



Pharmacy

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Contents

2007 CPT-4/HCPSC Updates: Implementation August 1, 2007.....	1
2007 HCPSC Updates for DME and O&P: Implementation August 1, 2007.....	2
Provider IDs Must Match when Filing Reversals, Rebills; NPI Software Coming	5
Redirection of TAR Services.....	5
Processing Changes for TARs.....	6
Universal Product Number Pilot Delay.....	8
Family PACT: New Digital Mammography and Computer Aided Detection Benefits	9
2007 CPT-4/HCPSC Updates: Implementation August 1, 2007	9
New Infant Formula for WIC	10
Regular Infant Formula Not a Medi-Cal Benefit	11
Enzyme Replacement Drugs Reimbursement Update.....	11
Billing Ranibizumab with HCPSC Code J3590.....	12
Infliximab Diagnoses Expanded	12
Billing Code for Abatacept Revised	12

2007 CPT-4/HCPSC Updates: Implementation August 1, 2007

The 2007 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPSC) National Level II codes will be effective for Medi-Cal for dates of service on or after August 1, 2007. Specific policy changes are detailed below. Unless otherwise stated, the policy of deleted code(s) applies to the replacement code(s). Providers are reminded that Medi-Cal enforces CPT-4 instructions.

DRUGS, INJECTIONS AND BLOOD FACTORS

Deleted and Replacement Codes

<u>Deleted Code</u>	<u>Replacement Code</u>
J7188	J7187
X7484	Q4084

Billing Restrictions

Injection code C9233 (ranibizumab [LucentisTM]) is reimbursable with prior authorization. Providers must document on the *Treatment Authorization Request* (TAR) that the patient has exudative senile macular degeneration (ICD-9-CM code 362.52). Reimbursement is limited to 12 injections per eye, per year. Providers should bill with the appropriate site modifiers (LT, RT or 50 if bilateral). C9233 must be billed on the same claim as CPT-4 code 67028 (intravitreal injection of a pharmacologic agent).

Injection codes J0348 (andulafungin, 1mg) may be billed up to 200 mg and must be billed with ICD-9-CM diagnosis codes 112 – 112.9.

Injection code J0894 (decitabine, 1 mg) is reimbursable for patients with myelodysplastic syndrome. Claims must be billed with ICD-9-CM diagnosis codes 238.72 – 238.75. Maximum dosage for three consecutive days is 122 mg per day unless there is documentation that the Body Surface Area (BSA) is greater than 2.7 m². Treatment may be repeated in six weeks.

Injection code J1740 (ibandronate sodium, 1 mg [BonivaTM]) is reimbursable for the treatment of women with post-menopausal osteoporosis. Claims must be billed with ICD-9-CM diagnosis code 733.01. Providers must submit the following documentation, either in the *Reserved for Local Use* field (Box 19) or on an attachment:

- A diagnostic T score of -2.5 or more in women who have documented difficulty with the oral bisphosphonates dosing requirement, which includes an inability to sit upright for 30 to 60 minutes and/or difficulty in swallowing a pill; or,
- A diagnostic T score of -2.5 or more in women with documented esophagitis, gastritis, gastric or esophageal ulcers that prohibit the use of oral bisphosphonates

Dosing frequency is 3 mg every three months administered intravenously over 15-30 seconds by a health care provider. Boniva is contraindicated in patients with hypocalcemia or those who have a known hypersensitivity to ibandronate sodium.

Please see CPT-4/HCPSC Updates, page 2

CPT-4/HCPCS Updates (continued)

Code J2248 (micafungin sodium, 1 mg) may be billed up to 150 mg and must be billed with ICD-9-CM diagnosis codes 112-112.9.

Code J3243 (tigecycline, 1 mg) may be billed up to 100 mg.

HCPCS codes J7611 and J7613 (albuterol inhalation solution, 1 mg) will be added as Medi-Cal benefits. Claims billed in excess of 30 mg will be cut back unless the provider submits documentation, either in the *Reserved for Local Use* field (Box 19) or on an attachment, that the patient required more than the allowed amount due to continued airflow obstruction.

Injection code J9261 (nelarabine, 50 mg) is reimbursable to patients with lymphosarcoma or acute lymphoid leukemia. Claims must be billed with ICD-9-CM diagnosis codes 200.10 – 200.18 or 204.00 – 204.01. Maximum daily dosage on days one, three and five is 4,050 mg unless documentation BSA is greater than 2.7 m². Treatment may be repeated in 21 days.

