MEDI-CAL UPDATE

Outpatient Services
Bulletin 347

Billing and Policy
Clinics and Hospitals Bulletin 347 **September 2003**

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Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

HIPPA: Provider Manual Updates

The September 2003 Health Insurance Portability and Accountability Act (HIPAA) implementation resulted in the following changes in the Medi-Cal provider manuals. All changes are effective for dates of service on or after September 22, 2003.

Important: When you follow the remove and replace instructions in this bulletin and update your manual, please retain the pages you remove. Place them after the *Appendix* tab at the back of your manual. These pages will help you bill for services that you rendered prior to September 22, 2003.

New HIPAA In Review

A handy *HIPAA In Review* guide has been included in this bulletin for you to insert in your provider manual at the end of the *UB-92 Completion: Outpatient Services* section. This guide summarizes important outpatient-related changes that resulted from the September 2003 initial phase of Medi-Cal HIPAA implementation.

Conversion of Place of Service to Facility Type Codes

Type of Bill Field (Box 4)

4. TYPE OF BILL
734

Local Medi-Cal Place of Service codes are being replaced with national facility type codes, which are entered as the first two digits in the Type of Bill field (Box 4) in the upper right-hand corner of the claim. Previously, Box 4 was optional but now is required. The third character in the Type of Bill field is a claim frequency code (a single number or letter).

50. Payer
O/P Medi-Cal ~~9~~

Local Medi-Cal Place of Service codes are no longer included in the Payer field (Box 50).The words "O/P Medi-Cal" are still required.

Manual Changes

- Facility type and claim frequency codes are explained in the *National Uniform Billing Committee (NUBC) UB-92 Billing Manual.* This information is included in the claim completion section.
- Medi-Cal manual references to Place of Service are changed to "facility type."
- A *Code Correlation Guide* showing the relationship between Place of Service and facility type codes is added at the end of the *UB-92 Completion: Outpatient Services* section to help you understand how the Medi-Cal Place of Service codes have been converted to national facility type codes.

Please see **HIPAA**, *page 2*

HIPAA *(continued)*

Conversion of Billing Limit Exception to Delay Reason Codes

Delay Reason Field (Box 31)

Condition Codes							31
24	25	26	27	28	29	30	**405**

Local Medi-Cal billing limit exception codes are being replaced with national delay reason codes. Delay reason codes are entered in Box 31, to the right of the Condition Codes boxes on the claim. Do not enter delay reason codes in the Condition Codes field (Boxes 24 – 30) where you previously entered billing limit exception codes.

- A *Code Correlation Guide* showing the relationship between billing limit exception and delay reason codes is added at the end of the *UB-92 Completion: Outpatient Services* section to help you understand how Medi-Cal billing limit exception codes have been converted to national delay reason codes.

"From-Through" Billing

Service Date Field (Box 45)

43. DESCRIPTION	44.	45. SERV. DATE
SERVICES FOR SEPTEMBER		**092203 ("From" date)**
9/21 9/24 9/27 9/29 9/30		**093003 ("Through" date)**

"From-through" services with a "from" date of service on or after September 22, 2003 are to be billed with national codes. "From-through" services with a "from" date prior to September 22, 2003 are billed with local Medi-Cal codes.

Guidelines

Changes for the September 2003 phase of HIPAA implementation established the following guidelines:

- Claims with dates of service on or after September 22, 2003 must be submitted with national condition, delay reason and patient status codes.
- Claims for services prior to September 22, 2003 must be billed with local Medi-Cal condition, billing limit exception and patient status codes.
- Claims for services rendered on dates of service that include both pre- and post-September 22, 2003 dates must be billed on separate claims (split billed) with national codes on one claim and local Medi-Cal codes on another.

"From-Through" Exemption

Claims for services that require "from-through" billing (identified in policy sections) do not require the split billing. They are billed as indicated in the italicized text under the preceding diagram.

Manual Changes

- The *UB-92 Special Billing Instructions for Outpatient Services* section is updated to include the preceding "from-through" information.

Please see **HIPAA**, *page 3*

HIPAA *(continued)*

Conversion of Condition Codes

Condition Codes Field (Boxes 24 – 30)

Medi-Cal condition code A3 is being changed to national condition code "AI," which is used to bill for services related to Family Planning (FP).

