MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Outpatient Services • Clinics and Hospitals

September 2007 • Bulletin 396

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HPV Vaccine Update

Retroactively effective for dates of service on or after January 1, 2007, CPT-4 code 90649 (Human Papilloma virus [HPV] vaccine, types 6, 11, 16, 18 [quadrivalent], 3-dose schedule, for intramuscular use) is a Medi-Cal benefit for females 19 through 26 years of age who are not pregnant. Prior authorization is not required. Code 90649 is limited to reimbursement three times in 12 months, per recipient.

The HPV vaccine Gardasil® consists of a three-dose regimen, injected at 0-, 2- and 6-month intervals. Providers must maintain a vaccination log and document in the recipient's medical records the dates of vaccinations, the vaccination sites, the dosage given and the lot number of the vaccine given.

This information is reflected on manual replacement pages inject 30 (Part 2) and inject list 9 (Part 2).

Deep Brain Stimulation Benefits Expanded

Effective for dates of service on or after October 1, 2007, surgery for simultaneous bilateral Deep Brain Stimulation (DBS) is reimbursable for recipients with Parkinson's Disease when medical necessity has been established. Unilateral DBS was already a benefit, as were bilateral procedures with appropriate documentation, when performed at least three months apart from one another.

In addition, surgery for unilateral or bilateral (including simultaneous bilateral) DBS is reimbursable for recipients with dystonia when medical necessity has been established as follows:

- Recipient is 7 years of age or older
- Recipient requires DBS as an aid in the management of primary dystonia that is chronic, intractable (drug refractory)
- The service is performed in an implant center that received Institutional Review Board (IRB) approval for the procedure

Providers should indicate on the *Treatment Authorization Request* (TAR) for dystonia-related DBS services that the implant center has IRB approval for the procedure.

Bilateral placement of implantable neurostimulator electrodes for recipients with Parkinson's Disease or dystonia is reimbursable on the same date of service.

Medical necessity for implantation of two smaller pulse generators (HCPCS codes L8685 and L8686), rather than one larger dual array pulse generator, must be documented in the *Remarks* field (Box 80) of the claim, or on a claim attachment.

Please see **Stimulation Benefits**, *page 2*

Stimulation Benefits *(continued)*

Claims submitted for DBS services require one of the following ICD-9-CM diagnosis codes, as appropriate:

ICD-9-CM Code	Description
332.0	Parkinson's Disease
333.1	Essential tremor and other forms of tremor
333.6	Genetic torsion dystonia
333.7	Acquired torsion dystonia
333.83	Spasmodic torticollis

This information is reflected on manual replacement pages surg nerv 3 thru 7 (Part 2).

Diagnosis Restrictions for Ferritin Blood Test

Effective for dates of service on or after October 1, 2007, CPT-4 code 82728 is reimbursable only when billed in conjunction with one of the following ICD-9-CM diagnosis codes:

001 – 009.93	530 – 538	799.4 – 799.49
010 – 018.96	555 – 557.9	964 – 964.9
042	562.0 – 562.1	984 – 984.9
070 – 070.9	564.0 – 564.9	996 – 996.99
080 – 088.9	569.0 – 573.9	999.8 – 999.8
090 – 099.9	578 – 579.9	V08
110 – 118	581 – 586	V12.1
120 – 129	608.3 – 608.39	V12.3
140 – 165.9	626 – 627.9	V15.1 – V15.2
170 – 176.9	648 – 648.9	V43.2 – V43.4
179 – 208.99	698.0 – 698.9	V43.6 – V43.69
210 – 238.9	704.0 – 704.9	V56.0
239 – 289.9	709.0 – 709.9	V56.8
303.0 – 303.99	713 – 714.9	
306.4 – 306.49	716.0 – 716.9	
307.1 – 307.19	719.00 – 719.99	
307.5 – 307.59	773 – 773.9	
403.0 – 404.9	783.9	
425 – 428.9	790 – 790.9	

This information is reflected on manual replacement page path chem 4 (Part 2).

TAR/SAR Requirement for Capsule Endoscopy

Effective for dates of service on or after October 1, 2006, claims billed with CPT-4 code 91110 (gastrointestinal tract imaging, intraluminal [eg, capsule endoscopy], esophagus through ileum, with physician interpretation and report) no longer require documentation submitted with a *Treatment Authorization Request* (TAR) or *Service Authorization Request* (SAR) that in the investigation of obscure gastrointestinal bleeding (OGIB), small bowel radiography be non-diagnostic.

To be reimbursed for services provided from October 1, 2006 through September 30, 2007, providers should bill code 91110 with a retroactively approved TAR or SAR. Claims with dates of service October 1, 2006 through September 30, 2007, and received through September 30, 2008, will have the timeliness restriction for billing overridden.

