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

Medical Services • General Medicine

June 2010 • Bulletin 432

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2010 CPT-4/HCPCS Annual Update: Implementation September 1, 2010

The 2010 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes are listed below. Only those codes representing current or future Medi-Cal benefits are included in this list. Medi-Cal will implement the code additions, changes and deletions for dates of service on or after September 1, 2010. Please refer to the 2010 CPT-4 and HCPCS Level II code books for complete descriptions of these codes. Specific policy, billing information and manual replacement pages reflecting these changes will be released in a future *Medi-Cal Update.*

CPT-4 Code Additions

Immunizations
90470

Medicine
92540, 92550, 92570, 93750, 94011 – 94013, 95905

Pathology and Laboratory
83987, 86305, 86780, 86825, 86826, 87150, 87153, 87493, 88387, 88388, 89398

Radiology
75791, 77338, 78451 – 78454

Surgery
14301, 14302, 21011 – 21014, 21016, 21552, 21554, 21558, 21931 – 21933, 21936, 22901 – 22905, 23071, 23073, 23078, 24071, 24073, 24079, 25071, 25073, 25078, 26111, 26113, 26118, 27043, 27045, 27059, 27337, 27339, 27364, 27616, 27632, 27634, 28039, 28041, 28047, 29581, 31626, 31627, 32552, 32553, 32561, 32562, 33782, 33783, 33981 – 33983, 36147, 36148, 37761, 43281, 43282, 43775, 45171, 45172, 46707, 49411, 51727 – 51729, 53855, 57426, 63661 – 63664, 64490 – 64495

Modifier Additions
AI, J4, PA, PB, PC, PI, PS, V5, V6, V7, V8, V9

Please see **CPT-4/HCPCS**, *page 2*

HCPCS Level II Code Additions

Chemotherapy
J2562, J9155, J9171, J9328

Pathology and Laboratory
G0430, G0431, S3713

Physician-Administered Drugs
C9254 – C9256, J0461, J0598, J0718, J0833, J0834, J1680, J2793, J2796, Q0138, Q0139

Radiology
A9581 – A9583, A9604

Sterilization
A4264

Surgery
A4264, C9250, C9360 – C9364, Q0506, Q4116, Q9968

CPT-4 Codes with Description and/or Administration Changes

Immunizations
90378, 90663, 90669

Medicine
93279 – 93287, 95992, 99241 – 99245, 99251 – 99255, 99292, 99304 – 99310, 99358, 99382

Pathology and Laboratory
80055, 82306, 82652, 82784, 82785, 82787, 83516, 83518 – 83520, 83919, 83986, 86592, 86593, 87149, 88172, 88312 – 88314, 88332

Radiology
72291, 72292, 76802, 77003, 77371, 78290

Surgery
16036, 17311 – 17315, 19295, 21015, 21555 – 21557, 21930, 21935, 22520 – 22522, 22534, 22857, 22862, 22865, 22900, 23075 – 23077, 23200, 23210, 23220, 24075 – 24077, 24150, 24152, 25075 – 25077, 25170, 26115 – 26117, 26250, 26260, 26262, 27047 – 27050, 27075 – 27078, 27327 – 27329, 27365, 27615, 27618 – 27620, 27640, 27641, 27645 – 27647, 28043, 28045, 28046, 28171, 28173, 28175, 30801, 30802, 31622, 31632, 31633, 31641, 31643, 31645, 31646, 31656, 32560, 33216, 33217, 33223, 34826, 36481, 37183, 37760, 42894, 43761, 46200, 46220, 46221, 46230, 46250, 46255, 46257, 46258, 46260 – 46262, 46270, 46275, 46280, 46285, 46320, 46945, 46946, 47382, 47525, 50200, 50205, 51726, 51736, 51797, 52282, 55876, 59897, 61630, 61635, 61868, 63043, 63044

HCPCS Level II Codes with Description and/or Administration Changes

Medical Supplies
S9433

Medicine
C9728, S2270

Pathology and Laboratory
G0416 – G0419, S3860, S3862

Physician-Administered Drugs
J7611, J7613

Radiology
A9500

Surgery
L8680, Q0496, S2118

Please see **CPT-4/HCPCS**, *page 3*

CPT-4/HCPCS *(continued)*

CPT-4 Code Deletions

Anesthesia
01632

Medicine
92569, 99185, 99186

Pathology and Laboratory
82307, 86781

Radiology
75558, 75560, 75562, 75564, 75790, 78460, 78461, 78464, 78465, 78478, 78480

