Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

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Medicaid bulletins contain important policy and billing information and should be shared promptly with billing staff.

Bulletins supplement information in the Medicaid Provider Manual and should be retained with the provider manual for reference. Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.

Please direct questions about bulletins and billing information to Medicaid Provider Services.

Distribution: Independent & Hospital Radiology & Laboratory Providers **February 2002**

Reference: B0200123

This document *replaces* Medicaid Bulletin B0000084 (12/00).
Bulletin B0000084 should be discarded.

Radiology & Laboratory CMS and local codes

The Colorado Medicaid Program uses the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration's (HCFA), Common Procedural Coding System (HCPCS) to identify Medicaid services. HCPCS include codes in the *Physicians' Current Procedural Terminology* (CPT), codes developed by CMS and Medicare, and "local" codes developed by the Department of Health Care Policy and Financing specifically for the Colorado Medicaid Program.

Effective for services provided on and after January 1, 2002, providers may bill Medicaid using the codes listed in this bulletin. These codes for laboratory and x-ray services are in addition to existing procedure codes. Insert this bulletin into the Medicaid Provider Manual for reference. Coding updates and revisions are published in Medicaid bulletins.

Introduction

Please read the following information carefully:

Colorado Medicaid claims must be submitted electronically through the Automated Medical Payments (AMP) system. Electronically mandated claims submitted on paper are processed, denied, and marked "Electronic Filing Required."

Exceptions to electronic filing include:

- Claims from providers who consistently submit fewer than 10 claims per month.
- Claims with service dates more than 365 days old.
- Claims that, by federal or state policy or regulation, require attachments.
- Reconsideration claims.

AMP claims: Submit AMP interactive independent laboratory and x-ray facility services on the electronic Colorado 1500 format using HCPCS. Submit hospital laboratory and x-ray services on the electronic UB-92 claim format, using both HCPCS and revenue codes. Complete the place of service field using the codes identified in the help screens.

Paper claims: If paper claim submission is required, independent laboratories and x-ray facilities must submit charges on the Colorado 1500 claim form using HCPCS. Hospital laboratories and x-ray facilities must submit charges on the UB-92 paper claim form, using both HCPCS and revenue codes.

Procedure code table descriptions: HCPCS codes include codes in the current CPT edition, supplemental codes developed by CMS and Medicare, and codes developed by the Department of Health Care Policy and Financing specifically for the Medicaid program. The Medicaid program adds and deletes codes as they are published in the current CPT and annual CMS coding bulletins. Unless otherwise noted, use CMS codes only when CPT codes are not available.

Code Column: CMS and local codes consist of a letter followed by four numbers and numbers followed by the letter "T". Codes authorized for the Medicaid program may not correspond to codes approved for Medicare billing. This list identifies the CMS and local codes approved for billing the Colorado Medicaid Program. CMS codes that are not identified in this listing are not benefits of the Colorado Medicaid Program.

Fees for blood drawing and specimen collection or handling are not reimbursable to laboratories. *AMP claims for non-payable procedure codes are rejected. Do not submit detail lines for procedure codes, which are not payable to laboratory providers.*

Narrative column: When appropriate, the procedural description defines the billing unit.

Benefit column: The notation "Yes" indicates this service is a benefit of the Colorado Medicaid Program.

Comments Column: Expands on the description, identifies special billing instructions.

Modifiers: Procedure code modifiers describe circumstances that may change or alter payment. The following modifiers are valid for laboratory codes and must be used when applicable (Modifiers that impact pricing are identified by "**"):

-TC**	Technical component	Use when the technical component is performed separately.
-26**	Professional component	Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separated professional and technical component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional and technical components.
-XL	Specimen handling & conveyance from one laboratory to another	Use to certify that the necessary laboratory equipment was not functioning or that the lab is not certified to perform the test.
-91	Repeat clinical diagnostic laboratory test	When it is necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier "-91." This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient. *NOTE: This modifier may not be used (a) when the tests are rerun to confirm initial results, (b) due to testing problems with specimens or equipment, (c) for any other reason when a normal, one-time, reportable result is all that is required, or (d) when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing).*

Note: By regulation, the provider who actually performs the laboratory procedure is the only one who is eligible to bill and receive payment. Physicians may only bill for tests actually performed in their office or clinic. Tests performed by independent laboratories or hospital outpatient laboratories must be billed by the performing laboratory. To receive Medicaid payment, independent and hospital laboratories must be state certified and Medicaid enrolled.

In accordance with the Federal Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), effective September 1, 1992, the Colorado Medicaid Program requires that all providers of clinical laboratory services obtain a CLIA certificate of waiver or certificate of registration to perform and receive payment for laboratory testing services.