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

Computerized Corneal Topography Reimbursement Update

Effective retroactively to August 1, 2007, CPT-4 code 92025 (computerized corneal topography, unilateral or bilateral, with interpretation and report) is not reimbursable when performed pre- or post-operatively for corneal correction surgery (codes 65772 and 65775).

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

Emergency Room X-Ray Interpretation

Providers are reminded that X-ray interpretations and written reports performed at the same time as the diagnosis and treatment of a recipient in an emergency room are reimbursable according to the following policies:

One Interpretation
Outpatient claims for emergency room services on the *UB-04* claim include two-digit facility type code "14" (outpatient emergency room) and one-character claim frequency code "1" as "141" in the *Type of Bill* field (Box 4).

Repeated X-Ray
If an X-ray has been repeated by any provider, for the same recipient and date of service, justification must be included in the *Remarks* field (Box 80) of the claim.

This information is reflected on manual replacement page radi dia 21 (Part 2).

Fluoride Varnish Application Is a New Benefit for Medi-Cal and Managed Care

Effective immediately, HCPCS code D1203 (topical application of fluoride [prophylaxis not included] – child) is a Medi-Cal and managed care benefit for children younger than 6 years of age, up to three times in a 12-month period.

This updated information is reflected on manual replacement page dental 1 (Part 2).

RHC and FQHC Rate Changes

Effective October 1, 2007, the Medicare Economic Index (MEI) percentage increase is 2.1 percent for any Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) with an established Prospective Payment System (PPS) rate. Per federal requirements, any FQHC or RHC that has an established PPS rate must have it adjusted according to the MEI.

New Family PACT Policies, Procedures and Billing Instructions Manual

The Family PACT (Planning, Access, Care and Treatment) Program will release its new *Policies, Procedures and Billing Instructions* manual in October 2007.

New Manual Features
The new Family PACT Program provider manual offers these user-friendly features:

- The familiar Medi-Cal manual format and style
- Unique section titles with locator keys to quickly identify sections of interest
- An online version for providers to access and view

Please see **Family PACT**, *page 4*

Family PACT *(continued)*

Subscription Process – Enrolled and Non-Enrolled Providers
All enrolled Family PACT Program providers will automatically receive one copy of the new manual and a subscription at no charge. County public health providers with multiple facility locations may order two additional copies free-of-charge. County providers who wish to subscribe to more than three copies of the manual will be required to pay a nominal subscription charge and complete a *Subscriber Order Form* or call the Telephone Service Center (TSC) at 1-800-541-5555. Non-enrolled providers must do the same and will be charged for a copy of the new provider manual. Family PACT providers and other subscribers who would like more than one provider manual may order additional manuals for the same nominal subscription charge. The *Subscriber Order Form* is included with this *Medi-Cal Update*.

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.

Family PACT providers will continue to receive monthly bulletin updates, manual replacement pages and other program-related special mailings as long as they remain active providers. Family PACT providers who subscribe to receive additional manuals will have their subscriptions renewed upon the provider's submission of an annual renewal notice. Non-enrolled providers who subscribe, such as pharmacies and laboratories, will be charged for annual subscription renewals.

Opt Out
Family PACT providers who are currently subscribers may choose to "opt out" of receiving hard copy bulletins and instead receive e-mail notices with direct links to monthly *Family PACT Updates*, manual pages and training information on the Medi-Cal Web site. For providers who would like to "opt out," but are not yet subscribers, please complete a *Subscriber Order Form* first before following the Opt Out enrollment process.

To enroll in Opt Out you must have a valid e-mail address and complete the short *Opt Out Enrollment Form***.** Once your enrollment process is successfully completed, the *Family PACT Updates* will no longer be mailed to you via U.S. Postal Service.

Contact Information
For more information regarding the Family PACT Program, please call the 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.

Family PACT
Planning • Access • Care • Treatment

Family PACT Benefit and Program Updates

Effective for dates of service on or after September 1, 2007, Family PACT (Planning, Access, Care and Treatment) Program updates are as follows.

BENEFIT UPDATE

The following is a benefit update for CPT-4 code 71020 (radiologic examination, chest, two views, frontal and lateral):

- Bill in conjunction with primary diagnosis codes S701, S702 and S7034
- Reimbursable for females ages 21 – 55 years of age only
- Reimbursable when medically indicated in the context of provision of sterilization services or when required by the outpatient facility
- No *Treatment Authorization Request* required

Please see **Benefit and Program Updates**, *page 5*

Benefit and Program Updates *(continued)*

PROGRAM UPDATE

Services After Abortion
Pregnancy care, other than the diagnosis of pregnancy and the required counseling about pregnancy options, is not covered by the Family PACT Program. Also, abortions and services ancillary to abortions also are not benefits. The global post-operative period for abortion procedures has been defined as 21 days by Medi-Cal. Office visits for any reason are not covered by Family PACT during this period.

