Woman's Choice specialty and procedure/diagnosis code requirements

For BCN HMO℠ (commercial)

Under BCN's Woman's Choice program, procedures can be billed as professional services by specialists without a referral from the member's primary care physician, subject to the requirements outlined in this document and in the **Woman's Choice Referral and Authorization Guidelines**. (Facility services are not included in the Woman's Choice program.) These requirements are effective Jan. 1, 2012, and apply to all BCN HMO℠ (commercial) products. All procedures are for females, except for circumcisions and the initial hospital care for newborns. For additional Woman's Choice program information, refer to the Care Management chapter of the *BCN Provider Manual*.

Note: The specialty of the billing provider is what qualifies the claim for consideration under Woman's Choice.

A For women's health specialists, all professional services can be billed without either a referral or a specific diagnosis code.

For the specialists identified below, all professional services are seen as part of the Woman's Choice program and can be billed without a referral from the member's primary care physician. No specific diagnosis code is required.

- Certified nurse midwife
- Gynecologic oncologist
- Maternal and fetal medicine specialist
- Neonatal perinatal medicine specialist (MD only)
- Nurse practitioner, OB/GYN
- Nurse practitioner, women's health
- Obstetrician/gynecologist
- Reproductive endocrinologist

Exception: One exception to this is surgeries performed outside of the office, which are not included in the Woman's Choice program. Circumcisions (procedure codes *54150 and *54160), can be performed in any setting and still be included in the Woman's Choice program. In addition, the following services are not included in the Woman's Choice program: any service performed in an emergency room or urgent care setting and laboratory services rendered in any setting.

B For primary care-related specialists and provider types, certain professional services can be billed without either a referral or a specific diagnosis code.

For the specialists and provider types identified below, the procedures listed in the table can be billed as professional services without a referral from the member's primary care physician when done in any setting (unless otherwise noted). No specific diagnosis code is required.

Note: The specialists listed in Part A can also perform any procedure listed in this table without a referral from the primary care physician and without a specific diagnosis code.

Procedure code	Location[1]	Specialists / provider types who can bill without a referral			
		Diagnostic / general / nuclear / pediatric radiologists and other designated specialists and provider types[2]	General surgeons	Pharmacists[3]	Other designated specialists [4]
*11976	Office				X
*11981 (eff. Jan. 1, 2017)	Office				X
*19081-*19086	Office	X	X		X
*54150, *54160	Any				X
*57170	Office				X

List is continued on page 2.

[1] Services rendered in an emergency room or urgent care setting are not included in the Woman's Choice program.

[2] "Other designated specialists and provider types" here include practitioners in the following specialties: body imaging, critical care / medical obstetrics-gynecology, clinical genetics, public health / general preventive medicine and public health / welfare agency. The provider type included is freestanding radiology clinics (effective Jan. 1, 2017).

[3] Specialty pharmacy that bills under the medical benefit

[4] "Other designated specialists" here include acute care/adult nurse practitioners, certified nurse practitioners, family nurse practitioners, family practitioners, general practitioners, geriatric nurse practitioners, hospitalists, internists, internist/pediatricians, neonatal nurse practitioners, neonatologists (DO only) and pediatricians.

Woman's Choice specialty and procedure/diagnosis code requirements

For BCN HMO℠ (commercial)

Under BCN's Woman's Choice program, procedures can be billed as professional services by specialists without a referral from the member's primary care physician, subject to the requirements outlined in this document and in the **Woman's Choice Referral and Authorization Guidelines**. (Facility services are not included in the Woman's Choice program.) These requirements are effective Jan. 1, 2012, and apply to all BCN HMO℠ (commercial) products. All procedures are for females, except for circumcisions and the initial hospital care for newborns. For additional Woman's Choice program information, refer to the Care Management chapter of the *BCN Provider Manual*.

Note: The specialty of the billing provider is what qualifies the claim for consideration under Woman's Choice.

