



Outpatient Services • Clinics and Hospitals

August 2007 • Bulletin 395

Contents

Medi-Cal Training Seminars

New Claim Form Submission Reminders	1
RSV Update 2007	1
Diagnosis Code Expansion for Diagnostic Mammography	2
Gender Restrictions for Gonadotropin Follicle Stimulating and Luteinizing Hormones Diagnostic Codes	3
Documentation Requirement Removed for Fetal Fibronectin Testing	3
New Maternal Serum Screen Benefit	3
Decitabine Dosing Methods Update	3
New Presumptive Eligibility Program Benefits	4
Apligraf Billing Update	4
Laparoscopic Colectomy Rates Update.....	4
Oxaliplatin Code Conversion and Policy Update	4
Reminder: Manual Pricing for Intraocular Lenses	5
TAR Not Required for Certain Assistant Surgeon Services.....	5
No Additional Documentation Required for Extended Ophthalmoscopy and Fundus Photography Procedures	5
E&M Consultation and Hospital Care Codes Clarification and Update	5
Radiation Codes Reorganization.....	6
Family PACT:	
New Provider Manual Update.....	7
Provider Orientation and Update Sessions.....	7
Contract Drugs List Available at Epocrates, Inc.....	9
CCS Service Code Groupings Update	9

New Claim Form Submission Reminders

The following are reminders for correctly submitting the new *UB-04* claim form:

- *UB-04* claim forms must be printed on scanner-quality paper. Forms printed on low-quality or thin paper are not acceptable, as they tear easily during the scanning process.
 - Original claim forms must be submitted. Copies will not be accepted.
 - All provider information fields must be completed.
 - Claim information must be properly entered within the borders of the appropriate area or box. Claims with the information in the middle or outside of a border may be rejected.
 - Code 001 should be entered on line 23 of field 42. The total charges amount should be entered on line 23 of field 47.
 - In the *Payer Name* field (Box 50), either O/P MEDI-CAL or I/P MEDI-CAL must be entered, depending on the type of service being billed.
 - The Medi-Cal provider number must be entered in Box 57 through November 25, 2007. The *Health Plan ID* field (Box 51) is not the correct field for the Medi-Cal provider number. Claims without the Medi-Cal provider number in Box 57 will not be processed. The National Provider Identifier (NPI) should be entered in Box 56. Beginning November 26, 2007, the NPI will be the only identifier accepted on claim forms, and must be entered in Box 56.
- Note:** The only exceptions to the NPI requirement are atypical providers (blood banks, Christian Science practitioners and Multipurpose Senior Services Program providers).

Respiratory Syncytial Virus (RSV) Update 2007

The Department of Health Care Services (DHCS) and MedImmune, Inc. invite providers to participate in a live interactive Webcast at www.livemeeting.com/cc/medimmune/join. The event features presentations by:

- Vincent A. Haynes, M.D., FAAP – Director, Medical Sciences for MedImmune, Inc., and Clinical Associate Professor of Pediatrics at USC School of Medicine.
- Barry Handon, M.D. – Medical Consultant for Medi-Cal Pharmacy Benefits for DHCS
- Kathy Chance, M.D. – Medical Consultant for Children’s Medical Services for DHCS

Please see **Respiratory**, page 2

Respiratory (*continued*)**Objectives**

- Discuss the epidemiology of Respiratory Syncytial Virus (RSV)
- Define the risk factors for severe lower respiratory disease caused by RSV
- Identify RSV prevention strategies
- Discuss Medi-Cal and California Children’s Services (CCS) policy for RSV prevention
- Provide opportunity for questions

When

The same Webcast will be offered at the following two dates and times:

Wednesday**September 12, 2007**

12 – 1:30 p.m.

Conference ID: 6973632

Thursday**September 13, 2007**

12 – 1:30 p.m.

Conference ID: 6976447

The only requirement necessary to join the Webcast is a telephone near a computer with an Internet connection. To listen to the audio portion, call 1-877-663-9524 and enter the appropriate Conference ID number noted above. To view the Webcast, log on to the Web site at www.livemeeting.com/cc/medimmune/join and enter the following information:

- Your name
- The appropriate Conference ID number
- Leave the Meeting Key field blank

Webcast viewers should log on to <http://go.microsoft.com/fwlink/?linkid=52354> prior to the day of the Webcast (but no later than 15 minutes before the Webcast) to make sure their system is compatible with Microsoft Office Live Meeting. For technical support with the Webcast, please call 1-877-812-4520.