Surgery
14300, 23221, 23222, 24151, 24153, 26255, 26261, 27079, 36834, 45170, 46210, 46211, 46937, 46938, 51772, 51795, 63660, 64470

HCPCS Level II Code Deletions

Chemotherapy
C9245, C9252, X7638

Medical Supplies
A4365, A6200 – A6202

Physician-Administered Drugs
C9249, J0460

Radiology
A9605, C9246, C9247

Surgery
A9535, G0392, G0393

Modifier ZS No Longer Reimbursable with MRA, MRI and PET Scans

Effective for dates of service on or after August 1, 2010, modifier ZS will no longer be reimbursable with MRI, MRA and PET scans. Providers will be required to use modifiers 26 (professional component) and TC (technical component) with CPT-4 codes used to bill MRI, MRA and PET scan services. Providers are instructed to use one of the following scenarios when submitting a *Treatment Authorization Request* (TAR) for services requiring authorization.

Scenario 1:
One TAR and one provider for both the professional (26) and technical (TC) components of service.

The TAR must be submitted with two lines of service. The first line must have the CPT-4 code and one of the two modifiers (26 or TC). The second line must have the same CPT-4 code and the corresponding modifier (26 and TC).

Scenario 2:
One TAR and two different providers for the professional (26) and technical (TC) components of service. This is the preferred method for two different providers.

One of the two providers submits the TAR on behalf of both providers of the two components of service (26 and TC) and both providers should use the same TAR for claim submission. The TAR must be submitted with two lines of service. The first line must have the CPT-4 code and one of the two modifiers (26 or TC). The second line must have the same CPT-4 code and corresponding modifier (26 or TC).

Scenario 3:
Two TARs and two different providers for the professional (26) and technical (TC) components of service.

Each provider submits their own TAR with one line of service and the appropriate modifier (26 or TC) designating the service they will provide or have provided.

Manual replacement pages will be updated with the July Medi-Cal Update.

Botulinumtoxins: New Benefit and Updates

Effective for dates of service on or after June 1, 2010, abobotulinumtoxinA (DYSPORT), 5 units, HCPCS code J0586 is a new Medi-Cal benefit. Additionally, policy for onabotulinumtoxinA (BOTOX), 1 unit, code J0585 and rimabotulinumtoxinB (Myobloc), 100 units, code J0587 are updated. New policy for abobotulinumtoxinA is as follows. Updates for the other botulinum toxins are included in the provider manual.

AbobotulinumtoxinA
AbobotulinumtoxinA is reimbursable for the treatment of any of the following:

- Adults with cervical dystonia
- Achalasia (see following "Authorization" information)

The botulinum toxins are a family of neurotoxins produced by various toxigenic strains of the gram-positive anaerobic bacterium Clostridium botulinum and are comprised of seven antigenetically distinct serotypes (A to G). All botulinum neurotoxin serotypes produce their clinical effect of flaccid paralysis by blocking the release of acetylcholine from nerve endings.

Three botulinum toxin products have been approved by the U.S. Food and Drug Administration (FDA).

Two botulinum toxin serotype A products:

- AbobotulinumtoxinA (DYSPORT)
- OnabotulinumtoxinA (BOTOX)

One botulinum toxin serotype B product:

- RimabotulinumtoxinB (Myobloc)

A significant difference within botulinum toxin type A serotypes is that the units are not interchangeable between the two FDA-approved products as there is no common international standard methodology for assaying units within the botulinum toxin serotypes. Therefore, one unit of abobotulinumtoxinA is not equivalent to one unit of onabotulinumtoxinA. Similarly, the units of one botulinum toxin serotype cannot be converted into units of any other botulinum toxin serotype as there is no common international standard methodology for assaying units among the different botulinum toxin serotypes. Consequently, neither the units of abobotulinumtoxinA nor onabotulinumtoxinA are interchangeable with rimabotulinumtoxinB. The dosing of any botulinum toxin product must be individualized to each specific patient based upon many factors including, but not limited to, size of the muscles to be injected, the number of muscles to be injected, body weight, the condition being treated, expected patient response and general health of the patient. Standard doses do not exist.

Authorization
Medical necessity must be established and an approved *Treatment Authorization Request* (TAR) is required for reimbursement.

