PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Drive
Fairfield, California 94534

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Healthy Kids

Important Provider Notice #49

Subject: 2012 HCPC changes effective 1/1/13

The updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Healthy Kids for dates of service on or after January 1, 2013. The affected codes are listed below. Only those codes representing current or future Healthy Families benefits are included. Please refer to the 2012 CPT-4 and HCPCS Level II code books for complete descriptions of these codes.

AUDIOLOGY

CPT-4 code 92558 must be billed "By Report," which requires the documentation of deficits identified in comparison with the standard tests and describing changes from prior assessments. Code 92558 is limited to four times per year same recipient, any provider. If billed more than four times a year, medical justification must be entered in the *Remarks* field (Box 80)/*Reserved for Local Use Field* (Box 19) of the claim or on an attachment to the claim.

IMMUNIZATIONS

Deleted and Replacement Codes
The following deleted codes have no replacement. Providers may refer to the appropriate 2012 codebook for alternative codes.

Deleted Code (No Replacements)
90470
90663

MEDICINE

Deleted and Replacement Codes
The following deleted codes have no replacements. Providers may refer to the appropriate 2012 codebook for alternative codes.

Deleted Codes (No Replacements)

93875	94370
94240	94720
94260	94725
94350	S2270
94360	S3905

92618, 93561, 93562, 93998, 94729 – 4729, 95885 – 95887, 95938, 95939

Billing Information and Restrictions
Special billing policy applies to orthotic and prosthetic codes as follows:

- 92618 is exempt from modifier 51 reimbursement cutback; one billing unit equals 30 minutes with a maximum of 2 units
- 92621 is exempt from modifier 51 reimbursement cutback
- 93998 requires an approved TAR and is billed "By Report."
- 94726 is reimbursable for respiratory therapists with an approved TAR; split-billed, must be billed with modifier 26, TC or ZS; not reimbursable with code 94727 or 94728
- 94727 is reimbursable for respiratory therapists with an approved TAR; split-billed, must be billed with modifier 26, TC or ZS; not reimbursable with code 94726
- 94728 is reimbursable for respiratory therapists with an approved TAR; split-billed, must be billed with modifier 26, TC or ZS; not reimbursable with code 94010, 94060, 94070, 94375 or 94726
- 94729 is reimbursable for respiratory therapists with an approved TAR; split-billed, must be billed with modifier 26, TC or ZS; exempt from modifier 51 reimbursement cutback
- 94781 is exempt from modifier 51 reimbursement cutback
- 95885 and 95886 are split-billed and must use modifier 26, TC or ZS; may use modifiers 99 and U7; exempt from modifier 51 reimbursement cutback; payable only with an ICD-9-CM diagnosis code of 053.11, 351.0 – 351.9, 352.4, 353.0, 353.1, 354.0 – 354.9, 355.0 – 355.9, 356.0 – 356.9, 357.0 – 357.9, 723.4, 724.4, 728.2, 728.9, 782.0, 951.4, 951.6, 955.0 – 956.9; not reimbursable with codes 95860 – 95864, 95870 and 95905
- 95887 is split-billed and must use modifier 26, TC or ZS; may use modifiers 99 and U7; exempt from modifier 51 reimbursement cutback; payable only with an ICD-9-CM diagnosis code of 053.11, 351.0 – 351.9, 352.4, 353.0, 353.1, 354.0 – 354.9, 355.0 – 355.9, 356.0 – 356.9, 357.0 – 357.9, 723.4, 724.4, 728.2, 728.9, 782.0, 951.4, 951.6, 955.0 – 956.9; not reimbursable with codes 95867 – 95870 and 95905.
- 95938 is split-billed and must be billed with modifier 26, TC or ZS; when used as a monitoring procedure, claim must indicate the duration of monitoring; frequency restricted to 4 per year, more allowed with medical justification
- 95939 is split-billed and must use modifier 26, TC or ZS; frequency restricted to 4 per year, more allowed with medical justification

PATHOLOGY AND LABORATORY

Deleted and Replacement Codes
The following are deleted codes and their replacements. When a replacement code is provided, the policy of the deleted code applies to the replacement(s) unless otherwise specified. If no replacement is listed, providers may refer to the appropriate 2012 codebook for alternative codes.