Contraceptive drugs, supplies, devices and Intrauterine Contraceptive insertion are Family PACT benefits when provided immediately after an abortion and are not considered services ancillary to abortion. Contraceptives are reimbursed by Family PACT as long as all eligibility criteria are met, including no Other Health Coverage (OHC) for family planning services, and the client is certified as eligible after the abortion.

Eligibility for Clients with OHC
Upon occasion, clients with OHC may be eligible for enrollment in Family PACT. This includes any of the following circumstances, when all other eligibility criteria are met:

- The OHC does not cover any family planning contraceptive methods. Seeking a specific method of birth control not offered by OHC is not a criterion for Family PACT eligibility.
- A barrier to access exists. A barrier to access is when a client's OHC does not assure provision of services to a client without his or her spouse, partner or parents being notified or informed. If the client indicates on the Family PACT Program Client Eligibility Certification (CEC) form that family planning services should be kept confidential from spouse, partner or parent, there is a barrier to access and the client is eligible for Family PACT benefits, if the client meets the family size and income eligibility requirements.

  Note: This applies to all clients regardless of age or marital status.
- The client has a Medi-Cal unmet Share of Cost (SOC) on the date of service. Family PACT eligibility must be affirmed at every visit. After any SOC has been met and the client has full-scope Medi-Cal benefits, the client is not eligible for Family PACT benefits, and the provider must bill Medi-Cal for any services and deactivate Family PACT eligibility.
- The client has limited scope Medi-Cal that does not cover family planning.
- The client is a student who has only student health care services and no health care coverage for any contraceptive methods. Seeking a specific method of birth control not offered by OHC is not a criterion for Family PACT eligibility. The student must meet the family size and income eligibility requirements.

Clients with Medi-Cal Managed Care
When a Medi-Cal managed care enrolled member seeks family planning care outside of their designated health plan, the health plan is required to reimburse out-of-plan providers for covered clinical, laboratory, radiology and pharmacy services. Family PACT providers should serve Medi-Cal managed care members and then bill the managed care health plan, rather than enrolling clients into Family PACT. Seeking a specific method of birth control not covered by their health plan of enrollment is not a criterion for eligibility in Family PACT. Providers may obtain more detailed plan enrollment information for Medi-Cal managed care clients through the Medi-Cal Point of Service (POS) device or online eligibility verification systems.

Information about Medi-Cal managed care plans and copies of the policy letters are available at the Medi-Cal Managed Care Division's (MMCD) Web site through the following link: **www.dhs.ca.gov/mcs/mcmcd/default.htm**.

Please see **Benefit and Program Updates**, *page 6*

Benefit and Program Updates *(continued)*

The following are paraphrased excerpts from "MMCD All-Plan Letter 03010 - Medi-Cal Managed Care Plan Requirements for Provision of Contraceptive Drug Services and Supplies" and the "MMCD Policy Letter 98-11: Family Planning Services in Medi-Cal Managed Care."

- Plans must reimburse without prior authorization any qualified out-of-plan family planning provider who provides family planning services to a plan member, including those services to identify and treat sexually transmitted infections (STI) or human immunodeficiency virus (HIV) when provided during a family planning visit.
- Plans must receive a copy of the completed sterilization *Consent Form* (PM 330) when a claim for tubal ligation or vasectomy and related services (anesthesia and facility charges) is submitted.
- Plans must reimburse for pregnancy testing and counseling when performed by trained personnel under the supervision of a licensed physician.
- Plans are not required to reimburse for every approved contraceptive device and product. Plans may require prior authorization for certain prescriptive contraceptive products but must also satisfy continuing care requirements for clients already using a particular product or method prior to plan enrollment. Health plans are required to provide formulary information to out-of-plan prescribers serving plan members upon request.
- Coding and billing requirements must be obtained from the health plan(s). For contact information see the "Directory of Medi-Cal Managed Care Health Plans" page at **www.dhs.ca.gov/mcs/mcmcd/htm/MedicalManagedCareHealthPlans.htm**.

Outpatient Surgery Centers
Outpatient surgical centers, or "surgi-centers," may not be used for services related to cervical abnormalities, for example, colposcopy or loop electrosurgical excision procedure (LEEP) services, except when it is the only resource accessible in the local area. Both the facility and the clinician must be participating Family PACT or Medi-Cal providers who have a referral from an enrolled Family PACT provider.