If the request is for the treatment of achalasia, the TAR must document any of the following:

- Failed pneumatic dilation or myotomy
- Poor surgical candidate
- High risk for complications such as perforation
- History of hiatal hernia or epiphrenic diverticulum
- History of perforation

Please see **Botulinumtoxins**, *page 5*

Botulinumtoxins *(continued)*

Dosing
The initial dose of abobotulinumtoxinA is 500 units given intramuscularly as a divided dose among the affected muscles. Re-treatment is based on return of clinical symptoms with doses administered between 250 and 1,000 units to optimize clinical benefit. Re-treatment should not occur in intervals of less than 12 weeks.

Billing
Billed with HCPCS code J0586 per 5 units. One unit billed is equivalent to 5 units of abobotulinumtoxinA.

Due to the short half life of abobotulinumtoxinA, Medi-Cal will reimburse the unused portion of the drug only when vials are not split between patients. Scheduling of more than one patient is encouraged to prevent wastage of abobotulinumtoxinA. If a vial is split between two or more patients, the billing must be for the exact amount of drug administered to each individual patient.

Updates are reflected on manual replacement pages inject cd list 2, 3, 13 and 16 (Part 2), inject drug a-l 2, 3, 6 and 7 (Part 2) and inject drug m-z 3 thru 7, 14 and 15 (Part 2).

Calcitriol New Benefit

Effective for dates of service on or after July 1, 2010, HCPCS code J0636 (injection, calcitriol, 0.1 mcg) is a Medi-Cal benefit. Calcitriol is indicated in the management of hypocalcemia in patients undergoing chronic renal dialysis.

This information is reflected on manual replacement pages inject drug a-l 7 (Part 2) and inject cd list 4 (Part 2).

E&M Codes for Subacute Subsequent Hospital Care: New Policy

Effective for dates of service on or after June 1, 2010, reimbursement for Evaluation and Management (E&M) HCPCS codes X9928 – X9932 (subacute subsequent care) will be restricted to any combination of two services by the same provider, for the same recipient and same date of service. Providers may be reimbursed for more than two services if there is documentation that either the patient's status deteriorated or there was a significant change which necessitated more than two physician visits to the bedside on the same day.

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

Cosmetic Injections: Medi-Cal Non-Benefits

Effective for dates of service on or after July 1, 2010, HCPCS codes Q2026 (injection, Radiesse, 0.1 ml) and Q2027 (injection, Sculptra aesthetic, 0.1 mg) will be non-benefits for the Medi-Cal program. Code Q2026 is considered a cosmetic filler used to treat deep lines and wrinkles around the nose and mouth. Code Q2027 is an injectable facial implant.

Menveo Joins Menactra as Reimbursable Meningitis Vaccine

Effective retroactively for dates of service on or after April 1, 2010, the administration fee for meningitis vaccine Menveo (CPT-4 code 90734) is a new Medi-Cal and Vaccines For Children (VFC) benefit. Menveo is a quadrivalent meningococcal conjugate vaccine licensed in February by the Food and Drug Administration, which recommends the vaccine for all people 11 – 18 years of age and people 2 – 55 years of age who are at high risk for meningococcal diseases.

Please see **Menveo**, *page 6*

Menveo *(continued)*

Menactra Policy Update
Menactra is a second meningitis vaccine that is reimbursable by both Medi-Cal and VFC. Policy for this vaccine is also being updated: Menactra is no longer reimbursable by Medi-Cal for recipients 2 – 10 years of age.

Claims Submitted to VFC
Menveo is a VFC benefit for the following age classifications.

- Recipients 2 – 10 years of age who are considered at high-risk for exposure to meningitis, such as those who are complement deficient, or are recipients with functional or anatomic asplenia.
- Recipients 11 – 18 years of age.

Providers enter SK and SL modifiers on the claim for recipients 2 – 10 years of age and document in the *Reserved for Local Use* field (Box 19), or on an attachment to the claim, the reason why the patient is considered high risk. For example: "Recipient is asplenic."

For claims with the age classification of 11 – 18 years of age, providers only need to enter the SL modifier on the claim.

Claims Submitted to Medi-Cal
Menveo policy and billing instructions are as follows:

- Recipients 2 – 10 years of age are not covered by Medi-Cal
- SL modifier for recipients 11 – 18 years of age
- SK modifier for recipients 19 – 55 years of age

Medi-Cal claims billing for Menveo must be submitted with modifier SK. In addition, providers must document in the *Reserved for Local Use* field (Box 19), or on an attachment to the claim, the reason why the patient is considered high risk. For example: "Recipient is young adult living in a college dormitory."

