



MEDI-CAL UPDATE

Part 2

Billing and Policy

www.medi-cal.ca.gov

Outpatient Services • Clinics and Hospitals

January 2007 • Bulletin 387

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Medi-Cal Claim Form Changes May 23, 2007; Transition from Current Form Begins March 26

Effective May 23, 2007, the California Department of Health Services (CDHS) will complete a transition from the current *UB-92 Claim Form* to the new *UB-04* claim form. Beginning March 26, 2007, providers will have a two-month transition period in which they can use both the new and old form to submit claims. The transition period ends at the close of business on May 22, 2007. Beginning May 23, 2007, only the *UB-04* will be accepted for Medi-Cal billing.

All boxes mentioned below are only updates to the new form. Not all new and updated boxes must be filled in for proper billing and payment. New claim form billing instructions will be published in the appropriate Part 2 provider manual in May 2007.

Also, providers using the new forms must continue to use their Medi-Cal provider number until May 23, 2007.

Below are the changes from the current *UB-92* to the new *UB-04* claim form.

Box 1

Old Form

1	2		3 P.A.	
	5 I.L.U. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 C.O.V.D.
12 PATIENT NAME		13 PATIENT ADDRESS		

New Form

1	2	3 P.A.
12 PATIENT NAME		13 PATIENT ADDRESS

Lines are added in Boxes 1 and 2.

Please see Claim Form, page 2

Claim Form (continued)

Box 3

Old Form

3 PATIENT CONTROL NO.				4 TYPE OF BILL	23 MEDICAL RECORD NO.	
8 N-C.D.	9 C-I.D.	10 L-R.D.	11			
				32 OCCURRENCE CODE	36 OCCURRENCE DATE	

New Form

3a PAT. CNTL. #				4 TYPE OF BILL
b MED. REC. #				
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM		7 THROUGH	

Box 3 is divided into two sections (*Patient Control Number* field [Box 3A] and *Medical Record Number* field [Box 3B]). The Medical Record Number moved from Box 23 to Box 3B.

Boxes 12, 14 thru 22, and 32 thru 35

Old Form

12 PATIENT NAME												13 PATIENT ADDRESS							
14 BIRTHDATE		15 SEX	16 MS	17 DATE				18 HR	19 TYPE	20 SRC	21 DHR	22 STAT	23 MEDICAL RECORD NO.		24				
32 OCCURRENCE CODE		33 OCCURRENCE DATE		34 OCCURRENCE CODE		35 OCCURRENCE DATE		36 OCCURRENCE CODE		36 OCCURRENCE DATE		36 OCCURRENCE FROM		36 OCCURRENCE THROUGH					
38												39 VALUE CODES				40			

New Form

8 PATIENT NAME						9 PATIENT ADDRESS											
10 BIRTHDATE		11 SEX	12 DATE	13 HR		14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22 CONDITION CODES		23	24
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE		35 OCCURRENCE DATE		35 OCCURRENCE FROM		35 OCCURRENCE THROUGH			
38												39 VALUE CODES				40	

Box 12 (Patient Name) moved to Boxes 8A and 8B. Boxes 14 – 22 (Birthdate, Sex, Admission information) moved to Boxes 10 – 17. Box 16 (MS) was removed. Boxes 32 – 35 (Occurrence Codes) moved to Boxes 31 – 34

Please see Claim Form, page 3

Claim Form (continued)

Boxes 13, 24 thru 31, and 36

Old Form

13 PATIENT ADDRESS												
21 DHR	22 STAT	23 MEDICAL RECORD NO.				24	25	CONDITION CODES			31	
							26	27	28	29	30	
35 OCCURRENCE CODE		36 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37				
								A				
								B				
								C				
39 VALUE CODES						40 VALUE CODES			41 VALUE			

New Form

9 PATIENT ADDRESS												
a												
d												
o												
g												
17 SIA1	18	19	20	21	CONDITION CODES			26	27	28	29 ACCT STATE	30
	10				22	23	24	25				
34 OCCURRENCE CODE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		36 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37
39 VALUE CODES						40 VALUE CODES			41 VALUE			

Box 13 (Patient Address) was divided in five sections and moved to Boxes 9A – E. Boxes 24 – 30 (Condition Codes) moved to Boxes 18 – 24. Additionally, Boxes 25 – 28 were created for additional condition codes. Box 31 (unlabeled) moved to box 37. Box 36 (Occurrence Span) expanded to Boxes 35 and 36.

