

Medicine

This section contains billing instructions for procedures not included in the medicine sections listed in the *Contents* section of this manual. Subsequent medicine sections are categorized by headings used in the *Physicians' Current Procedural Terminology – 4th Edition*.

Hyperbaric Oxygen Therapy (HBO)

Hyperbaric Oxygen Therapy (HBO) is defined as the intermittent administration of 100 percent oxygen inhaled at a pressure greater than sea level. Topical oxygen therapy is not considered HBO therapy and is not a covered benefit of the Medi-Cal program.

Billing Restrictions

Reimbursement for the use of a hyperbaric oxygen chamber is limited to hospitals, hospital outpatient departments and the physician's office. Authorization is required for all HBO services. No more than two treatments (two-hour maximum duration, each) will be reimbursed for the same recipient and date of service.

Inpatient facilities must bill for use of the HBO chamber with ancillary code 413 (respiratory services, hyperbaric oxygen therapy). Outpatient departments bill for use of the chamber with HCPCS code Z7606 (hyperbaric oxygen chamber, first 15 minutes or fraction thereof, at atmosphere absolute) or Z7608 (hyperbaric oxygen chamber, each subsequent 15 minutes or major portion thereof, at atmosphere absolute). Providers must list the total number of minutes at atmosphere absolute in the *Remarks* field (Box 80) of the *UB-04* claim.

Reimbursement of Z7606 and Z7608 covers the technical component of hyperbaric oxygen service only and includes all equipment, supporting staff and supply services routinely required for all HBO.

Note: Physicians' services should be billed separately on the *CMS-1500* claim form with CPT-4 code 99183.

Providers must document an appropriate ICD-9-CM diagnosis code when requesting a TAR for HBO chamber (Z7606, Z7608 and 99183). TAR requests will be denied if it does not include an appropriate diagnosis code.

Non-Routine Supplies

Supplies that are not routinely given to all patients undergoing HBO may be billed separately. An itemization of the supplies billed is required for reimbursement. An example of non-routine supplies follows:

I.V. Supplies – When a physician orders a continuous I.V., it must not be interrupted by the hyperbaric therapy. Therefore, the I.V. must be restarted through special ports in the chamber wall while the patient undergoes therapy and subsequently, after therapy, started again. Not all patients require an I.V. during therapy. Providers must submit an invoice to substantiate reimbursement of I.V. supplies (solution, tubing, etc.).

Unlisted supplies should be billed under CPT-4 code 99070 for providers using the *CMS-1500* claim form.

Covered Conditions

Medi-Cal coverage for HBO is limited to that which is administered in a chamber for the following ICD-9-CM code conditions:

1. Actinomycosis refractory to medical or surgical treatment (039)
2. Air embolism (958.0, 999.1)
3. Arterial embolism and thrombosis (444 – 444.9)
4. Arteritis unspecified (447 – 447.9)
5. Aseptic necrosis of bone (radiation necrosis) (733.4, 990)
6. Caisson disease, effects of air pressure caused by explosion, other specified effects of air pressure, unspecified effects of air pressure (993.3 – 993.9)
7. Chronic osteomyelitis (730.1)
8. Crushing injury of upper limb, lower limb, crushing injury of multiple and unspecified sites (927 – 929.9)

9. Embolism (639.6)
10. Gangrene, NOS (785.4)
11. Gas gangrene (040.0)
12. Toxic effects of hydrocyanic acid and cyanides (989.0)
13. Injury to blood vessel of upper extremity and lower extremity and unspecified sites (903 – 904.9)
14. Occlusion of precerebral/cerebral arteries (433 – 434.9)
15. Other complications of internal prosthetic device, implant and graft (996.7)
16. Other local infections of skin and subcutaneous tissues (686)
17. Other peripheral vascular disease (443 – 443.9)
18. Other venous embolism and thrombosis (453 – 453.9)
19. Polyarteritis nodosa, etc. (446 – 446.7)
20. Preparation of graft site or preservation of compromised skin grafts (996)
21. Radiation necrosis of soft tissue (941.4, 942.4, 943.4, 945.4, 946.4, 949.4)
22. Toxic effect of carbon monoxide (986)
23. Toxic effect of HCN gas (987.7)

Extracorporeal Membrane Oxygenation (ECMO)

The technique of Extracorporeal Membrane Oxygenation (ECMO) is a Medi-Cal benefit for newborns with severe acute cardiac and/or respiratory failure who have failed to respond to conventional medical management. The physician's performance of ECMO is subject to authorization based not on a specific diagnosis, but on an infant's meeting all the following entry criteria:

