



Update
January 2018

No. 2018-04

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

2018 CPT and HCPCS Procedure Code Changes

Effective for dates of service (DOS) on and after January 1, 2018, ForwardHealth has updated covered services, policies, and service limitations to reflect the 2018 *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
- Changes to HCPCS procedure codes for Provider-Administered Drugs
- Added HCPCS procedure codes for the Family Planning Only Services benefit
- Added HCPCS procedure codes for the Tuberculosis-Related Services-Only benefit
- Changes to the list of services reimbursable only as inpatient hospital services

ForwardHealth is also announcing changes to coverage policy based on annual policy review. These changes include the following:

- Added covered services based on provider recommendations
- Changes to reimbursement for environmental lead investigation

Procedure Code Changes for BadgerCare Plus and Wisconsin Medicaid

ForwardHealth has adopted updates to CPT and HCPCS procedure codes for BadgerCare Plus and Wisconsin Medicaid. These changes include:

- Enddating deleted CPT and HCPCS procedure codes
- Adding new CPT and HCPCS procedure codes
- Adopting revised descriptions for certain CPT and HCPCS procedure codes

Providers should refer to the 2018 CPT and HCPCS code books for a complete list of new, deleted, and revised procedure codes.

This *ForwardHealth Update* provides ForwardHealth coverage information for certain updated procedure codes.

For complete information on ForwardHealth coverage related to the updated CPT and HCPCS procedure codes, including information on allowable rendering provider types and maximum allowable fees, providers should refer to 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 ForwardHealth Online

Handbook for the most current policy and coverage information.

Changes for Durable Medical Equipment

New Procedure Codes

ForwardHealth covers the following new HCPCS procedure codes with an approved prior authorization (PA) request:

- E0953 (Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each)
- E0954 (Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot)

ForwardHealth covers the following new HCPCS procedure codes without PA:

- L3761 (Elbow orthosis [EO], with adjustable position locking joint[s], prefabricated, off-the-shelf)
- L7700 (Gasket or seal, for use with prosthetic socket insert, any type, each)
- L8625 (External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each)
- L8694 (Auditory osseointegrated device, transducer/actuator, replacement only, each)

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. Providers should refer to the fee schedules for complete information about ForwardHealth coverage for emerging molecular pathology and diagnostic genetic testing as coverage status has changed for many procedure codes.

Refer to Attachment 1 of this *Update* for a list of covered molecular pathology and diagnostic genetic testing procedure codes that require PA.

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.

Policy Changes for Surgical Procedures

Implantation of Artificial Heart

ForwardHealth covers the following new CPT procedure codes for implantation of an artificial heart with an approved PA request:

- 33927 (Implantation of a total replacement heart system [artificial heart] with recipient cardiectomy)
- 33928 (Removal and replacement of total replacement heart system [artificial heart])

In addition, ForwardHealth covers the new CPT procedure code 33929 (Removal of a total replacement heart system [artificial heart] for heart transplantation [List separately in addition to code for primary procedure]) without PA.

These codes are allowable when used as a bridge to transplantation of a solid organ. The member must be at risk for imminent death from biventricular heart failure and must have sufficient space in the chest cavity to accommodate the device.

Changes to Coverage Policy for Physical and Occupational Therapy

Procedure Code Changes for Occupational Therapy

Procedure code 97532 (Development of cognitive skills to improve attention, memory, problem solving [includes compensatory training], direct [one-on-one] patient contact, each 15 minutes) for occupational therapy (OT) has been deleted from the CPT code set and replaced with the new procedure code 97127 (Therapeutic interventions that focus on cognitive function [eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning] and compensatory strategies to manage the performance of an activity [eg, managing time or schedules, initiating, organizing and sequencing tasks], direct [one-on-one] patient contact).

ForwardHealth covers procedure code 97127 for OT providers.

PA Requests for OT

If a provider has a current valid PA for procedure code 97532 and will render the service on a DOS on or after January 1, 2018, the provider must submit a Prior Authorization Amendment Request form, F-11042 (07/12), to change the approved procedure code from 97532 to 97127. It is the provider's responsibility to amend the PA.

If a provider has a current valid PA for procedure code 97532 and rendered the service prior to January 1, 2018, the provider does not need to amend the PA. Procedure code 97532 should be billed on claims in these cases.

Providers should continue to use appropriate modifiers on PA requests and claims submissions. All therapy and rehabilitation PA requirements for coverage continue to apply. For more information, refer to the fee schedule on the ForwardHealth Portal, available by clicking the Fee Schedules link in the Providers box on the Portal home page.

