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.

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

<u>How To Apply</u>

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 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:

- *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 available at both the "California Children's Services (CCS) Forms" page of the DHCS website (*http://www.dhcs.ca.gov/formsandpubs/forms/Pages/CCSForms.aspx*) and on the "Forms" page of the Medi-Cal Providers website: (*https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/forms*)

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 and Electronic SARs (eSARs)

CCS/GHPP providers can submit SARs in an electronic format (eSAR) with attachments for fee-for-service claims. Attachments must be in format of PDF, JPG or TIF. Attachments must be less than 15 megabytes (MB) in size, with the sum of all attachments being less than 150 MB. This feature aims to eliminate the paper SAR process for providers with internet connectivity.

To submit eSARs, providers must:

- Register, or already be registered, as an active Medi-Cal provider

- Have access to the Children's Medical Services Network (CMS Net) Provider Electronic Data Interchange (PEDI) website

- Register, and be approved as a trading partner with DHCS, Integrated Systems of Care Division, CMS Net by agreeing to all the terms and conditions contained within the eSAR Trading Partner Agreement

Then, select one of the available options to submit:

- Utilize the newly enhanced online fillable form of the PEDI system to submit SARs electronically

- Generate and submit one of the supported file-based transmission formats:

  - Web-based file upload utility in the eSAR system to submit ASC X12 275/278 transactions

  - Simple Object Access Protocol (SOAP)/Hypertext Transfer Protocol Secure (HTTPS) secure web services method to transmit and receive ASC X12 275/278 transactions

Registered providers and clearinghouses can complete and submit the eSAR requests on behalf of the providers and facilities in their network.

Paper SAR submissions remain an option for low-volume SAR providers or submitters who may have technical limitations or other practical reasons to do so. 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

Providers interested in converting from paper SAR to eSAR submission should contact the CMS Net Help Desk at cmshelp@dhcs.ca.gov or 1-866-685-8449 for helpful guidance and additional information. More information is available in the *California Children's Services (CCS) Program Service Authorization Request (SAR)* section of the Part 2 manual.

SAR Processing

After GHPP review, providers will receive a hard copy authorization approval or denial for each submitted SAR, unless the provider has approved access to the CMS Net PEDI website.

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.

Service Code Grouping (SCG)

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. ‹‹Refer to the *California Children's Services (CCS) Program Service Code Groupings* Excel sheet linked in the California Children's Services (CCS) Program section of this manual.››

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.

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.

‹‹All reimbursable HCPCS and CPT® codes included in all SCGs, including physician, orthopedic, surgeon, ophthalmology and podiatry, are listed in the *California Children's Services (CCS) Program Service Code Groupings* Excel sheet linked in the *California Children's Services (CCS) Program* section of this manual.››

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.

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.

Physician SAR Requirement

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 *California Children's Services (CCS) Program Service Code Groupings* Excel sheet linked in the *California Children's Services (CCS) Program* section of this manual for a list of CPT and HCPCS codes included in the physician SCG.››

Physician SAR for Rendering Provider

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.

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.

Services not included in the physician SCG must be requested with specific procedure codes and may be listed on one SAR form.

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:

<u>Hospital</u>: 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.

<u>Physician with Primary Responsibility to Care for Hospitalized Client</u>: 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

For pharmacy services billed on the *CMS-1500* claim, refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* section in this manual.

Physicians prescribing drugs to a GHPP client must include the SCG SAR number on the prescription for drugs billed on a medical claim.

Drugs and Nutritional Products Requiring Separate Authorization

The following drugs and nutritional products are not included in a physician SCG and <u>require a separate SAR.</u>

Drugs and Nutritional Products Requiring Separate Authorization

AbobotulinumtoxinA

Anithemophilic factors

Antithromblin III (hum plas)

Antithromblin III (hum recombinant)

Avanafil

Axicabtagene ciloleucel

Blood factors, miscellaneous

Boceprevir

Botulinum toxin Type A

Botulinum toxin Type B

Cannabidiol

‹‹Casimersen››

Cerliponase alfa

Controlled substances listed as Schedule II

Controlled substances listed as Schedule III

Daclatasvir dihydrochloride

Deflazacort

Elbasvir/grazoprevir

Elexacaftor/ivacaftor/tezacaftor

Emicizumab-KXWH

Enteral nutrition amino acid products (contracted)