Medical Necessity
Contraceptive method-specific laboratory tests and other services may have additional restrictions on use. These services are not to be used routinely, but may be used when medically indicated in the context of provision of contraceptive services or when required by an outpatient facility.

Medical justification for ordering the following CPT-4 codes must be documented in the client's medical record:

CPT-4 Code	Description *	Gender	Primary Diagnosis S-Code	Restriction
85013	Blood count; spun microhematocrit	Female	S401 – S402	When medically indicated
85014	hematocrit	Female	S401 – S402	When medically indicated
85018	hemoglobin (Hgb)	Female	S401 – S402	When medically indicated
85025	complete (CBC), automated and automated differential WBC count	Female Male	S701 – S702 S801 – S802	When medically indicated or required by outpatient facility
85027	complete (CBC), automated	Female Male	S701 – S702 S801 – S802	When medically indicated or required by outpatient facility

* For full description, see *Common Procedural Terminology – 4th Edition*.

Please see **Benefit and Program Updates**, *page 7*

Benefit and Program Updates *(Continued)*

Claim Forms to Bill Family PACT

Family PACT is a state program separate from Medi-Cal. However, providers of Family PACT services use the Medi-Cal claims processing system for reimbursement. The same claim types used to submit Medi-Cal claims (*CMS 1500* and *UB-04* or electronic software submission) also are used by Family PACT providers. Family PACT policies and procedures may differ from those of Medi-Cal. Unless stated otherwise, Medi-Cal policies and billing procedures apply to Family PACT claims. Providers should refer to the monthly *Medi-Cal Update* bulletins for updates to both the Family PACT Program and the Medi-Cal program.

Family PACT Standards

Occasionally the Family PACT Standards are updated for accuracy and to reflect evidence-based medicine and current medical practices. The standards are designed as minimum quality improvement requirements for providers and provider organizations and serve as the basic framework of the program.

Highlights of updates to the standards are as follows:

- Effective July 1, 2007, the Office of Family Planning became part of the new California Department of Public Health. This department replaces former references to California Department of Health Services.
- Referrals to local resources for services beyond the scope of the program include referrals for primary care.
- Parameters for physical exam are updated in the Clinical and Preventive Services standard as follows:
  - Family planning and reproductive health clinical preventive services for men and women shall include:
    a. A comprehensive health history with updates at least every 24 months, including health risk factors; a complete family history; personal medical, sexual and contraceptive history; plans for having children; and obstetrical and gynecological history for women.
    b. A physical exam, as clinically indicated for contraceptive and STI services. Women prescribed hormonal contraceptives must have a blood pressure evaluation at the initiation of the method and at least every two years thereafter.
    c. A physical exam may be declined by the client and is not required for contraceptive services.
- Confidential HIV screening or referral to a source of anonymous testing is offered to all Family PACT clients along with client-centered counseling and referral for treatment.
- Medical record documentation includes client's signature when dispensed a device, product or prescription or when a laboratory specimen is obtained.
- The English and Spanish versions of *Family Planning Patient Rights* have been updated.

New Manual

A new *Family PACT Policies, Procedures and Billing Instructions* manual will be issued in a future mailing to Family PACT providers.

UB-04 Examples: Billing Drugs and Contraceptive Supplies

Effective retroactively to May 1, 2007, claims that do not specify condom type (male/female) in the *Remarks* field (Box 80) will be reimbursed at the male condom rate.

The following examples are supplied to help providers bill on the *UB-04* claim for Family PACT (Planning, Access, Care and Treatment) clinic dispensed drugs and contraceptive supplies. In the examples, the provider is billing for acyclovir using HCPCS codes Z7610 (miscellaneous drugs for non-surgical procedures) and condoms, foams and lubricants using code X1500 (contraceptive supplies). These updates to codes Z7610 and X1500 are effective for dates of service on or after May 1, 2007.

Clinic Dispensed Drugs (Z7610)
Code Z7610 may be used only by community clinics, hospital outpatient departments, emergency rooms and surgical clinics.

For each drug billed with code Z7610, providers must enter the following in the *Remarks* field (Box 80) of the claim:

- Name of the drug
- Dosage size (ounces must be converted to grams)
- Number of units dispensed multiplied by the Family PACT fixed rate (the subtotal)
- Clinic Dispensing Fee (CDF), if claimed

***Remarks* field (Box 80) of the *UB-04* claim**				**Box 46**	**Box 47**
Drug name	**Unit of measure**	**Number of units dispensed multiplied by fixed claim rate (subtotal)**	**Plus CDF**	**Service Units**	**Total Charges**
Acyclovir	Capsule	50 capsules X $0.15/capsule = $ 7.50	$ 3.00	1	$ 10.50

Every Z7610 claim must have an acceptable secondary diagnosis code. Only one secondary diagnosis code can be processed per claim form.