Injection code J9035 (bevacizumab 10 mg [Activa®]) will be activated to replace deleted code S0116 (bevacizumab, 100 mg).

- Code J9035 must be billed in conjunction with diagnosis codes 153.0 – 154.8 (malignant neoplasm of the colon, rectum, rectosigmoid junction and anus) or 162.2 – 162.9 (malignant neoplasm of bronchus and lung).
- The provider must document that treatment was either for metastatic colorectal cancer or for unresectable, locally advanced, recurrent or metastatic non-squamous, non-small cell lung cancer.

Bevacizumab is packaged in 100 mg vials. If it is necessary to waste the unused portion of a vial, providers may bill for a quantity that is equal to the amount given to the patient plus the amount wasted. Providers must justify in the *Reserved for Local Use* field (Box 19) of the claim the amount of bevacizumab that was wasted.

Injection codes Q4084 (Synvisc), Q4085 (Euflexxa) and Q4086 (Orthovisc) are reimbursable, with prior authorization.

The TAR may be approved for one or both knees when there is documentation of one of the following conditions:

- Painful osteoarthritis of one or both knees
- Significant knee pain, decreased mobility, or significant effusion of one or both knees
- Knee pain that is not relieved with use of non-steroidal anti-inflammatory drugs (NSAIDs)

Quantity and frequency restrictions:

- Synvisc and Euflexxa are restricted to a total of three injections per knee (one injection, one week apart, for a total of three weeks) in a six month period
- Orthovisc is restricted to a total of four injections per knee (one injection, one week apart, for a total of four weeks) in a six month period

The manual replacement pages reflecting these policies will be released in the July *Medi-Cal Update*.

2007 HCPCS Updates for DME and O&P: Implementation August 1, 2007

The 2007 updates to the Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after August 1, 2007. Specific policy changes are detailed below.

Please see **DME/O&P HCPCS Updates**, page 3

DME/O&P HCPCS Updates (continued)

DURABLE MEDICAL EQUIPMENT

Deleted and Replacement Codes

The following are deleted codes and replacement codes based on Noridian Administrative Services, Medicare’s contractor for Durable Medical Equipment (DME). The policy of the deleted codes applies to the replacement codes unless otherwise noted.

<u>Deleted Code(s)</u>	<u>Replacement Code(s)</u>
E0164	E0163
E0166	E0165
E0180	E0181
E0701	A8000, A8001
E2320	E2373 (modifier KC is not applicable)
K0090	E2381, E2386, E2390 (frequency restriction has changed)
K0091	E2382 (frequency restriction has changed)
K0094	E2384, E2387, E2391
K0095	E2385

Billing Restrictions

HCPCS codes A8000, A8001 (prefabricated helmets), A8002 and A8003 (custom helmets) and A8004 (replacement interface) will be Medi-Cal benefits. Codes A8000 – A8004 are reimbursable to physicians, certified orthotists and prosthetists, and California Children’s Services (CCS) providers; codes A8000, A8001 and A8004 are reimbursable to DME providers. These items are not rented (modifier RR is not allowed); claims for A8000 – A8004 must be billed as a purchase (modifier NU) or repair (modifiers RPNU) only. Claims for code A8004 must include documentation that the patient owns the helmet. Codes A8000, A8001 and A8004 are taxable items. Codes A8000 – A8004 are all subject to the orthotic cumulative per-month *Treatment Authorization Request* (TAR) threshold of \$250.

Mobile commode chairs previously billed with terminated HCPCS codes E0164 (fixed arms) and E0166 (detachable arms) must now be billed with revised mobile or stationary commode chair code E0163 (fixed arms) and activated code E0165 (detachable arms).

Replacement commode pail/pan HCPCS code E0167 is a purchase-only item (modifier NU). Claims must include documentation that the patient owns the commode. Labor is not separately reimbursable for replacing this item.

Alternating pressure pads previously billed with terminated HCPCS code E0180 must now be billed with revised code E0181 (power pressure reducing mattress overlay/pad, alternating, with pump, include heavy duty). The rental rate for code E0181 has been adjusted from \$18.34 to \$20.85.

The description of HCPCS code E0182 has been revised from “pump for alternating pressure pad” to add the words “for replacement only.” This item must now be billed as a purchase-only (modifier NU); labor for replacement is not payable. The *Reserved for Local Use* field (Box 19) of the claim must document that the patient owns the alternating pressure pad.

