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ForwardHealth UPDATE

Wisconsin serving you

Your First Source of ForwardHealth Policy and Program Information

2020 CPT AND HCPCS PROCEDURE CODE CHANGES

Effective for dates of service (DOS) on and after January 1, 2020:

- ForwardHealth has updated covered services, policies, and service limitations to reflect the 2020 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
  - Enddated, added, and revised Current Dental Terminology (CDT) codes
- ForwardHealth has added new covered services based on provider recommendations.
- ForwardHealth reminds providers of annual durable medical equipment (DME) maximum allowable fee adjustments consistent with the federal Consolidated Appropriations Act of 2016 and the federal 21st Century Act of 2016.

AFFECTED PROGRAMS
BadgerCare Plus, Medicaid

TO
All Providers, HMOs and Other Managed Care Programs

QUICK LINKS
- ForwardHealth Online Handbook
- Interactive maximum allowable fee schedules

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(2).

Procedure Code Changes for BadgerCare Plus and Medicaid

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

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

Providers should refer to the 2020 CPT and HCPCS procedure code books for a complete list of new, deleted, and revised codes.

For complete information on general 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. 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.

In addition, as a result of the national code set changes, allowable procedure code changes have been made to ForwardHealth-specific coverage policies. Refer to the Online Handbook topics for further information and procedure code changes. Some of the notable changes are as follows.

> **National Correct Coding Initiative restrictions apply to most ForwardHealth services. Providers are expected to follow national correct coding guidelines when submitting claims. For more information on National Correct Coding Initiative guidelines, refer to the National Correct Coding Initiative topic (#11537) of the Online Handbook.**

Restorative Plastic Surgery

ForwardHealth is adding procedure codes allowable for breast reconstructive surgery. ForwardHealth covers breast reconstructive surgery procedure codes without an approved prior authorization (PA) request when performed following a mastectomy for breast cancer. For all other diagnoses, providers should follow coverage requirements under restorative plastic surgery policy.

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For more information regarding allowable International Classification of Diseases diagnosis codes and specific coverage requirements for breast reconstructive surgery, refer to the Breast Reconstruction topic (#560) of the Online Handbook. Refer to the interactive max fee schedules and the Restorative Plastic Surgery and Procedures topics (#13817 and #13797) of the Online Handbook for allowable codes and requirements.

Durable Medical Equipment

ForwardHealth is adding procedure codes allowable for DME. Refer to the interactive max fee schedules or the DME Index for allowable codes and requirements.

Note: If a current valid PA request includes approval for services to be used on a DOS on or after January 1, 2020, the provider will need to submit a Prior Authorization Amendment Request form, F-11042 (07/2012), requesting a change to a new procedure code, as applicable. It is the provider's responsibility to submit this request to change codes.

Durable Medical Equipment Rate Changes

Providers are reminded that the federal Consolidated Appropriations Act of 2016 and the federal 21st Century Cures Act of 2016 limit Medicaid funding for certain DME based on the lowest Medicare max fee rates in each state. The federal Centers for Medicare & Medicaid Services have identified the DME HCPCS codes impacted by the federal legislation.

To comply with the federal legislation, ForwardHealth will again compare max fees for all impacted DME codes to Medicare's annual max fee updates. On January 1, 2020, ForwardHealth will reduce max fees for any impacted DME codes where ForwardHealth's max fee is above the lowest corresponding Medicare max fee for Wisconsin.

For current maximum allowable fees, refer to interactive max fee schedules or the DME Index.

Molecular Pathology

New procedure codes have been added to the CPT code set for emerging molecular pathology and diagnostic genetic testing. Refer to the Medical – Laboratory service area of the interactive max fee schedule for allowable molecular pathology and diagnostic genetic testing procedure codes and requirements.

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Advanced Imaging Services

As a reminder, most advanced imaging services, including computed tomography, magnetic resonance, magnetic resonance elastography, and positron emission tomography imaging, require PA when performed in either outpatient hospital settings or in non-hospital settings (for example, radiology clinics), unless the ordering provider has been granted an exemption from PA requirements for computed tomography and magnetic resonance services.

A private radiology benefits manager, eviCore healthcare, is authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Providers work directly with eviCore healthcare and should submit to eviCore healthcare all information necessary to make a PA determination. eviCore healthcare uses approved national clinical guidelines for imaging services when making PA determinations.

New and Revised Procedure Codes

As a result of CPT code set changes, ForwardHealth is adding procedure codes allowable for advanced imaging services. Refer to the interactive max fee schedules for allowable codes and requirements. For specific coverage requirements, including situations exempt from PA requirements and information for ordering providers who are exempt from PA requirements, refer to the Advanced Imaging Services topic (#10677) of the Online Handbook.

Outpatient Mental Health Services Health and Behavior Assessment and Intervention

As a result of CPT code set changes, ForwardHealth is enddating and adding procedure codes allowable for outpatient mental health services under the health and behavior assessment and intervention policy. Refer to the interactive max fee schedules and the Procedure Codes topic (#6123) of the Online Handbook for allowable codes and requirements.