Emergency Services

Admit Type Field (Box 19)

80. ADMISSION			
17. DATE	18. HR	19. TYPE	20. SRCE
NA	**NA**	**1**	**NA**

Enter admit type code 1 when billing for outpatient emergency services. This is now a required field when billing for emergency services.

Manual Changes

- The *UB-92 Completion: Outpatient Services* section is updated to include instructions to complete the *Admit Type* field (Box 19) when emergency services are rendered.

Modifiers

HCPCS/Rates Field (Box 44)

44. HCPCS/RATES	45.	46.	47.	48.	49.
XXXXX2647					**6062**

Up to four modifiers may be entered on outpatient UB-92 claims. Modifiers one and two (-26 and -47 in the preceding example) must be billed immediately following the procedure code, with no spaces, in the HCPCS/Rates field (Box 44). The remaining two modifiers (-60 and -62 in the preceding example) are entered, with no spaces, in Box 49.

Manual Changes

- The *UB-92 Completion: Outpatient Services* section is updated to include instructions for billing with up to four modifiers.
- When billing for services rendered to recipients who are patients in subacute care facilities, you must enter facility type code "27" in the *Type of Bill* field (Box 4) and enter modifier -HA (pediatric) or -HB (adult) in the last-used modifier field. These modifiers must be submitted with every procedure on the claim.

2003 CPT-4 and HCPCS Updates: Implementation September 22, 2003

The 2003 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II and local Level III codes are effective for Medi-Cal for dates of service on or after September 22, 2003. Some of the policy changes are highlighted below.

ANESTHESIA

Deleted and Replacement CPT-4 Code
The following is a deleted anesthesia code and its 2003 replacement code. The policy of the deleted code applies to the replacement code.

Deleted	Replacement
00869	00921

Please see manual replacement page ster 21 (Part 2).

Minimum Age Restriction
CPT-4 code 00320 is now restricted to recipients 1 year of age and older.

SURGERY

Deleted and Replacement CPT-4 Codes
The following are deleted codes and their 2003 replacement surgery codes. Unless otherwise noted, the policy of the deleted code applies to the replacement code.

Deleted	Replacement
36520	36511 and 36512
36521	36516
38231	38205 and 38206
44209	44238
53670	51701 and 51702
53675	51703
58551	58545 and 58546
86915 (Pathology/Laboratory)	38210 – 38213

The updated information is reflected on manual replacement pages blood 7 (Part 2), non ph 6 and 10 (Part 2), surg cardio 7 (Part 2) and transplant 3 and 4 (Part 2).

Please see **HCPCS**, *page 5*

HCPCS *(continued)*

Reimbursement Restrictions
The following CPT-4 codes have Medi-Cal reimbursement restrictions:

- 36450 may only be reimbursed for newborns (up to 1 month of age)
- 36455 may only be reimbursed for recipients older than 1 month of age
- 38204 and 38242 will be priced "By Report"
- 43219, 45317, 51705 and 62284 are no longer reimbursable to an assistant surgeon
- 55866, 58290 – 58294 and 58552 – 58554 are once-in-a-lifetime procedures
- 57452 is not reimbursable when billed with codes 57454 – 57461
- 57456 is not reimbursable when billed with code 57461
- 58146 is not reimbursable when billed with codes 58140 – 58145 and/or 58150 – 58240
- 58263 requires a *Treatment Authorization Request* (TAR) for the primary surgeon
- 58290 and 58291 require a *Treatment Authorization Request* (TAR) for both the primary and assistant surgeon
- 61313 is not reimbursable when billed with codes 61322 and/or 61323
- 62263 and 62264 are not reimbursable when billed with codes 76005 and/or 72275
- 62264 is not reimbursable when billed with code 62263

The updated information is reflected on manual replacement pages eval 11 (Part 2) and non ph 6 and 10 (Part 2).

