

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

## Genetically Handicapped Persons Program (GHPP)

This section contains program, policy and billing information for the Genetically Handicapped Persons Program (GHPP).

### Program Overview

GHPP provides health care services for adults with genetic diseases specified in the *California Code of Regulations* (CCR), Title 17, Section 2932.

GHPP eligibility determination, case management and authorization of services are conducted on a statewide basis by the GHPP state office.

### Eligibility Requirements

Applicants must meet age, residence, income and medical eligibility requirements to participate in GHPP. Applicants must submit completed *Genetically Handicapped Persons Program (GHPP) Application to Determine Eligibility* and *Genetically Handicapped Persons Program (GHPP) Initial/Annual Income Verification* forms. Eligibility requirements are as follows.

#### Age

Applicants must be 21 years of age or older. Persons younger than 21 years of age with GHPP-covered genetic diseases may be eligible for GHPP if they have been determined to be financially ineligible to receive services from the California Children's Services (CCS) program.

#### Residence

Applicants must be residents of California.

#### Income

There is no income limit for GHPP. However, GHPP clients may be required to pay an annual enrollment fee. The amount of the enrollment fee is based on the client's adjusted gross income. For adjusted gross income between 200 and 299 percent of the federal poverty level, the annual enrollment fee shall be 1.5 percent of adjusted gross income. For adjusted gross income equal to or greater than 300 percent of the federal poverty level, the annual enrollment fee shall be 3 percent of adjusted gross income.

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### Medical Eligibility

GHPP covers genetic disease conditions specified in the *California Code of Regulations* (CCR), Title 17, Section 2932. The following is a summary of GHPP-eligible medical conditions. This summary is solely to assist providers in understanding the medical eligibility criteria of the GHPP program. It is not an authoritative statement of, and should not be cited as, authority for any decisions, determinations or interpretations of the GHPP program. Providers should refer to the CCR section cited above for a definitive description of GHPP medical eligibility requirements.

- Hemophilia and other genetic bleeding disorders
- Cystic fibrosis
- Hemoglobinopathies with anemia, including sickle-cell disease and thalassemia
- Huntington's disease, Joseph's disease, Friedreich's ataxia and other neurologic diseases
- Phenylketonuria, Wilson's disease, galactosemia and other metabolic diseases
- Von Hippel-Lindau syndrome

### How To Apply

The GHPP application and referral forms can be found on the GHPP "How to Apply" page of the Department of Health Care Services (DHCS) website at <http://www.dhcs.ca.gov/services/ghpp/Pages/apply.aspx>.

The GHPP application and referral forms must be mailed or faxed.

Department of Health Care Services  
Genetically Handicapped Persons Program  
MS 8100  
P.O. Box 997413  
Sacramento, CA 95899-7413  
Fax: (916) 440-5318

**Service Authorization Request**

A Service Authorization Request (SAR) must be submitted to the GHPP state office for approval of all GHPP diagnostic and treatment services. GHPP will issue a unique SAR number for services authorized by GHPP. This SAR number will begin with "99." The SAR number must be indicated on the claim in the appropriate *Treatment Authorization Request (TAR)* field prior to submission to the Department of Health Care Services (DHCS) Fiscal Intermediary (FI) for payment.

The provider is responsible for ensuring that the SAR number is indicated on the claim. Claims submitted without the correlating SAR number in the TAR field will be denied.

For emergency services, authorization must be obtained from GHPP by the close of the next business day following the date of service.

Providers may request services for GHPP clients using one of the following SAR forms. Copy-ready versions of these forms are located at the end of the *California Children's Services (CCS) Program Service*

*Authorization Request (SAR)* section in the appropriate Part 2 manual:

- *New Referral CCS/GHPP Client Service Authorization Request (SAR)* (form DHCS 4488)
- *Established CCS/GHPP Client Service Authorization Request (SAR)* (form DHCS 4509)
- *CCS/GHPP Discharge Planning Service Authorization Request (SAR)* (form DHCS 4489)

The forms are also available under the "California Children's Services (CCS)" heading on the "Forms" page of the Medi-Cal website at <http://files.medi-cal.ca.gov/pubsdoco/forms.asp>.

