



# MEDI-CAL UPDATE

## Part 2

Billing and Policy

[www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)

### Outpatient Services • Clinics and Hospitals

#### October 2006 • Bulletin 384

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#### 2006 CPT-4/HCPCS Codes Reminder

Effective November 1, 2006, Medi-Cal will adopt the 2006 CPT-4 and HCPCS Level II codes. Claims billed for dates of service on or after November 1, 2006 must use the appropriate 2006 codes.

Codes to be added, modified or deleted were listed in the July 2006 *Medi-Cal Update*. Policy for new benefits was announced in the September 2006 *Medi-Cal Update*. Provider manual updates are included in this month's *Medi-Cal Update*.

#### Reminder: Genetic Testing and Counseling Code Conversion

Effective for dates of service on or after November 1, 2006, six Medi-Cal interim billing codes for genetic testing and counseling services will be end-dated and converted to HCPCS Level II codes. The code conversions were announced in the September 2006 *Medi-Cal Update*. Provider manual updates are included in this month's *Medi-Cal Update*.

*Updated information is reflected on the following manual replacement pages: [remit cd600 11](#) (Part 1), [remit elect corr600 10](#) (Part 1), [cal child ser 1](#) (Part 2), [gene 1 thru 5](#) (Part 2), [hcpcs ii 2](#) (Part 2), [modif 2](#) (Part 2), [non ph 11](#) (Part 2), [once 1](#) (Part 2), [path an over 3](#) (Part 2), [presum 19](#) (Part 2), [rates max 3 and 7](#) (Part 2), [rates max lab 8](#) (Part 2) and [subacut adu 4](#) (Part 2).*

#### National Drug Code (NDC) Roundtable Discussion

The California Department of Health Services (CDHS) is seeking provider input regarding the implementation of National Drug Codes (NDCs) as they pertain to non-retail pharmacy drugs.

Federal law (Title VI, Section 6002 of Public Law 109-171) currently requires state Medicaid programs to use NDCs or HCPCS Level II codes to report single-source, physician-administered drugs for the purpose of collecting and submitting utilization data. However, the federal Deficit Reduction Act of 2005 requires state Medicaid programs to also begin using NDCs to secure rebates for multiple-source and single-source, physician-administered drugs no later than January 1, 2007, unless the U.S. Department of Health and Human Services specifies that an alternative coding system be used.

CDHS recommends that, effective for dates of service on or after January 1, 2008, the use of Medi-Cal interim codes (X codes) for physician-administered drugs be discontinued. Providers would be required to submit both the most specific HCPCS code (either Level I or Level II) and the NDC for these physician-administered drugs, with reimbursement based on the NDC. CDHS also suggests that the NDC be supplied for claims with CPT-4 codes for vaccines, again with reimbursement based on the NDC.

*Please see NDC Roundtable Discussion, page 2*

**NDC Roundtable Discussion** *(continued)*

The interim CPT-4 and HCPCS Level II code groups described on the preceding page are reimbursable to medical professionals such as physicians and physician groups, outpatient providers such as clinics and various hospital outpatient settings, and home infusion providers. The code groups include, but are not limited to, the following categories:

- Blood factor
- Blood products
- Chemotherapy
- Injections
- Vaccines

CDHS invites all interested parties – including providers, software developers and vendors, clearinghouses, billing agents and electronic submitters – to a roundtable discussion about this topic. Issues to be discussed include understanding the requirements of the federal law, identifying barriers and/or risks involved, and considering solutions to mitigate those risks.

In preparation for this discussion, providers or other attendees are encouraged to submit any questions, comments or feedback via the Medi-Cal Comment Forum, located on the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)). From the home page, providers or other attendees should click the “HIPAA” link in the left hand navigation bar, and then the “Medi-Cal Comment Forum” link.

The Comment Forum may also be used to convey any logistical needs providers or other attendees may require for the roundtable, such as teleconferencing capability (minimum notification 10 days in advance). If an interpreter for the hearing impaired or a listening device is required, please call EDS at 1-800-541-5555 at least 10 days in advance of the roundtable. A Telecommunications Device for the Deaf (TDD) is available for your convenience. A live TDD customer service agent is available Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Medi-Cal values provider-community comments and feedback about the code conversion process. Such comments are very important and are considered very carefully. Please plan to attend the upcoming roundtable discussion below. Attendees are encouraged to arrive early and allow sufficient time for parking.