New HCPCS code E0936 (continuous passive motion exercise device for use other than the knee) is a rental-only code and must be billed with modifier RR (rental). The established reimbursement rate includes payment for all accessories. The device is a taxable item.

HCPCS codes E2374 – E2376 and E2381 – E2396 (power wheelchair accessories) may only be reimbursed as purchased replacement items for patient-owned equipment. They are not separately reimbursable with the initial purchase of codes K0813 – K0891 (Group 1 – 5 power wheelchairs). Claims must be billed with modifier RPNU (labor for replacement is allowed). Documentation of the patient-owned equipment these accessories are applied to must be included in the *Reserved for Local Use* field (Box 19) of the claim.

HCPCS code E2377 (power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue) may be reimbursed separately with the rental or initial purchase of wheelchair codes K0835 – K0891. This code will only be reimbursed as a purchase or rental (modifiers NU or RR). Labor is not separately reimbursable for this upgrade.

Please see **DME/O&P HCPCS Updates**, page 4

DME/O&P HCPCS Updates *(continued)*

Existing HCPCS code T5001 (special orthotic positioning seat) will now be a Medi-Cal benefit, subject to prior authorization. Reimbursement will be “By Report.” Code T5001 must be billed with modifier NU (purchase), RR (rental) or RP (repair). Claims billing for repair of this item with modifier RP must document that the patient owns the positioning seat. Separate reimbursement for labor is allowed for the repair of patient-owned equipment. This device is a taxable item.

Purchase Frequency Restrictions

Codes A8000, A8001 and A8004 are limited to one in 12 months.

Codes E0165, E0936, E2373 – E2377, K0800 – K0898 and T5001 are limited to one in three years.

Codes E2381 – E2396 are limited to six in 12 months.

All of the above restrictions apply to any provider.

ORTHOTICS AND PROSTHETICS

Deleted and Replacement Codes

The following are deleted codes and replacement codes based on Noridian Administrative Services, Medicare’s contractor for orthotics and prosthetics (O&P). The policy of the deleted codes applies to the replacement codes.

<u>Deleted Code(s)</u>	<u>Replacement Code(s)</u>
L0100	A8002, A8003
L0110	A8000, A8001
L6700, L6720 –L6370	L6704
L6705, L6710, L6715, L6735 – L6795	L6706
L6800, L6806 – L6808	L6707
L6825, L6835 – L6860, L6867, L6872, L6873, L6880	L6708
L6830, L6875	L6709
L7015	L7008

Billing Restrictions

HCPCS codes A8000, A8001 (prefabricated helmets), A8002 and A8003 (custom helmets) and A8004 (replacement interface) will be Medi-Cal benefits. Codes A8000 – A8004 are reimbursable to physicians, certified orthotists and prosthetists, and CCS providers; codes A8000, A8001 and A8004 are reimbursable to DME providers. These items are not rented (modifier RR is not allowed); claims for A8000 – A8004 must be billed as a purchase (modifier NU) or repair (modifiers RPNU) only. Claims for code A8004 must include documentation that the patient owns the helmet. Codes A8000, A8001 and A8004 are taxable items. Codes A8000 – A8004 are all subject to the orthotic cumulative per-month TAR threshold of \$250.

HCPCS code L1001 (infant spinal immobilizer) is reimbursable, with prior authorization, for custom-made devices designed for the stabilization of the cervical spine, upper thoracic spine and/or airway of a child younger than one year of age. A CCS denial is required for Medi-Cal authorization. Claims must include an invoice. Coverage of L1001 excludes an infant immobilizer used to restrain infants during surgical or radiological procedures (for example, Circumstraint device for restraint during circumcision).

HCPCS codes L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639, L6703, L6704, L6706 – L6709, L6805, L6810, L7040 and L7045 may be billed as bilateral appliances.

Prior authorization is always required for codes L1001, L5993, L5994, L6611, L6624 and L6639, and is required for all other codes when the amount billed exceeds TAR thresholds.

Please see DME/O&P HCPCS Updates, page 5

DME/O&P HCPCS Updates *(continued)*

Existing HCPCS code T5001 (special orthotic positioning seat) will now be a Medi-Cal benefit, subject to prior authorization. Reimbursement will be “By Report.” It must be billed with modifier NU (purchase), RR (rental) or RP (repair). Separate reimbursement for labor is allowed for the repair of patient-owned equipment. Claims billing code T5001 with modifier RP must document that the patient owns the positioning seat. This device is a taxable item.

