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

Medical Services • Obstetrics

May 2008 • Bulletin 407

Contents

Revised Proprietary Forms Reminder

New versions of Medi-Cal and Child Health and Disability Prevention (CHDP) program proprietary forms are available from Medi-Cal. **Effective April 15, 2008, Medi-Cal is no longer accepting the old version of these forms.** These new forms are updated to accommodate the 10-digit National Provider Identifier (NPI).

The following is the list of proprietary forms that have been revised and must be submitted instead of the old versions.

Form Number	Form Name
18-1	*Request for Extension of Stay in Hospital*
18-1C	*Request for Extension of Stay in Hospital*
18-2	*Request for Extension of Stay in Hospital* (Fax)
18-3	*Request for Mental Health Stay in Hospital*
20-1CZ	*Long Term Care Treatment Authorization Request*
25-1CZ	*Payment Request for Long Term Care*
30-1	*Pharmacy Claim Form*
30-1CZ	*Pharmacy Claim Form*
30-4	*Compound Drug Pharmacy Claim Form*
30-4CZ	*Compound Drug Pharmacy Claim Form*
50-1	*Treatment Authorization Request*
50-1C	*Treatment Authorization Request*
50-2	*Treatment Authorization Request* (Fax)
50-2C	*Treatment Authorization Request*
50-3	*Treatment Authorization Request* (Vision Care)
55-1	*Medi-Cal Managed Care Authorization* Form (Discharge Planning Option)
60-1	*Claims Inquiry Form*
60-1C	*Claims Inquiry Form*
90-1	*Appeal Form*
PM 160 *	*CHDP Assessment Confidential Screening/Billing Report* (Version 8)
PM 160INF *	*CHDP Assessment Confidential Screening/Billing Report* (Information Only) (Version 8)
TAR 3 Form	*Treatment Authorization Request Attachment Form*

* CHDP providers should continue to order claim forms through their local county CHDP program – phone orders will not be accepted.

At the direction of the Department of Health Care Services, the old version non-NPI compliant forms will be returned and may result in claim timeliness issues. If the new form versions are not used, the timeliness of claims may be jeopardized, **and reimbursements may be cut back or denied as a result.**

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Essure (*continued*)

- Bilateral placement of Essure System ESS305 is restricted to once-in-a-lifetime per recipient, any provider.
- Unilateral placement of Essure System ESS305 is restricted to twice-in-a-lifetime per recipient, any provider.
- A hysterosalpingogram, (CPT-4 code 74740), must be performed at 12 weeks after placement of Essure to confirm bilateral tubal occlusion. If tubal occlusion cannot be confirmed at that time, the hysterosalpingogram must be repeated 12 weeks from the date of the first hysterosalpingogram.
- Providers must bill code CPT-4 code 74740 in conjunction with diagnosis code V26.51 (tubal ligation status) when billed as a follow-up to placement of Essure.

Reimbursement
The total reimbursement rate for code 58565 is $2,282.33. The reimbursement includes the procedure, the device and supplies. No invoice is required. Code 58565 will only be reimbursed when billed in conjunction with ICD-9-CM diagnosis code V25.2 (sterilization) and one of the following modifiers: AG, ZM, ZN, 50, 52, or 99 even when the procedure was not successful.

The following restrictions apply to providers billing code 58565 with modifier AG (primary surgeon):

- Documentation must specify whether the procedure was bilateral or unilateral.
- If documentation indicates bilateral, the reimbursement rate is $737.50.
- If documentation indicates unilateral, the reimbursement rate is $368.75.
- Restricted to twice-in-a-lifetime, same recipient, any provider. Failed attempts of either a bilateral or unilateral placement of the Essure micro-inserts should be billed with CPT-4 code 58555 (hysteroscopy, diagnostic).
- Not reimbursable for assistant surgeons.

When code 58565 is billed with modifier 50 (bilateral placement of Essure micro-inserts):

- Reimbursement is $1,299.00 for two Essure micro-inserts.
- Reimbursement is restricted to once in a lifetime, same recipient, any provider.