Only active Medi-Cal providers may receive authorization to provide GHPP program services. Services may be authorized for varying lengths of time during the GHPP client's eligibility period.

**Submission of SARs**

Providers may fax, mail or hand deliver SARs to the GHPP state office.

Department of Health Care Services  
Genetically Handicapped Persons Program  
MS 8100  
P.O. Box 997413  
Sacramento, CA 95899-7413  
Fax: (916) 440-5318

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#### SAR Processing

After GHPP review, providers will receive a hard copy authorization approval or denial for each submitted SAR.

#### Types of SAR Forms

##### New Referral

The *New Referral CCS/GHPP Client Service Authorization Request (SAR)* (form DHCS 4488) is used when referring an applicant who may have a GHPP-eligible medical condition to the GHPP program. The applicant's case may be opened by GHPP staff for diagnostic or treatment services.

##### Established Client

The *Established CCS/GHPP Client Service Authorization Request (SAR)* (form DHCS 4509) is used when requesting service authorization for an established GHPP client currently enrolled in the GHPP program. The Established Client SAR form does not require as much information about the client as the *New Referral CCS/GHPP Client Service Authorization Request (SAR)* form.

##### Discharge Planning

The *CCS/GHPP Discharge Planning Service Authorization Request (SAR)* (form DHCS 4489) is used when requesting specific services for a GHPP client who is discharged from an inpatient hospital stay. The requested services may include, but are not limited to, Home Health Agencies (HHAs), Durable Medical Equipment (DME) or medical supplies.

<b>Service Code Grouping (SCG)</b>	<p>A Service Code Grouping (SCG) is a group of reimbursable codes authorized to a provider under one SAR for the care of a GHPP client. Please reference the <i>California Children's Services (CCS) Program Service Code Groupings</i> section in the appropriate Part 2 manual.</p> <p>An SCG allows providers to render multiple services for a GHPP client without the submission of a separate SAR for each service needed by the client. A SCG removes barriers to providing services for GHPP clients and is intended to facilitate health care delivery to the GHPP client.</p> <p>An SCG is authorized to the physician, podiatrist or Special Care Center (SCC) for a specified length of time, usually up to the end of the GHPP client's next eligibility redetermination.</p> <p>All reimbursable HCPCS and CPT-4 codes included in all SCGs, including physician, orthopedic, surgeon, ophthalmology and podiatry, are listed in the <i>California Children's Services (CCS) Program Service Code Groupings</i> section in the appropriate Part 2 manual.</p>
Physician SCG	Physicians assign a unique SCG (SCG 01) to facilitate the diagnosis and treatment of GHPP clients. The orthopedic SCG (SCG 07) includes all codes available in the physician SCG (SCG 01).
Special Care Center (SCC)	Special Care Centers (SCCs) are assigned a unique SCG (SCG 02) to facilitate the diagnosis and treatment of GHPP clients. The SCC (SCG 02) includes all codes available in the physician SCG 01. In addition, SCG 02 contains codes for diagnostic studies relative to SCC-unique services.
Transplant Center SCG	Transplant Centers are identified with unique SCG (SCG 03) to facilitate the diagnosis and treatment of GHPP clients. The Transplant Center SCG includes all codes available in physician SCG 01 and SCC SCG 02, in addition to transplant-related HCPCS codes.
Orthopedic Surgeon SCG	Orthopedic surgeons have a unique SCG (SCG 07) to facilitate the diagnosis and treatment of GHPP clients. The orthopedic SCG includes all codes available in the physician SCG (SCG 01).
RHC/FQHC Service SCG	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) all-inclusive per visit codes comprise a unique SCG (SCG 08) to facilitate the diagnosis and treatment of GHPP clients.