Maximum Payment Reimbursement: Code Combinations
Reimbursement for the following combination of laparoscopic/open procedure codes will be paid only up to the amount of the CPT-4 code with the highest maximum allowable amount if both are billed for the same date of service, any provider:

Laparoscopy Code	Open Procedure Code(s)
44206	44143
44207	44145
44208	44146
44210	44150
44211	44152 or 44153
44212	44155
44701	44300 or 44950 – 44960
50542	50220 – 50240
50543	50240
55866	55840
58545	58140 or 58150
58546	58146
58552	58262
58553	58290
58554	58291

Please see **HCPCS**, *page 6*

HCPCS *(continued)*

Add-On Codes
The following CPT-4 codes are "add-on" codes and must be billed on the same claim with the corresponding code:

Add-On Code	Corresponding Code(s)
33508	33510 – 33523
35572	33510 – 33523, 34502, 34520, 35001 – 35002, 35011 – 35022, 35102 – 35103, 35121 – 35152, 35231 – 35256, 35501 – 35587, 35879 – 35881 or 35901 – 35907
44701	44140, 44145, 44150 or 44604
61316	61304, 61312, 61313, 61322, 61323, 61340, 61570 or 61680 – 61705
61517	61510 or 61518
62148	62140 – 62147
62160	61107, 61210, 62220, 62223, 62225 or 62230
66990	65820, 65875, 65920, 66985, 66986, 67038, 67039 or 67040

RADIOLOGY

Reimbursement Restrictions
CPT-4 code 76999 is for unlisted ultrasound procedures and requires a TAR. *The updated information is reflected on manual replacement pages radi 3 and 4 (Part 2) and subacut adu 4 (Part 2).*

Codes Requiring Split-Billing Modifiers
The following CPT-4 codes must be billed with the appropriate split-billing modifier -26, -99, -TC or -ZS: 75901, 75902, 75954, 76496, 76497, 76498, 76801, 76802, 76811, 76812 and 76817.

Obstetrical Ultrasound Codes
Significant changes were made to CPT-4 codes within the range 76801 – 76817 (obstetrical ultrasound). Obstetrical ultrasound is now reimbursable when services meet the following guidelines:

- Diagnosis on the claim must be appropriate for the code
- Frequency restrictions
- Second and subsequent claims must have documentation in the *Remarks* area of the claim to justify medical necessity.

The following are the new codes and descriptions:

New Code	Description
76801	Transabdominal ultrasound, pregnant uterus, first trimester; single or first gestation
76802	each additional gestation
76811	Transabdominal ultrasound, pregnant uterus, fetal and maternal evaluation, single or first gestation
76812	each additional gestation
76817	Transvaginal ultrasound, pregnant uterus

Please see **HCPCS**, *page 7*

HCPCS *(continued)*

The following are the revised descriptions of current codes:

Current Code	Revised Description
76805	Transabdominal ultrasound, pregnant uterus, single or first gestation
76810	each additional gestation
76815	Ultrasound, pregnant uterus, limited, one or more fetuses
76816	Transabdominal ultrasound, pregnant uterus, follow-up, per fetus

Note: New national modifier -59 (distinct procedural services) may be billed only with code 76816.

Frequency restrictions and billing requirements for these codes are found on the *Diagnosis, Frequency and Documentation Guidelines* chart on manual replacement pages *preg early 6 and 7 (Part 2).*

The updated information is reflected on manual replacement pages abort 3 and 4 (Part 2), altern 1 and 2 (Part 2), modif app 1 (Part 2), preg com los 1 (Part 2), preg early 5 thru 7 (Part 2) and presum 17 (Part 2).

PATHOLOGY/LABORATORY

Deleted and Replacement Codes
The following are deleted pathology/laboratory codes and their 2003 replacement codes. Unless otherwise noted, the policy of the deleted code applies to the replacement code.

Deleted	Replacement
85031	85014, 85018 and 85032
85590	85032
85595	85049
86915	38210 – 38213 (Surgery)
87198	87271
87199	87267
88144	For automated screening of automated thin layer preparation, see 88174 and 88175
88145	For automated screening of automated thin layer preparation, see 88174 and 88175

The updated information is reflected on manual replacement pages rates max lab 5 thru 8 (Part 2).

Reimbursement Restrictions
The following CPT-4 codes have reimbursement restrictions:

- 89055 is a 100 percent technical procedure and must be billed with modifier -TC
- 85004 and 85032 are reimbursable to podiatrists with prior authorization
- 85048 is no longer reimbursable to podiatrists

The updated information is reflected on manual replacement page non ph 6 (Part 2).