When the same secondary diagnosis code applies to more than one Z7610 drug claimed, more than one regimen may be listed in the *Remarks* field (Box 80) of the claim or on an attachment. If a combination of drug regimens is claimed under a single secondary diagnosis code, it should be entered as one (service) unit. If two or more drugs are dispensed with different secondary diagnoses, then a separate claim must be submitted for each secondary diagnosis and its corresponding drug(s). If the *Remarks* field is left blank, the claim will be denied.

Documentation Requirements
The following is an example of documentation required in the *Remarks* field of the claim, or on an attachment, if code Z7610 is billed on Line 1 of the claim and X1500 is billed on Line 2 on the same claim.

L1: Acyclovir 50@0.15=7.50+3.00 = Total $10.50

L2: Male condoms 12@0.28=3.36+0.34=3.70; foam 40g@0.21=8.40+0.84=9.24;
lub 54g@0.03=1.62+0.16=1.78 = Total $14.72

The unit of measure as specified in the *Family PACT Price Guide* must be included in the *Remarks* field of the claim, or on the attachment. Ounces must be converted to grams (1 ounce = 28 grams).

Contraceptive Supplies (X1500)
The following example is supplied to help providers bill on the *UB-04* claim for Family PACT clinic dispensed contraceptive supplies. In the example, the provider is billing for condoms, foams, lubricants and a dispensing fee using code X1500 (contraceptive supplies). This update to code X1500 is effective for dates of service on or after May 1, 2007.

Please see **UB-04 Examples**, *page 9*

UB-04 Examples *(Continued)*

When billing code X1500, the following is required in the *Remarks* field of the claim, or on an attachment: the quantity of condoms, film, suppositories, contraceptive sponges, diaphragms, cervical caps or grams of spermicide/lubricant dispensed.

***Remarks* field (Box 80) of the *UB-04* claim**				**Box 46**	**Box 47**
Supply name	**Unit of measure**	**Number of units dispensed multiplied by fixed claim rate (subtotal)**	**Plus CDF**	**Service Units**	**Total Charges**
Male condoms	Each	12 condoms X $0.28/condom = $ 3.36	$ 0.34		
Spermicidal foam	Gram	1 can (40 grams) X $0.21/gram = $ 8.40	0.84	1	$ 14.72
Lubricant	Gram	54 grams (1 tube) X $0.03/gram = $ 1.62	0.16		

Documentation Requirements
The following is an example of documentation required in the *Remarks* field of the claim, or on an attachment, for code X1500.

L1: Male condoms 12@0.28=3.36+0.34=3.70; foam 40g@0.21=8.40+0.84=9.24;
lub 54g@0.03=1.62+0.16=1.78 = Total $14.72

The unit of measure as specified in the *Family PACT Price Guide* must be included in the *Remarks* field of the claim, or on the attachment. Ounces must be converted to grams. (1 ounce = 28 grams).

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**.

Family PACT Clinic and Pharmacy Update

Effective immediately, Family PACT (Planning, Access, Care and Treatment) Program updates are as follows.

New Contraceptive Barrier Methods
Two new contraceptive barrier methods are now available to women in the Family PACT Program. The cervical cap benefit now includes the Fem Cap contraceptive device. The diaphragm benefit has been updated to include the Lea's Shield contraceptive device. These products are available for dispensing onsite by all Family PACT providers using HCPCS code X1500 (other contraceptive supplies). The Family PACT reimbursement per diaphragm or cervical cap is $13.50 per unit. Contraceptive supplies are eligible for a 10 percent clinic dispensing fee (CDF). The combined total of all contraceptive supplies, plus the 10 percent CDF, cannot exceed the Medi-Cal basic rate of $14.99 for code X1500.

Pharmacy dispensing of all covered cervical barrier methods will continue to be reimbursable by prescription for Family PACT clients and are subject to prevailing Medi-Cal guidelines.

Policy Updates for STIs
The Family PACT Program treats uncomplicated sexually transmitted infections (STIs) and has updated policy for the following:

- Treatment for Pelvic Inflammatory Disease (PID) is limited to oral and intramuscular regimens only. Intravenous treatment of PID is beyond the scope of the Family PACT Program and is not covered.
- Benefits for Gonorrhea treatment have changed to reflect current Centers for Disease Control and Prevention (CDC) recommendations. Ciprofloxacin (Z7610) and ofloxacin (Z7610) are no longer recommended or reimbursable as alternative treatments for Gonorrhea infections.
- Ofloxacin (Z7610) is available only for the treatment of PID and is no longer a covered benefit for treatment of Chlamydia.