Purchase Frequency Restrictions

Codes A8000 – A8004, L0631, L1001, L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639, L6703, L6704, L6706 – L6709, L6805, L6810 and L6884 are limited to one in 12 months.

Codes L5848, L6881, L7007 – L7009, L7040 and L7045 are limited to one in three years.

The manual replacement pages reflecting this policy will be released in the July *Medi-Cal Update*.

Provider IDs Must Match When Filing Reversals, Rebills; NPI Software Coming

Pharmacy providers must submit the provider identifier used on the original transaction when filing claim reversals or rebills, even after the NPI implementation date of November 26, 2007.

On May 23, 2007, the California Department of Health Services (CDHS) implemented a “dual-use” provider number period during which providers must use both Medi-Cal provider numbers and, if available, NPIs. All electronic pharmacy claims and proprietary paper Medi-Cal forms, including the *Pharmacy Claim Form* (30-1) and *Compound Drug Pharmacy Claim Form* (30-4), are exceptions where space is available for only the Medi-Cal provider number.

Since pharmacy providers are required to only use Medi-Cal provider numbers on electronic and proprietary claim forms prior to November 26, 2007, any reversals or rebills filed after November 26, 2007 must also use the Medi-Cal provider number as a reference.

NPI software download

Beginning August 25, 2007, messages will appear on Point of Service (POS) devices announcing an automatic software update download. No action is required by providers except to leave the device on at the end of the day. The software will download automatically.

This software update accommodates the 10-digit NPI in preparation for Medi-Cal’s implementation on November 26, 2007. However, providers are not required to enter the NPI until November 26, 2007. Providers must continue to enter the Medi-Cal provider number until the NPI implementation. An error message will be returned on the POS device if an NPI is entered before the implementation date.

Once the software is downloaded, a test transaction is required. Instructions for performing the test transaction are provided in the Device System Transactions section of the *POS Device User Guide* available on the Medi-Cal Web site (www.medi-cal.ca.gov). From the home page, click “User Guides” (under “Provider Resources”), then “POS Device User Guides” and, finally, click the “Device System Transactions” link. Providers may also call the POS Help desk at 1-800-541-5555, choose option 16 from the main menu, then option 16 from the submenu.

Redirection of Treatment Authorization Request Services

Effective July 1, 2007, several regionalized Treatment Authorization Request (TAR) services provided by the Fresno Medi-Cal Field Office (FMCFO) are being redirected to the Northern and Southern Pharmacy Sections (NPS and SPS), Sacramento Medi-Cal Field Office (SMCFO) and San Francisco Medi-Cal Field Office (SFMCFE).

TAR services currently handled by the FMCFO will be redirected as follows:

- Intravenous home infusion equipment services, including all medical supplies related to infusion therapy, and all Durable Medical Equipment (DME) and medical supplies related to enteral feeding, have been redirected to the NPS and SPS.
- Medical supplies related to incontinence, including urinary catheters and bags, have been redirected to the SMCFO.

Please see **Redirection of TAR**, page 6

Redirection of TAR *(continued)*

- Breast pumps and supplies have been redirected to the SFMCFO.
- Physician-administered drugs and/or physician-performed services/procedures, radiology services, inpatient and outpatient surgeries and procedures that require a TAR and elective acute hospital admissions have been redirected to the SMCFO.

Providers located in Oregon border cities were required to submit their TARs, for core services only, to SMCFO effective May 1, 2004.

The California Department of Health Services (CDHS) does not anticipate any delays in adjudication of these TAR types. Manual replacement pages will be released in a future *Medi-Cal Update*.

Processing Changes for Treatment Authorization Requests

Beginning May 1, 2007, the California Department of Health Services (CDHS) started phasing in several changes that impact how paper *Treatment Authorization Requests* (TARs) are processed.

These changes are being implemented to minimize the key data entry of incomplete or erroneous TAR information and to reduce the volume of paper documents containing Protected Health Information (PHI), particularly Social Security Numbers (SSNs) that are sent via:

- United States Postal Service
- Courier services
- Other types of delivery services

CDHS expects to complete this phased implementation by September 2007.