B

For primary care-related specialists and provider types, certain professional services can be billed without either a referral or a specific diagnosis code.

List is continued from page 1.

Procedure code	Location[1]	Specialists / provider types who can bill without a referral			
		Diagnostic / general / nuclear / pediatric radiologists and other designated specialists and provider types[2]	General surgeons	Pharmacists[3]	Other designated specialists[4]
*57420–*57421	Office				X
*57452, *57454–*57456, *57461	Office				X
*57511	Office				X
*58300–*58301	Office				X
*59025	Any				X
*59400, *59409–*59410	Any				X
*59425–*59426, *59430	Any				X
*59510, *59514–*59515	Any				X
*59612, *59614	Any				X
*59820, *59840–*59841	Any				X
*76641-*76642	Any	X			X
*76801–*76802, *76805	Any	X			X
*76810–*76821, *76825–*76828	Any	X			X
*76830–*76831, *76856–*76857	Any	X			X
*76945–*76946	Any	X			X
*77063 (eff. March 1, 2018)	Any	X			X
77065-*77067 (eff. Jan. 1, 2017)	Any	X			X
*99460–*99465	Any				X

List is continued on page 3.

[1] Services rendered in an emergency room or urgent care setting are not included in the Woman's Choice program.

[2] "Other designated specialists and provider types" here include practitioners in the following specialties: body imaging, critical care / medical obstetrics-gynecology, clinical genetics, public health / general preventive medicine and public health / welfare agency. The provider type included is freestanding radiology clinics (effective Jan. 1, 2017).

[3] Specialty pharmacy that bills under the medical benefit

[4] "Other designated specialists" here include acute care/adult nurse practitioners, certified nurse practitioners, family nurse practitioners, family practitioners, general practitioners, geriatric nurse practitioners, hospitalists, internists, internist/pediatricians, neonatal nurse practitioners, neonatologists (DO only) and pediatricians.

Woman's Choice specialty and procedure/diagnosis code requirements

For BCN HMO℠ (commercial)

Under BCN's Woman's Choice program, procedures can be billed as professional services by specialists without a referral from the member's primary care physician, subject to the requirements outlined in this document and in the **Woman's Choice Referral and Authorization Guidelines**. (Facility services are not included in the Woman's Choice program.) These requirements are effective Jan. 1, 2012, and apply to all BCN HMO℠ (commercial) products. All procedures are for females, except for circumcisions and the initial hospital care for newborns. For additional Woman's Choice program information, refer to the Care Management chapter of the *BCN Provider Manual*.

Note: The specialty of the billing provider is what qualifies the claim for consideration under Woman's Choice.

B

For primary care-related specialists and provider types, certain professional services can be billed without either a referral or a specific diagnosis code.

List is continued from page 2.

Procedure code	Location[1]	Specialists / provider types who can bill without a referral			
		Diagnostic / general / nuclear / pediatric radiologists and other designated specialists and provider types[2]	General surgeons	Pharmacists[3]	Other designated specialists[4]
A4266	Any				X
G0101	Any				X
J1050, J1950	Any			X	X
J2790	Any			X	X
J7296-J7298 (eff. Jan. 1, 2018, for code J7296)	Any			X	X
J7300–J7304, J7307	Any			X	X
Q0091	Any				X
S0190–S0191	Any			X	X
S0199	Any				X
S0610, S0612–S0613	Any				X

[1] Services rendered in an emergency room or urgent care setting are not included in the Woman's Choice program.

[2] "Other designated specialists and provider types" here include practitioners in the following specialties: body imaging, critical care / medical obstetrics-gynecology, clinical genetics, public health / general preventive medicine and public health / welfare agency. The provider type included is freestanding radiology clinics (effective Jan. 1, 2017).

[3] Specialty pharmacy that bills under the medical benefit

[4] "Other designated specialists" here include acute care/adult nurse practitioners, certified nurse practitioners, family nurse practitioners, family practitioners, general practitioners, geriatric nurse practitioners, hospitalists, internists, internist/pediatricians, neonatal nurse practitioners, neonatologists (DO only) and pediatricians.