- Respiratory failure that is life-threatening (greater than 80 percent anticipated mortality without ECMO), or severe refractory cardiac and/or respiratory failure with sudden decompensation, unresponsive to maximum medical management; that is, documented failure of:
 - Mechanical ventilation utilizing 100 percent inspired O₂
 - High airway pressures, dependent on patient's condition and disease state
 - Vasoactive drugs as appropriate
 - Other aggressive but less risky and/or invasive therapies as appropriate and available
- Presence of an inherently reversible underlying pulmonary process with expectation of successful termination of ECMO within two weeks or less
- Absence of untreatable and likely lethal non-pulmonary disease
- Absence of intraventricular hemorrhage (grade II or greater) or any other major uncontrolled site of bleeding or uncontrolled diagnosed predisposition toward bleeding
- Gestational age of 35 weeks or greater
- The ECMO is performed in a regional Neonatal Intensive Care Unit (NICU) in a California Children Services (CCS) designated ECMO center

For other entry criteria, ECMO is still considered experimental and will not be covered by Medi-Cal.

Neonatologist Services

The following HCPCS code is used for reimbursement of the neonatologist's time in supervising and monitoring the infant receiving ECMO.

HCPCS

<u>Code</u>	<u>Description</u>
Z0312	Extracorporeal Membrane Oxygenation (ECMO) of a single infant performed in an ECMO inpatient unit requiring the continuous personal care and monitoring by an ECMO physician/specialist over a 24-hour period.

This code represents 24 hours of care and covers all examinations and procedures performed on the infant by the neonatologist. Medi-Cal reimbursement coverage for the 24-hour period commences on the day that ECMO treatment began but does not include the day of discharge.

HCPCS code Z0312 is an all-inclusive global code for ECMO and may not be billed in conjunction with any other code in the 10000 – 99999 range.

Cannula Procedures

Surgeons who insert, revise or remove the cannulas are to bill Medi-Cal using the following "By Report" CPT-4 codes:

CPT-4

<u>Code</u>	<u>Description</u>
36822	Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)

For revision or removal of cannula:

CPT-4

<u>Code</u>	<u>Description</u>
37799	Unlisted procedure, vascular surgery

Billing Inpatient Services

ECMO services are billed with revenue code 174 (nursery, newborn, Level IV) in conjunction with ICD-9-CM Volume 3 procedure code 39.65 (extracorporeal membrane oxygenation [ECMO]).

ECMO services must be submitted on the claim with all revenue/sick baby codes applicable to the entire stay. The claim is submitted for services rendered to the baby only. Services to the mother are billed separately.

Hospital Reimbursement:
DRG-Reimbursed Facilities

ECMO services for hospitals are paid according to diagnosis-related groups (DRG) reimbursement methodology. (Refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in the Inpatient Part 2 provider manual for DRG information.)

To qualify for reimbursement the hospital must:

- Have a Neonatal Intensive Care Unit (NICU) approved by California Children's Services (CCS) as a Regional NICU
- Have a CCS-approved Neonatal ECMO Center
- Provide Inhaled Nitric Oxide (INO) services for neonates

Inhaled Nitric Oxide (INO)

Inhaled Nitric Oxide (INO) is a selective pulmonary vasodilator. The mechanism of action involves the activation of an enzyme system that leads to smooth muscle relaxation. In infants at 34 weeks gestation or more, INO can improve oxygenation when conventional therapy has failed.

Billing Inpatient Services

INO services are billed with revenue code 174 (nursery, newborn; level IV) in conjunction with ICD-9-CM Volume 3 procedure code 00.12 (administration of inhaled nitric oxide).

INO services must be submitted on a claim with all revenue/sick baby codes applicable to the entire stay. The claim is submitted for INO services rendered to the baby only. Services to the mother are billed separately.

Hospital Reimbursement:
DRG-Reimbursed Facilities

INO services for hospitals are paid according to diagnosis-related groups (DRG) reimbursement methodology. (Refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in the Inpatient Part 2 provider manual for DRG information.)

To qualify for reimbursement the hospital must:

- Have a Neonatal Intensive Care Unit (NICU) approved by California Children's Services (CCS) as a Regional NICU
- Have a CCS-approved Neonatal ECMO Center
- Provide Inhaled Nitric Oxide (INO) services for neonates

Therapeutic Phlebotomy

Therapeutic phlebotomy (CPT-4 code 99195) is reimbursable only when the recipient is diagnosed with a disease that requires the removal of blood to relieve symptoms or complications.

Note: Code 99195 must not be used to bill for routine blood draws. Code 99000 (handling and/or conveyance of specimen) is the appropriate code to bill for this procedure. (See "Blood Specimens – Collection and Handling" in the *Pathology: Blood Collection and Handling* section of the appropriate Part 2 manual.)