Enteral nutrition flavoring products (contracted)

Enteral nutrition products: elemental and semi-elemental

Enteral nutrition products: metabolic

Enteral nutrition products: specialized

Enteral nutrition products: specialty infant

Enteral nutrition products: standard

Eteplirsen

Factor IX complex (PCC) preparations

Factor IX preparations

Factor X preparations

Factor XIII preparations

Food oils

Glecaprevir/pibrentasvir

Golodirsen

Histrelin acetate implant (Supprelin LA and Vantas)

‹‹Immune Globulin G (IGG) Gly-IgA Over 50 Mcg/Ml

Immune Globulin G (IGG) klhw››

IncobotulinumtoxinA

Intrathecal baclofen

Ivacaftor

Drugs and Nutritional Products Requiring Separate Authorization (continued)

Ledipasvir/sofosbuvir

Leuprolide acetate

Lumacaftor/ivacaftor

Nursinersen

Ombitasvir/paritaprevir/ritonavir

Ombitasvir/paritaprevir/ritonavir and dasabuvir

Onasemnogene abeparvovec-xioi

Palivizumab

Pegvaliase-pqpz

Risdiplam

Sapropterin dihydrochloride

Sildenafil

Simeprevir

Sofosbuvir

Sofosbuvir/velpatasvir

Sofosbuvir/velpatasvir/voxilaprevir

Somatrem

Somatropin

Tadalafil

Telaprevir

Tezacaftor/ivacaftor

Tisagenlecleucel

Triptorelin pamoate

Vardenafil

Viltolarsen

Voretigene Neparvovec-rzyl

DME and Medical Supply

Providers may bill for specific HCPCS Level II product codes for SAR Requirements 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 Providers website at (*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 Supplies* section 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. 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.

Diagnosis Codes

The following is a list of ICD-10-CM diagnosis codes that qualify clients for GHPP. The qualifying GHPP condition is not required in the primary diagnosis field on the claim.

Table of ICD-10-CM Diagnosis Codes

ICD-10-CM Code	Description
D47.3	Essential (hemorrhagic) thrombocythemia
D56.9	Thalassemia, unspecified
D57.00	Hb-SS disease with crisis
D57.1	Sickle-cell disease without crisis
D57.20	Sickle-cell/Hb-C disease without crisis
D57.819	Other sickle cell disorders with crisis
D58.2	Other hemoglobinopathies
D66	Hereditary factor VIII deficiency
D67	Hereditary factor IX deficiency
D68.0	Von Willebrand's disease
D68.1	Hereditary factor XI deficiency
D68.2	Hereditary deficiency of other clotting factors
D69.1	Qualitative platelet defects
E70.0	Classic phenylketonuria
E70.21	Tyrosinemia
E72.00 thru E72.09	Disorders of amino-acid transport, unspecified
E72.10	Disorders of sulphur-bearing amino-acid metabolism, unspecified
E72.20	Disorder of urea cycle metabolism, unspecified
E74.21	Galactosemia
E83.01	Wilson's disease
E84.11	Meconium ileus in cystic fibrosis
E84.9	Cystic fibrosis, unspecified
G10	Huntington's disease
G11.0	Congenital nonprogressive ataxia
‹‹G11.10, G11.11, G11.19››	Early-onset cerebellar ataxia
G11.4	Hereditary spastic paraplegia
G23.8	Other specified degenerative diseases of basal ganglia
G60.0	Hereditary motor and sensory neuropathy
G60.1	Refsum's disease
Q85.8	Other phakomatoses, not elsewhere classified (Von Hippel-Lindau syndrome)

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.

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:

> California MMIS 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 California MMIS Fiscal Intermediary (FI) 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 <u>without </u>the required delay reason code. This is in accordance with Medi-Cal policy.

<u>CMC Billing</u>

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.

<u>Medi-Cal Dental</u>

Claims for dental services authorized by GHPP with a SAR number beginning with a prefix of "99" for GHPP clients must be submitted to the Medi-Cal Dental Fiscal Intermediary 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.

<u>Legend</u>

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.