Diagnosis Code Expansion for Diagnostic Mammography

Effective for dates of service on or after September 1, 2007, ICD-9-CM codes for diagnostic mammography (CPT-4 codes 77051, 77055 and 77056 and HCPCS codes G0204 and G0206) are expanded to include codes 610.0 through 611.99 (disorder of breast) and 793.80 through 793.89 (non-specific abnormal findings on radiological or other examination of body structure, breast).

The new codes allow diagnoses that include the following:

- The recipient has distinct signs and symptoms for which a mammogram is indicated; or
- The recipient has a history of breast cancer; or
- The recipient is asymptomatic, but on the basis of the recipient’s history and other significant factors in the physician’s judgment, a diagnostic mammogram is indicated and is appropriate.

The updated information is reflected on manual replacement page [radi dia 26](#) (Part 2).

Gender Restrictions for Gonadotropin Follicle Stimulating and Luteinizing Hormones Diagnostic Codes

In the August 2007 *Medi-Cal Update*, restrictions for billing CPT-4 codes 83001 (gonadotropin; follicle stimulating hormone [FSH]) and 83002 (...luteinizing hormone [LH]) were announced, including diagnostic billing code requirements. Effective for dates of service on or after September 1, 2007, additional gender restrictions apply to the diagnostic codes listed below when billed in conjunction with CPT-4 codes 83001 and 83002.

The following ICD-9-CM codes may be used only for female recipients:

174.0 – 174.9	627.0 – 627.9
220	628.0 – 628.1
256.0	752.0 – 752.49
626.0	758.6
626.9	

The following ICD-9-CM codes may be used only for male recipients:

072.0	456.4
175.0 – 175.9	606 – 606.9
185	752.5 – 752.69
257.0	752.8 – 752.89
259.5	758.7

This information is reflected on manual replacement page path chem 5 (Part 2).

Documentation Requirement Removed for Fetal Fibronectin Testing

Effective September 1, 2007, documentation requirements for fetal fibronectin testing (CPT-4 code 82731) will change. Providers no longer need to document in the *Remarks* field (Box 80) of the claim that the patient is symptomatic for pre-term labor. The Department of Health Care Services (DHCS) has determined that entering ICD-9-CM diagnosis code 644.03 (premature labor after 22 weeks but before 37 weeks of completed gestation without delivery) in the diagnosis field on the claim is sufficient documentation to justify billing code 82731.

This information is reflected on manual replacement pages preg early 9 (Part 2) and presum 17 (Part 2).

New Maternal Serum Screen Benefit

Effective for dates of service on or after September 1, 2007, HCPCS code S3626 (maternal serum quadruple marker screen including Alpha-Fetoprotein [AFP], estriol, human Chorionic Gonadotropin [hCG] and Inhibin A) replaces HCPCS code S3625 (maternal serum triple marker screen including Alpha-Fetoprotein [AFP], estriol and human Chorionic Gonadotropin [hCG]) as a Medi-Cal benefit. This test is called the Expanded AFP (XAFP) in California. The rate is set at \$162.

The updated information is reflected on manual replacement pages remit cd600 11 (Part 1) remit elect corr600 11 (Part 1), gene 2 (Part 2), hcpcs ii 5 (Part 2), modif 2 (Part 2), presum 19 (Part 2) and subacut adu 4 (Part 2).

Decitabine Dosing Methods Update

In the June 2007 *Medi-Cal Update*, dosing limits were given for injection code J0894 (decitabine, 1 mg), effective with HCPCS implementation (August 1, 2007). The Department of Health Care Services (DHCS) recognizes that there are alternate dosing methods. Effective for dates of service on or after August 1, 2007, providers may be reimbursed for alternative dosing methods for code J0894.

This information is reflected on manual replacement page inject 60 (Part 2).