**October 25, 2006**

**1:30 p.m. to 3 p.m.**

California Department of Health  
Services Auditorium  
1500 Capitol Avenue  
Sacramento, CA 95814

### Reimbursement Clarification for Synagis

Reimbursement criteria have been updated for Synagis, CPT-4 code 90378 (Respiratory Syncytial Virus [RSV] Immune Globulin, intramuscular). In order for providers to be reimbursed properly, recipients must meet one of the following conditions:

- Infants born at less than 29 weeks of gestation and are younger than 12 months of age at the start of the RSV season
- Infants born between 29 and 32 weeks of gestation and are younger than 6 months of age at the start of the RSV season
- Children under 2 years of age with chronic lung disease of prematurity requiring medical treatment (for example, receiving supplemental oxygen, bronchodilators, diuretics or corticosteroids in the previous six months)
- Children with severe immune deficiency
- Infants younger than 2 years of age who have been diagnosed with hemodynamically significant congenital cyanotic or acyanotic heart disease
- Infants born between 32 and 35 weeks of gestation whose physicians document other factors making a child high risk (for example, young children in the home who attend daycare) and children with potential high-risk conditions (for example, an infant with a neuromuscular disorder and respiratory compromise, or child 2 years of age or older receiving immunosuppressive drugs post-transplant). Such situations will be reviewed on a case-by-case basis for authorization of treatment.

*This information is reflected on manual replacement page [inject 9 \(Part 2\)](#).*

### California Children's Services (CCS) Updates

#### Drugs Requiring Separate Authorization

Injectable drug sermorelin acetate (HCPCS code Q0515) has been added to the table of Drugs Requiring Separate Authorization, effective for dates of service on or after November 1, 2006.

#### Service Code Groupings (SCGs)

Effective for dates of service on or after November 1, 2006, updates will be made to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03, 04 and 05.

HCPCS code X7038 has been end-dated retroactively for dates of service on or after July 1, 2006.

In addition, CPT-4 codes 78990, 79900, 88182, 88367 – 88368, 91034 – 91035, 91037 – 91038 and 91040 have been added retroactively for dates of service on or after November 1, [2005](#).

**Reminder:** SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01. These same “rules” apply to end-dated codes.

*The updated information is reflected on manual replacement pages [cal child sar 6 \(Part 2\)](#) and [cal child ser 1 thru 3, 5, 7 thru 17 and 22 \(Part 2\)](#).*

**TAR Requirement for Capsule Endoscopy**

Effective for dates of service on or after November 1, 2006, CPT-4 code 91110 (gastrointestinal tract imaging, intraluminal [eg, capsule endoscopy], esophagus through ileum, with physician interpretation and report) requires prior authorization.

Documentation of either of the following must be submitted with the *Treatment Authorization Request*:

- In the investigation of obscure gastrointestinal bleeding when esophagogastroduodenoscopy, colonoscopy and small bowel radiography are all non-diagnostic
- Suspected small bowel Crohn’s disease when lower endoscopy and small bowel follow-through X-rays are both non-diagnostic

Claims for code 91110 must be billed with modifier -26, -TC or -ZS.

*This information is reflected on manual replacement page medne 7 (Part 2).*

**Carboplatin Benefits Expanded**

Effective retroactively for dates of service on or after August 1, 2003, carboplatin 50 mg (HCPCS code X7582) is reimbursable when billed in conjunction with the following ICD-9 code:

<u>ICD-9 Code</u>	<u>Description</u>
195.0	Malignant neoplasm of head, face and neck

Providers need not take action. Affected claims will be reprocessed automatically.

In addition, providers are reminded that carboplatin is reimbursable in connection with ICD-9 code 194.0 (malignant neoplasm of the adrenal gland).