Deleted Codes	Replacement Codes
88107	88104, 88106
88318	88313
S3628	None
S3711	None

S3713	81275 (policy updated)
S3820	81211
S3822	81215 or 81217
S3823	81212
S3828	81292 (policy updated)
S3829	81295 (policy updated)
S3843	None
S3847	None
S3848	None
S3851	None
S3860	81280
S3862	81281

81206 – 81208, 81210 – 81212, 81215, 81217, 81220, 81243, 81244, 81250, 81256, 81260, 81265 – 81268, 81270, 81275, 81280, 81281, 81292 – 81301, 81315 – 81319, 81331, 81370 – 81383, 81400 – 81405, 87389

PHYSICIAN-ADMINISTERED DRUGS

Deleted and Replacement Codes
The following are deleted codes and their replacements. When a replacement code is provided, the policy of the deleted code applies to the replacement(s) unless otherwise specified. If no replacement is listed, providers may refer to the appropriate 2012 codebook for alternative codes.

Deleted Codes	**Replacement Codes**
C9270	J1557
C9272	J0897
C9273	None
C9274	J0840
C9276	J9043
C9277	J0221
C9278	None
C9280	J9179
Q0179	None
Q2044	J0490
S0181	None

C9285, J0131, J0221, J0257, J0490, J0712, J0840, J0897, J1557, J2265, J2507, J7326, J7665, J9043, J9179

Billing Information and Restrictions
Special billing policy applies to physician-administered drug codes as follows:

- C9285: One billing unit is 2 patches, with a maximum dose of 2 patches per day
- J0131: One billing unit is 10 mg; for recipients at least 2 years of age, with a maximum dose of 4,000 mg (400 units)
- J0220 is now used to bill for Myozyme injection for recipients younger than 8 years of age
- J0221 is used to bill for Lumizyme injection for recipients 8 years of age and older. One billing unit is 10 mg with a recommended dose of 20 mg/kg every two week
- J0256 and J0257: One billing unit is 10 mg; for recipients 18 years of age or older, with a maximum dose of 8,400 mg; only reimbursable with ICD-9-CM diagnosis code 492.8
- J0490: One billing unit is 10 mg with a recommended dosage regimen of 10 mg/kg at two-week intervals for the first three doses and at four-week intervals thereafter; only reimbursable with ICD-9-CM diagnosis code 710.0
- J0712: One billing unit is 10 mg with a maximum dose of 1,200 mg (120 units); for recipients 18 years of age or older
- J0840: One billing unit is 1 gm or fraction thereof with a maximum dose of 24 gm (24 units)
- J0897: One billing unit is 1 mg
- J1557: One billing unit is 500 mg
- J2265: One billing unit is 1 mg with a maximum dose of 400 mg/day (400 units); for recipients 8 years of age or older
- J2507: One billing unit is 1 mg with a maximum dose of 8 mg (8 units) I.V. every 2 weeks; for recipients 18 years of age or older; only reimbursable with ICD-9-CM diagnosis code 274.00 – 274.9
- J7326: One billing unit is 1 dose with a usual dose of 3 ml into the affected knee and a maximum quantity of 2 doses; billed “By Report;” an approved TAR documenting the following is required:
    - Painful osteoarthritis of one or both knees
    - Inadequate response to conservative nonpharmacologic therapy
    - Inadequate response to analgesics (for example, acetaminophen) and non-steroidal anti-inflammatory drugs
- J7665: One billing unit is 5 mg with a maximum dose of 635 mg (127 units)
- J9043: One billing unit is 1 mg with a maximum dose of 62 mg (62 units), except with documentation that the patient’s body surface area exceeds 2.5 meters squared; for recipients 18 years of age or older; only reimbursable for males with ICD-9-CM diagnosis code 185
- J9179: One billing unit is 0.1 mg with a maximum dose of 3 mg (30 units), except with documentation that the patient’s body surface area exceeds 2 meters squared; only reimbursable with ICD-9-CM diagnosis code 174.0 – 175.9

RADIOLOGY

Deleted and Replacement Codes

The following deleted codes have no replacements. Providers may refer to the appropriate 2012 codebook for alternative codes.