When code 58565 is billed with modifier 52 (unilateral placement of Essure micro-inserts):

- Reimbursement is $649.50 for one Essure micro-insert.
- Reimbursement is restricted to twice-in-a-lifetime, same recipient, any provider.

When code 58565 is billed with modifier ZM or ZN (supplies):

- Reimbursement is $245.00 for the supplies.
- Reimbursement is restricted to two times in a lifetime, same recipient, any provider.

Claims submitted without required documentation will be denied.

The six month timeliness will be overridden for claims billing code 58565 or 74740 in conjunction with diagnosis code V26.51 with Dates of Service (DOS) January 1, 2008 – April 1, 2008. Claims must be received before November 1, 2008 to have the six month timeliness overridden.

Manual replacement pages reflecting the policy in this article and will be included in a future *Medi-Cal Update.*

Ultrasound Policy Expanded to Include Abortions

Effective retroactively for dates of service on or after March 1, 2005, the following ultrasound codes can now be billed as payment for the treatment of spontaneous abortions (using diagnosis codes 634.00 – 634.92) and unspecified abortions, which include complete, incomplete and inevitable abortions (using diagnosis codes 637.00 – 637.92):

Please see **Ultrasound,** *page 4*

Ultrasound (*continued*)

CPT-4 Code	Description
76801	Transabdominal ultrasound, pregnant uterus, first trimester; single or first gestation
76802	each additional gestation
76805	Transabdominal ultrasound, pregnant uterus, after first trimester; single or first gestation
76810	each additional gestation
76811	Transabdominal ultrasound, pregnant uterus, fetal and maternal evaluation; single or first gestation
76812	each additional gestation
76815	Ultrasound, pregnant uterus, limited, one or more fetuses
76816	Transabdominal ultrasound, pregnant uterus, follow-up, per fetus
76817	Transvaginal ultrasound, pregnant uterus

Claims previously denied for the above-listed procedure codes and diagnosis codes will be automatically reprocessed.

This information is reflected on manual replacement pages preg early 5 thru 7 (Part 2).

Rate Increase for Mirena Intrauterine System®

Effective retroactively to September 24, 2007, the rate for HCPCS code X1532 (Mirena Intrauterine System [IUS]) is increased from $420.33 to $468.71. Previously paid claims will be adjusted.

For a listing of all rates, providers should refer to the "Medi-Cal Rates" page of the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "References" tab then the "Medi-Cal Rates" link.

Extended Presumptive Eligibility Coverage Update

Effective for dates of service on or after June 1, 2008, a qualified provider is no longer required to contact the Presumptive Eligibility (PE) Support Unit for approval of PE coverage extensions. For further coverage extensions, the same process is followed as with the initial extension, if an application remains pending beyond the "Second Good Thru" date.

If a PE recipient has a good reason for not applying or following through with her application for Medi-Cal, the provider must contact the PE Support Unit at 1-800-824-**0800**. The PE Support Unit will assess each situation individually and give specific instructions to the provider about how to proceed.

Details on PE coverage extensions are found in "Extending PE Coverage" in the *Presumptive Eligibility* section of the Part 2 manual.

This information is reflected on manual replacement page presum 10 (Part 2).

CPT-4 Codes 88147 and 88148 Billing Restrictions Update

Retroactive for dates of service on or after October 1, 2006, CPT-4 codes 88147 (cytopathology smears, cervical or vaginal; screening by automated system under physician supervision) and 88148 (screening by automated system with manual rescreening under physician supervision) are split-billed and may be billed with modifiers 26, TC or ZS. Claims denied inappropriately or paid incorrectly will be re-processed.

This information is reflected on manual replacement pages path bil 1, 2, 3 and 5 (Part 2).

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National Drug Code (NDC) Reporting Requirements

Beginning September 1, 2008, providers are encouraged to begin using the National Drug Code (NDC) for physician-administered drugs, in conjunction with the customary Healthcare Common Procedure Coding System (HCPCS) Level I, II or III code, on all Medi-Cal claims.

- Claims submitted for dates of service from September 1, 2008 through March 31, 2009 without an NDC will not be denied.
- Claims with dates of service on or after April 1, 2009 that do not meet the NDC reporting requirements to include a valid NDC paired with a HCPCS code, will result in claims being denied.