*The updated information is reflected on manual replacement page chemo 10 (Part 2).*



**Policy Clarification for CPT-4 87800 Laboratory Test**

The Office of Family Planning is clarifying Family PACT (Planning, Access, Care and Treatment) Program policy for the use of CPT-4 code 87800 (infectious agent detection by nucleic acid [DNA or RNA], multiple organisms; direct probe technique).

This screening test is to be used only for detecting Chlamydia trachomatis and Neisseria gonorrhoeae. While laboratories have the ability to detect additional organisms, such as those associated with bacterial vaginosis, vaginal candidiasis and vaginal trichomoniasis, code 87800 is not reimbursable to screen for those or other organisms.

For a list of laboratory tests offered by Family PACT, please refer to the “Family PACT Program 2006 Provisional Clinical Services Benefits Grid” in the “Family PACT Clinical Services and Pharmacy Benefit Update” article, published in the June 2006 *Medi-Cal Update*.



### Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for upcoming sessions are listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

#### *Redding*

**October 27, 2006**

**8:30 am – 4:30 pm**

Redding Convention Center  
700 Auditorium Drive  
Redding, CA 96001  
(530) 225-4133

#### *Palm Springs*

**December 11, 2006**

**8:30 am – 4:30 pm**

SPA Resort in Palm Springs  
100 N. Indian Canyon Drive  
Palm Springs, CA 92262  
(760) 883-1000

#### *Fresno*

**February 22, 2007**

**8:30 am – 4:30 pm**

Picadilly Inn – West Shaw Hotel  
2305 West Shaw Ave.  
Fresno, CA 93711  
(559) 226-3850

#### *San Bernardino*

**April 12, 2007**

**8:30 am – 4:30 pm**

Clarion Hotel & Convention Center  
295 North E Street  
San Bernardino, CA 92401  
(909) 381-6181

For a map and directions for these locations, go to the Family PACT Web site ([www.familypact.org](http://www.familypact.org)) and click “Providers” at the top of the home page, then “Provider Training,” and finally, click the appropriate location. In the “Provider Orientation & Update Session” document, click the “For directions: click here” link.

#### **Registration**

To register for an orientation and update session, go to the Family PACT Web site ([www.familypact.org](http://www.familypact.org)) and click “Providers” at the top of the home page, then “Provider Training,” and finally, click the “Registration” link next to the appropriate date and location and print a copy of the registration form.

Fill out the form and fax it to the Office of Family Planning, Attn: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

*Please see **Provider Orientation**, page 6*

**Provider Orientation** (*continued*)**Check-In**

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

**Note:** Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

**Certificate of Attendance**

Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

**Contact Information**

For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at [www.familypact.org](http://www.familypact.org).

*The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.*

**Updated Contact Information for Laboratory Field Services**

The California Department of Health Services (CDHS) Laboratory Field Services contact information has been updated.

California Department of Health Services  
Laboratory Field Services  
850 Marina Bay Parkway  
Bldg. P, 1<sup>st</sup> Floor  
Richmond, CA 94804-6403  
(510) 620-3800

*The updated information is reflected on manual replacement pages [path an over 7 \(Part 2\)](#) and [radi 2 \(Part 2\)](#). This information has also been updated on manual page [prov guide 3 \(Part 1\)](#).*

**Synagis (Palivizumab) Billing Update**

Effective for dates of service on or after September 1, 2006, providers may no longer bill for Synagis (palivizumab) using local codes X7441 (Synagis 50 mg) and X7439 (Synagis 100 mg).

In accordance with the provisions of *Business and Professions Code* (B&P Code), Section 4051, Pharmacy providers who purchase and then dispense Synagis directly to a physician's office or medical clinic for administration in the medical office or clinic setting, or to a Home Health Agency (HHA) for an approved in-home visit, which may include, but not be limited to, Synagis administration, may bill Medi-Cal through the CAL-POS online system, Computer Media Claims (CMC) or paper claims using the drug's National Drug Code (NDC). The physician's office or clinic will continue to bill Medi-Cal separately for the cost of administration of Synagis. The reimbursement for the cost of Synagis administration is included in an HHA visit, so it should not be billed separately.

*Please see **Synagis**, page 7*

**Synagis** (*continued*)

All claims require an approved *Treatment Authorization Request* (TAR).