Boxes 43 and 50

Old Form

22											
23											
50 PAYER					51 PROVIDER NO.			52 REL INFO	53 ASG BEN	54 PRIOR	
A											
B											
C											

New Form

23	PAGE ____ OF ____				CREATION DATE						
50 PAYER NAME					51 HEALTH PLAN ID			52 REL INFO	53 ASG BEN	54 PRIOR	
A											
B											
C											
58 INSURED'S NAME						59 PTEL	60 INSURED'S UNIQUE ID				

On line 23 in the Box 43 (Code Description) column, “Page ____ Of ____” was added to identify multiple pages for the same claim. The name of Box 50 was changed to “Payer Name.”

Please see Claim Form, page 4

Claim Form (continued)

Boxes 60 and 66

Old Form

USE FROM PATIENT			
59 P.REL.	60 CERT. -SSN-HIC-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
63	65 EMPLOYER NAME	66 EMPLOYER LOCATION	

New Form

59 P.REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	

The name of Box 60 changed to “Insured’s Unique ID.” Box 66 (Employer Location) was removed.

Boxes 67 and 68 thru 75

Old Form

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG. CODES:		73 CODE	74 CODE	75 CODE	76 NUM. DIAG. CD.	77 E-CODE	78
				71 CODE	72 CODE						
74 PRIN. PROCEDURE		75 OTHER PROCEDURE		76 OTHER PROCEDURE		77		78		79	

New Form

67	A	B	C	D	E	F	G	H	I
68	J	K	L	M	N	O	P	Q	
69	a	b	c						
70									
71									
72									
73									
74									
75									
76									
77									
78									
79									

Box 67 (Primary Diagnosis Codes) was enlarged to accommodate future changes in diagnosis codes. Boxes 68 through 75 (Other Diagnosis Codes) changed numbering sequence to Boxes 67A through Q.

Please see **Claim Form**, page 6

Claim Form (continued)

Boxes 80, 81A – E and 84

Old Form

79 P.C.	80	PRINCIPAL PROCEDURE CODE	DATE	81	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
		OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	
a	84 REMARKS							
b								
c								
d								

New Form

74	PRINCIPAL PROCEDURE CODE	DATE	a	OTHER PROCEDURE CODE	DATE	b	OTHER PROCEDURE CODE	DATE	75
	OTHER PROCEDURE CODE	DATE	a	OTHER PROCEDURE CODE	DATE	a	OTHER PROCEDURE CODE	DATE	
	80 REMARKS				81C	d			

UB-04 CMS-1450 © 2005 NUBC
 CMS APPROVAL PENDING
 NUBC™ 80092 04/06/05
 8110 01/01/06 LIC#213257

Box 80 (Principal Procedure Code/Date) moved to Box 74. Boxes 81A – E (Other Procedure Code/Date) moved to Boxes 74A – E. Box 84 (Remarks) moved to Box 80 and was reduced in size.

Boxes 82, 83A – B, 85 and 86

Old Form

82 ATTENDING PHYS. ID	a
	b
83 OTHER PHYS. ID	a
	b
OTHER PHYS. ID.	a
	b
85 PROVIDER REPRESENTATIVE	86 DATE
X	

New Form

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Box 82 (Attending Physician ID) moved to Box 76 for reporting the physician’s NPI. Boxes 83A and B (Other Physician ID) moved to Boxes 77 (Operating) and 78 (Other) for reporting the operating and/or physician’s NPI. Boxes named “Qual” were added to Boxes 76 – 78 to indicate a Medicaid Identifier and help identify atypical provider numbers. Boxes for provider first and last names were also added. Boxes 85 (Provider Representative) and 86 (Date) were removed.

Cancer Detection Programs Forms and Directory Available Only on the Web

The following Cancer Detection Program forms and *Regional Cancer Detection Partnership Contacts Directory* section have been removed from the hard copy and online manuals. The Cancer Detection forms are now available in electronic format only on the “Cancer Detection Programs: Every Woman Counts Downloads” page of the Medi-Cal Web site (www.medi-cal.ca.gov). To access the following three forms, click the “Cancer Detection” link on the Medi-Cal home page.

- *Cancer Detection Programs: Every Woman Counts – Recipient Eligibility Form* (English form)
- *Cancer Detection Programs: Every Woman Counts – Recipient Eligibility Form* (Spanish form)
- *Consent to Participate in Program and Notice of Privacy Practices* (English)

Information on the *Regional Cancer Detection Partnerships* is located on the *Cancer Detection Programs: Every Woman Counts* Web site at: www.dhs.ca.gov/cancerdetection/cancerpartnerships.htm.