PA Requests for Birth to 3

PA requests for OT that were approved through the Birth to 3 PA process will automatically be updated to add procedure code 97127 for DOS on and after January 1, 2018. Providers will receive a decision notice when the PA requests have been updated. No action is required by providers.

New Procedure Codes for Physical Therapy and OT

ForwardHealth covers the new CPT procedure code 97763 (Orthotic[s]/prosthetic[s] management and/or training, upper extremity[ies], lower extremity[ies], and/or trunk, subsequent orthotic[s]/prosthetic[s] encounter, each 15 minutes) for therapy and rehabilitation providers.

In addition, effective January 1, 2018, ForwardHealth covers CPT procedure code 97760 (Orthotic[s] management and training [including assessment and fitting when not otherwise reported], upper extremity[ies], lower extremity[ies] and/or trunk, initial orthotic[s] encounter, each 15 minutes) for therapy and rehabilitation providers.

The description for CPT procedure code 97761 (Prosthetic[s] training, upper and/or lower extremity[ies], initial prosthetic[s] encounter, each 15 minutes) has been revised. ForwardHealth continues to cover procedure code 97761 for therapy and rehabilitation providers.

If a provider with a current valid PA request for procedure code 97761 will render the service on or after January 1, 2018, but the service to be rendered is now more accurately described by procedure code 97760 or 97763 due to the description change for procedure code 97761, the provider is required to submit a PA amendment requesting a change from 97761 to the most appropriate new procedure code. It is the provider's responsibility to amend the PA.

All therapy and rehabilitation PA requirements for coverage continue to apply. For more information, refer to the fee schedule on the Portal, available by clicking the Fee Schedules link in the Providers box on the Portal home page.

Behavioral Treatment Benefit

Effective January 1, 2018, procedure code 97532 (Development of cognitive skills to improve attention, memory, problem solving [includes compensatory training], direct [one-on-one] patient contact, each 15 minutes) has been deleted from the CPT code set. While ForwardHealth did not normally use this code under the behavioral treatment benefit, ForwardHealth did recognize this code for purposes of coordination of benefits if a member's primary insurance required the code.

ForwardHealth will recognize the new HCPCS procedure code G0515 (Development of cognitive skills to improve attention, memory, problem solving [includes compensatory training], direct [one-on-one] patient contact, each 15 minutes), in the same manner as 97532 for coordination of benefits.

PA Requests

If a current valid PA request includes procedure code 97532 and will be used on a DOS on or after January 1, 2018, the provider is required to submit a Prior Authorization Amendment Request, F-11042 (07/12), requesting a change from procedure code 97532 to the procedure code required by the member's primary insurance carrier. It is the provider's responsibility to amend the PA.

Changes to Dental Coverage Policy

New CDT Procedure Codes

ForwardHealth covers the following new CDT procedure codes for dental services without PA:

- D5511 (Repair broken complete denture base, mandibular)
- D5512 (Repair broken complete denture base, maxillary)
- D5611 (Repair resin partial denture base, mandibular)
- D5612 (Repair resin partial denture base, maxillary)
- D5621 (Repair cast partial framework, mandibular)
- D5622 (Repair cast partial framework, maxillary)
- D7979 (Non-surgical sialolithotomy)

ForwardHealth covers the following new CDT procedure codes with an approved PA request:

- D8695 (Removal of fixed orthodontic appliances for reasons other than completion of treatment)
- D9222 (Deep sedation/general anesthesia first 15 minutes)
- D9239 (Intravenous moderate [conscious] sedation/analgesia – first 15 minutes)

Note: All coverage criteria and PA requirements for D9222 are the same as those for D9223. All coverage criteria and PA requirements for D9239 are the same as those for D9243.

Coverage Criteria for D8695

Procedure code D8695 is covered for members ages 0 to 20 years and is allowable once per member per provider. ForwardHealth considers coverage of D8695 on a case-by-case basis with review of the following requirements:

- Supporting documentation explaining the rationale for terminating existing treatment, including, but not limited to, clinical or member considerations.
- A HealthCheck referral has been received.
- A signed statement showing the member's, and/or member's authorized representative, approval of the service.

Changes to Provider-Administered Drugs Coverage Policy

Provider-Administered Drugs

Changes have been made to the Provider-Administered Drugs Carve-Out Procedure Codes table that include new, revised, and enddated HCPCS procedure codes. Refer to the Physician page of the Provider-specific Resources area of the Portal for the table.

Changes to Alpha Hydroxyprogesterone Caproate (17P) Compound Injections and Makena Injections

Both the 17P compound injection and the Makena injection are covered services and are reimbursed fee-for-service for

members enrolled in BadgerCare Plus and Wisconsin Medicaid, including members enrolled in state-contracted HMOs.