New Presumptive Eligibility Program Benefits

Effective for dates of service on or after September 1, 2007, the following procedure codes are benefits of the Presumptive Eligibility (PE) program:

<u>CPT-4 Code</u>	<u>Description</u>
80101	Drug screen, qualitative; single drug class method
86703	Antibody, HIV-1 and HIV-2, single assay
87086	Culture, bacterial; quantitative colony count, urine
87088	Culture, bacterial; with isolation and presumptive identification of each isolate, urine
87186	Susceptibility studies, antimicrobial agent; microdilution or agar dilution

Pregnant women should be screened for asymptomatic bacteriuria at 12 to 16 weeks of gestation with codes 87086, 87088 and 87186. PE providers must not bill bacteriuria testing for pregnant women with CPT-4 code 81007 (urinalysis; bacteriuria screen, except by culture or dipstick.)

This information is reflected on manual replacement pages presum 17 and 18 (Part 2).

Apligraf Billing Update

Effective for dates of service on or after September 1, 2007, HCPCS code J7340 (Apligraf) will be reimbursed at \$1,265.00 per 44 square centimeter disk (\$28.75 per sq. cm.). Providers should bill one unit for the entire 44 sq. cm. disk.

Laparoscopic Colectomy Rates Update

Effective for dates of service on or after September 1, 2007, the following laparoscopy procedures have new reimbursement rates.

- For CPT-4 code 44204 (laparoscopy, surgical; colectomy, partial with anastomosis), the rate will be \$1,158.22 for the primary surgeon and \$218.17 for the assistant surgeon.
- For CPT-4 code 44207 (laparoscopy, surgical; colectomy, partial with anastomosis, with coloproctostomy [low pelvic anastomosis]), the rate will be \$1,264.33 for the primary surgeon and \$238.27 for the assistant surgeon.

Providers are reminded that add-on codes must be billed on the same claim with the corresponding code for the primary procedure. The new rates can be found on the Medi-Cal Web site (www.medi-cal.ca.gov) by clicking the “Medi-Cal Rates” link on the home page.

Oxaliplatin Code Conversion and Policy Update

Effective for dates of service on or after September 1, 2007, local code X7658 (oxaliplatin, 50 mg) will be converted to HCPCS injection code J9263 (oxaliplatin, 0.5 mg).

Policy Updates

Also effective for dates of service on or after September 1, 2007, billing policy will be updated for this benefit. Oxaliplatin will no longer be required to be administered in combination with fluorouracil and leucovorin, and may be billed separately. Use of oxaliplatin will be expanded to include treatment of malignant neoplasm of the stomach (ICD-9-CM codes 151.0 –151.9). Drug treatment frequency is limited to one dose every 14 days.

*Please see **Policy Update**, page 5*

Policy Update (*continued*)**Dosage**

For colorectal cancer, the usual dose is from 85 to 130 mg/m², but with significant neuropathy and other toxicities, a dose reduction to 65 mg/m² is recommended. For gastric cancer, the usual dose range is 65 to 85 mg/m². Dosage is based on Body Surface Area (BSA) with the following restrictions:

- If the dosage for colorectal cancer exceeds 358 mg (715 units of quantity) per day, providers must document that the patient's BSA is greater than 2.75 in the *Remarks* field (Box 80) of the claim or on an attachment.
- If the dosage for gastric cancer exceeds 234 mg (468 units of quantity) per day, providers must document that the patient's BSA is greater than 2.75.

This information is reflected on manual replacement pages chemo 3 (Part 2) and inject list 13 (Part 2).

Reminder: Manual Pricing for Intraocular Lenses

Providers are reminded that claims for intraocular lenses (HCPCS codes V2630 – V2632) are manually priced and must include an invoice.

The updated information is reflected on manual replacement pages rates max 3 (Part 2) and supp drug op 3 (Part 2).

TAR Not Required for Certain Assistant Surgeon Services

Effective for dates of service on or after September 1, 2007, assistant surgeons are not required to get a *Treatment Authorization Request* (TAR) for CPT-4 codes 19316 (mastopexy) and 28289 (hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint).

No Additional Documentation Required for Extended Ophthalmoscopy and Fundus Photography Procedures

Effective for dates of service on or after September 1, 2007, no additional documentation is required to determine medical necessity when billing for CPT-4 codes 92225 (ophthalmoscopy, extended, with retinal drawing, with interpretation and report; initial) and 92250 (fundus photography with interpretation and report). However, CPT-4 codes 92225 and 92250 still require a valid ICD-9-CM diagnosis code for reimbursement.