This article is provided as information only for Pharmacy providers. Code 90734 is not reimbursable to Pharmacy providers.

This information is reflected on manual replacement pages immun 2 and 9 (Part 2) and vaccine 4, 7 and 9 (Part 2).

Micafungin Sodium Injection 1 mg Policy Change

Effective for dates of service on or after July 1, 2010, ICD-9-CM diagnosis codes 112 – 112.9 are not required for HCPCS code J2248 (micafungin sodium, 1 mg).

Micafungin is indicated for the treatment of the following:

- Treatment of patients with candidemia, acute disseminated candidiasis, candida peritonitis and abscesses
- Treatment of patients with esophageal candidiasis
- Prophylaxis of candida infections in patients undergoing hemotopoietic stem cell transplantation
- Treatment or prophylaxis of other cancer related fungal infections such as, but not limited to patients who have received a bone marrow transplant

The usual dose is 50 – 150 mg daily for the duration of treatment or prophylactic therapy.

This information is reflected on manual replacement pages inject drug m-z 3 (Part 2).

Radiological Examination Rate Update

Effective for dates of service on or after July 1, 2010, the rate for CPT-4 code 74270 (radiological examination colon; barium enema, with or without KUB) is reduced to $51.90.

Outpatient Intravenous Insulin Treatment Medi-Cal Non-Benefit

Effective for dates of service on or after July 1, 2010, HCPCS code G9147 (Outpatient Intravenous Insulin Treatment [OIVIT]) is a Medi-Cal non-benefit with a minimum age of 2 years.

OIVIT refers to an outpatient regimen that integrates pulsatile or continuous intravenous infusion of insulin, performed in scheduled recurring periodic intermittent episodes, via any means guided by the results of measuring:

- Respiratory quotient; and/or
- Urine urea nitrogen; and/or
- Arterial, venous, or capillary glucose; and/or
- Potassium concentration.

Case Management Payments for CDP: EWC – Billing Update

Effective for dates of service on or after July 1, 2010, Cancer Detection Programs: Every Woman Counts (CDP:EWC) primary care providers must bill two CPT-4 codes for records requiring additional case management time. CPT-4 code 99359 (prolonged evaluation and management service before and/or after direct [face-to-face] patient care [eg, review of extensive records and tests, communication with other professionals and/or the patient/family]; each additional 30 minutes) will be payable in conjunction with CPT-4 code 99358 (prolonged evaluation and management service) to CDP: EWC program providers with the following billing and payment changes:

CPT-4 Code	Billing Restrictions	Payment
99358	Normal results that reflect provider time to track and report a screening record. Pays one time per calendar year, per recipient, per provider.	$10
99359	Abnormal results that require coordination of referrals and additional reporting. Pays one time per calendar year, per recipient, per provider.	$40

This information is reflected on manual replacement pages can detect 14, 39 and 40 (Part 2), can detect exc 3 (Part 2) and tar and non cd9 7 (Part 2).

CDP: Every Woman Counts Documents Revised

The Cancer Detection Programs: Every Woman Counts *Covered Procedures* documents will be revised in May. The revised documents will be available on the CDP: Every Woman Counts page.

The following change has been incorporated in the updated worksheets:

CPT-4 Code	Description
G0206	Diagnostic mammography, direct digital image, unilateral, all views (paid at the CPT-4 code 77055 rate)

Hospice Providers Maintain Terminal-Illness Certification in Patient Records

Effective for dates of service on or after July 1, 2010, Hospice providers no longer need to submit terminal-illness certification and recertification documents to the Department of Health Care Services (DHCS). Instead, the certifications and recertifications are to be maintained in the terminally ill patient's medical record.

There is no change to the patient election process for hospice. For information about the election process, providers may refer to "Eligible Recipients" in the *Hospice Care* section of the Part 2 provider manual.

This information is reflected on manual replacement pages hospic 1 thru 3 (Part 2).