CPT lists tests that can be and frequently are done as groups and combinations ("profiles") on automated multichannel equipment. For organ or disease oriented panels (check CPT narrative), use the appropriate code in the range 80048-80092. Tests included in the panel are not to be performed or billed separately when ordered in a group/combination. Panels must be billed with one unit of service.

In accordance with Section 1903(i)(7) of the Social Security Act, Medicaid shall not expend funds for clinical diagnostic laboratory services in excess of the amount that would be recognized under Medicare. Providers therefore may not bill the Medicaid Program for specific tests for which a claim for the same test, inclusive in a panel or multichannel test, has been or will be submitted. Reimbursement received as a result of incorrect billing is subject to recovery.

Please direct questions about billing or the use of this listing to Medicaid Provider Services.

Code	Narrative	Benefit	Comments
Radiology			
G0050	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound	Yes	
G0125	PET imaging regional or whole body; single pulmonary nodule; full- and partial-ring PET scanners only	Yes	
G0126	PET lung imaging of solitary pulmonary nodules, using 2-(fluorine-18)-Fluoro-2-Deoxy-D-Glucose (FDG), following CT (71250/71260 or 71270); initial staging of pathologically diagnosed non-small cell lung cancer	Deleted	Deleted 12/31/01
G0130	Single energy x-ray absorptiometry (SEXA) Bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	Yes	
G0131	Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)	Yes	
G0132	Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	Yes	
G0163	Positron Emission Tomography (PET), whole body, for recurrence of colorectal metastatic cancer	Deleted	Deleted 12/31/01. See G0215.
G0164	Positron Emission Tomography (PET), whole body, for staging and characterization of lymphoma	Deleted	Deleted 12/31/01. See G0221, G0222.
G0165	Positron Emission Tomography (PET), whole body, for recurrence of Melanoma or Melanoma metastatic cancer	Deleted	Deleted 12/31/01. See G0218, G0219.
G0173	Stereotactic Radiosurgery, complete course of therapy in one session	Yes	
G0174	Intensity Modulated Radiation Therapy (IMRT) Plan, per session	Deleted	Deleted 12/31/01

Code	Narrative	Benefit	Comments
G0178	Intensity Modulated Radiation Therapy (IMRT) Delivery to multiple areas with treatment setup and verification images	Deleted	Deleted 12/31/01
G0179	Intensity Modulated Radiation Therapy (IMRT) Planning, includes dose volume nistograms, inverse plan optimization, plan positional accuracy and dose verification	Yes	
G0188	Full length radiography of lower extremity, which includes hip, knee and ankle	Deleted	Deleted 12/31/01
G0202	Screening mammography, producing direct digital image, bilateral, all views	Yes	Effective 01/01/02
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views	Yes	Effective 01/01/02
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views	Yes	Effective 01/01/02
G0210	PET imaging whole body; full- and partial-ring PET scanners only, diagnosis; lung cancer; non-small cell	Yes	Effective 01/01/02
G0211	PET imaging whole body; full- and partial-ring PET scanners only, initial staging; lung cancer; non-small cell	Yes	Effective 01/01/02
G0212	PET imaging whole body; full- and partial-ring PET scanners only, restaging; lung cancer; non-small cell	Yes	Effective 01/01/02
G0213	PET imaging whole body; full- and partial-ring PET scanners only, diagnosis; colorectal cancer	Yes	Effective 01/01/02
G0214	PET imaging whole body; full- and partial-ring PET scanners only, initial staging; colorectal cancer	Yes	Effective 01/01/02
G0215	PET imaging whole body; full- and partial-ring PET scanners only, initial staging; colorectal cancer	Yes	Effective 01/01/02
G0216	PET imaging whole body; full- and partial-staging PET scanners only, diagnosis; melanoma	Yes	Effective 01/01/02
G0217	PET imaging whole body; full- and partial-ring PET scanners only, initial staging; melanoma	Yes	Effective 01/01/02
G0218	PET imaging whole body; full- and partial-ring PET scanners only, restaging; melanoma (replaces G0165)	Yes	Effective 01/01/02
G0219	PET imaging whole body; full- and partial-ring PET scanners only, restaging; melanoma (replaces G0165)	Yes	Effective 01/01/02