The 17P compound injection and the Makena injection are provider-administered drugs and must be administered by a medical professional. Members may not self-administer a 17P compound injection or a Makena injection.

The following HCPCS procedure codes have been added and replace the deleted procedure code J1725:

- J1726 (Injection, hydroxyprogesterone caproate, [Makena], 10 Mg)
- J1729 (Injection, hydroxyprogesterone caproate, not otherwise specified, 10 Mg)

To be reimbursed for the Makena injection, the following must be indicated on the claim according to the completion instructions for the 1500 Health Insurance Claim Form:

- A quantity of 250 mg for a single DOS
- Procedure code J1726
- The National Drug Code (NDC) from the product administered

To be reimbursed for the 17P compound injection (alpha hydroxyprogesterone caproate), the following must be indicated on the claim according to the completion instructions for the 1500 Health Insurance Claim Form (02/12):

- A quantity of 250 mg for a single DOS
- Procedure code J1729
- Modifier U1
- The NDC and description from the bulk powder used to compound the 17P injection

All other clinical criteria and program requirements for both the 17P compound injection and Makena injection will remain the same. Refer to the Pharmacy service area of the Online Handbook for the most current policy and coverage information.

Procedure Code Changes for the Family Planning Only Services Benefit

The following deleted procedure codes have been ended from the Family Planning Only Services benefit as of December 31, 2017:

- Q9984 (Levonorgestrel-releasing intrauterine contraceptive system [Kyleena], 19.5 Mg)
- 71010 (Radiologic examination, chest; single view, frontal)
- 71020 (Radiologic examination, chest, 2 views, frontal and lateral)

The following new procedure codes are allowable under the Family Planning Only Services benefit effective January 1, 2018:

- J7296 (Levonorgestrel-releasing intrauterine contraceptive system, [Kyleena], 19.5 Mg)
- 71045 (Radiologic examination, chest; single view)
- 71046 (Radiologic examination, chest; 2 views)

Procedure Code Changes for the Tuberculosis-Related Services-Only Benefit

The following deleted procedure codes have been ended from the Tuberculosis-Related Services-Only benefit as of December 31, 2017:

- 71010 (Radiologic examination, chest; single view, frontal)
- 71020 (Radiologic examination, chest, 2 views, frontal and lateral)

The following new procedure codes are allowable under the Tuberculosis-Related Services-Only benefit effective January 1, 2018:

- 71045 (Radiologic examination, chest; single view)
- 71046 (Radiologic examination, chest; 2 views)

Changes to Services Reimbursable Only as Inpatient Hospital Services

Changes have been made to the list of services that may be reimbursed only when performed in an inpatient hospital setting. For specific information, refer to the Procedures Reimbursable Only as Inpatient Hospital Services topic

(topic #15297) in the Codes chapter of the Covered and Noncovered Services section of the Online Handbook and the fee schedules.

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 procedures that have been reviewed and have coverage policy changes or are now covered by ForwardHealth as a result of provider recommendations.

Changes to Reimbursement Rate for Environmental Lead Investigation

Effective for DOS on and after January 1, 2018, Wisconsin Medicaid and BadgerCare Plus reimbursement rates for environmental lead investigation and follow-up inspections will increase as authorized in the 2017-19 state biennial budget, Wisconsin Act 59. The new rates will be published in the fee schedule on the Portal.

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 (MCO). MCOs 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 Medicaid Services, the 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, DHS.

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

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This *Update* was issued on 01/10/2018 and information contained in this *Update* was incorporated into the Online Handbook on 03/01/2018.

ATTACHMENT 1

Molecular Pathology and Diagnostic Genetic Test Procedure Codes That Require 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 only 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
81120	<i>ldh1 (isocitrate dehydrogenase 1 [NADP+], soluble)</i> (eg, glioma), common variants (eg, R132H, R132C)
81121	<i>ldh2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial)</i> (eg, glioma), common variants (eg, R140W, R172M)
81161	<i>DMD (dystrophin)</i> (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed
81162	<i>BRCA1, BRCA2 (breast cancer 1 and 2)</i> (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis
81175	<i>ASXL1 (additional sex combs like 1, transcriptional regulator)</i> (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence
81176	<i>ASXL1 (additional sex combs like 1, transcriptional regulator)</i> (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, exon 12)
81201	<i>APC (adenomatous polyposis coli)</i> (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence
81203	<i>APC (adenomatous polyposis coli)</i> (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants
81211	<i>BRCA1, BRCA2 (breast cancer 1 and 2)</i> (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	<i>BRCA1, BRCA2 (breast cancer 1 and 2)</i> (eg, hereditary breast and ovarian cancer) gene analysis; uncommon duplication/deletion variants
81214	<i>BRCA1 (breast cancer 1)</i> (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	<i>BRCA2 (breast cancer 2)</i> (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis

Procedure Code	Description
81222	<i>CFTR</i> (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants
81223	<i>CFTR</i> (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence
81238	<i>F9</i> (coagulation factor IX) (eg, hemophilia B), full gene sequence
81247	<i>G6PD</i> (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)
81248	<i>G6PD</i> (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)
81249	<i>G6PD</i> (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence
81287	<i>MGMT</i> (O-6-methylguanine-DNA methyltransferase) (eg, glioblastoma multiforme), methylation analysis
81292	<i>MLH1</i> (<i>mutL</i> homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81294	<i>MLH1</i> (<i>mutL</i> homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81295	<i>MSH2</i> (<i>mutS</i> homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81297	<i>MSH2</i> (<i>mutS</i> homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81298	<i>MSH6</i> (<i>mutS</i> homolog 6 [<i>E. coli</i>]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81300	<i>MSH6</i> (<i>mutS</i> homolog 6 [<i>E. coli</i>]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81302	<i>MECP2</i> (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis
81304	<i>MECP2</i> (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants
81317	<i>PMS2</i> (postmeiotic segregation increased 2 [<i>S. cerevisiae</i>]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81319	<i>PMS2</i> (postmeiotic segregation increased 2 [<i>S. cerevisiae</i>]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81321	<i>PTEN</i> (phosphatase and tensin homolog) (eg, Cowden syndrome, <i>PTEN</i> hamartoma tumor syndrome) gene analysis; full sequence analysis
81323	<i>PTEN</i> (phosphatase and tensin homolog) (eg, Cowden syndrome, <i>PTEN</i> hamartoma tumor syndrome) gene analysis; duplication/deletion variant
81324	<i>PMP22</i> (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis
81325	<i>PMP22</i> (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis

Procedure Code	Description
81334	<i>RUNX1</i> (<i>runt related transcription factor 1</i>) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy), gene analysis, targeted sequence analysis (eg, exons 3–8)
81335	<i>TPMT</i> (<i>thiopurine S-methyltransferase</i>) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)
81400	Refer to the 2018 CPT code book for full description.
81401	Refer to the 2018 CPT code book for full description.
81402	Refer to the 2018 CPT code book for full description.
81403	Refer to the 2018 CPT code book for full description.
81404	Refer to the 2018 CPT code book for full description.
81405	Refer to the 2018 CPT code book for full description.
81406	Refer to the 2018 CPT code book for full description.
81407	Refer to the 2018 CPT code book for full description.
81408	Refer to the 2018 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 <i>FBN1</i> , <i>TGFBR1</i> , <i>TGFBR2</i> , <i>COL3A1</i> , <i>MYH11</i> , <i>ACTA2</i> , <i>SLC2A10</i> , <i>SMAD3</i> , and <i>MYLK</i>
81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for <i>TGFBR1</i> , <i>TGFBR2</i> , <i>MYH11</i> , and <i>COL3A1</i>
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 <i>ANK2</i> , <i>CASQ2</i> , <i>CAV3</i> , <i>KCNE1</i> , <i>KNCE2</i> , <i>KCNH2</i> , <i>KCNJ2</i> , <i>KCNQ1</i> , <i>RYR2</i> , and <i>SCN5A</i>
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 <i>KCNH2</i> and <i>KCNQ1</i>
81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including <i>CDH23</i> , <i>CLRN1</i> , <i>GJB2</i> , <i>GPR98</i> , <i>MTRNR1</i> , <i>MYO7A</i> , <i>MYO15A</i> , <i>PCDH15</i> , <i>OTOF</i> , <i>SLC26A4</i> , <i>TMC1</i> , <i>TMPRSS3</i> , <i>USH1C</i> , <i>USH1G</i> , <i>USH2A</i> , and <i>WFS1</i>
81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for <i>STRC</i> and <i>DFNB1</i> deletions in <i>GJB2</i> and <i>GJB6</i> 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 <i>ABCA4</i> , <i>CNGA1</i> , <i>CRB1</i> , <i>EYS</i> , <i>PDE6A</i> , <i>PDE6B</i> , <i>PRPF31</i> , <i>PRPH2</i> , <i>RDH12</i> , <i>RHO</i> , <i>RP1</i> , <i>RP2</i> , <i>RPE65</i> , <i>RPGR</i> , and <i>USH2A</i>