This information is reflected on MRPs can detect 2 and 9 thru 11 (Part 2) that were released with the December 2006 Medi-Cal Update.



Family PACT Formulary Update

Effective for dates of service on or after January 16, 2007, Family PACT (Planning, Access, Care and Treatment) is adding oral contraceptive pills to the Family PACT Pharmacy Formulary for dispensing by pharmacies and clinicians. Clinicians must bill these contraceptives using HCPCS code X7706 (oral contraceptive medication).

The following drugs and strengths are added as Family PACT Pharmacy Formulary benefits for Pharmacy providers and clinicians:

- Drospirenone/Ethinyl Estradiol (Yaz tablets) – The 28-day treatment cycle consists of 24 active tablets, each containing 3 mg of drospirenone and 0.02 mg of ethinyl estradiol, as well as four inert tablets.
- Norethindrone/Ethinyl Estradiol/Ferrous Fumarate (Femcon 35 Fe chewable tablets) – The 28-day treatment cycle consists of 21 tablets, each containing 0.4 mg of norethindrone and 0.035 mg of ethinyl estradiol, as well as seven placebo tablets, each containing 75 mg of ferrous fumarate.
- Norethindrone Acetate/Ethinyl Estradiol/Ferrous Fumarate (Loestrin 24 Fe) – The 28-day treatment cycle consists of 24 tablets, each containing 1 mg of norethindrone acetate and 0.02 mg of ethinyl estradiol, as well as four placebo tablets, each containing 75 mg of ferrous fumarate.

The following contraceptive has been added as a Family PACT benefit and may be dispensed by Pharmacy providers only:

- Levonorgestrel/Ethinyl Estradiol (Seasonique tablets) – The 91-day treatment cycle consists of 84 active tablets, each containing 0.15 mg of levonorgestrel and 0.03 mg of ethinyl estradiol, as well as seven tablets, each containing 0.01 mg of ethinyl estradiol.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at www.familypact.org.



Annual Family PACT Updates and Policy Clarification

Effective for dates of service on or after February 1, 2007, the following CPT-4 code information is updated to reflect current Family PACT Program policy. These updates affect billing requirements and restrictions but do not expand program benefits.

CPT-4 Code Additions

The following CPT-4 codes are added to the Family PACT Program:

<u>Code</u>	<u>Description</u>
58110	Endometrial sampling (biopsy) done in conjunction with colposcopy
78456	Acute venous thrombosis imaging
90760	Intravenous infusion, hydration, up to one hour
90761	Intravenous infusion, additional hours
99144	Moderate sedation, first 30 minutes
99145	Moderate sedation, each additional 15 minutes

CPT-4 Code Restriction Modifications

Code 58110 is restricted to females 15 to 55 years of age when clinically indicated for the follow-up of a Pap smear result finding atypical glandular cells (ICD-9-CM code 795.00) and any of the following:

- Atypical endometrial cells, or
- A recent history of abnormal vaginal bleeding pattern suspicious for endometrial hyperplasia or cancer, or
- Recipient is 36 to 55 years of age

This procedure is reimbursable to non-physician medical practitioners. The procedure is payable for all primary diagnosis codes except S60 and S80. A secondary diagnosis code of 795.00 is required or the claim will deny.

Code 78456 is restricted to females. A primary diagnosis code of S1031 and an approved *Treatment Authorization Request* (TAR) are required or the claim will deny.

Codes 90760 and 90761 are restricted to females. The procedure is payable only for primary diagnosis code S2031 or S3035 and requires an approved TAR. The claim must include documentation that a physician administered or supervised the procedure.

Code 99144 is restricted to females 21 to 55 years of age with a primary diagnosis code of S702 and to males 21 to 60 years of age with a primary diagnosis code of S802.

Code 99145 is billed only in conjunction with 99144. It is restricted to females 21 to 55 years of age with a primary diagnosis code of S702 and to males 21 to 60 years of age with a primary diagnosis code of S802.

Code 58100 (endometrial sampling, with or without endocervical sampling, without cervical dilatation, any method, separate procedure) is restricted to females 40 to 55 years of age with a finding of endometrial cells on Pap and a recent history of menstrual irregularity. A secondary diagnosis of 795.09 (other abnormal Pap) is required on the claim or the claim will deny.