Vitiligo

Providers may use CPT-4 code 96912 to bill psoralen with ultraviolet light (PUVA) treatments for vitiligo. Code 96900 is used to bill ultraviolet treatment alone for psoriasis. CPT-4 codes 96900, 96910 (ultraviolet treatment Goeckerman type) and 96912 do not require prior authorization. However, prior authorization is required for HCPCS code Z0308 (psoriasis day care).

Esophageal Acid Reflux Testing

CPT-4 codes 91030 – 91040 are used to bill for esophageal acid reflux testing. Within this range, CPT-4 codes 91034, 91035, 91037 and 91038 are split-billed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC. When billing for both professional and technical components, a modifier is neither required nor allowed.

Note: Do not bill modifier 99 when billing with modifiers 26 or TC.

<u>CPT-4 Code</u>	<u>Description</u>
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
91035	with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation
91038	prolonged (greater than 1 hour, up to 24 hours)
91040	Esophageal balloon distention provocation study

Capsule Endoscopy

CPT-4 code 91110 (gastrointestinal tract imaging, intraluminal [for example, capsule endoscopy], esophagus through ileum, with physician interpretation and report) requires prior authorization.

Documentation of either of the following must be submitted with the *Treatment Authorization Request (TAR)* or a *Service Authorization Request (SAR)*:

- In the investigation of obscure gastrointestinal bleeding, esophagogastroduodenoscopy and colonoscopy are non-diagnostic.
- Non-diagnostic results of lower endoscopy and small bowel follow-through X-rays in suspected small bowel Crohn's disease.

Claims for code 91110 may be billed with modifier 26 and TC. When billing for both professional and technical components, a modifier is neither required nor allowed.

Note: Do not bill modifier 99 on claims for capsule endoscopy. The claim will be denied.

Capsule endoscopy is contraindicated in patients with known or suspected gastrointestinal obstruction, strictures or fistulae.

Wireless Capsule

CPT-4 code 91112 (gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report) is restricted to patients 18 years of age and older.

Pulsed Irrigation Enhanced Evacuation (PIEE)

Pulsed Irrigation Enhanced Evacuation (PIEE) may be authorized for patients with neuropathic bowel due to underlying neurologic problems that dispose them to severe fecal impaction and who have failed all traditional and conservative attempts at bowel control. The PIEE procedure may be approved for patients with serious neurologic problems, such as spinal cord injury, stroke, brain injury or multiple sclerosis, under the following conditions:

- Symptomatic fecal impaction with pain, abdominal distention, nausea and vomiting, significant weight loss, recurrent liquid stools, autonomic dysreflexia, and unresponsive to oral bowel medication, suppositories and or enemas
- Asymptomatic fecal impaction with abdominal distention and no response to a bowel program

TAR Requirement

The PIEE equipment and supplies require a TAR. They are billed with the following codes:

<u>HCPCS Code</u>	<u>Description</u>
E0350	Control unit for electronic bowel irrigation/evacuation system
E0352	Disposable pack (water reservoir bag, speculum, valving mechanism and collection bag/box) for use with the electronic bowel irrigation/evacuation system

Related supplies other than the disposable pack are billed with HCPCS code A9900 (miscellaneous DME supply, accessory and/or service component of another HCPCS code). Separate TARs may be required for the approval of services related to PIEE and for the equipment and/or supplies.

The PIEE device will have an initial two-month trial of rental to provide documentation that long-term use will be medically necessary and effective. Following this two-month rental, a TAR must be submitted for purchase of the PIEE device by the Medi-Cal program for permanent use by the recipient. The initial authorization for all services related to the PIEE procedure may be approved for no more than two months of treatment, through the last date of the month, to permit better utilization and ensure PIEE safety and efficacy for the recipient. Subsequent TARs for services related to the PIEE procedure and the treatment pack supplies may be approved for up to six-month increments, if there is medical documentation that indicates the recipient continues to require the procedure and that the procedure continues to provide effective evacuation for the recipient.

Documentation Requirements

The attending physician's documentation of the medical necessity for PIEE must include a complete history and physical exam; documentation of adequate caregiver support for training in the use of PIEE; and arrangement of skilled nursing home health visits to provide assistance and support for this service.

Negative Pressure Wound Therapy (NPWT) Devices

Negative Pressure Wound Therapy (NPWT) devices include pumps and wound care sets. They are typically used after other appropriate wound treatment modalities have failed to heal skin wounds or ulcers.