Procedure Code	Description
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 <i>MAX</i> , <i>SDHB</i> , <i>SDHC</i> , <i>SDHD</i> , <i>TMEM127</i> , and <i>VHL</i>
81438	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for <i>SDHB</i> , <i>SDHC</i> , <i>SDHD</i> , and <i>VHL</i>
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 <i>DSG2</i> , <i>MYBPC3</i> , <i>MYH7</i> , <i>PKP2</i> , and <i>TTN</i>
81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including <i>BCS1L</i> , <i>C10orf2</i> , <i>COQ2</i> , <i>COX10</i> , <i>DGUOK</i> , <i>MPV17</i> , <i>OPA1</i> , <i>PDSS2</i> , <i>POLG</i> , <i>POLG2</i> , <i>RRM2B</i> , <i>SCO1</i> , <i>SCO2</i> , <i>SLC25A4</i> , <i>SUCLA2</i> , <i>SUCLG1</i> , <i>TAZ</i> , <i>TK2</i> , and <i>TYMP</i>
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
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
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score
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

Changes to Coverage Policy and New Covered Services Based on Provider Recommendations

The following table includes information on changes to coverage policy and new codes covered as a result of provider-recommended review.

Procedure Code	Description	Policy Change
90649-90651	Human papillomavirus vaccine	Coverage allowed on Family Planning Only Services benefit effective 1/1/2018.
96161	Administration of caregiver-focused health risk assessment instrument	HealthCheck providers added as allowable providers effective 1/1/2017.
92558	Evoked otoacoustic emissions, screening	Nurse midwives, licensed midwives, and HealthCheck providers added as allowable providers effective 3/1/2018.
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	Nurse midwives and HealthCheck providers added as allowable providers effective 1/1/2018.
Q4132, Q4133	Cellular/tissue-based product	Coverage allowed for Grafix Core and Grafix Prime effective 1/1/2018. Grafix Core and Grafix Prime are covered for neuropathic diabetic foot ulcers and non-infected venous leg ulcers without prior authorization (PA).
A6545	Gradient compression wrap, non-elastic, below knee 30-50 mm hg, each	Providers are no longer required to submit claim attachments with the claim and a maximum allowable fee has been assigned effective 1/1/2018. Refer to the Requirements for Burn and Gradient Compression Garments topic (topic #3504) of the Submission chapter of the Claims section and the Burn and Gradient Compression Garments topic (topic #11697) of the Compression Garments chapter of the Covered and Noncovered Services section of the Durable Medical Equipment service area of the ForwardHealth Online Handbook, and the maximum allowable fee schedule for more information.
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask	Rental beyond 90 days covered with PA effective 1/1/2018. Refer to the C-Pap, BiPap topic (topic #1863) of the Oxygen and Respiratory Equipment chapter of the Prior Authorization section of the Durable Medical Equipment service area of the Online Handbook for more information.

Procedure Code	Description	Policy Change
E0601	Continuous positive airway pressure (C-Pap) device	Rental beyond 90 days covered with PA effective 1/1/2018. Refer to the C-Pap, BiPap topic (topic #1863) of the Oxygen and Respiratory Equipment chapter of the Prior Authorization section of the Durable Medical Equipment service area of the Online Handbook for more information.
E0562	Humidifier heated, used with positive airway pressure device	Rental beyond 90 days covered with PA effective 1/1/2018. Refer to the Humidifier topic (topic #1864) of the Oxygen and Respiratory Equipment chapter of the Prior Authorization section of the Durable Medical Equipment service area of the Online Handbook for more information.
99204, 99205, 99214, 99215, 99243, 99244, 99245	High-level evaluation and management codes	Podiatry providers added as allowable providers effective 1/1/2018. Documentation must support the level of service billed.
<i>Current Procedural Terminology</i> (CPT) codes considered supplemental vision tests	Supplemental vision tests	Separate reimbursement allowed for supplemental vision tests billed on the same day as a comprehensive or low vision examination when appropriate per CPT and National Correct Coding Initiative coding guidelines effective 1/1/2018.
A9900	Miscellaneous DME supply, accessory, or service component of another HCPCS code	This code is no longer covered effective 1/1/2018. Adaptive equipment will be covered with PA and Healthcare Common Procedure Coding System code E1399. To purchase adaptive equipment, providers must use E1399 and follow the instructions outlined in the "Not Otherwise Classified" Procedure Codes topic (topic #1781) of the "Not Otherwise Classified" Procedure Codes chapter of the Prior Authorization section of the Durable Medical Equipment service area of the Online Handbook.