CPT-4 Code Deletions

Codes 78455, 90780, 90781 and 99141 are no longer active and are deleted as Family PACT Program benefits.

“Family PACT Program 2006 Provisional Clinical Services Benefits Grid”

The “Family PACT Program 2006 Provisional Clinical Services Benefits Grid” presents the benefits package codes for procedures, medications and contraceptive supplies. Code 58110 is added to the benefits package effective February 1, 2007.

Please see Family PACT, page 9

Family PACT (continued)

The following information replaces the 9th page of the Family PACT Provisional Services Benefits Grid (see June 2006 *Medi-Cal Update* Part 2 bulletin). The bulletin page number to be replaced will vary depending on which bulletin the provider received.

Secondary Diagnosis: Cervical Abnormalities

A secondary diagnosis code is required for cervical abnormality diagnostic and treatment services. These services are restricted to females 15 to 55 years of age.

Other Secondary Services						Complications Services (10)
Diagnosis Codes	Description	Procedures	Laboratory	Supplies	Medications	Description
ICD-9-CM 795.01 795.02 795.03 795.04 795.05 622.2	ASC-US Pap ASC-H Pap LGSIL Pap HGSIL Pap Abn Pap with HPV high risk pos. <u>Presumptive Dx.</u> Leukoplakia, cervix	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies	None	Pelvic infection resulting from cervical treatment Hemorrhage from cervical biopsy or treatment site requiring surgical repair Vaso-vagal episode
795.00	AGC Pap	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 58110 Endometrial biopsy (19)	• 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies 58100ZM Supplies	None	
622.11 622.12 233.1	CIN I (biopsy) CIN II (biopsy) CIN III (biopsy)	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 57511 Cryocautery of cervix (16) 57460 LEEP (16)	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology • 88307 Surgical pathology (17)	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies 57511ZM Supplies 57460ZM Supplies	None	
795.09	Other abnormal Pap	58100 Endometrial biopsy (20)	• 88305 Surgical pathology			

- (10) Complication services for a secondary diagnosis require a primary diagnosis (Sxx.3) and a TAR – see *Family PACT: Treatment Authorization Request (TAR)*.
- (16) Restricted to biopsy proven CIN II or CIN III or persistent CIN I lesions of greater than 12 months.
- (17) Restricted to biopsy specimens collected by LEEP procedure.
- (18) DNA Amplified Probe HPV (High Risk Only) is covered in the following circumstances (see ASCCP, Guidelines 2002) and limited to one per year per client:
 - Reflex HPV DNA testing after an ASC-US cytology result.
 - Follow-up of LSIL cytology result in women less than 21 years of age. HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
 - Follow-up post-colposcopy; Women with Paps read as ASC-H, LSIL, or HPV DNA positive ASC-US in whom CIN is not identified at colposcopy can be followed up at 12 months with HPV DNA testing in lieu of cytology at 6 and 12 months.
 - Follow-up of women with biopsy proven untreated CIN I; HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
 - Follow-up post treatment of CIN II, III: HPV DNA test at least six months after treatment in lieu of follow-up cytology.
- DNA Amplified Probe HPV testing is not covered for a diagnosis of HGSIL Pap, ICD9-CM 795.04 or Leukoplakia cervix, ICD9-CM 622.2.
- (19) Endometrial biopsy is covered only if AGC (atypical glandular cells) cytology result and any of:
 - “Atypical endometrial cells” on AGC cytology result.
 - Woman is having abnormal vaginal bleeding pattern suspicious for endometrial hyperplasia or cancer.
 - Woman is 36 through 55 years of age.
- (20) Endometrial biopsy restricted to women aged 40 years or older with a finding of endometrial cells on Pap and a recent history of menstrual irregularity.

Please see **Family PACT**, page 10

Family PACT (*continued*)**Family PACT Formulary Update**

The following policy clarifications correct errors in the printed version of the Family PACT Pharmacy Formulary only. Online adjudication of pharmacy claims is not affected.

The following formulations are not available:

- Norethindrone and ethinyl estradiol 1 mg – 20 mcg tablets from 28 tablet pack
- Norethindrone and ethinyl estradiol 1.5 mg – 30 mcg tablets from 28 tablet pack

Corrected dosage information:

- Norelgestromin and ethinyl estradiol Transdermal Patch is 0.15mg/20mcg/day.
- Etonogestrel and ethinyl estradiol Vaginal Ring is 0.120mg/15mcg/day.