California Children's Services Updates

New SCG 51 Excludes Codes
Effective for dates of service on or after July 1, 2010, a new California Children's Services (CCS) Program Service Code Grouping (SCG), SCG 51, has been developed to facilitate the authorization of surgical services for CCS clients. When an SCG 51 Service Authorization Request (SAR) is approved by the CCS program, all surgical codes that are payable by the California Medicaid Management Information System are reimbursable pursuant to the SAR except for the surgical codes identified in *California Children's Services (CCS) Program Service Code Groupings* section in the appropriate Part 2 manual. Other service codes that are not payable pursuant to an SCG 51 SAR include the additional codes identified in the same manual section, inpatient hospital days, and those codes on the CCS restricted drug table (see page 7). Services rendered pursuant to SCG 51 are subject to a systematic post-payment audit and quality assurance review.

AbobotulinumtoxinA Requires Separate SAR
AbobotulinumtoxinA (DYSPORT), 5 mg, billed with HCPCS code J0586 has been added to the CCS restricted drug table and requires a separate SAR. This policy is effective for dates of service on or after June 1, 2010.

CCS Service Code Groupings Update
The following codes will be added/end-dated to/from the California Children's Services (CCS) Service Code Groupings (SCGs):

Added Codes

Effective Date	Code	SCGs
November 1, 2009	CPT-4 code 90650	01, 02, 03 and 07
March 1, 2010	CPT-4 code 90670	01, 02, 03 and 07
June 1, 2010	HCPCS code J3370 and S0077	01, 02, 03, 07 and 12

End-Dated Codes

Effective Date	Code	SCGs
April 1, 2010	HCPCS code Z5436	03
June 1, 2010	HCPCS code X5956, X5958 and X6998	01, 02, 03, 07 and 12

Reminder: SCG 02 includes all the codes in SCG 01, plus additional codes applicable only to SCG 02. SCG 03 includes all the codes in SCG 01 and SCG 02, plus additional codes applicable only to SCG 03. SCG 07 includes all the codes in SCG 01 plus additional codes applicable only to SCG 07.

This information is reflected on manual replacement pages cal child sar 7 (Part 2) and cal child ser 1, 2, 4, 12, 16, 24, 25 and 28 (Part 2).

Authorized Drug Manufacturer Labeler Codes Update

The *Drugs: Contract Drugs List Part 5 – Authorized Drug Manufacturer Labeler Codes* section has been updated as follows.

Addition, effective April 1, 2010

NDC Labeler Code	Contracting Company's Name
00941	BAXTER HEALTHCARE CORPORATION

Additions, effective July 1, 2010

NDC Labeler Code	Contracting Company's Name
14550	ACTAVIS PHARMA MFGING PRIVATE LTD
36800	TOPCO ASSOCIATES LLC
43351	ALLAIRE PHARMACEUTICALS, LLC
49685	NEUROGESX, INC.
50222	LEO PHARMA INC.
50236	QLT OPHTHALMICS INC.
50268	AVPAK
52304	GENSAVIS, LLC
68405	PHYSICIAN THERAPEUTICS LLC

Terminations, effective July 1, 2010

NDC Labeler Code	Contracting Company's Name
24430	MICROBIX BIOSYSTEMS, INC.
42212	LE VISTA INC.
59243	SAGE PHARMACEUTICALS, INC.

Voluntary Terminations, effective July 1, 2010

NDC Labeler Code	Contracting Company's Name
00165	BLAINE COMPANY, INC.
17205	TARGACEPT
58211	TOPIX PHARMACEUTICALS, INC.

These updates are reflected on manual replacement pages drugs cdl p5 3, 5, 7 thru 11 and 16 (Part 2).

Monthly Claim Line Limit Restriction Updates

The following cancer drugs are no longer exempt from the monthly claim line limit, effective for dates of service on or after June 1, 2010:

- Alemtuzumab
- Lenalidomide
- Panitumumab
- Thalidomide
- Toremifene Citrate
- Valrubicin

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs, Drugs: Contract Drugs List Part 2 – Over-the-Counter Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications Drugs.*

Drug	Strength and/or Size	Billing Unit
Additions, effective June 1, 2010		
AMLODIPINE/TELMISARTAN		
Tablets	5 mg/40 mg	ea
	5 mg/80 mg	ea
	10 mg/40 mg	ea
	10 mg/80 mg	ea
***** ILOPERIDONE		
* Restricted to use in individuals 6 years of age and older.		
Tablets	1 mg	ea
	2 mg	ea
	4 mg	ea
	6 mg	ea
	8 mg	ea
	10 mg	ea
	12 mg	ea
Addition, effective July 1, 2010		
* ASENAPINE		
***** Restricted to individuals 6 years of age and older only.		
Sublingual Tablets	5 mg	ea
	10 mg	ea
Change, effective April 19, 2010		
‡ TRIPTORELIN PAMOATE		
Powder for injection	3.75 mg/vial	ea
	11.25 mg/vial	ea
	22.5 mg/vial	**ea**

‡ Drug is exempt from the monthly drug claim line limit.