The Deficit Reduction Act of 2005 (DRA) requires all state Medicaid agencies to collect rebates from drug manufacturers for physician-administered or dispensed drugs. Only those products manufactured by companies participating in the federal Medicaid rebate program are reimbursable under Medi-Cal. A list of manufacturers participating in the rebate program, which changes periodically, is available in the Part 2 Medi-Cal pharmacy manual under *Drugs: Contract Drugs List Part 5 – Authorized Manufacturer Labeler Codes* or on the Medi-Cal Web site (www.medi-cal.ca.gov).

National Drug Code Description

The NDC is a number that identifies a specific drug. The NDC number consists of 11 digits in a 5-4-2 format. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into three segments. A complete 11-digit number must have five digits in the first segment, four digits in the second segment, and two digits in the last segment. The first five digits of an NDC identify the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The remaining digits are assigned by the manufacturer and identify the specific product and package size. Leading zeros are added wherever they are needed to complete a segment with the correct number of digits.

Example: 5-4-2 Format

Package Number	Zero Fill	11-digit NDC
1234-1234-12	(01234-1234-12)	01234123412
12345-123-12	(12345-0123-12)	12345012312
2-22-2 (00002-0022-02)	00002002202	

The NDC is found on the drug container (vial, bottle or tube). The NDC submitted to Medi-Cal must be the actual NDC number on the package or container from which the medication was administered. Providers should not bill for one manufacturer's product and dispense another. It is considered to be a fraudulent billing practice to bill using an NDC other than the one administered.

Physician-Administered Drugs

A physician-administered drug includes any covered outpatient drug provided or administered to a recipient, which is billed by a provider other than a pharmacy. Such providers would include, but not be limited to, physician offices, clinics and hospitals.

Please see **NDC Reporting**, *page 2*

Presumptive Eligibility Program: Benefits Expanded

Effective retroactively for dates of service on or after September 1, 2005, the following obstetric panel procedure codes are Medi-Cal benefits for the Presumptive Eligibility (PE) Program:

CPT-4 Code	Description
82951	Glucose; tolerance test (GTT), three specimens (includes glucose)
82952	Glucose; tolerance test, each additional beyond three specimens
85004	Blood count; automated differential WBC count
85007	blood smear, microscopic examination with manual differential WBC count
85009	manual differential WBC count, buffy coat
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC count
85027	complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count)
86592	Syphilis test; qualitative (e.g., VRDL, RPR, ART)
86762	Antibody; rubella
86850	Antibody screen, RBC, each serum technique
86900	Blood typing; ABO
86901	Rh (D)
87340	Infectious agent detection by enzyme immunoassay technique, qualitative or semi-quantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
87621	Papillomavirus, human, amplified probe technique
88141	Cytopathology, cervical or vaginal, requiring interpretation by physician
88174	Cytopathology cervical or vaginal, collected in preservation fluid, automated thin layer preparation, screening by automated system, under physician supervision
88175	and manual rescreening or review, under physician supervision
88300	Level I – Surgical pathology, gross examination only
88304	Level III – Surgical pathology, gross, and microscopic examination
88305	Level IV – Surgical pathology, gross, and microscopic examination
90760	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
90761	each additional hour
90774	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
90775	each additional sequential intravenous push of a new substance/drug
99281	Emergency department visit; self limited or minor
99282	low to moderate severity
99283	moderate severity
99284	high severity
99285	high severity with immediate threat to life or physiologic function

HCPCS Code	Description
Z7502	Use of emergency room

In addition, claims for services provided to PE recipients for codes 84702 (gondadotropin, chorionic [hCG]; quantitative) and 84703 (gondadotropin, chorionic [hCG]; qualitative) will no longer be benefits only when an ectopic pregnancy has been established. The same diagnosis restrictions that apply to Medi-Cal recipients for codes 84702 and 84703 will also apply to PE recipients. Providers should refer to the *Pathology* section in the appropriate Part 2 manual for specific billing information.

Claims for services provided to PE recipients that were previously denied for one of the procedure codes identified above will be automatically reprocessed.

This information is reflected on manual replacement pages presum 17 thru 21 (Part 2).