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Chronic Dialysis Clinic SCG	Chronic Dialysis Clinics are identified with unique SCG (SCG 09) to facilitate the diagnosis and treatment of GHPP clients.
Ophthalmology SCG	Ophthalmologists have a unique SCG (SCG 10) to facilitate authorization of multiple ophthalmologic procedures. This SCG does not include codes in other SCGs so the ophthalmologist will also use the physician SCG (SCG 01).
Medical Therapy SCG	Physical and occupational therapists are identified with unique SCG (SCG 11) to facilitate the diagnosis and treatment of GHPP clients.
Podiatry SCG	Podiatrists have a unique SCG (SCG 12) to facilitate authorization of multiple services. This SCG does not include codes in other SCGs, but does include all the array of codes a podiatrist would need. Individual codes cannot be authorized to podiatrists.
<b>Physician SAR Requirement</b>	Physicians may be authorized to provide services for an eligible GHPP client in an SCC as well as in a community setting. Physicians may be authorized to render services by receiving approval for an SCG under one SAR, or separately for specific procedure codes. Refer to the <i>California Children's Services (CCS) Program Service Code Groupings</i> section in the appropriate Part 2 manual for a list of CPT-4 and HCPCS codes included in the physician SCG.
<b>Physician SAR for Rendering Provider</b>	<p>An SCG SAR authorized to a physician may be shared for reimbursement by other health care providers from whom the physician has requested services, such as laboratory, pharmacy or radiology providers.</p> <p>The rendering provider will use a physician's SAR number and indicate the National Provider Identifier (NPI) of the authorized physician as a either a referring or attending provider.</p> <p>Services not included in the physician SCG must be requested with specific procedure codes and may be listed on one SAR form.</p>

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Services Not Included  
In Physician SCG

Instructions for services not included in a physician SCG are as follows:

Inpatient Surgery: Physicians must submit a SAR for surgical procedures. All anticipated surgical procedure codes and the SCG (SCG 01) may be listed on one SAR.

A physician surgical assistant and anesthesiologist may be reimbursed using the surgeon's authorization number. If the presence of a physician surgical assistant is medically necessary and the procedure code is not reimbursable for a physician surgical assistant, a separate SAR must be submitted for surgical assisting.

Hospital Stay: Hospitals reimbursed according to a diagnosis-related group (DRG) model must submit a separate admission SAR for surgical procedures and post-operative care.

Non-DRG reimbursed hospitals must submit a separate SAR for the specific number of inpatient days required for surgical procedures and post-operative care.

Outpatient Surgery: Physicians must submit a SAR for surgical procedures. All anticipated surgical procedure codes and the SCG (SCG 01) may be listed on one SAR.

Authorization for elective surgery may be requested for a specified time period during which the surgery can take place. The outpatient surgery facility will be reimbursed using the surgeon's authorization number.

Transplant: A separate SAR must be submitted for transplant services for GHPP clients.

**Inpatient SAR Requirements**

The following two separate authorizations are required for approval of a client's inpatient care. Both the hospital and physician authorizations may be requested on the same SAR:

Hospital: Hospitals reimbursed according to a diagnosis-related group (DRG) model require an admission SAR for a GHPP client's inpatient stay.

Non-DRG reimbursed hospitals require a SAR that designates the anticipated length of stay. If a client requires additional time in the hospital, non-DRG reimbursed hospitals must submit a SAR to request extension days.

Physician with Primary Responsibility to Care for Hospitalized Client: This authorization may be granted to physician consultants and other physicians as requested by the authorized physician.

**Diagnostic Laboratory SAR Requirements**

Laboratory tests related to a GHPP-eligible medical condition are covered if listed in a physician's SCG.

**SAR Requirements**

Laboratory tests not covered in the physician's authorized SCG require a separate SAR. The physician must provide the laboratory with a SAR number. The laboratory must use the physician's SAR number when billing for services related to the GHPP-eligible medical condition. Providers who use a physician's SAR number must bill as the rendering provider with the physician's provider number indicated as the referring or attending provider.

