorithm analysis of digital image data for lesion detection] with further review for interpretation, with or without digitization of film radiographic images; screening

mammography [List separately in addition to code for primary procedure])
- 77055 (Mammography; unilateral)
- 77056 (Mammography; bilateral)
- 77057 (Screening mammography, bilateral [2-view study of each breast])

New Procedure Codes

The following CPT procedure codes for mammography have been added:

- 77065 (Diagnostic mammography, including computer-aided detection [CAD] when performed; unilateral)
- 77066 (Diagnostic mammography, including computer-aided detection [CAD] when performed; bilateral)
- 77067 (Screening mammography, bilateral [2-view study of each breast], including computer-aided detection [CAD] when performed)

Prior authorization is not required for these procedure codes. Providers should follow CPT guidelines for using these codes.

Policy Changes

The following HCPCS procedure codes have been revised to align with the definitions of new CPT codes 77065–77067:

- G0202 (Screening mammography, bilateral [2-view study of each breast], including computer-aided detection [CAD] when performed)
- G0204 (Diagnostic mammography, including computer-aided detection [CAD] when performed; bilateral)
- G0206 (Diagnostic mammography, including computer-aided detection [CAD] when performed; unilateral)

The revised HCPCS codes will no longer be covered by ForwardHealth. Providers should instead submit claims for breast mammography with new CPT procedure codes 77065–77067.

Telehealth

As of January 1, 2017, the Centers for Medicare and Medicaid Services has created place of service (POS) code 02 to report services furnished via telehealth.

As of January 1, 2017, CPT has created modifier 95 (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system). *Note:* Healthcare Common Procedure Coding System modifier GT (Via interactive audio and video telecommunications systems) remains active.

At this time ForwardHealth telehealth policy remains unchanged. Any changes to Telehealth policy will be announced in a future *Update*. For current policy, providers should refer to the Telehealth topics (topics #510 and #3829) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Online Handbook.

Intrathecal Infusion Pumps

Discontinued Procedure Codes

The following CPT procedure codes for intrathecal infusion pumps have been discontinued:

- 62310 (Injection[s], of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic)
- 62311 (Injection[s], of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral [caudal])

New Procedure Codes

The following CPT procedure codes for intrathecal infusion pumps have been added:

- 62320 (Injection[s], of diagnostic or therapeutic substance[s] [eg, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance)

- 62321 (Injection[s], of diagnostic or therapeutic substance[s] [eg, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance [ie, fluoroscopy or CT])
- 62322 (Injection[s], of diagnostic or therapeutic substance[s] [eg, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral [caudal]; without imaging guidance)
- 62323 (Injection[s], of diagnostic or therapeutic substance[s] [eg, anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral [caudal]; with imaging guidance [ie, fluoroscopy or CT])

Providers submitting PA requests and subsequent claims for trial bolus doses of either baclofen or opioid pain killers under one of the above CPT procedure codes are required to use modifier U5.

Moderate/Conscious Sedation

New Procedure Codes

Moderate/conscious sedation has been unbundled from numerous procedure codes that previously had been included in the service. The following new CPT procedure codes are allowable by ForwardHealth:

- 99151 (Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age)
- 99152 (Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older)
- 99153 (Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intraservice time [List separately in addition to code for primary service])
- 99155 (Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age)
- 99156 (Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older)
- 99157 (Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time [List separately in addition to code for primary service])

New Revenue Code for Allogeneic Stem Cell Acquisition Services

ForwardHealth will now accept revenue code 0815 (Allogeneic Stem Cell Acquisition/Donor Services), recently created by the National Uniform Billing Committee, when submitted on hospital claims.

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor
- Tissue typing of donor and recipient
- Donor evaluation
- Physician pre-admission/pre-procedure donor evaluation services
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services)
- Post-operative/post-procedure evaluation of donor
- Preparation and processing of stem cells

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the member). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the member) because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment.

As a reminder, all stem cell transplant procedures require PA. Refer to the Transplant Services topic (topic #1400) of the Surgery Services chapter of the Covered and Noncovered Services section of the Hospital, Inpatient service area of the Online Handbook for information.

Provider-Administered Drugs

New HCPCS codes have been added to the Provider-Administered Drugs Carve-Out Procedure Codes table. Refer to the Physician page of the Provider-specific Resources area of the Portal for the table.

New Covered Services Based on Provider Recommendations

Throughout the course of the year, ForwardHealth is asked by providers to consider procedures and services for coverage. Refer to Attachment 2 for a list of procedure codes that have been reviewed and are now covered by ForwardHealth as a result of provider recommendations.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at *www.forwardhealth.wi.gov/*.

P-1250

This *Update* was issued on 1/9/17 and information contained in this *Update* was incorporated in the Online Handbook on 2/6/17.

ATTACHMENT 1
Molecular Pathology and Diagnostic Genetic Test Procedure Codes That Are Covered with Prior Authorization

The following table contains a list of molecular pathology and diagnostic genetic testing *Current Procedural Terminology* (CPT) procedure codes that are covered by ForwardHealth with prior authorization (PA).