Deleted Codes (No Replacements)

71090	77079	78585	78593
73542	77083	78586	78594
75722	78220	78587	78596

75724	78223	78588	S8049
75940	78584	78591	

74174, 77424, 77425, 77469, 78226, 78227, 78579, 78582, 78597, 78598

Billing Information and Restrictions
Special billing policy applies to radiology codes as follows:

- 74174 is split-billed and must use modifier 26, TC or ZS; more than one is allowed with the appropriate National Correct Coding Initiative (NCCI) modifier and documentation of medical necessity; for multiple scans during the same session, the provider must document the CPT code and time for each scan and state "same session;" the professional component is reimbursed fully for each scan and the technical component is reimbursed fully for the first scan and reduced to 50 percent for subsequent scans; not reimbursable with codes 72191 – 72194, 73706, 74175 – 74178, 75635, 76376, 76377; Exception: Code 72192 is reimbursable with code 72194 with documentation of medical necessity
- 77424 and 77425 are billed "By Report"
- 78226, 78227, 78579 and 78582 are split-billed and must use modifier 26, TC or ZS
- 78597 and 78598 are split-billed and must use modifier 26, TC or ZS; not reimbursable with 78451 – 78454

RADIOPHARMACEUTICALS

A9584, A9585

Billing Information and Restrictions
Special billing policy applies to radiology codes as follows:

- A9584: One billing unit is one study dose with a maximum dose of 5 millicuries per study dose; reimbursable "By Report"

- A9585: One billing unit is 0.1 ml with a maximum dose of 18 ml (180 units), except with documentation that the patient's weight is greater than 180 kg; for recipients 2 years of age and older; reimbursable "By Report"

SURGERY AND SURGICAL SUPPLIES

Deleted and Replacement Codes
The following are deleted codes and their replacements. When a replacement code is provided, the policy of the deleted code applies to the replacement(s) unless otherwise specified. If no replacement is listed, providers may refer to the appropriate 2012 codebook for alternative codes.

Deleted Codes	Replacement Codes	Deleted Codes	Replacement Codes
11975	11981	32402	32098
11977	11976 or 11981	32500	32505 – 32507
15170	15271 – 15278	32602	32607 – 32609
15171	15271 – 15278	32603	32601

15175	15271 – 15278	32605	32601
15176	15271 – 15278	32657	32666 – 32668
15300	15271 – 15274	32660	None
15301	15271 – 15274	35548	35537, 35539, 35565
15320	15275 – 15278	35549	35537 – 35540, 35565
15321	15275 – 15278	35551	35539, 35540, 35556, 35583
15330	15271 – 15274	35651	35646, 35647, 35656
15331	15271 – 15274	37620	37191 or 37619 as appropriate
15335	15275 – 15278	49080	49082 – 49084
15336	15275 – 15278	49081	49082 – 49084
15340	15271 – 15278	64560	None
15341	15271 – 15278	64577	None
15360	15271 – 15274	64622	64633 – 64636
15361	15271 – 15274	64623	64633 – 64636
15365	15275 – 15278	64626	64633 – 64636
15366	15275 – 15278	64627	64633 – 64636
15400	15271 – 15274	69802	None
15401	15271 – 15274	C9729	None
15420	15275 – 15278	G0440	None
15421	15275 – 15278	G0441	None
15430	15271 – 15278	Q1003	None
15431	15271 – 15278	S2344	None
32095	32096 – 32098		

Note:
The following deleted codes had a policy restriction that denied reimbursement for assistant surgeon services. The following replacement codes, except for code 11976, **are** reimbursable for assistant surgeons.