**Pharmacy SAR Requirements**

A pharmacy is not required to submit a separate SAR for reimbursement if the treating physician has authorization to prescribe drugs to the GHPP client. The rendering pharmacy must bill using the physician's SAR number. Physicians prescribing drugs to a GHPP client must include the SCG SAR number on the prescription.

Drugs and Nutritional Products Requiring Separate Authorization

The following drugs and nutritional products are not included in a physician SCG and require a separate SAR:

AbobotulinumtoxinA	Factor IX Complex (PCC) Preparations
Anthemophilic Factors	Factor IX Preparations
Antithromblin III (Hum Plas)	Factor XIII Preparations
Antithromblin III (Hum Recombinant)	Food Oils
Avanafil	Immune Serum Globulin (I.V.)
<b><u>Boceprevir</u></b>	Immune Serum Globulin Caprylate (I.V.)
Botulinum Toxin Type A	Immune Serum Globulin Maltose (I.V.)
Botulinum Toxin Type B	IncobotulinumtoxinA
Controlled Substances listed as Schedule II	Intrathecal Baclofen
Controlled Substances listed as Schedule III	Ivacaftor
Enteral Nutrition Amino Acid Products (Contracted)	<b><u>Ledipasvir/Sofosbuvir</u></b>
Enteral Nutrition Flavoring Products (Contracted)	Leuprolide Acetate
Enteral Nutrition Products: Elemental and Semi-Elemental	<b><u>Ombitasvir/Paritaprevir/Ritonavir and Dasabuvir</u></b>
Enteral Nutrition Products: Metabolic	Palivizumab
Enteral Nutrition Products: Specialized	Sapropterin Dihydrochloride
Enteral Nutrition Products: Specialty Infant	Sildenafil
Enteral Nutrition Products: Standard	<b><u>Simeprevir</u></b>
	<b><u>Sofosbuvir</u></b>
	Somatrem
	Somatropin
	Supprelin LA Implant
	Tadalafil
	<b><u>Telaprevir</u></b>
	Vardenafil

**DME and Medical Supply  
SAR Requirements**

Providers may bill for specific HCPCS Level II product codes for medical supplies or DME without a product-specific SAR when such items are Medi-Cal benefits, if: (1) the medical supplies requested do not exceed the billing limits set by Medi-Cal, and/or the DME requested does not exceed the thresholds for authorization as referenced on the Medi-Cal website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) and the *Durable Medical Equipment (DME): An Overview* section in the appropriate Part 2 manual; (2) the medical supply codes are not miscellaneous codes; and (3) Medi-Cal does not require a TAR for the medical supply codes.

The provider prescribing the medical supplies or DME must have an SCG SAR with dates of service that include the dates of service on which the medical supplies and/or DME are dispensed. For Medi-Cal billing limitations and authorization requirements, refer to the *Durable Medical Equipment (DME): An Overview* section and the *Medical Supply Products* sections in the appropriate Part 2 manual.

A separate SAR is required for medical supplies if the billing limits of the product(s) (for example, quantity) are exceeded, in accordance with Medi-Cal policy, or if there is no specific code for the medical supply (that is, a miscellaneous code is needed for billing), or Medi-Cal requires a TAR for the medical supply.

A separate, product-specific SAR is also required for DME that exceeds the thresholds for authorization.

DME

In addition to what is required by Medi-Cal, the following must be submitted with a DME SAR for DME that exceeds the thresholds for authorization as referenced in *Durable Medical Equipment (DME): An Overview* section of the appropriate Part 2 manual.