Please see **HCPCS**, *page 8*

HCPCS *(continued)*

Codes Requiring Split-Billing Modifiers
The following CPT-4 codes must be billed with with the appropriate split-billing modifier -26, -99, -TC or -ZS: 83880, 84302, 85004, 85032, 85049, 85380, 87255, 87267, 87271, 88174 and 88175.

MEDICINE

Deleted and Replacement Codes
The following are deleted medicine codes and their 2003 replacement codes. Unless otherwise noted, the policies of the deleted codes will apply to the replacement codes.

Deleted	Replacement
92525	92610 and 92611
92599	92700

Note: CPT-4 codes 92610 and 92611 are 100 percent professional procedures and may not be split billed.

The updated information is reflected on manual replacement pages medne oto 2 (Part 2) and modif used 6 (Part 2).

Maximum Payment Reimbursement: Code Combinations
Maximum payment is reimbursed only to the amount of the CPT-4 code with the greatest maximum allowance if the following code combinations are billed for the same date of service, any provider:

- CPT-4 code 92612 and/or 92614 billed with 92616
- CPT-4 code 92613 and/or 92615 billed with 92617

Maximum Age Restriction
CPT-4 codes 99289 and 99290 now have a maximum age restriction of 24 months of age.

Surgical Procedure Codes Update

Effective for dates of service on or after September 22, 2003, providers may no longer bill with CPT-4 code 53670 (catheterization, urethra; simple). Providers must instead bill with one of the following new CPT-4 codes:

CPT-4 Code	Description
51701	Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)
51702	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)

Codes 51701 and 51702 are considered incidental procedures and are not separately reimbursable when billed with CPT-4 surgery codes 10021 – 69979 for the same recipient, by the same provider, for the same date of service.

The updated information is reflected on manual replacement pages tar and non cd5 1 and 3 (Part 2), surg 2 (Part 2) and non ph 6 (Part 2).

Provider Orientation and Update Sessions

The Family PACT (Planning, Access, Care and Treatment) Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

To be eligible to enroll as a medical provider in the Family PACT Program, the Medi-Cal provider seeking enrollment is required to attend a Provider Orientation and Update Session. When a group provider wishes to enroll, a physician-owner must attend the session. When a clinic wishes to enroll, the medical director or clinician responsible for oversight of the medical services rendered in connection with the Medi-Cal provider number is required to attend.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain up to date with program policies and services.

Note: Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

Dates and Locations

The following dates and locations are scheduled for the remainder of 2003:

September 16, 2003 **Visalia** Holiday Inn and Conference Center 9000 West Airport Drive Visalia, CA 93277 **For directions, call** (559) 651-5000	**October 1, 2003** **Pasadena** Sheraton Pasadena Hotel 303 East Cordova Street Pasadena, CA 91101 **For directions, call** (626) 449-4000	**October 28, 2003** **Emeryville** Holiday Inn Bay Bridge 1800 Powell Street Emeryville, CA 94608 **For directions, call** (510) 658-9300
November 5, 2003 **Ventura** Ventura Beach Marriott 2055 Harbor Boulevard Ventura, CA 93001 **For directions, call** (805) 643-6000	**November 19, 2003** **Redding** Red Lion Hotel Redding 1830 Hilltop Drive Redding, CA 96002 **For directions, call** (530) 221-8700	**December 4, 2003** **Riverside** Riverside Marriott 3400 Market Street Riverside, CA 92501 **For directions, call** (909) 784-8000

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials.

Please see **Family PACT**, *page 10*

Family PACT *(continued)*

Provider Orientation and Update Session Registration

Providers should call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session they plan to attend. Providers must supply the name of the Medi-Cal provider or facility, the Medi-Cal provider number, a contact telephone number, the anticipated number of people who will be attending and the location of the orientation session. At the session, providers must present their Medi-Cal provider number, medical license number and photo identification. Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Completing the Provider Orientation and Update Session

Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services.

Providers arriving late or leaving early will not be mailed a *Certificate of Attendance.* Currently enrolled Family PACT providers will not receive a certificate.