Note: Some of these services are allowable as telehealth services. Refer to the Telehealth topic (#510) of the Online Handbook for allowable codes and requirements for telehealth services.

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Coverage Limitations

As a reminder, the following coverage limitations continue to apply for the services identified by the new procedure codes:

- The member's primary diagnosis must be physical in nature.
- Per CPT guidelines, providers who provide these services and can report an evaluation and management service are required to submit an evaluation and management services procedure code.

Changes for Physical Medicine and Rehabilitation

As a result of CPT code set changes, ForwardHealth is enddating and adding procedure codes allowable for physical medicine and rehabilitation. Refer to the interactive max fee schedules and the Speech and Language Pathology Procedure Codes topic (#2794), the Occupational Therapy Procedure Codes topic (#2793), and the Occupational Therapy Birth to 3 Procedure Codes topic (#2796) of the Online Handbook for allowable codes and requirements.

Prior Authorization

Occupational Therapy and Speech and Language Pathology

Providers are required to amend any unused PA requests that will be needed for DOS on and after January 1, 2020, to reflect the new procedure codes.

Birth to 3

Approved Birth to 3 PA requests for occupational therapy and speech and language pathology that include a nationally enddated procedure code cannot be processed for DOS on or after January 1, 2020. ForwardHealth will convert these PA requests to add a new national procedure code for DOS on and after January 1, 2020. Providers will receive a decision notice when the PAs have been converted. No action is required by providers.

Cataract Surgery

ForwardHealth is adding allowable procedure codes for cataract surgery. Refer to the interactive max fee schedules and to the Procedure Codes (#2263) and Cataract Surgery (#2265) topics of the Online Handbook for allowable codes and policy.

Changes to Dental Coverage Policy

As a result of CDT code set changes, ForwardHealth is enddating, adding, and revising procedure codes allowable for dental services. Refer to the interactive max fee schedules, the BadgerCare Plus/Medicaid Diagnostic, Preventive,

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Restorative, Endodontics, Periodontics, General Codes topic (#2808), and the BadgerCare Plus/Medicaid Prosthodontics, Maxillofacial Prosthetics, Maxillofacial Surgery, and Orthodontics topic (#2818) of the Online Handbook for allowable codes and requirements.

Note: Providers are required to amend any unused approved PA requests that will be needed for DOS on and after January 1, 2020, to reflect the new procedure codes.

Coverage Limitations

As a reminder, the following coverage limitations still apply for the services identified by the new procedure codes:

- Certain procedure codes are only allowable for members under age 21.
- Some new and revised procedure codes require the appropriate area of the oral cavity code for each requested quadrant. Each quadrant must be indicated on a separate detail. Refer to the Area of Oral Cavity Codes topic (#2806) of the Online Handbook for allowable areas of oral cavity codes.

Provider-Administered Drugs

As a result of HCPCS code set changes, new HCPCS codes have been added to the Provider-Administered Drugs Carve-Out Procedure Codes table according to 2020 CPT and HCPCS procedure code changes. The Physician Provider-specific Resources page of the Portal includes the complete table.

Services Reimbursable Only as Inpatient Hospital Services

As a result of changes to Enhanced Ambulatory Patient Groups assignments, changes have been made to the list of services that may be reimbursed only when performed in an inpatient hospital setting. Refer to the interactive max fee schedules and the Procedures Reimbursable Only as Inpatient Hospital Services topic (#15297) in the Online Handbook for allowable codes and requirements.

> **Responsibilities for which providers are held accountable are described throughout the Online Handbook. For more information, refer to, among others, the following chapters in the Provider Enrollment and Ongoing Responsibilities section of the Online Handbook:**
>
> - **Documentation**
> - **Ongoing Responsibilities**
> - **Sanctions**

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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 A 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.

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 information provided in this ForwardHealth Update is published in accordance with <<insert relevant citations from CE here>>

This Update was issued on 01/06/2020 and information contained in this Update was incorporated into the Online Handbook on 01/22/2020.

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 within 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 within DHS.

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

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

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

PROCEDURE CODE	DESCRIPTION	POLICY CHANGE
E0118	Crutch substitute, lower leg platform, with or without wheels, each	As of January 1, 2020, procedure code E0118 is allowable for reimbursement with an approved prior authorization request for rental only.
E0165	Commode chair, mobile or stationary, with detachable arms	As of January 1, 2020, procedure code E0165 is allowable for reimbursement.
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	As of January 1, 2020, procedure code 33285 is allowable for reimbursement with an approved prior authorization request.
90632	Hepatitis A vaccine (HepA), adult dosage, for intramuscular use	As of January 1, 2020, procedure code 90632 is allowable for reimbursement to pharmacy providers for members ages 6 to 99 years.
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	As of January 1, 2020, procedure code 90653 is allowable for reimbursement for members ages 65 years and older.
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	As of January 1, 2020, procedure code 90682 is allowable for reimbursement for members ages 18 years and older.

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