Processing Change Schedule

Processing changes to paper TARs impact providers interacting with the Medi-Cal field offices and pharmacy sections on the following dates:

May 2007 Sacramento Medi-Cal Field Office	August 2007 Fresno Medi-Cal Field Office
June 2007 Northern Pharmacy Section (Stockton) Southern Pharmacy Section (L.A.)	San Bernardino Medi-Cal Field Office San Diego Medi-Cal Field Office San Francisco Medi-Cal Field Office
July 2007 L.A. Medi-Cal Field Office In-Home Operations South	September 2007 TAR Administrative Remedy Section In-Home Operations North

Incomplete TARs

CDHS Medi-Cal field offices and pharmacy sections will be unable to enter paper TARs with incomplete information into the TAR system. These paper TARs will be deferred back to the submitting provider, with a Medi-Cal field office/pharmacy section *Incomplete TAR Form* identifying the reasons for deferral and instructions about how to resubmit the paper TAR with the necessary corrections.

Providers are to:

- Make the necessary corrections/changes on the paper TAR, and
- Resubmit with a copy of the *Incomplete TAR Form* on top of the paper TAR.

Paper TARs that are returned to the submitting provider for correction will not be available for inquiry through the Provider Telecommunications Network (PTN).

Any one of the reasons below will not allow the paper TAR information to be entered into the system. The reason(s) will be marked on the *Incomplete TAR Form* and sent back to the submitting provider for corrections. These reasons may consist of one or more of the following:

Please see Processing Changes, page 7

Processing Changes (*continued*)

- The TAR form is illegible or damaged.
- The submitting provider number is missing, inactive, suspended or invalid for the category of service requested.
- The patient's Medi-Cal ID number is missing, invalid or invalid in length, and the patient's name/date of birth is missing.
- The patient is not Medi-Cal eligible.
- Information in the *Admit From* field (Box 14) on the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is missing or invalid.
- The requested service information is missing, invalid or invalid in length.
- The ICD-9-CM diagnosis code, admitting ICD-9-CM diagnosis code and/or primary DX diagnosis code is missing or invalid.
- The County Medical Services Program (CMSP) pharmacy services are covered by MEDIMPACT. Providers may call 1-800-788-2949 for further information.
- The requested Adult Day Health Care (ADHC) service should specify the months and the number of requested days for each calendar month on separate lines of the TAR. The TAR request should not exceed six months or have more than one service line for a given calendar month. Providers may refer to the appropriate Part 2 manual for specific TAR preparation instructions.

Adjudication Response

CDHS will discontinue the practice of returning adjudicated paper TAR copies to providers based on the schedule above. Instead, providers will receive an *Adjudication Response* (AR), which will display:

- The status of requested service(s)
- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal
- The adjudicator's request for additional information, if necessary

The AR will enable the provider to respond to the requested information or proceed to bill for authorized services. (See the *Adjudication Response* example at the end of this article.) Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

When requesting an update/correction, a copy of the AR must be placed on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify what change(s) are being requested.

The ARs will be mailed to the provider's address on file with CDHS' Payment Systems Division, Provider Enrollment Branch (PEB). Providers should ensure PEB has their most up-to-date mailing address on file. Instructions about changing/updating a provider address may be found on the Medi-Cal Web site (www.medi-cal.ca.gov). From the home page, click the "Provider Enrollment" link and then the "Provider Reminders" link at the top of the page.

Attachments

On November 15, 2006, CDHS notified providers via a flyer that attachments were no longer being returned with deferred paper TARs. Medi-Cal field offices and pharmacy sections will continue to retain and archive all attachments for reference.

Providers responding to a deferred TAR should return the AR and any new attachment(s) requested.

SSN on TARs

In accordance with *Medi-Cal Updates* issued in August and September 2006, providers should use the recipient's Benefits Identification Card (BIC) number on the TAR, rather than the SSN. If a TAR is returned to a provider because of inaccurate and/or incomplete information, the SSN will be removed. Provider questions may be directed to the local Medi-Cal field office or pharmacy section.

Please see **Processing Changes**, page 8

Processing Changes (continued)

National Provider Identifier (NPI) Number

Providers should be aware that the NPI number will not be accepted on TARs until after the official NPI implementation date of November 26, 2007. For detailed information about the new NPI implementation date, providers can view the “Important NPI Time Frame Changes” article posted in the “HIPAA News” area of the Medi-Cal Web site (www.medi-cal.ca.gov).

TARs issued under the old provider number (legacy number) prior to November 26, 2007 can still be used for claims submitted with an NPI starting on or after November 26, 2007. Providers will not have to request an updated TAR with the NPI information.