Permanent Contraception (Sterilization) Policy Clarifications

Postoperative core services refer to the routine care associated with a surgical procedure, including routine postoperative care. Services for the management of complications are not core services. Related reproductive health services are not routine postoperative care. This policy applies to services for both female and male recipients.

Postoperative core services are provided during the global period defined for the surgical procedure. The global period is 90 days for surgical procedure codes 55250, 58600, 58615, 58670 and 58671.

At the end of the 90-day post-operative period, or earlier as determined by the clinician, sterilized clients are no longer eligible for the Family PACT Program. This clarification applies to both female and male recipients that have elected permanent contraception.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at www.familypact.org.

Capsule Endoscopy Split-Billing Reimbursement Policy Update

Effective for dates of service on or after February 1, 2007, the split-bill reimbursement for the professional component of CPT-4 code 91110 (gastrointestinal tract imaging, intraluminal [eg, capsule endoscopy], esophagus through ileum, with physician interpretation and report) will change from 85 to 15 percent.

Claims for code 91110 must be billed with modifier 26, TC or ZS, and require prior authorization. Information about reimbursement rates can be found on the Medi-Cal Web site (www.medi-cal.ca.gov) by clicking “Medi-Cal Rates” under the “Provider Reference” heading.

Plan B Update

On August 26, 2006, the federal Food and Drug Administration (FDA) announced the approval of the emergency contraceptive drug Plan B as being over-the-counter (OTC) for women 18 years of age or older. Though the FDA has removed the prescription requirement as noted, access to Plan B as a covered drug through the fee-for-service Medi-Cal program will continue to require a prescription for all recipients due to restrictions in federal Medicaid drug coverage statutes (Social Security Act, Section 1927).

The federal Medicaid requirement for a prescription is met by a prescription generated by a pharmacist pursuant to standardized procedures or protocols developed by the pharmacist and an authorized prescriber, who is acting within his or her scope of practice, or the standardized procedures or protocols established by the California Board of Pharmacy pursuant to *Business and Professions Code* (B&P Code), Section 4052.

The statewide standardized protocol and information regarding the dispensing of emergency contraception under protocol can be obtained from the Board of Pharmacy Web site at:

www.pharmacy.ca.gov/consumers/emergency_cont.htm.

Termination of Intrauterine Device (IUD) – Code X1512

Effective for dates of service on or after February 1, 2007, HCPCS Level III code X1512 (CU-7, Lippes Loop® or unspecified IUD) is no longer reimbursable.

Codes X1522 (ParaGard®) and X1532 (Mirena Intrauterine System®) remain benefits for IUD devices.

This information is reflected on manual replacement pages fam planning 7 (Part 2) and non ph 11 (Part 2).

Updated Benefit Status of Select Drug and Medicine Codes

Effective February 1, 2007, HCPCS code J3490 (unclassified drugs) is a Medi-Cal benefit and should be used instead of CPT-4 codes 90399 and 90749. Effective February 1, 2007, CPT-4 codes 90399 (unlisted immune globulin) and 90749 (unlisted vaccine/toxoid) are no longer benefits.

HCPCS code J3490 is to be reimbursed “By Report” and an invoice is required. When billing code J3490, providers must include a diagnosis code and document the following in the *Remarks* area of the claim:

- Medical necessity for using the drug
- Name, dosage, strength and unit price of the medication

HCPCS code J3590 (unclassified biologics) requires a *Treatment Authorization Request* (TAR) and must be billed with an invoice for pricing. Providers must also document the following on the TAR:

- Medical necessity for using the drug
- Name, dosage, strength and unit price of the medication

Note: Providers should use codes J3490 and J3590 only if an appropriate injection code is not found.

This information is reflected on manual replacement pages inject 2 and 3 (Part 2), inject list 9 and 18 (Part 2), non ph 5 and 11 (Part 2) and tar and non cd9 1 (Part 2).

Synagis Guidelines Revisions

In October 2006, the American Academy of Pediatrics published “Guidelines for Bronchiolitis,” which revised the previous guidelines for Synagis. The updated information, effective immediately, is as follows.

Dosage

The Respiratory Syncytial Virus (RSV) season generally occurs during the months of November through March. The severity, onset, peak and end of season cannot be predicted accurately. In a typical season, children receive five monthly doses of Synagis, beginning early in November. For children meeting the guidelines, up to six doses may be authorized for use between October and the following May. Once a child qualifies for initiation of prophylaxis, administration should continue throughout the season and not stop at the point an infant reaches an age cutoff.

