PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Drive
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Date: November 30, 2015

Healthy Kids

Important Provider Notice # 51

Subject: Reminder - 2015 CPT-4/HCPCS Updates: Implementation January 1, 2016

The 2015 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 PHC for dates of service on or after January 1, 2016.

2015 HCPCS Code Additions

Chemotherapy

A9606, C9442, J9267, J9301

A9606

Billing is for males only.

C9442

Belinostat is used for the treatment of recipients with relapsed or refractory peripheral T-cell lymphoma. The recommended dose is 1,000 mg per m2 once daily, on days one through five of a 21 day cycle.

Billing is for recipients 18 years of age and older. An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

DME

A4602, A7048

A4602

Providers must document the equipment is patient-owned. Modifier NU is required when billing. Billing frequency is limited to one in six months. Reimbursement is determined "By Report." This item is taxable.

A7048

Providers must document the equipment is patient-owned. Modifier NU is required when billing. Billing frequency is limited to one per month. Reimbursement is determined "By Report." This item is non-taxable.

Evaluation & Management

99490, 99497, 99498

99490

Billing frequency is limited to once per month.

99497

Billing frequency is limited to twice a year with a TAR override.

99498

Billing frequency is limited to once a year with a TAR override.

Immunization

90630, **90651**

90651

Billing is for females 10 through 25 years of age.

Laboratory

80163, 80165, 80300 – 80304, 80320 – 80377, **81288,** 81420, **81435, 81436, 81519,** 87505 – 87507, **87624, 87625, 87806,** 88341, 88344, 88364, 88366, 88369, 88373, 88374, 88377, **G0472**

81288

Billing frequency is limited to once in a lifetime, a TAR documenting the following criteria is required:

Recipient with colon cancer, and

The tumor demonstrates microsatellite instability or immunohistochemistry results indicating loss of MLH1 protein expression

81435, 81436

Billing frequency is limited to once in a lifetime with a TAR override. These codes are only reimbursable with one of the following ICD-10-CM diagnosis codes:

- C18.0, C18.2 – C18.9, C19, Z80.0, Z85.030 – Z85.038, Z85.040 – Z85.048 and Z86.010

81519

Providers must document on the claim form or on an attachment that all of the following criteria of early stage breast cancer have been met. Failure to document the criteria below will result in the claim being denied:

The recipient is estrogen receptor (ER) positive

The recipient is HER2-receptor negative

The recipient is lymph node negative

The recipient has stage I or stage II breast cancer

The recipient is a candidate for chemotherapy

The assay is used within six months of diagnosis

The intention to treat or not to treat with adjuvant chemotherapy will be contingent, at least in part, on the test results

This benefit applies exclusively to use of the Oncotype DX test. Other tests are not benefits of the Medi-Cal program.

This once-in-a-lifetime benefit may be billed more than once for the same recipient if the provider can prove via documentation that the recipient has a new second primary breast cancer that meets the same criteria listed above.

87624, 87625

Billing is for recipients 15 through 65 years of age. Billing frequency is limited to once every three years. A TAR override is allowed.

87806

This code is reimbursable when billed with any ICD-10-CM diagnosis code, including nonspecific diagnosis codes.

G0472

The determination of high risk for HCV is identified by the primary care physician or practitioner who assesses the recipient's history, typically as part of an annual wellness visit, and considers risk of infection in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

Indications for adults at high risk of HCV infection include:

A current or past history of illicit injection drug use, and

Receiving a blood transfusion prior to 1992

Repeat screening for high risk adults is covered annually only for recipients who continued their illicit injection drug use since the prior negative screening test. Recipients who do not meet the high risk criteria defined above, but who were born from 1945 through 1965 may receive a single,

once-in-a-lifetime screening test.

Medicine

91200

An approved TAR is required for reimbursement. Code is split billable and must be billed with modifier 26 and TC. Allowable modifiers are 22, 24, 25, 99, SA, SB and U7.

Performance of transient elastography more than twice per year or within six months following a liver biopsy is considered not medically necessary.

Documentation is recommended and may include the following ICD-10-CM codes:

K70.2	K70.41	K73.2	K74.	K74.5	K75.81
K70.30	K70.9	K73.8	K74.	K74.60	K76.0
K70.31	K73.0	K73.9	K74.	K74.69	K76.89
K70.40	K73.1	K74.0	K74.	K75.4	K76.9

93260, 93261

These codes are split billable, and must be billed with modifier TC and/or 26. No modifier is required if billing for the global service. Allowable modifiers are 22, 25, 99 and U7.