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Note: The specialty of the billing provider is what qualifies the claim for consideration under Woman's Choice.

C

For primary care-related specialists, certain professional services can be billed without a referral but must have a specific diagnosis code.

For the specialists identified below, the procedures shown in the table can be billed as professional services without a referral from the member's primary care physician when done in any setting except for an emergency room or urgent care setting. Specific diagnoses codes are required, as indicated in the table below.

- Acute care/adult nurse practitioner
- Certified nurse practitioner
- Family nurse practitioner
- Family practitioner
- General practitioner
- Geriatric nurse practitioner
- Hospitalist
- Internist
- Internist/pediatrician
- Neonatal nurse practitioner
- Neonatologist (DO only)
- Pediatrician

Note: The specialists listed in Part A can also perform any procedure listed in this table without a referral from the primary care physician and without a specific diagnosis code.

You must use the appropriate ICD diagnosis code for each procedure code, as shown in the table that follows:

When billing these procedure codes…	One of these diagnosis codes is required…	
• *96372	• Z01411 • Z01419 • Z0142 • Z113 • Z1231 • Z1239 • Z124 • Z1272 • Z2913 (eff. Oct. 1, 2016) • Z30013 (eff. Oct. 1, 2016) • Z3002 • Z3009 • Z3040 • Z3042 (eff. Oct. 1, 2016)	• Z308 • Z309 • Z3161 • Z317 (eff. Oct. 1, 2016) • Z3200 • Z3201 • Z3202 • Z331 • Z333 (eff. Oct. 1, 2016) • Z3400-Z3403 • Z3480-Z3483 • Z3490-Z3493 • Z392

List is continued on page 5.

Woman's Choice specialty and procedure/diagnosis code requirements

For BCN HMO℠ (commercial)

Under BCN's Woman's Choice program, procedures can be billed as professional services by specialists without a referral from the member's primary care physician, subject to the requirements outlined in this document and in the **Woman's Choice Referral and Authorization Guidelines**. (Facility services are not included in the Woman's Choice program.) These requirements are effective Jan. 1, 2012, and apply to all BCN HMO℠ (commercial) products. All procedures are for females, except for circumcisions and the initial hospital care for newborns. For additional Woman's Choice program information, refer to the Care Management chapter of the *BCN Provider Manual*.

Note: The specialty of the billing provider is what qualifies the claim for consideration under Woman's Choice.

C

For primary care-related specialists, certain professional services can be billed without a referral but must have a specific diagnosis code.

List is continued from page 4.

When billing these procedure codes…	One of these diagnosis codes is required…	
• *99201 through *99205 • *99211 through *99215 • *99383 through *99387 • *99393 through *99397	• R87612 • R87613 • R87620 • R87622 • Z01411 • Z01419 • Z0142 • Z113 • Z1231 • Z1239 • Z124 • Z1272 • Z2913 (eff. Oct. 1, 2016) • Z30011 • Z30015-Z30017 (eff. Oct. 1, 2016) • Z3002 • Z3009	• Z3040 • Z3041 (eff. Oct. 1, 2016) • Z30431 (eff. Oct. 1, 2016) • Z3044-Z3046 (eff. Oct. 1, 2016) • Z308 • Z309 • Z3161 • Z317 (eff. Oct. 1, 2016) • Z3200 • Z3201 • Z3202 • Z331 • Z333 (eff. Oct. 1, 2016) • Z3400-Z3403 • Z3480-Z3483 • Z3490-Z3493 • Z392
• *99221 through *99223 • *99231 through *99239	• Z3800 • Z3801 • Z382 • Z3830 • Z3831	• Z385 • Z3862 • Z3864 • Z3866 • Z3869
• *99401 through *99404[5]	• Z391	

[5] These procedures can be performed by any specialist as long as they are billed with the appropriate diagnosis code.