Deleted Codes	**Replacement Codes**
11975	11981
11977	11976 or 11981
32402	32098
32602	32607 – 32609
32657	32666 – 32668

15271 – 15278, 15777, 20527, 22551, 22633, 22634, 26341, 29582 – 29584, 32096 – 32098, 32491, 32505 – 32507, 32607 – 32609, 32666 – 32674, 33221, 33227 – 33231, 33262 – 33264, 36251 – 36254, 37191 – 37193, 37619, 38232, 49082 – 49084, 62369, 62370, 64633 – 64636

Surgical supply codes C1830, C1840, C1886, C9366, Q4122 – Q4130

Billing Information and Restrictions
Special billing policy applies to surgery and surgical supply codes as follows:

- 22551 is reimbursable to primary and assistant surgeons
- 22612 is not separately reimbursable with 22630 or 22633 for the same interspace and segment unless documentation submitted with the claim indicates the procedure was performed at a different interspace and segment, for the same recipient, same date of service, any provider
- 22633 is not separately reimbursable with 22612 or 22630 for the same level unless documentation submitted with the claim indicates the procedure was performed at a different level, for the same recipient, same date of service, any provider
- 32491 is reimbursable to primary and assistant surgeons
- 32604, 32606, 32651 – 32656, 32658, 32659, 32661 – 32665 are reimbursable to the assistant surgeon
- 62311 is not reimbursable with 62287 when performed at the same spinal level. Providers must document when performed at a different spinal level.
- C1830 is billed "By Report"
- C1840 is billed "By Report;" operative report must show that the procedure for insertion of ocular telescope prosthesis including removal of crystalline lens was performed; only reimbursable with ICD-9-CM diagnosis codes 362.50 – 362.52
- C1886 is billed "By Report"
- C9366 and Q4122 – Q4130 are billed "By Report" and reimbursable to a podiatrist with an approved TAR

Note:
CPT-4 codes 11603, 11604, 11606, 11623, 11624, 11626, 11643, 11644, 11646, 12045, 15150 – 15152, 15155 – 15157, 15271 – 15278, 15777, 20527, 26341, 29582 – 29584, 33206 – 33208, 33210 – 33213, 33218, 33220, 33221, 33224 – 33231, 33233, 33240, 33241, 33249, 33262 – 33264, 36200, 36245 – 36248, 36251 – 36254, 37191 – 37193, 39400, 49082 – 49084, 62369, 62370, 64633 – 64636 are not payable to the assistant surgeon. In addition, the following codes are not payable to assistant surgeons:

- 22520 – 22522 are not reimbursable with 20225, 22310 – 22315, 22325, 22327 when performed at the same level. Document in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim, or on a claim attachment, when the surgery is performed at a different level. Codes require an approved TAR documenting all of the following four criteria:
    - Loss of mobility with severe debilitating pain, caused by an acutely fractured vertebra presently at 50 percent of original height or greater, and
    - Etiology of the severe debilitating pain from sources other than the vertebral fracture have been previously worked up and ruled out (for example, protruded disc at same vertebral level), and
    - Non-invasive corrective medical treatments, including a two-week trial of opioids and physical therapy with modalities, have been tried and failed, and
    - Associated conditions that may have caused the fracture have also been concurrently evaluated and treated (for example, multiple myeloma, hemangioma, malignant neoplasm or severe osteoporosis

- 36251 is not reimbursable with 36253 when performed on the same kidney. Providers must document in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) or on a claim attachment when performed on a different kidney; modifier 50 not allowed
- 36253 is not reimbursable with 36251 when performed on the same kidney. Providers must document in the *Remarks* field (Box80)/*Reserved for Local Use* field (Box 19) or on a claim attachment when performed on a different kidney; modifier 50 not allowed
- 62287 is not reimbursable with 62267, 62290, 62311, 77003, 77012, 72295 when performed at the same spinal level. Providers must document when performed at a different spinal level.

Note:
The following surgical codes are exempt from modifier 51 cutback: 15272, 15274, 15276, 15278, 15777, 22634, 29826, 32506, 32507, 32667, 32668, 32674, 64634 and 64636.

MODIFIERS
Healthy Kids is recognizing but not requiring the use of the following new national modifiers:

Modifier	Description
33	Preventive service: When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory).
92	Alternative Laboratory Platform Testing: When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber.

Healthy Kids is eliminating the use of the following national modifiers:

Modifier	Description
V8	Infection present
V9	No infection present