NPWT devices and supplies are billed with the following codes:

<u>HCPCS Code</u>	<u>Description</u>	<u>Limitations</u>
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	Reimbursable for purchase only. Frequency is limited to 15 per month (all may be reimbursed for the same date of service).
A7000	Canister, disposable, used with suction pump, each	Reimbursable for purchase only. Frequency is limited to 10 per month (all may be dispensed on the same date of service).
A7001	Canister, non-disposable, used with suction pump, each	Reimbursable for purchase only. Frequency is limited to 1 in 6 months.
E2402	Negative pressure wound therapy electrical pump, stationary or portable	Reimbursable for daily rental only. Frequency limitation is one per 120 days. Must be capable of accommodating more than one wound dressing set, for multiple wounds on a patient. More than one code E2402 billed per recipient for the same time period will be denied as not medically necessary.
<u>K0743</u>	<u>Suction pump, home model, portable, for use on wounds</u>	<u>Maximum rental period is 120 days. Reimbursement is “By Report.”</u>

<u>K0744</u>	<u>Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less</u>	<u>Reimbursement is “By Report.” Frequency is limited to 2 per day with a maximum of 10 in 30 days.</u>
<u>K0745</u>	<u>...pad size more than 16 square inches but less than or equal to 48 square inches</u>	<u>Reimbursement is “By Report.” Frequency is limited to 2 per day with a maximum of 10 in 30 days.</u>
<u>K0746</u>	<u>...pad size greater than 48 square inches</u>	<u>Reimbursement is “By Report.” Frequency is limited to 2 per day with a maximum of 10 in 30 days.</u>

Note: CPT-4 codes 97605 – 97606 (negative pressure wound therapy) are not Medi-Cal benefits. Reimbursement for these services is included in the payment for HCPCS code E2402.

TAR Requirement

NPWT pumps and supplies require a TAR. The initial TAR for the pump will be granted for a period of no more than 15 days. Reauthorization TARs may be granted in increments of up to 15 days, not to exceed a total treatment duration of 120 calendar days. Only one pump may be authorized for the 120-day period. In an inpatient setting, the NPWT devices are included in the per diem payment and are not separately reimbursable. For non-inpatient places of service, the pump code E2402 and wound care set code A6550 are reimbursable only to DME providers.

Documentation Requirements

The following must be submitted with each TAR:

- Written prescription form signed by a licensed practitioner functioning within the scope of his or her practice that details medical necessity of the NPWT, including all of the following:
 - Summary of the patient’s medical condition

- Relevant wound history, including prior treatments, such as: debridement, offloading, turning, detection and treatment of wound infection, presence of osteomyelitis and others. Surgery dates and operative reports should be included. For dehisced wounds, date of original surgery and chronology of dehiscence, possible cause and initial treatment should be documented.
- Documentation of the medical condition necessitating the NPWT
- Duration of time the patient is expected to require the NPWT
- Documentation of the treatment plan, including all of the following:
 - A detailed description of each wound, including wound care notes, precise measurements, and description of exudates, necrotic tissue and granulation tissue as well as evidence of tunneling, slough, eschar infection and odor, if present.
 - Comorbid conditions
 - ❖ If patient is diabetic, status of diabetic control, HbA1c value.
 - Nutritional status.
 - Operative note if the request is for the use of NPWT in surgical and/or traumatic wounds.
 - Wound care plan (must document that appropriate wound care is being provided)
 - Nursing care plan (must document that appropriate nursing care is being provided)
 - Concurrent issues relevant to wound therapy (debridement, nutritional status, support surfaces in use, positioning and incontinence control)
- Documentation, at least every 15 calendar days, of quantitative wound characteristics, including wound surface area (length, width and depth)

Requirements by Wound Type	<p>For all wounds there should be documentation of a moist wound environment for at least two weeks or greater without progression or healing and surgical debridement as appropriate.</p> <ul style="list-style-type: none"> • Stage III or IV pressure ulcer: Documentation should include previous therapies and appropriate pressure reducing positions and surfaces. • Diabetic ulcer: Treatment with a comprehensive diabetic management program. If treating a foot ulcer, documentation of reduction in pressure with appropriate modalities. • Venous: Leg elevation has been encouraged. Compression garments have been consistently applied. • Acute/Traumatic: Evidence of significant traumatic tissue loss. Primary wound closure not possible. Wound must be left open or was reopened due to an infection.
Contraindications	<p>NPWT coverage will be denied as not medically necessary if any of the following contraindications are present:</p> <ul style="list-style-type: none"> • Necrotic tissue with eschar in the wound • Untreated osteomyelitis within the vicinity of the wound • Malignancy in the wound • Inadequate circulation to the wound site
Continued Authorization	<p>Evidence of significant wound improvement must be demonstrated. Date of assessment and description of the wound must be provided, together with interventions implemented.</p>
Gender Identity Disorder	<p>For detailed policy information on the treatment of Gender Identity Disorder (GID), refer to the <i>Surgery</i> section in the appropriate Part 2 provider manual.</p>
Extracorporeal Photopheresis	<p>For detailed policy information on the process of extracorporeal photopheresis (ECP), refer to the <i>Blood and Blood Derivatives</i> section in the appropriate Part 2 provider manual.</p>