93355

Allowable modifiers are 25, 99, SA, SB and U7.

93644

Required modifiers are TC and/or 26. No modifier is required if billing for the global service. Allowable modifiers are 25, 99, SA, SB and U7.

93702

This is a Medicare non-covered code. Billing frequency is limited to two times per year.

96127

Billing frequency is limited to three times per year.

99188

Billing frequency is limited to three times per year for recipients through 5 years of age.

Orthotics & Prosthetics

L3981, L6026, L7259

L3981, L6026, L7259

Billing frequency is limited to one in five years. Bill with modifier LT or RT. Item is non-taxable.

Physician Administered Drugs

C9444, C9446, C9447, J0153, J1071, **J1322, J1439,** J2274, J2704, **J3145, J7181, J7200, J7327, J7336**

C9444

Minimum age for billing is 18 years of age. Maximum dosage is 1,200 mg per day.

C9446

Minimum age for billing is 18 years of age. Maximum dosage is 200 mg per day.

C9447

Minimum age for billing is 18 years of age. Maximum dosage is 4 ml per day.

J1322

An approved TAR is required for reimbursement and must include a diagnosis of Mucopolysaccharidosis

IV A. Recommended dosage is 2 mg/kg once a week.

J1439

Minimum age for billing is 18 years of age. Maximum accumulative dosage is not to exceed 1500 mg per course.

J3145

Billing is for males 18 years of age and older. Maximum dosage is 750 mg every four weeks.

J7181, J7200

A TAR is required for reimbursement.

J7327

A TAR is required for reimbursement. One billing unit equals the entire dose administered.

J7336

Billing is for recipients 18 years of age and older.

Radiology

76641, 76642, 77061 – 77063, 77085, 77086, 77306, 77307, 77316 – 77318, 77385, 77386, **77387,** G0279, G6001 – G6017

76641, 76642

These codes are split billable and must be billed with modifiers 26 and TC. Billing is allowed for up to two units.

77061 – 77063, 77085, 77086, 77306, 77307, 77316 – 77318

These codes are split billable and must be billed with modifiers 26 or TC.

77387

This is a Medicare non-covered code. Medicare denial is not required for claims processing.

Surgery

20604, 20606, 20611, 20983, 21811, 21812, 21813, 22510, 22511, 22512, 22513, 22514, 22515, 22858,

27279, 33270 – 33273, 33418, 33419, 34839, 37218, 43180, 44381, 44384, 44401 – 44404, 44405,

44406 – 44408, 45346, 45347, 45349, 45350, 45388 – 45390, 45393, 45398, 45399, 46601, 46607,

47383, 52441, 52442, 62302 – 62305, 64486 – 64489, 66179, 66184, C2624, **C9742,** L8696

20604, 20606

A TAR is required for reimbursement to podiatrist, not reimbursable to assistant surgeon.

20611, 2098366165

Not reimbursable to assistant surgeon.

21811, 21812

Reimbursable to primary surgeon and assistant surgeon.

21813

Reimbursable to primary surgeon and assistant surgeon.

22510, 22511

Reimbursable to primary surgeon and not reimbursable to assistant surgeon. A TAR is required.

22512

Reimbursable to primary surgeon and not reimbursable to assistant surgeon. A TAR is required. Exempt from modifier 51 cutback.

22513, 22514

A TAR is required for reimbursement to the primary surgeon. Assistant surgeon services do not require a TAR.

22515

A TAR is required for reimbursement to the primary surgeon. Assistant surgeon services do not require a TAR. Exempt from modifier 51 cutback.

22858

A TAR is required for reimbursement to the primary surgeon. Assistant surgeon services do not require a TAR. Exempt from modifier 51 cutback.

27279

Reimbursable to primary surgeon and assistant surgeon. For recipients undergoing minimally invasive sacroiliac joint (SIJ) fusion, the following must be documented in the recipient's medical record and available on request. A TAR must include the following documentation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or on a claim attachment:

- A complete history and physical documenting the likely existence of SIJ pain
- Performance of a fluoroscopically guided intra-articular SIJ block using local anesthetic on the affected side (or both sides) which shows at least a 75 percent acute reduction in pain
- A course of conservative treatment that includes use of non-steroidal anti-inflammatory drugs and/or opioids (unless contraindicated) and one of the following:
  - An adequate period of rest, or
  - An adequate course of physical therapy wherein the physical therapist specifically documents a lack of response to treatment, or
  - SIJ steroid injections into the affected joint with inadequate response or a return of pain in the weeks to months following the injections, or
  - Radiofrequency ablation of the affected SIJ with either inadequate response or a return of pain in the weeks to months following the procedure
- SIJ pain has continued for a minimum of six months
- All other diagnoses that could be causing the recipient's pain have been ruled out
- Within one month after surgery, pain level and/or functional disability is continuing, and it is the surgeon's opinion SIJ fusion is the only treatment option that will provide long term relief

33270 – 33273

Not reimbursable to assistant surgeon.