E&M Consultation and Hospital Care Codes Clarification and Update

Effective for dates of service on or after September 1, 2007, the following CPT-4 code combinations may be reimbursed under certain conditions:

- 99251 – 99255 (new or established patient, inpatient consultation) and 99231 – 99233 (subsequent hospital care)
- 99221 – 99223 (new or established patient, initial hospital care) and 99231 – 99233

The above codes may be reimbursed when:

- Two different physicians provide inpatient services to the same recipient on the same date with the same group provider number. Documentation must be submitted with the claim to medically justify two services on the same day.
- One physician provides inpatient services to a recipient twice on the same date of service. Documentation must be submitted with the claim to medically justify two services on the same day.

*Please see **E&M Consultation**, page 6*

E&M Consultation (*continued*)

Also effective for dates of service on or after September 1, 2007, codes 99211 – 99215 (established patient, office or other outpatient visit) are reimbursable if the same doctor, or two doctors with the same group number, sees the recipient twice on the same day. Documentation must be submitted with the claim to medically justify a second visit on the same date of service by the same or different doctor. Services authorized by the CCS program are not affected by this change.

This information is reflected on manual replacement pages eval 2 and 3 (Part 2).

Radiation Codes Reorganization

The following CPT-4 codes were moved from the *Radiology* section to the *Radiology: Oncology* section of the Part 2 manual.

<u>CPT-4 Code</u>	<u>Description</u>
77371	Radiation treatment delivery, stereotactic radiosurgery; Cobalt 60 based
77372	linear accelerator based
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions
77421	Stereoscopic X-ray guidance
77427	Radiation treatment management, five treatments
77432	Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)
77435	Stereotactic body radiation therapy, treatment management
77750	Infusion or instillation of radioelement solution
77761	Intracavitary radiation source application; simple
77762	intermediate
77763	complex
77776	Interstitial radiation source application; simple
77777	intermediate
77778	complex
77789	Surface application of radiation source
77790	Supervision, handling, loading of radiation source
77799	Unlisted procedure, clinical brachytherapy

The following CPT-4 code was moved from the *Radiology* section to the *Radiology: Diagnostic* section of the Part 2 manual.

<u>CPT-4 Code</u>	<u>Description</u>
77013	Computerized tomography guidance for, and monitoring of, parenchymal tissue ablation

The following CPT-4 code was moved from the *Radiology* section to the *Radiology: Diagnostic Ultrasound* section of the Part 2 manual.

<u>CPT-4 Code</u>	<u>Description</u>
76998	Ultrasonic guidance, intraoperative

This information is reflected on manual replacement pages radi 5 (Part 2), radi dia 2 (Part 2), radi dia ult 2 (Part 2) and radi onc 2 and 3 (Part 2).



Family PACT Program – New Provider Manual Update

The Family PACT (Planning, Access, Care and Treatment) Program is developing a new provider manual. It will replace the current *Policies, Procedures and Billing Instructions* (PPBI) manual. Program providers are asked to use the new manual once it is received.

Manual Improvements

The new Family PACT Program provider manual will contain improvements that will help ensure its overall quality and usefulness. These new features will include:

- A user-friendly format and style modeled after the Medi-Cal provider manuals
- Unique section titles with locator keys to quickly identify sections of interest
- Concise billing instructions
- An online version for providers to access and view

Annual Subscription Contents

Annual subscriptions include monthly bulletin updates, manual replacement pages and other program-related special mailings. Monthly updates ensure that providers have access to the most current program policies and procedures.

Subscriptions and Charges

Enrolled Family PACT Program providers will automatically receive an initial copy of the new provider manual at no charge. Additional provider manuals will be available for a nominal subscription charge for providers who would like more than one provider manual.

Providers who are not enrolled in the Family PACT Program, but would like to receive a provider manual, may request a subscription to the new Family PACT provider manual for a nominal charge. To request the new provider manual, providers must complete a *Subscriber Order Form*, which will be available in a future *Medi-Cal Update*.