Code	Narrative	Benefit	Comments
G0220	PET imaging whole body; full- and partial-ring PET scanners only, diagnosis; lymphoma	Yes	Effective 01/01/02
G0221	PET imaging whole body; full- and partial-ring PET scanners only, initial staging; lymphoma (replaces G0164)	Yes	Effective 01/01/02
G0222	PET imaging whole body; full- and partial-ring PET scanners only, restaging; lymphoma (replaces G0164)	Yes	Effective 01/01/02
G0223	PET imaging whole body or regional; full- and partial-ring PET scanners only, diagnosis; head and neck cancer; excluding thyroid and CNS cancers	Yes	Effective 01/01/02
G0224	PET imaging whole body or regional; full- and partial-ring PET scanners only, initial staging; head and neck cancer; excluding thyroid and CNS cancers	Yes	Effective 01/01/02
G0225	PET imaging whole body or regional; full- and partial-ring PET scanners only, restaging; head and neck cancer; excluding thyroid and CNS cancers	Yes	Effective 01/01/02
G0226	PET imaging whole body; full- and partial-ring PET scanners only, initial staging; esophageal cancer	Yes	Effective 01/01/02
G0227	PET imaging whole body; full- and partial-ring PET scanners only, initial staging; esophageal cancer	Yes	Effective 01/01/02
G0228	PET imaging whole body; full- and partial-ring PET scanners only, restaging; esophageal cancer	Yes	Effective 01/01/02
G0229	PET imaging; metabolic brain imaging for pre-surgical evaluation of refractory seizures; full- and partial-ring PET scanners only	Yes	Effective 01/01/02
G0230	PET imaging; metabolic assessment for myocardial viability following inconclusive spect study; full- and partial-ring PET scanners only	Yes	Effective 01/01/02
G0231	PET, whole body, for recurrence of colorectal or colorectal metastatic cancer; gamma cameras only	Yes	Effective 01/01/02
G0232	PET, whole body, for recurrence of colorectal or colorectal metastatic cancer; gamma cameras only	Yes	Effective 01/01/02
G0233	PET, whole body, for recurrence of colorectal or colorectal metastatic cancer; gamma cameras only	Yes	Effective 01/01/02
G0234	PET, regional or whole body, for solitary pulmonary nodule following CT or for initial staging of pathologically diagnosed non small cell lung cancer; gamma cameras only	Yes	Effective 01/01/02

Code	Narrative	Benefit	Comments
G0236	Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure)	Yes	Effective 01/01/02
G0242	Multi-source photon stereotactic radiosurgery (cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment	Yes	Effective 01/01/02
G0243	Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions	Yes	Effective 01/01/02
R0070	Transportation of portable X-ray equipment & personnel to home or nursing home, per trip to facility or location, one patient seen, per patient	Yes	
R0076	Transportation of portable EKG to facility or location, per patient	Yes	
A4641	Supply of radiopharmaceutical diagnostic imaging agent	Yes	
A4644	Supply of low osmolar contrast material (100-199 mgs of iodine)	Yes	
A4645	Supply of low osmolar contrast material (200-299 mgs of iodine)	Yes	
A4646	Supply of low osmolar contrast material (300-399 mgs of iodine)	Yes	
A9500	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99m Sestamibi, per dose	Yes	
A9502	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99m Tetrofosmin, per unit dose	Yes	
A9503	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99m Medronate, up to 30 mci	Yes	
A9504	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99M Apcitide	Yes	
A9505	Supply of radiopharmaceutical diagnostic imaging agent, Thallous Chloride TL 201, per mci	Yes	
A9507	Supply of radiopharmaceutical diagnostic imaging agent, Indium in 111 Capromab Pendetide, per dose	Yes	

Code	Narrative	Benefit	Comments
A9508	Supply of radiopharmaceutical diagnostic imaging agent, Iobenguane Sulfate I-131, per 0.5 mci	Yes	
A9510	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC99M Disofenin, per vial	Yes	
A9511	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99M, Depreotide, per MCI	Yes	Effective 01/01/02
A9605	Supply of therapeutic radiopharmaceutical, Samarium SM 153 Lexidronamm, 50 mci	Yes	
A9600	Supply of therapeutic radiopharmaceutical, Strontium-89 chloride, per mci	Yes	
A9700	Supply of injectable contrast material for use in echocardiography, per study	Yes	
Q3001	Radioelements for Brachytherapy, any type, each	Yes	
Q3002	Supply of radiopharmaceutical diagnostic imaging agent, Gallium GA 67, per mci	Yes	
Q3003	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99M Bicisate, per unit dose	Yes	
Q3004	Supply of radiopharmaceutical diagnostic imaging agent, Xenon XE 133, per 10 mci	Yes	
Q3005	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99M Mertiatide, per mci	Yes	
Q3006	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99M Glucepatate, per 5 mci	Yes	
Q3007	Supply of radiopharmaceutical diagnostic imaging agent, Sodium Phosphate P32, per mci	Yes	
Q3008	Supply of radiopharmaceutical diagnostic imaging agent, Indium 111-IN Pentetreotide, per 3 mci	Yes	
Q3009	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99M Oxidronate, per mci	Yes	
Q3010	Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99M Labeled red blood cells, per mci	Yes	
Q3011	Supply of radiopharmaceutical diagnostic imaging agent, Chromic Phosphate P32 Suspension, per mci	Yes	