Please see **Clinic and Pharmacy Update**, *page 10*

Clinic and Pharmacy Update *(Continued)*

TAR Requirements

Drugs and medical supplies not listed in the Family PACT Pharmacy Formulary are payable by the program in the following circumstances, both of which require a *Treatment Authorization Request* (TAR):

- Drugs that are needed to treat complications arising from the utilization of Family PACT benefits.
- Drug substitutions of a similar product when the client is unable to use the specific drug included in the Family PACT Pharmacy Formulary. Substitutions are limited to drugs and supplies identified in the Medi-Cal List of Contract Drugs.

When preparing such TARs, enter "Family PACT client" in the *Medical Justification* field and explain why the requested item is needed to treat a complication arising from a Family PACT benefit. All other fields are completed according to standard Medi-Cal TAR form instructions as described in the *TAR Completion* section in the appropriate Part 2 manual.

Family PACT Education and Counseling Office Visits Billing and Policy Updates

Effective October 1, 2007, the following Family PACT (Planning, Access, Care and Treatment) Education and Counseling (E&C) and TeenSMART enhanced counseling visit services are updated as follows.

- Family PACT HCPCS code Z9750 (Family Planning Group Education, including orientation to Family PACT) <u>or</u> Z9751 (individual orientation to Family PACT) is reimbursed once per client, per provider. The selected code may be billed alone or in conjunction with one code from the following: CPT-4 Evaluation & Management (E&M) codes 99201 – 99204, 99211 – 99214, or E&C codes Z9752 – Z9754, on the same date of service, per client, per provider.
- One E&C code Z9752 – Z9754 is reimbursed per date of service, per client, per provider. Any combination of E&C visits billed with codes Z9752 – Z9754 is limited to two per month, per client, per provider. These E&C codes do not reimburse on the same date of service as E&M codes 99201 – 99204 or 99211 – 99214.
- TeenSMART enhanced counseling HCPCS codes Z9760 and Z9761, reimbursed to designated Family PACT providers, must be billed with one E&M office visit code (99201 – 99204 or 99211 – 99214) on the same date of service, per client, per provider. These codes are not reimbursable on the same date of service as Family PACT E&C codes Z9752 – Z9754.

Note: Billing CPT-4 codes 99204 and 99214 for males is restricted for management of complications, and requires an approved *Treatment Authorization Request* (TAR).

Clarification of Existing Policy

The following policy clarifications will assist providers in selecting the appropriate E&M or E&C code for Family PACT services. Providers may choose to include non-clinician counselors in the process of client E&C. Please refer to CPT 2007 for additional information about E&M coding.

Visits billed with an E&M code must be performed by a clinician, although the computation of the E&M level of the visit also may include services provided by non-clinician counselors. When "time" is the criterion for selection of an E&M code, the amount of face-to-face time is cumulative of all staff who counsel the client and total time must be documented in the medical record.

E&M visits may be reimbursed on the same date of service as a procedure when a significant, separately identifiable E&M service is provided by the same clinician on the same day of the procedure. Use modifier 25 with the E&M code. Documentation of medical justification must be submitted with the claim.

Please see **Education and Counseling**, *page 11*

Education and Counseling *(continued)*

E&C visits may be provided either by clinicians or by supervised non-clinician counselors. The provider shall take into consideration the cumulative time spent counseling the client by all staff when selecting the E&C code for billing. In order to be reimbursed by the program, E&C services must be conducted at the site of clinical services. (See California *Health and Safety Code*, sections 1206(h) and 1248.1(h).)

Summary of Differences between E&M and E&C Codes

Code Type	Code Source	Provided by	Level computed by
E&M	CPT-4	Clinician, with or without Counselor services	Documented history, exam, and medical decision making ***OR*** Clinician time plus Counselor time *
E&C	HCPCS	Clinician and/or Counselor	Clinician time plus Counselor time

* If greater than 50% of total face-to-face time is spent in counseling.

Providers must ensure that non-clinician counselors have been trained in all family planning methods, are knowledgeable about the *Family PACT Standards* and program benefits and have the essential core competence to deliver E&C services. Non-clinician counselors shall work under the direction of the enrolled Family PACT provider. Practice-specific E&C protocols or other written delegation arrangements must be established for non-clinician counselors and must be consistent with Family PACT Standards.

Services provided by non-clinician counselors must be accompanied by onsite direct supervision. Acceptable supervisors of non-clinician counselors include: physicians; non-physician medical practitioners; registered nurses and public health nurses; counseling professionals, including the categories of Marriage, Family and Child Counselor or Marriage and Family Therapist, Licensed Clinical Social Worker, clinician psychologist, or masters-degree prepared health educator. (Section 1905, [a][5], [6], [9], [13], [17], [21], [28] of the *Social Security Act*; Title 42, *Code of Federal Regulations* Part IV, Subpart A, Section 440.2 and 440.60).