State of California - Health and Human Services Agency Department of Health Services	<h2 style="margin: 0;">CONFIDENTIAL</h2> <p style="margin: 0;">Medi-Cal Operations Division</p> <h1 style="margin: 0;">ADJUDICATION RESPONSE</h1>	ARNOLD SCHWARZENEGGER, Governor 							
Provider Number: HSCXXXXXX XXX CONTRACT HOSP #2 3215 PROSPECT PARK DR RNCHO CORDOVA, CA 95670-6017	DCN (Internal Use Only): 123456789101 Date of Action: 06/27/2006 Regarding: Jane Doe TAR Control Number: 9876543210								
This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:									
Svc #	Service Code	Modifier(s)	Service Description	From Date of Service	Thru Date of Service	Units	Quantity	Status	P.I.
1	123ABC	1	Service Description 1	01-01-2006	01-31-2006	12345	1000000.123	1 Approve	1
2	ABC123	2	Service Description 2	01-01-2006	01-31-2006	12345	1000000.123	2 Modify	0
Reason(s):		GEN: Modified, refer to comments							
Comment(s):		Comments from Field Office Consultant 2							
3	ABC123	3	Service Description 3	01-01-2006	01-31-2006	12345	1000000.123	3 Deny	3
Reason(s):		GEN: Denied, refer to comments							
Comment(s):		Comments from Field Office Consultant 3							
4	ABC123	4	Service Description 4	01-01-2006	01-31-2006	12345	1000000.123	4 Defer	5
Reason(s):		GEN: Deferred, refer to comments							
Comment(s):		Comments from Field Office Consultant 4							
Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service. If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.									

Universal Product Number Pilot Delay

The California Department of Health Services (CDHS) has delayed implementation of the Universal Product Number (UPN) pilot for an indefinite period of time.

Notification of the UPN pilot delay will be sent to providers who have expressed an interest in participating and/or completed the *Request to Participate* form. CDHS remains committed to the concept of the UPN as a means to streamline and expedite medical supply billing and payment. Providers will be notified when a firm implementation date for the pilot is available.

Please continue to bill for medical supplies according to existing policies until further notice. Providers are encouraged to review the information published in future *Medi-Cal Updates* and in the “HIPAA News” area of the Medi-Cal Web site (www.medi-cal.ca.gov) for up-to-date details.



New Digital Mammography and Computer Aided Detection Benefits

Effective retroactively for dates of service on or after December 1, 2006, the following two codes are new Family PACT (Planning, Access, Care and Treatment) program mammography benefits.

<u>Code</u>	<u>Description</u>
G0202	Screening mammography, producing direct digital image, bilateral, all views
76083	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)

Restrictions

CPT-4 code 76083 is only reimbursed with HCPCS code G0202 or CPT-4 code 76092 when findings warrant further physician (radiology) review for interpretation. Code 76083 must be billed with one of the appropriate primary procedure CPT-4 codes.

Family PACT recipients are limited to either one analog (film) or one digital screening mammogram per year. The following restrictions apply for both codes:

- Recipients must be females 40 – 55 years of age.
- All primary ICD-9-CM diagnosis codes apply except S601 – S602 and S801 – S802.
- One screening is provided per year, any provider.

Providers may resubmit previously denied claims until October 1, 2007 for dates of service on or after December 1, 2006.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers.

2007 CPT-4/HCPCS Updates: Implementation August 1, 2007

The 2007 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for the Family PACT (Family Planning, Access, Care and Treatment) Program for dates of service on or after August 1, 2007. Specific policy changes are detailed below.

CPT-4 Codes with Description Changes

The following codes contain new or revised text: 76856, 76880, 90761, 99251 – 99255

Deleted and Replacement Codes

<u>Deleted Code</u>	<u>Replacement Code</u>
49085	49402
54820	54865
76083	77052
76090	77055
76092	77057

Billing Restrictions

CPT-4 code 49402 (removal of peritoneal foreign body from peritoneal cavity) is reimbursable for females only. It requires a *Treatment Authorization Request* (TAR) and a primary diagnosis code (PDC) of S4032 or S4033.

Code 54865 (exploration of epididymis, with or without biopsy) is reimbursable for males only. It requires a TAR and a PDC of S8031 or S8033.