33418

Reimbursable for primary and assistant surgeon services.

33419

Reimbursable for primary and assistant surgeon services. Exempt from modifier 51 cutback.

34839

Not reimbursable to assistant surgeon.

37218

Reimbursable for primary and assistant surgeon services.

43180, 44381

Not reimbursable to assistant surgeon.

44384, 44401 – 44404

Not a Medicare benefit. Not reimbursable to assistant surgeon.

44405

Not a Medicare benefit. Not reimbursable to assistant surgeon. Must be billed with modifier 59 for each stricture dilated.

44406 – 44408

Not a Medicare benefit. Not reimbursable to assistant surgeon.

45346, 45347, 45349

Not reimbursable to assistant surgeon.

45350, 45388 – 45390, 45393, 45398

Not a Medicare benefit. Not reimbursable to assistant surgeon.

45399

Not a Medicare benefit. A TAR is required for reimbursement to the primary surgeon. Assistant surgeon services do not require a TAR. Unlisted procedure and requires TAR.

46601, 46607

Not a Medicare benefit. Not reimbursable to assistant surgeon.

47383, 52441

Not reimbursable to assistant surgeon.

52442

Not reimbursable to assistant surgeon. Exempt from modifier 51 cutback. Limited to 3 implants.

62302 – 62305, 64486 – 64489

Not reimbursable to assistant surgeon.

66179, 66184

Reimbursable for primary and assistant surgeon.

C9742

Not reimbursable to assistant surgeon.

2015 HCPCS Change Codes

DME

A9279, E0986, E1002 – E1008, E1010, E1014 , E1029, E1030, E1161, E1232 – E1238, E2227, E2230, E2310 – E2313, E2321, E2322, E2325 – E2330, E2373, E2376 – E2378, E2500, E2502, E2504, E2506, E2508, E2510, E2599

A9279

Now a Medicare non-covered code.

E0986, E1002 – E1008, E1010, E1014 , E1029, E1030, E1161, E1232 – E1238, E2227, E2230,

E2310 – E2313, E2321, E2322, E2325 – E2330, E2373, E2376 – E2378, E2500, E2502, E2504, E2506, E2508, E2510, E2599

No longer Medicare non-covered codes.

Evaluation & Management

99487, 99489

Laboratory

86900, 86901, 87501, 87502, 88342

Medicine

90654, 93282, 93283, 96110

Orthotics & Prosthetics

L7367

Physician Administered Drugs

J7195, J7301

Radiology

77402, 77407, 77412, G0204, G0206

Surgery

20982, 27370, 33218, 33220, 33241, 33262 – 33264, 37215, 37216, 43194, 43215, 44363, 44380, 44382, 44386, 44388 – 44392, 44799, 45332, 45379, 45391, 45392, 62284

Vision Care

V2799

2015 HCPCS Deleted Codes

Chemotherapy

Deleted Code	Replacement Code
C9021	J9301
J9265	J9267

Laboratory

Deleted Code	Replacement Code
82055	80320, 80321
82101	80323
82145	80325, 80326
82205	80345
82520	80353
83840	80358
83925	80361 – 80364
87621	87624, 87625

Medicine

Deleted Code	Replacement Code
99481, 99482	99184

Physician Administered Drugs

Deleted Code	Replacement Code
C9133	J7200
C9134	J7181
J0150, J0151	J0153
J1070, J1080	J1071
J2271, J2275	J2274
J7335	J7336
Q9970	J1439
Q9974	J2274
S0144	J2704

Radiology

Deleted Code	Replacement Code
76645	76641, 76642
77082	77086
77403, 77404, 77406	77402
77408, 77409. 77411	77407
77413, 77414, 77416	77412

Surgery

Deleted Code	Replacement Code
22520 – 22525	22510 – 22515
69401	99201 – 99205, 99211 – 99215
C9735	46999