- Signed prescription by a physician
- HCPCS code
- Detailed description of the DME item
- If using an unlisted or miscellaneous code, an explanation of why an unlisted or miscellaneous code is being used, instead of a HCPCS code
- Model number
- Manufacturer
- Rental or purchase with the appropriate modifier
- Duration of rental
- Any special features

Medical Supply

In addition to what is required by Medi-Cal, the following must be submitted with a medical supply SAR for medical supplies that exceed the billing limits set by Medi-Cal policy:

- Signed prescription including the physician/prescriber name, address, telephone number, license classification and federal registry number if a controlled substance is prescribed
- HCPCS code(s)

DME Modifiers

A SAR submitted to the GHPP by a DME or hearing aid provider for DME that exceeds the thresholds for authorization as referenced in *Durable Medical Equipment(DME): An Overview* section of the appropriate Part 2 manual must contain appropriate modifiers and HCPCS codes.

The following modifiers must be included on the SAR, if applicable: NU (new equipment purchase), RR (rental) or RB (replacement as part of a repair) as appropriate.

**Home Health Agencies  
SAR Requirements**

A SAR must be submitted for Home Health Agencies (HHA) services. In addition, HHA services can be requested in the following ways:

- The authorized physician treating the GHPP client as an inpatient may proactively request authorization for anticipated post-discharge HHA services at the same time as the inpatient request.
- The physician may request HHA services using a discharge planning SAR. The GHPP program may authorize an initial home assessment and up to three additional visits if requested by a discharging physician at the time of the GHPP client's discharge from the inpatient stay. For additional medically necessary HHA visits, a SAR and the unsigned plan of treatment must be submitted for authorization.

HHA services not requested on a Discharge Planning SAR, nor requested prior to hospitalization, must be submitted within three working days of the date the services began. Any services provided during this three-day grace period must be included on the SAR. GHPP authorization is contingent on a client's GHPP program eligibility.

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**Diagnosis Codes**

The following is a list of ICD-9-CM diagnosis codes that qualify clients for GHPP. The qualifying GHPP condition is not required in the primary diagnosis field on the claim.

<u>ICD-9-CM Code</u>	<u>Description</u>
270.0	Disturbances of amino-acid transport
270.1	Phenylketonuria (PKU)
270.2	Tyrosenemia
270.4	Disturbances of sulphur-bearing amino-acid metabolism
270.6	Disorders of urea cycle metabolism
271.1	Galactosemia
275.1	Wilson's disease
277.0	Cystic fibrosis
277.00	Cystic fibrosis, without mention of meconium ileus
277.0	Cystic fibrosis, with meconium ileus
282.4	Thalassemias
282.6	Sickle cell disease
282.60	Sickle cell disease, unspecified
282.61	Hb-SS disease without crisis
282.62	Hb-SS disease with crisis
282.63	Sickle Cell/Hb-C Disease
282.69	Other sickle cell disease with crisis
282.7	Other hemoglobinopathies
286.0	Congenital factor VIII disorder
286.1	Congenital factor IX disorder
286.2	Congenital factor XI disorder
286.3	Congenital deficiency of other clotting factors I, II, V, VII, XII, XIII deficiency
286.4	Von Willebrand's disease

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ICD-9-CM <u>Code</u>	<u>Description</u>
287.1	Thrombasthenia
287.3	Thrombocytopenia, primary hereditary, congenital
333.0	Olivopontocerebellar degeneration (Dejerine-Thomas syndrome)
333.4	Huntington's chorea
334.0	Friedreich's ataxia
334.1	Hereditary spastic paraplegia
334.3	Roussy-Levy syndrome
356.1	Charcot-Marie-Tooth disease
356.3	Refsum's disease
759.6	Von Hippel-Lindau syndrome

For claims using the *Pharmacy Claim Form* (30-1) or *Compound Drug Pharmacy Claim Form* (30-4), ICD-9-CM diagnosis codes are optional.

**Hospital and Physician  
Services Billed Separately**

Hospitals that render services to GHPP clients must bill physician services separately from hospitalization. Physician services are ancillary to hospitalization and should be billed on a *CMS-1500* claim. Hospitalization is billed on the *UB-04* claim.

**Managed Care Plans,  
Private Health Insurance  
and Commercial HMOs**

Medi-Cal contracts with a variety of managed care organizations to provide health care on a capitated basis to Medi-Cal recipients residing within specific service areas. Some GHPP clients who are eligible for Medi-Cal reside in these areas and are enrolled in these Medi-Cal managed care plans.