Code	Narrative	Benefit	Comments
Q3012	Supply of oral radiopharmaceutical diagnostic imaging agent, Cyanocobalamin Cobalt CO57, per 0.5 mci	Yes	
S0820	Computerized Corneal Topography, unilateral	Yes	
S8030	Scleral application of Tantalum ring(s) for localization of lesions for proton beam therapy	Yes	Effective 01/01/02
S0830	Ultrasound Pachymetry to determine corneal thickness, with interpretation and report, unilateral	Yes	
S8001	Radiofrequency Stimulation of the Thalamus for tremor accomplished by stereotactic method, including burr holes, localizing and recording techniques and placement of the electrode(s)	Deleted	Deleted 12/31/01
S8037	Magnetic resonance cholangiopancreatography (MRCP)	Yes	Effective 01/01/02
S8080	Scintimammography (Radioimmunoscintigraphy of the breast), unilateral, including supply of radiopharmaceutical	Yes	
S8085	Fluorine-18 Fluorodeoxyglucose (F-18 FDG) imaging using dual-head coincidence detection system (non-dedicated PET scan)	Yes	
0003T	Cervicography	Yes	Effective 01/01/02

Laboratory

Billing information

The provider who actually performs the laboratory test is the only one who is eligible to bill & receive payment. Physicians may only bill for tests actually performed in their office or clinic. Testing performed by independent laboratories or hospital outpatient laboratories must be billed by the laboratory. To receive Medicaid payment, all providers of laboratory services must be CLIA certified & Medicaid enrolled.

CPT lists tests that can be & frequently are done as groups & combinations (profiles) on automated multichannel equipment. For organ or disease oriented panels (check CPT narrative), use the appropriate code in the range 80048-80092. These tests are not to be performed or billed separately when ordered in a group/combination. Procedures must be billed with one unit of service.

In accordance with Section 1903(i)(7) of the Social Security Act, Medicaid shall not expend funds for clinical diagnostic laboratory services in excess of the amount that would be recognized under Medicare. Providers therefore may not bill the Medicaid Program for specific tests for which a claim for the same test, inclusive in a panel or multichannel test, has been or will be submitted. Reimbursement received as a result of incorrect billing is subject to recovery.

0010T	Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response	Yes	Effective 01/01/02
G0026	Fecal Leucocyte examination	Yes	

Code	Narrative	Benefit	Comments
0026T	Lipoprotein, direct measurement, intermediate density lipoproteins (IDL) (remnant lipoproteins)	Yes	Effective 01/01/02
G0103	Prostate cancer screening, Prostate Specific Antigen test (PSA), total	Yes	
G0107	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations	Yes	Bill with 1 unit of service.
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	Yes	
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	Yes	
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	Yes	
G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	Yes	
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening by cytotechnologist under physician supervision	Yes	
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	Yes	
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	Yes	
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	Yes	
P2028	Cephalin flocculation, blood	Yes	
P2029	Congo red, blood	Yes	
P2031	Hair analysis (excluding arsenic)	Yes	
P2033	Thymol turbidity, blood	Yes	

Code	Narrative	Benefit	Comments
P7001	Culture, bacterial, urine; quantitative, sensitivity study	Yes	
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimens	Yes	
Q0112	All potassium hydroxide (KOH) preparations	Yes	
Q0113	Pinworm examinations	Yes	
Q0114	Fern test	Yes	
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous	Yes	
S3620	Newborn Metabolic Screening Panel, includes test kit, postage and the following laboratory tests specified by the State for inclusion in this panel (e.g., galactose, hemoglobin, electrophoresis; hydroxyprogesterone, 17-D, phenylanine (PKU); and thyroxine, total)	Yes	
S3630	Eosinophil count, blood, direct	Yes	Effective 01/01/02
S3700	Bladder tumor-associated antigen test	Deleted	Deleted 12/31/01
S3701	Immunoassay for nuclear matrix protein 22 (NMP-22), quantitative	Yes	Effective 01/01/02
S3708	Gastrointestinal fat absorption study	Yes	
Y8085	ANA Profile, includes: ANA, Anti-DNA, Anti-SM, Anti-RPN, Anti-SSA, Anti-SSB	Yes	
Y8160	Coagulation panel	Yes	
Genotype / Phenotype Resistance Testing			
Colorado Medicaid approves one resistance test per state fiscal year per HIV infected client. If a second resistance test is requested, the provider must submit a Prior Authorization Request (PAR) with supporting documentation justifying the need for the second test. The PAR must be approved prior to testing.			
87901	Genotype Human Immunodeficiency virus type-1 (HIV-1) testing (mutation analysis) for drug resistance	Yes	
87903	Phenotype HIV-1 susceptibility (covers the first 10 drugs that are tested)	Yes	
87904	Add on for each additional drug (up to five drugs) must be used in conjunction with 87903	Yes	
0023T	Predictive Phenotype – infectious agent drug susceptibility phenotype prediction (must be billed with 87901)	Yes	Effective 01/01/02

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