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 opens 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 seeking to enroll must send its medical director or a 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. However, these staff members 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.

New Session Format

Family PACT has created a new session format, which offers an option for currently enrolled providers and staff to attend only the afternoon update session, along with either the clinical session or the billing and coding session.

Please see **Orientation Sessions**, *page 12*

Orientation Sessions *(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 is 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.

Chico	*San Diego*	*Bakersfield*	*Santa Rosa*
October 11, 2007	**November 1, 2007**	**December 13, 2007**	**February 21, 2008**
8:30 a.m. – 4:00 p.m.	**8:30 a.m. – 4:00 p.m.**	**8:30 a.m. - 4:00 p.m.**	**8:30 a.m. - 4:00 p.m.**
Oxford Suites	Holiday Inn on the Bay	Double Tree Hotel	Hyatt Vineyard Creek
2035 Business Lane	1355 N. Harbor Drive	3100 Camino Del Rio Ct.	Hotel & Spa
Chico, CA 95925	San Diego, CA 92101	Bakersfield, CA 93308	170 Railroad Street,
(530) 899-9090	(619) 232-3861	(661) 323-7111	Santa Rosa, CA 95401
			(707) 636-7283

For a map and directions to these locations, providers can 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, providers should:

- 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
- Print a copy of the registration form.
- Identify desired session(s).
- 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 and National Provider Identifier (NPI)
- Contact telephone number
- Anticipated number of people attending

Please see **Orientation Sessions**, *page 13*

Orientation Sessions *(continued)*

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 and NPI
- 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 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.

CCS/GHPP SAR Requirements Update

Retroactively effective for dates of service on or after August 1, 2007, California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) providers must submit a Service Authorization Request (SAR) for nutritional therapy for Phenylketonuria (PKU).

This updated information is reflected on manual replacement page cal child sar 6 (Part 2).

CCS Service Code Groupings (SCGs) Update

Retroactively effective for dates of service on or after July 1, 2006, HCPCS code Z4303 has been added to California Children's Services (CCS) Service Code Grouping (SCG) 06.

Effective for dates of service on or after September 1, 2007, code X7658 has been end-dated and code J9263 has been added to CCS SCGs 01, 02, 03 and 07.

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 and 16 (Part 2).