In such cases the plans are capitated for and are responsible for providing comprehensive health care to these GHPP clients, including services to treat their GHPP eligible conditions. Providers should adhere to each plan's policies and requirements regarding authorization of services for GHPP clients enrolled in plans.

Similarly, some GHPP clients have private indemnity health insurance, or are enrolled in commercial health maintenance plans (HMO) or preferred provider organizations (PPOs). In these cases, GHPP is the health care payer of last resort and will authorize medically necessary services for the GHPP client only after it has been demonstrated that the services are beyond the scope of benefits of the indemnity insurance or health plan. The provider and/or client are required to exercise their appeal rights before GHPP will authorize and reimburse for these services. For information about appeals, refer to the *Appeal Process Overview* section in the *Part 1 – Medi-Cal Program and Eligibility* manual.

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**Claim Submission and  
Timeliness Requirements**

Providers must be enrolled in the Medi-Cal program and use their National Provider Identifier (NPI) on all authorized claims for GHPP clients, regardless of the client's GHPP eligibility type. An NPI must be used when billing for GHPP/Medi-Cal clients and GHPP-only clients. Hard copy claims are mailed to:

Medi-Cal Fiscal Intermediary  
P.O. Box 526006  
Sacramento, CA 95852-6006

More information is available in the *Claim Submission and Timeliness Overview* section of the Part 1, *Medi-Cal Program and Eligibility* manual.

**Six-Month Billing Limitation**

Original (or initial) claims must be received by the DHCS Fiscal Intermediary within six months following the month in which services were rendered. Providers submitting claims after the six-month billing limit must include a valid delay reason code on the claim. A list of valid delay reason codes and additional information is available in the *Submission and Timeliness Instructions* section of the appropriate Part 2 manual.

Claim payments will be reduced for providers who submit claims after the six-month billing limit without the required delay reason code. This is in accordance with Medi-Cal policy.

**CMC Billing**

Computer Media Claims (CMC) submission is the most efficient method of billing. Unlike paper claims, these claims already exist on a computer medium. As a result, manual processing is eliminated. CMC submission offers additional efficiency to providers because claims are submitted faster, entered into the claims processing system faster, and paid faster. For more information, refer to the *CMC* section of the Part 1 provider manual or call the Telephone Service Center (TSC) at 1-800-541-5555.

**Denti-Cal**

Claims for dental services authorized by GHPP with a SAR number beginning with a prefix of "99" for GHPP clients must be submitted to Delta Dental for claim processing.

**Remittance Advice Details and Warrants**

Standard Medi-Cal procedures apply for provider warrants and *Remittance Advice Details* (RADs). For more information, refer to the *Remittance Advice Details (RADs): Payments and Claims Status* section in the appropriate Part 2 manual.

**Claims Inquiry Forms**

A *Claims Inquiry Form* (CIF) must be used as a tracer for a GHPP Medi-Cal claim if the claim has not appeared on a RAD 60 days after submission to the GHPP state office. A CIF cannot be used to trace a GHPP claim billed for a non Medi-Cal eligible GHPP client. If such a claim does not appear on a RAD after 60 days, providers should contact the Telephone Service Center (TSC) at 1-800-541-5555.

For further information about CIFs and tracers, providers may refer to the *CIF Overview* section in the *Part 1 – Medi-Cal Program and Eligibility* manual.

**Resubmission Turnaround Documents**

A *Resubmission Turnaround Document* (RTD) may be generated by the DHCS Fiscal Intermediary and sent to providers when a submitted GHPP claim has questionable or missing information. Returning a completed RTD to the DHCS FI may eliminate the need to resubmit the entire claim to correct certain errors.

Completed RTDs may be mailed to the DHCS FI at the following address:

Xerox State Healthcare, LLC  
P.O. Box 15200  
Sacramento CA 95851-1200