Note: This list is not a comprehensive list of covered genetic testing services. This list includes current covered codes that require PA. The information included in the table is subject to change. For the most current information on all covered codes, providers are encouraged to refer to the maximum allowable fee schedules on the ForwardHealth Portal, available by clicking the Fee Schedules link in the Providers box on the Portal home page.

Procedure Code	Description
81161	*DMD (dystrophin)* (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed
81162	*BRCA1, BRCA2 (breast cancer 1 and 2)* (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis
81201	*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence
81203	*APC (adenomatous polyposis coli)* (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants
81211	*BRCA1, BRCA2 (breast cancer 1 and 2)* (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14–20 del 26kb, exon 22 del 510bp, exon 8–9 del 7.1kb)
81213	*BRCA1, BRCA2 (breast cancer 1 and 2)* (eg, hereditary breast and ovarian cancer) gene analysis; uncommon duplication/deletion variants
81214	*BRCA1 (breast cancer 1)* (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14–20 del 26kb, exon 22 del 510bp, exon 8–9 del 7.1kb)
81216	*BRCA2 (breast cancer 2)* (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81222	*CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; duplication/deletion variants
81223	*CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; full gene sequence
81287	*MGMT (O-6-methylguanine-DNA methyltransferase)* (eg, glioblastoma multiforme), methylation analysis

Procedure Code	Description
81292	*MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81294	*MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81295	*MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81297	*MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81298	*MSH6 (mutS homolog 6 [E. coli])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81300	*MSH6 (mutS homolog 6 [E. coli])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81302	*MECP2 (methyl CpG binding protein 2)* (eg, Rett syndrome) gene analysis; full sequence analysis
81304	*MECP2 (methyl CpG binding protein 2)* (eg, Rett syndrome) gene analysis; duplication/deletion variants
81317	*PMS2 (postmeiotic segregation increased 2 [S. cerevisiae])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81319	*PMS2 (postmeiotic segregation increased 2 [S. cerevisiae])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81321	*PTEN (phosphatase and tensin homolog)* (eg, Cowden syndrome, *PTEN* hamartoma tumor syndrome) gene analysis; full sequence analysis
81323	*PTEN (phosphatase and tensin homolog)* (eg, Cowden syndrome, *PTEN* hamartoma tumor syndrome) gene analysis; duplication/deletion variant
81324	*PMP22 (peripheral myelin protein 22)* (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis
81325	*PMP22 (peripheral myelin protein 22)* (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis
81400	Refer to the 2017 CPT code book for full description.
81401	Refer to the 2017 CPT code book for full description.
81402	Refer to the 2017 CPT code book for full description.
81403	Refer to the 2017 CPT code book for full description.
81404	Refer to the 2017 CPT code book for full description.
81405	Refer to the 2017 CPT code book for full description.
81406	Refer to the 2017 CPT code book for full description.
81407	Refer to the 2017 CPT code book for full description.
81408	Refer to the 2017 CPT code book for full description.
81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including *FBN1, TGFBR1, TGFBR2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3,* and *MYLK*

Procedure Code	Description
81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for *TGFBR1, TGFBR2, MYH11,* and *COL3A1*
81413	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KNCE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A
81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1
81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including *CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A,* and *WFS1*
81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for *STRC* and *DFNB1* deletions *in GJB2 and GJB6* genes
81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including *ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR,* and *USH2A*
81437	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes, including *MAX, SDHB, SDHC, SDHD, TMEM127,* and *VHL*
81438	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for *SDHB, SDHC, SDHD,* and *VHL*
81439	Inherited cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy) genomic sequence analysis panel, must include sequencing of at least 5 genes, including DSG2, MYBPC3, MYH7, PKP2, and TTN
81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including *BCS1L*, *C10orf2*, *COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2,* and *TYMP*
81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection

Procedure Code	Description
81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed
81479	Unlisted molecular pathology procedure
81545	Oncology (thyroid), gene expression analysis of 142 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)
81599	Unlisted multianalyte assay with algorithmic analysis

ATTACHMENT 2
New Covered Services Based on Provider Recommendations

Effective for dates of service (DOS) on and after January 1, 2017, the procedure code listed in the following table is covered by ForwardHealth.

Procedure Code	Description	Coverage Criteria
77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)	Coverage allowed without prior authorization (PA)

Effective for dates of service (DOS) on and after January 1, 2017, the procedure codes listed in the following table are covered by ForwardHealth with policy guidelines.

Procedure Code	Description	Coverage Criteria	Specific Policy Guideline
D3352	Apexification/recalcification-interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	Coverage allowed with policy guidelines and without PA	Allowed for dental providers who provide services to members age 0–20. Limited to one unit per day with two units per lifetime maximum per tooth. Allowable for permanent teeth (tooth numbers 2–15 and 18–31).
D3353	Apexification/recalcification-final visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.)	Coverage allowed with policy guidelines and without PA	Allowed for dental providers who provide services to members age 0–20. Limited to one unit per day with one unit per lifetime maximum per tooth. Allowable for permanent teeth (tooth numbers 2–15 and 18–31).