Family PACT Contact Information

For more information regarding the Family PACT Program, please call the Health Access Programs (HAP) Hotline at 1-800-257-6900 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Instructions for Manual Replacement Pages
Clinics and Hospitals (CAH) Bulletin 347 September 2003

Part 2

Remove and replace:	abort 3/4
Remove:	altern 1/2
Insert:	altern 1 thru 3 (new)
Remove and replace:	blood 7 thru 9 cardio 7 * chemo 1/2 * cif co 1/2 *
Remove:	cont ip 5 thru 15
Insert:	cont ip 5 thru 18 *
Remove and replace:	distinct 1* eval 3 thru 8 *, 11 thru 14 * gene 1/2 * hcpcs iii 1 thru 4 * inject list 1 thru 19 *

Notice: The September 2003 Clinics and Hospitals *Medi-Cal Update #347* was mailed to you in three parts (in separate envelopes) this month. Please watch for the second and third mailings containing additional pages and update your manual.

PLEASE RETAIN THE PAGES YOU REMOVE.
PLACE THEM AFTER THE *APPENDIX* TAB AT THE BACK OF YOUR MANUAL.
THESE PAGES WILL HELP YOU BILL FOR SERVICES THAT YOU RENDERED
PRIOR TO SEPTEMBER 22, 2003.

* Pages updated/corrected due to ongoing provider manual revisions.

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Clinics and Hospitals (CAH) Bulletin 347 September 2003

Notice

This mailing contains:
September 2003 Clinics and Hospitals
Medi-Cal Update #347

This is the second of three mailings.

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This second mailing contains more of the remaining manual replacement pages.

Part 2

Remove: inject 1 thru 44
Insert: inject 1 thru 43 *

Remove and replace: inject vacc 1 *
medi cr op 3/4, 7/8, 11/12, 23/24, 27/28
medi cr op ex 3/4, 7/8
medi non hcp 1/2
medne neu 1 thru 4
medne oto 1/2
medne pul 3/4 *
modif app 1 thru 4

Remove: modif used 3 thru 9
Insert: modif used 3 thru 10 (*new*)

Remove: non ph 5 thru 15
Insert: non ph 5 thru 14

Remove and replace: non ph ub 1 thru 3 *
once 3/4 *
oth hlth cpt 3 *
path bil 5/6 *
path cyto 1/2 *
path hema 1/2
podi 5/6 *
preg com 3/4, 7/8
preg com los 1 thru 3 (*new*) *
preg early 3 thru 9
preg fetal 1/2
preg glo 1/2 *
preg post 1/2
presum 17 thru 20
radi 3/4, 7
radi dia 19/20
rates max 3 thru 6

Remove: rates max lab 1 thru 9
Insert: rates max lab 1 thru 8 *

Remove and replace: respir 5/6 *
spe dev 5/6 *

* Pages updated/corrected due to ongoing provider manual revisions.

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Part 2

Remove and replace:	ster 21/22 subacut adu 3/4 subacut code 1/2 subacut lev 1 thru 4 * sub acute ped 3/4 * surg 1/2 surg aud 1/2 surg cardio 1/2, 7 surg integ 1/2 * tar and non cd1 1/2 * tar and non cd2 1 thru 6*, 9/10 *
Remove:	tar and non cd3 1 thru 6
Insert:	tar and non cd3 1 thru 7 * (*new*)
Remove and replace:	tar and non cd4 1 thru 6 * tar and non cd5 1 thru 8 tar and non cd6 1 thru 4 *, 7/8 * tar and non cd7 1/2 * tar and non cd8 1/2 * tar and non cd9 1 thru 7 * tar comp 9 thru 12 *
Remove:	transplant 3 thru 7
Insert:	transplant 3 thru 9 (*new*)
Remove and replace:	tuber 1/2 * ub comp op 1 thru 30 (*new*)
Insert at end of the *UB-92 Completion: Outpatient Services* section:	*HIPAA In Review (new)* *Code Correlation Guide (new)*
Remove:	ub spec op 1 thru 8
Insert:	ub spec op 1 thru 9 (new)
Remove and replace:	ub sub 1 thru 5
Remove:	ub tips op 1 thru 3
Insert:	ub tips op 1 thru 4 (*new*)
Remove and replace:	vaccine 3 thru 7 *

* Pages updated/corrected due to ongoing provider manual revisions.