Contact Information

For more information regarding the Family PACT Program, providers may 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.

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

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. Dates for upcoming sessions are listed below. Registration begins at 8:00 a.m., with Session I beginning promptly at 8:30 a.m.

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 client eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. The new session format offers the option for currently enrolled providers and staff to attend only the afternoon update session along with the clinical session or the billing and coding session.

*Please see **Provider Orientation**, page 8*

Provider Orientation (continued)

Session I – Overview of the Family PACT Program: 8:30 a.m. to 2:00 p.m. Attendance at this presentation is mandatory for clinician providers wishing to enroll in Family PACT and is recommended for other staff who are new to the program or need a refresher.

The afternoon sessions run concurrently from 2:00 p.m. to 4:00 p.m.

Session II – Clinical Practice Alerts: 2:00 p.m. to 4:00 p.m. Clinicians in attendance who wish to become a Family PACT provider must also attend this session. Free continuing education (CE) credit is available for Session II. Please bring your medical license number with you if requesting CE credit; a continuing education request form will be available during onsite registration. Other interested clinical staff are welcome to attend and may request free CE credit for this session.

Session III – Tips for Successful Family PACT Administration: 2:00 p.m. to 4:00 p.m. Administrators and billers interested in Family PACT program administration and billing information may attend.

Please note the upcoming Provider Orientation and Update Sessions below.

<i>Chico</i>	<i>San Diego</i>
October 11, 2007	November 1, 2007
8:30 a.m. – 4:00 p.m.	8:30 a.m. – 4:00 p.m.
Oxford Suites	Holiday Inn on the Bay
2035 Business Lane	1355 N. Harbor Drive
Chico, CA 95928	San Diego, CA 92101
(530) 899-9090	(619) 232-3861

For a map and directions to these locations, go to the Family PACT Web site (www.familypact.org) and click “Providers” at the top of the home page, then “Provider Training,” and finally, click the appropriate location.

Registration

To register for an orientation and update session, go to the Family PACT Web site (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. Please identify the session(s) you plan to attend.

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

Check-In

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:00 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.

Please see **Provider Orientation**, page 9

Provider Orientation *(continued)***Certificate of Attendance**

Upon completion of the orientation session, each prospective new Family PACT medical provider will receive 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 receive 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.

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

Contract Drugs List Available at Epocrates, Inc.

Effective June 13, 2007, the Contract Drug Lists for the Medi-Cal program and the AIDS Drug Assistance Program (ADAP) became available online to healthcare professionals through Epocrates, Inc. Access to Medi-Cal and ADAP formularies is free to healthcare providers. For access and free downloads to mobile devices, visit www.epocrates.com.

CCS Service Code Groupings Update

Retroactive for dates of service on or after July 1, 2007 a number of codes are end-dated and added to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03, 04, 05 and 07.

Effective for dates of service on or after August 1, 2007, an additional number of codes are end-dated and added to CCS SCGs 01, 02, 03 and 10.

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 ser 1, 3, 6, 7, 11, 14 thru 16 and 22 \(Part 2\)](#).

Clinics and Hospitals Bulletin 395

Remove and replace: appeal form 1/2 *
cal child ser 1 thru 8, 11 thru 16, 21/22
chemo 3/4
eval 1 thru 4
gene 1/2
hcpcs ii 5
inject 59/60
inject list 13/14
modif 1/2
path chem 5/6
path immun 1/2 *
preg early 9/10
presum 17 thru 20 *
radi 5/6
radi dia 1 thru 4, 25/26
radi dia ult 1/2

Remove: radi onc 1 thru 3
Insert: radi onc 1 thru 4

Remove and replace: rates max 3/4
subacut adu 3/4
supp drug op 3/4

DRUG USE REVIEW (DUR) MANUAL

Remove and replace from
the *Introduction* section: 10-1 thru 10-5 *

Remove and replace from
Retrospective Drug Use
Review section: 15-1/15-2 *

Remove and replace from
Prospective Drug Use
Review Section: 20-1/20-2 *, 20-7/20-8 *, 20-11/20-12 *

Remove and replace from
Appendix B: Sample DUR
Alerts section: 30-1 thru 30-3 *

* Pages updated due to ongoing provider manual revisions.