Please see Synagis, page 12

Synagis (continued)

Risk Categories

It is important to protect babies at high risk, who fall into three major categories:

- Chronic lung disease and less than 24 months old at the start of the RSV season, especially those who have received oxygen or medications within six months of the start of the RSV season.
- Prematurity
 - Born at 28 weeks gestation or less, first RSV season, less than 12 months of age at the start of the season
 - Born between 29 and 32 weeks gestation, first RSV season, less than 6 months of age at the start of the season
 - Born at 32 – 35 weeks gestation, less than 6 months of age at the start of the season with two or more of the risk factors below:
 - ❖ child care attendance
 - ❖ school-aged children in the home
 - ❖ environmental air pollutants, including second-hand tobacco smoke
 - ❖ congenital abnormalities of the airways
 - ❖ severe neuromuscular disease
- Congenital heart disease and less than 24 months old at the start of the RSV season, especially those on medication for congestive heart failure, or those with pulmonary hypertension or cyanosis

Children with severe immune deficiency (for example, severe combined immunodeficiency, acquired immunodeficiency syndrome, transplant recipients or children immunocompromised due to chemotherapy) may need prophylaxis, including another season or more, up to 48 months of age at the start of RSV season.

This information is reflected on manual replacement pages inject 9 and 10 (Part 2).

CPT-4 Code 13101 – Reimbursement Restriction

Effective for dates of service on or after February 1, 2007, CPT-4 code 13101 (repair, complex, trunk; 2.6 cm to 7.5 cm) is no longer reimbursable for assistant surgeon services.

This information is reflected on manual replacement page tar and non cd1 3 (Part 2).

Therapeutic Injection Benefits Update

Effective for dates of service on or after February 1, 2007, the following CPT-4 codes are Medi-Cal benefits:

CPT-4 <u>Code</u>	<u>Description</u>
90773	Therapeutic, prophylactic or diagnostic injections (specify substance or drug); intra-arterial
90774	intravenous push, single or initial substance/drug
90775	each additional sequential intravenous push of a new substance/drug

Providers may bill for CPT-4 code 90775 in conjunction with codes 90765, 90774, 96409 and 96413.

This information is reflected on manual replacement pages inject 4 (Part 2) and tar and non cd9 1 (Part 2).

Expanded Coverage for Docetaxel Reimbursement

Effective February 1, 2007, reimbursement for HCPCS code X7638 (docetaxel) will be expanded to include the following ICD-9-CM diagnosis codes:

<u>ICD-9-CM Diagnosis Code</u>	<u>Description</u>
151.2 – 151.9	Malignant neoplasm of stomach
188.1 – 188.4, 188.9	Malignant neoplasm of bladder

This information is reflected on manual replacement page chemo 18 (Part 2).

CPT-4 Code 87904 Policy Change

Effective February 1, 2007, the number of daily units that may be reimbursed for CPT-4 code 87904 (infectious agent phenotype analysis by nucleic acid [DNA or RNA] with drug resistance tissue culture analysis, HIV 1; each additional drug tested) has been increased to 10 drug tests per day for the same patient, same provider and same date of service.

This information is reflected on manual replacement pages path micro 4 (Part 2) and tar and non cd8 1 (Part 2).

HCPCS Code S3625 Rate Update

Effective January 1, 2007, the rate for HCPCS code S3625 (Maternal Serum Multiple Marker [MSMM], including Alpha-Fetoprotein [AFP], estriol and human Chorionic Gonadotropin [hCG]) has increased from \$105 to \$155. This rate change is in accordance with Senate Bill 155.

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Remove and replace: *Contents for Clinics and Hospitals Billing and Policy* vii/viii *
chemo 17/18
fam planning 7/8
inject 1 thru 4, 9 thru 12
inject list 9/10, 17/18
non ph 3/4 *, 5/6, 11/12
path micro 3/4
presum 17/18 *

Insert new section
after the *Why You
Cannot Get Presumptive
Eligibility Benefits*

form: prov bil 1 thru 4 *

Insert after the new
*Provider Billing
after Beneficiary
Reimbursement
(Conlan v. Shewry)*

section above: *Request for Beneficiary Reimbursement Letter (Letter 08) **

Remove and replace: tar and non cd1 3/4
tar and non cd8 1/2
tar and non cd9 1/2

* Pages updated due to ongoing provider manual revisions.