Please see Family PACT, page 10

Family PACT (*continued*)

Code 77052 (computer aided detection [computer algorithm analysis of digital image data for lesion detection] with further physician review for interpretation, with or without digitalization of film radiographic images; screening mammography [list separately in addition to code for primary procedure]) is reimbursable for females 40 – 55 years of age. It is limited to one per recipient, per year, any provider. It requires any PDC except S60 and S80. Code 77052 must be billed with one of the primary procedure CPT-4 codes. It may be used with CPT-4 code 77057 or HCPCS code G0202 only when further physician (radiology) review is warranted for interpretation of findings.

Code 77055 (mammography; unilateral) requires a PDC of S3031 and is reimbursable for females only.

Code 77057 (screening mammography, bilateral [2-view film study of each breast]) is reimbursable for females 40 – 55 years of age. It is limited to one per recipient, per year, any provider. It requires any PDC except S60 or S80. Recipients are limited to either one screening film mammogram (code 77057) or one screening digital mammogram (code G0202) per year, any provider.

New Infant Formula for WIC

Effective August 1, 2007, the California Women, Infants and Children (WIC) Supplemental Nutrition Program will change its infant formula rebate contract from Ross Laboratories to Mead Johnson Nutritionals. The WIC Program will provide the following Mead Johnson standard infant formulas:

- Enfamil LIPIL with Iron (milk-based)
- Enfamil LactoFree LIPIL (milk-based)
- Enfamil Gentlease LIPIL (milk-based)
- Enfamil AR LIPIL (milk-based)
- Enfamil ProSobee LIPIL (soy-based)

Mead Johnson's Enfamil Gentlease LIPIL will replace Nestle Good Start Supreme as the partially hydrolyzed protein formula and will not require a prescription.

Infant formula change can create concern for some parents of young infants. However, the infant formula rebate generates enough income for the WIC Program to provide nutritious food and nutrition services to 350,000 additional California participants each month, 23 percent of which are infants. Therefore, providers are requested to:

- Reassure parents that standard infant formulas are very similar and that changing formula should not cause health problems
- Encourage parents that any discomforts related to a formula change are temporary and should last no more than 3 to 4 days

Formulas for Medical Conditions

The WIC Program will continue to provide formulas for medical conditions using established procedures. For WIC Program participants who are Medi-Cal recipients, benefits include products designed to treat diagnosed conditions when medical justification can be demonstrated. WIC may also provide these formulas on a temporary basis to patients while they complete the Medi-Cal application and enrollment process.

For additional information about formulas for medical conditions available through WIC, or to find the phone number of any local WIC agency, providers can visit the WIC Web site at www.wicworks.ca.gov.

Regular Infant Formula Not a Medi-Cal Benefit

Providers are reminded that infant formula content requirements are defined in the Federal Food, Drug, and Cosmetic Act (FD&CA) to meet the normal needs of healthy infants. Infant formula products meeting those requirements are therefore regular food and not a Medi-Cal benefit. Specialized infant formula for diagnoses that preclude the full use of regular food, but meeting FD&CA nutrient content, may be considered via the prior authorization process.

Additionally, providers are reminded that regular infant formula with altered packaging (nursettes, ready to hang, closed system, etc.), mechanical form (thickened shakes), carbohydrate source (lactose removed) or iron content (reduced iron) do not constitute specialty infant formula and are not Medi-Cal benefits.

Regular infant formula is distinguished by the California Department of Health Services (CDHS) from specialty infant formula as follows:

- Regular infant formula contains FD&CS-required macro- and micro-nutrients for normal, healthy infants.
- Regular infant formula is cow or soy-milk-based.
- Regular infant formula has macronutrients that are intact proteins, carbohydrates and fats (not hydrolyzed, not elemental).

Also, to better define contracted products, Medi-Cal has renamed the policy section to *Enteral Nutrition: List of Contracted Products*.

This information is reflected on manual replacement pages enteral 1 and 2 (Part 2) and reimbursement 1 and 2 (Part 2).

Enzyme Replacement Drugs Reimbursement Update

Effective for dates of service on or after July 1, 2007, the following codes are now Medi-Cal benefits.

<u>HCPCS Code</u>	<u>Description</u>
C9232	Idursulfase, 1 mg, is for the treatment of Hunter syndrome (Mucopolysaccharidosis Type II [MPS II]).
C9234	Alglucosidase alfa, 10 mg, is for the treatment of Pompe Disease.
J1458	Galsulfase, 1 mg, is for the treatment of Maroteaux-Lamy Syndrome (Mucopolysaccharidosis Type VI [MPS VI]).