- Physicians who purchase Synagis directly for administration may continue to bill with CPT-4 code 90378 (Synagis 50 mg). The administration fee is included in the reimbursement for the drug.
- Providers who meet the criteria for billing Synagis using the drug's NDC must submit TARs to either the Southern Medi-Cal Pharmacy Office by fax at 1-800-869-4325, or the Northern Medi-Cal Pharmacy Office by fax at 1-800-829-4325, as determined by the provider's geographic location.
- Physician providers billing for Synagis with CPT-4 code 90378 must continue to submit TARs to the Los Angeles Medi-Cal Field Office by fax at 1-866-816-4377.

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Remove and replace:    abort 5/6 \*  
                              anest 5/6 \*, 15/16 \*  
                              blood 1/2 \*, 7/8 \*  
                              blood ub 3 thru 6 \*  
                              cal child sar 5/6  
                              cal child ser 1 thru 18, 21/22  
                              cardio 1/2 \*  
                              chemo 1/2, 7 thru 20, 23 thru 26, 29/30  
                              cif co 1/2 \*  
                              dial chr 11/12 \*  
                              eval 3 thru 6 \*  
                              fam planning 7 thru 10 \*  
                              gene 1 thru 6

Remove:                    hcpcs ii 1/2  
Insert:                     hcpcs ii 1 thru 5

Remove and replace:    hcpcs iii 1/2 \*  
                              hyst 3/4 \*  
                              inject 1 thru 10, 13 thru 22, 29 thru 34, 39/40

Remove:                    inject 53 thru 57  
Insert:                     inject 53 thru 58

Remove and replace  
after the  
*Injections* section:    *Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements form \**

Remove and replace:    inject bil ub 1 thru 4 \*

Remove and replace:    inject list 1 thru 19 \*  
                              medi cr op ex 7/8 \*  
                              medi non cpt 1 \*  
                              medi non hcp 1/2 \*

Remove:                    medne 7 thru 10  
Insert:                     medne 7 thru 11  
  
                              medne neu 5/6 \*  
                              modif 1/2  
                              modif app 5/6 \*  
                              modif used 3/4 \*, 9/10 \*  
                              non ph 5/6, 11/12  
                              once 1/2  
                              opthal 5/6 \*  
                              oth hlth cpt 1/2 \*  
                              path an over 3/4, 7  
                              path bil 5 thru 9 \*

Remove:                    path immun 1 thru 3  
Insert:                     path immun 1/2 \*

\* Pages updated due to ongoing provider manual revisions.

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# Instructions for Manual Replacement Pages

# Part 2

October 2006

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Remove and replace: path molec 1 \*

Remove: prescript 7 thru 11  
Insert: prescript 7 thru 9 \*

Remove and replace: presum 17 thru 20  
psych 1/2 \*  
radi 1/2, 5/6  
radi dia 19/20 \*

Insert: radi dia 27 \*

Remove and replace: radi onc 1/2 \*  
rates max 3 thru 8  
rates max lab 1 thru 8  
respir 5/6 \*  
spec 1 thru 4 \*  
subacut adu 3/4  
subacut code 1/2 \*, 7 \*  
supp drug 1/2 \*  
surg aud 3 \*  
surg bil mod 7/8 \*  
surg cardio 1/2 \*, 5/6 \*  
surg integ 1 thru 4 \*

Remove: surg muscu 5  
Insert: surg muscu 5/6 \*

Remove and replace: surg nerv 5 thru 8 \*

Remove: surg nerv 11 thru 15  
Insert: surg nerv 11/12 \*

Remove and replace: tar and non cd1 3/4 \*  
tar and non cd2 7/8 \*  
tar and non cd3 1/2 \*, 5 thru 8 \*  
tar and non cd4 3 thru 7 \*  
tar and non cd5 1 thru 6 \*  
tar and non cd6 3 thru 8 \*  
tar and non cd7 1 thru 3 \*  
tar and non cd9 1/2 \*, 5/6 \*  
ub spec op 5/6 \*

\* Pages updated due to ongoing provider manual revisions.