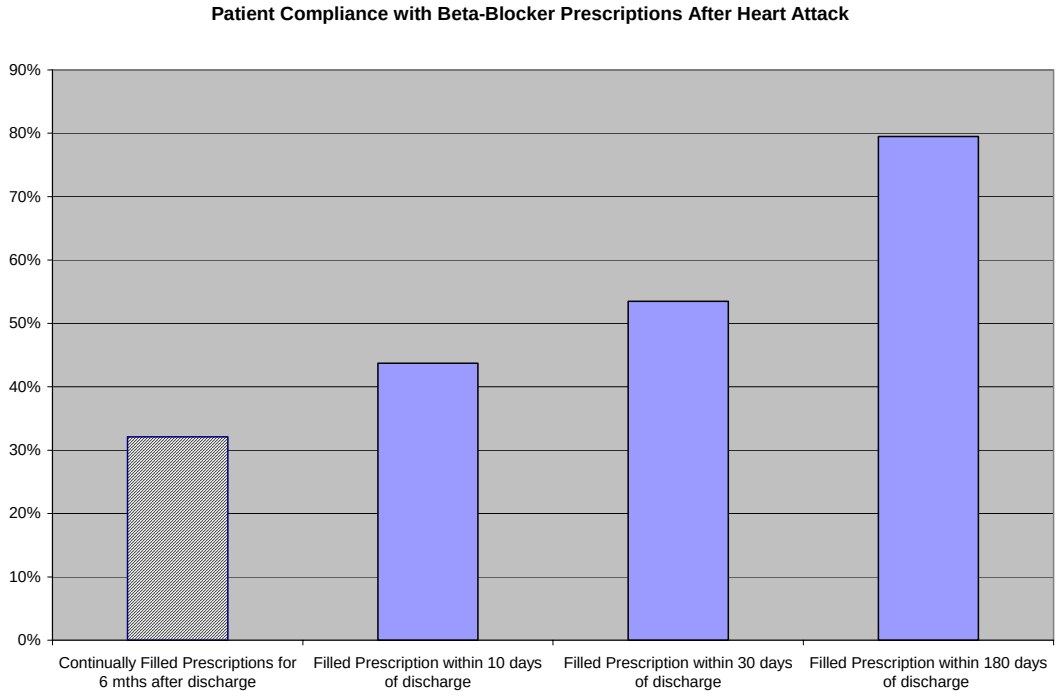
DRUG USE REVIEW
Educational Information

Persistence of Beta-Blocker Treatment After Myocardial Infarction

Myocardial infarction is classified as the death of a segment of the heart due to lack of blood supply. National statistics indicate there will be an estimated 700,000 Americans that suffer a myocardial infarction or other type of cardiac attack this year.[1] According to data collected by the National Center for Health Statistics, over the five-year period from 1999 through 2004, an estimated 7.9 million patients had an acute myocardial infarction (AMI).[2] The American Heart Association and American College of Cardiology both have guidelines for treatment after an AMI that recommend beta-blockers during the hospital stay and upon discharge for those patients who do not have contraindications to beta-blocker use. Beta-blockers decrease myocardial oxygen demand along with slowing heart rate and lowering blood pressure.

A retrospective study of Medi-Cal Fee-for-Service (FFS) recipients was conducted to measure the extent of compliance with treatment with beta-blocker medications after discharge from hospital after a heart attack. The study of Medi-Cal FFS recipients followed the study design prepared by the National Committee for Quality Assurance (NCQA) for HEDIS 2008.[3] The study, "Persistence of Beta-Blocker Treatment After a Heart Attack," outlines the specific diagnosis codes used to identify acute myocardial infarction (AMI) along with the diagnosis codes to use for excluding patients where beta-blocker therapy would be contraindicated. Though the HEDIS study covered a 12-month period, Medi-Cal used a 9-month period to find those patients who had a heart attack, with an additional 6 months to track prescriptions for beta-blockers after their heart attack.

- 576 Medi-Cal FFS recipients met the criteria outlined in the HEDIS 2008 study for inclusion in this study.
  - Though 80% filled a prescription for beta-blocker medications within 180 days of their discharge from a hospital after suffering an AMI, only 32% met the HEDIS criteria for continuing treatment for 6 months following their heart attack.
  - Over 53% of patients filled a prescription for beta-blocker medications within 30 days of discharge from hospital.



Please see **Treatment**, *page 15*

Treatment *(continued)*

The Medi-Cal data shows that about one-half of patients are filling an initial prescription for beta-blocker after an AMI, but the long term, continuing treatment for their condition is not occurring. Because compliance is often an issue, physicians should be talking to their patients about the importance of taking medications as prescribed at every appointment. Pharmacists can also help monitor that patients are getting their beta-blockers refilled at appropriate time intervals and by asking patients how they are coping with any side effects that may be occurring due to the medication. This can occur when other prescriptions are picked up and possibly through mailed notices or phone reminders that their prescriptions needs to be refilled.

Medi-Cal recommends prescribers and other health professionals follow the most current recommendations by the American Heart Association and American College of Cardiology for treatment after a myocardial infarction. The most current recommendations can be found at: **www.americanheart.org/presenter.jhtml?identifier=3003999**.

References

1. AHA/ASA Heart Disease and Stroke Statistics 2007 Update.
2. Rosamond, et al. Heart Disease and Stroke Statistics – 2007 Update: A report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. *Circulation* 2007; 115; 69-171.
3. National Committee for Quality Assurance (NCQA). Persistence of Beta-Blocker Treatment After a Heart Attack. HEDIS 2008, Volume 2 Technical Specifications.

Please refer to pages 36-41 and 36-42 in the Medi-Cal Drug Use Review manual.

Instructions for Manual Replacement Pages

September 2007

Clinics and Hospitals Bulletin 396

Remove and replace at front of manual :	*Medi-Cal Program* 1 *
Remove:	*Manual Organization* A-1
Insert:	*Manual Organization* A-1/A-2 *
Remove and replace:	*How to Use This Manual* B-1 thru B-6 *
Remove and replace at the end of the *How to Use This Manual* section:	*How Are We Doing?* 1/2 *
Remove and replace:	*Manual Ordering* C-1/C-2 *
Remove and replace at the end of the *How to Use This Manual* section:	*Subscriber Order Form* 1/2 *
Remove and replace:	cal child 1 thru 4 * cal child sar 5/6 cal child ser 1 thru 4, 15/16 cal child spec 1 * can detect 15 thru 18 * cont ip 1/2, 7/8, 17/18 * contra 1/2 * dental 1 dial chr 7/8 * drug 11 thru 14 * inject 29/30 inject list 9/10 medne 7/8 ophthal 1/2 path chem 3 thru 6 preg fetal 3 * radi dia 21/22 surg nerv 3 thru 8 tar comp 5 thru 8 *

DRUG USE REVIEW (DUR) MANUAL

Insert in the *Education* section:	36-41/36-42

* Pages updated due to ongoing provider manual revisions.