A *Treatment Authorization Request* (TAR) is required for the reimbursement of enzyme replacement drugs and must be submitted to the Los Angeles Medi-Cal Medical (not Pharmacy) Field Office (LAMFO). Initial drug therapy will be approved on a 3- or 6-month trial basis. Renewal of the TAR will require that follow-up documentation be submitted to the field office. For children under 21 years of age, a Service Authorization Request (SAR) should be made through California Children's Services (CCS).

See the "TAR Requirements" subsection under the specific drug name in the *Injections* section of the appropriate Part 2 provider manual for specific information on TAR submissions.

HCPCS Code Updates and Reminder

Age restrictions are removed from both laronidase (code J1931) and agalsidase beta (code J0180). Also, the correct diagnosis for laronidase is "Mucopolysaccharidosis Type I or Hurler, Hurler-Scheie or Scheie's syndrome."

This information is reflected on manual replacement pages inject 58 thru 60 (Part 2).

Billing Ranibizumab with HCPCS Code J3590

Providers are reminded to use HCPCS code J3590 (unclassified biologics) when billing for ranibizumab, a drug used in treatment of exudative senile macular degeneration. This drug requires a *Treatment Authorization Request* (TAR), which must be sent to the appropriate Medi-Cal field office with required documentation. For instructions to bill for J3590, providers may refer to “Unlisted Injections: HCPCS Codes Billed ‘By Report’ ” in the *Injections* section.

Note: The policy for code J3590 will only be effective through date of service July 31, 2007. On August 1, 2007, providers should use code C9233 (ranibizumab) when it becomes effective as part of the 2007 HCPCS code update.

HCPCS updates will be released in a future Medi-Cal provider bulletin.

Infliximab Diagnoses Expanded

Effective for dates of service on or after July 1, 2007, infliximab (Remicade) 100 mg (HCPCS code X7480) is now reimbursable for the treatment of plaque psoriasis.

Documentation stating that plaque psoriasis covers 10 percent or more of the patient’s body surface area must be on or attached to an approved *Treatment Authorization Request* (TAR).

This information is reflected on manual replacement page [inject 44](#) (Part 2).

Billing Code for Abatacept Revised

Effective for dates of service on or after July 1, 2007, abatacept (Orencia) 10 mg is billed with HCPCS code J0129 rather than code J3590 (unclassified biologics).

Abatacept is approved for the treatment of moderate to severely active rheumatoid arthritis (RA) in adult recipients, 18 years of age or older. A *Treatment Authorization Request* (TAR) is required and must document that the patient has had an inadequate response after treatment with:

- Two or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs), and
- At least one of the tumor necrosis factor (TNF) antagonists (infliximab, etanercept or adalimumab) or the interleukin-1 receptor antagonist, anakinra (inadequate response after at least one month of treatment).

In addition, the TAR must include all of the following:

- A requested dose of abatacept for 1000 mg or less (a quantity of “100” or less in the quantity field of the TAR)
- ICD-9-CM code 714.0, 714.1 or 714.2
- Documentation that the patient is 18 years of age or older

This information is reflected on manual replacement pages [inject 45](#) and [46](#) (Part 2).

Pharmacy Bulletin 657

Remove and replace
at the end of *Manual*

Ordering section: *Subscriber Order Form 1/2 **

Remove and replace: *Contents for Pharmacy Billing and Policy iii/iv **

cal child bil ph 1 thru 4 *
child 1 thru 4 *
compound comp 1/2 *
enteral 1/2
forms reo ph 1/2 *
inject 43 thru 46, 57 thru 60
mc sup lst1 15/16 *
medi cr ph ex 5/6 *, 9 thru 16 *
medi non hcp 1/2 *

Remove and replace
at the end of the *Orthotic
and Prosthetic*

Appliances section: *Physician Certification of Medical Necessity for Therapeutic Diabetic Shoes and Inserts form **

Remove and replace
at the end of the *Other
Health Coverage*

(OHC) section: *Pharmacy Long Term Care Insurance Denial of Coverage Referral form **

Remove and replace: pcf30-1 comp 1 thru 4 *, 7/8 *, 11/12 *

pcf30-1 ex 1 thru 9 *
reimbursement 1/2
tar comp 1 thru 13 *
tar submis 3 *

Remove: tar submit 1/2

Insert: tar submit 1 *

* Pages updated due to ongoing provider manual revisions.