Please see **Contract Drugs**, *page 11*

Contract Drugs *(continued)*

Drug	Strength and/or Size		Billing Unit
Changes, effective June 1, 2010			
* COLESEVELAM HCL			
* Restricted to use in patients who have failed or are unable to tolerate a HMG-CoA Reductase inhibitor.			
Tablets	625 mg		ea
Oral suspension	**3.75 Gm packet**	**30's**	**ea**
ISRADIPINE			
+ Capsules	2.5 mg		ea
	5 mg		ea
* + Tablets, controlled release	5 mg		ea
	10 mg		ea
* Restricted to NDC labeler code**s** 65726 (Reliant Pharmaceuticals, ~~Inc.~~**LLC**) **and 00173 (GlaxoSmithKline LLC corporate parent of Reliant Pharmaceuticals, LLC)** for controlled release tablets only.			
LEVONORGESTREL			
Tablets	* 0.75 mg		
* Restricted to NDC labeler codes 51285 (Barr Laboratories, Inc.) and 52544 (Watson Pharma, Inc.) and to a maximum quantity of two tablets per dispensing with a maximum of six dispensings in any 12-month period for **the 0.75 mg tablets and for** females only.			
	*** 1.5 mg**		**ea**
*** Restricted to NDC labeler code 51285 (Barr Laboratories, Inc.) and to a maximum quantity of one tablet per dispensing with a maximum of six dispensings in any 12-month period for the 1.5 mg tablet and for females only.**			
Note: This update applies to both the *Drugs: Contract Drugs List Part 1 – Prescription Drugs (E through M)* and the *Drugs: Contract Drugs List Part 2 – Over the Counter Drugs* sections.			
‡ * RALTEGRAVIR			
* Restricted to use ~~in~~ **as** combination **therapy** ~~with other antiretroviral agents for~~ **in** the treatment of **Human Immunodeficiency Virus (**HIV**)** ~~-1~~ infection ~~in treatment-experienced adult patients who have evidence of viral replication and HIV-1 strains resistant to multiple antiretroviral agents~~.			
Tablets	400 mg		ea
Change, effective August 1, 2010			
* FENTANYL			
* Restricted to **NDC labeler code 50458 (Janssen Pharmaceutical Products, L.P.) and to** a maximum of ten (10) transdermal patches per dispensing and a maximum of three (3) dispensings of any strength in a 75-day period **only**.			
Transdermal patch	~~2.5 mg~~	**25 mcg**	**ea**
	~~* 5 mg~~	**50 mcg**	**ea**
	~~* 7.5 mg~~	**75 mcg**	**ea**
	~~* 10 mg~~	**100 mcg**	**ea**
~~**Restricted to NDC labeler code 50458 (Janssen Pharmaceutical Products, L.P.) for the 5 mg, 7.5 mg and 10 mg transdermal patches only.**~~			

\+ Frequency of billing requirement
‡ Drug is exempt from the monthly drug claim line limit.

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Remove and replace: cal child sar 7/8
cal child ser 1 thru 4, 11/12, 15/16

Remove: cal child ser 23 thru 27
Insert: cal child ser 23 thru 28

Remove and replace: can detect 13/14, 39/40
can detect exc 3
cif co 9/10 *
drugs cdl p5 3 thru 12, 15/16
eval 1 thru 4
hcpcs iii 1/2 *
hospic 1 thru 4
immun 1/2, 9/10
inject bil cms 1/2 *
inject cd list 1 thru 4, 13 thru 16
inject drug a-l 1 thru 8, 17 thru 22 *

Remove and replace after page inject drug a-l 38: *Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements* form 1/2 *

Remove: inject drug m-z 1 thru 21
Insert: inject drug m-z 1 thru 33

Remove and replace: medi non cpt 1 *
medi non hcp 1/2 *
medne neu 5/6 *
modif app 7/8 *

Remove: opt ben exc 5 thru 19
Insert: opt ben exc 5 thru 20 *

Remove and replace: oth hlth cpt 1/2 *
ster 13 thru 16 *
tar and non cd9 7/8
vaccine 3/4, 7/8

* Pages updated due to ongoing provider manual revisions.