Medicine

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‹‹This section contains billing instructions for procedures not included in the medicine sections.›› Subsequent medicine sections are categorized by headings used in the *Current Procedural Terminology* (CPT®) code book.

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 code 99183.

Providers must document an appropriate ICD-10-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 code 99070 for providers using the *CMS-1500* claim form.

Covered Conditions

‹‹Medi-Cal covers conditions that may justify HBO include, but are not limited to one of the following ICD-10-CM codes:››

Table of ICD-10-CM Codes for Covered Conditions

Condition	**ICD-10-CM Code**
Actinomycosis refractory to medical or surgical treatment	A43.0 thru A43.9, L08.1
Air embolism	T79.0XXA thru T80.0XXS
Saddle embolus of abdominal aorta	I74.01 thru I74.9
Other disorders of arteries and arterioles	I77.0 thru I77.9
Idiopathic aseptic necrosis of unspecified bone	M87.00 thru M90.59, T66.XXXA thruT66.XXXS radiation sickness, unspecified
Caisson disease (decompression sickness)	T70.3XXA thruT70.9XXS
Chronic multifocal osteomyelitis, unspecified sites	M86.30 thru M86.8X9
Crushing injury	S47.1XXA thru S47.9XXS S57.00XA thru S57.82XS S67.00XA thru S67.92XS S77.00XA thru S77.22XS S87.00XA thru S87.82XS S97.00XA thruS97.82XS

Table of ICD-10-CM Codes for Covered Conditions (continued)

Condition	ICD-10-CM Code
Embolism following ectopic molar pregnancy	O08.2
Gangrene	E08.52, E09.52, E10.52 E11.52, E13.52 I70.361 thru I70.769, I73.01 I96
Gas gangrene	A48.0
Toxic effects of hydrocyanic acid and cyanides	T65.0X1A thruT65.0X4S
Injury of blood vessels	S45.001A thru S65.999S S75.001A thru S95.999S
Occlusion and stenosis of precerebral and cerebral arteries, not resulting in cerebral infraction	I65.01 thru I66.9
Unspecified complication of internal prosthetic device, implant and graft	T85.9XXA thru T85.9XXS
Pyoderma	L08.0
Raynaud's syndrome	I73.00 thru I73.9
Other venous embolism and thrombosis	I82.0 thru I82.91
Polyarteritis nodosa	M30.0 thru M30.8
Radiation necrosis of soft tissue	‹‹T20.30XA thru T20.39XS T20.70XA thru T20.79XS T21.30XA thruT21.39XS T21.70XA thru T21.79XS T22.30XA thru T22.39XS T22.70XA thru T22.799S T24.301A thru T24.399S T24.701A thru T24.799S, T30.0, T30.4››
Toxic effect of carbon monoxide	T58.01XA thru T58.94XS
Toxic effect of hydrogen cyanide	T57.3X1A thru T573X4S
Pyogenic granuloma	L98.0
Omphalitis not of newborn	L08.82
Other specified local infections of the skin and subcutaneous tissue	L08.89
Local infection of the skin and subcutaneous tissue, unspecified	L08.9
Skin graft (allograft)	T86.820 thru T86.822
Complication of unspecified transplanted organ and tissue	T86.91 thru T86.93

Extracorporeal Membrane Oxygenation (ECMO)/ECLS

ECMO or extracorporeal life support (ECLS) is defined as the use of a modified cardiopulmonary bypass circuit for temporary life support for patients with potentially reversible cardiac and/or respiratory failure. ECMO/ECLS provides a mechanism for gas exchange as well as cardiac support thereby allowing for recovery from existing lung and/or cardiac disease. ECMO/ECLS is an accepted treatment modality for recipients with respiratory and/or cardiac failure failing to respond to conventional medical therapy.

Indications

ECMO/ECLS is indicated for but not limited to the following diagnoses:

- Persistent pulmonary hypertension of the newborn
- Meconium aspiration syndrome
- Respiratory distress syndrome
- Sepsis/pneumonia
- Congenital diaphragmatic hernia
- Air leak syndrome
- Reversible cardiac failure
- Recipients meeting criteria for heart and/or lung transplant

Selection criteria include all of the following:

- Gestational age not less than 34 weeks
- Minimum birth weight of 2,000 grams
- No coagulopathy or uncontrolled bleeding
- No intracranial hemorrhage
- Mechanical ventilation less than 10 to14 days
- Reversible lung and cardiac disease
- No lethal congenital anomalies
- No uncorrectable congenital heart disease
- No irreversible brain damage
- Failure of maximal medical or conventional therapy

Institutional Requirements

Applicable for recipients of the California Children's Services (CCS) program:

- Neonates
  - Have a Neonatal Intensive Care Unit (NICU) approved by CCS as a regional NICU
  - Have a CCS-approved Neonatal ECMO/ECLS center
  - Provide Inhaled Nitric Oxide (INO) services for neonates
- Pediatric: CCS-approved Pediatric Intensive Care Unit (PICU) with congenital heart surgery program

Authorization

An approved *Treatment Authorization Request* (TAR) or Service Authorization Request (SAR) is required for reimbursement of CPT codes 33946 and 33947 only. All other ECMO/ECLS services do not require an approved TAR or SAR.

ECMO/ECLS services are billed with the following codes:

‹‹**Table of CPT Codes for ECMO/ECLS Services**››

CPT Code	Description
33946	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous
33947	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial
33948	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous
33949	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial
33951	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33953	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age

CPT Code	Description
33955	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age
33957	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33959	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33963	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33965	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age
33969	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age
33985	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age
33987	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS
33988	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS
33989	Extracorporeal membrane oxygenation. (ECMO)/extracorporeal life support (ECLS) provided by physician; Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS

Note: CPT codes 33946 thru 33949 are not reimbursable when billed with modifier 63.

Billing Physician Services

Neonatology services directly related to the cannulation, initiation, management and the discontinuation of the ECMO circuit and parameters are distinct from the daily overall management of the recipient.

‹‹Daily overall management of the recipient may be separately reported using the relevant hospital inpatient services, or critical care evaluation and management CPT codes (99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479 and 99480) and may be reimbursed to any provider for the same recipient and same date of service.›› Refer to the *Current Procedural Terminology* (CPT) code book for detailed physician billing instructions for the ECMO/ECLS services for each code.

Billing Inpatient Services

ECMO/ECLS must be performed in a regional Neonatal Intensive Care Unit (NICU) in a California Children Services (CCS) designated ECMO center.

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

ECMO/ECLS services are billed with the following revenue codes:

- 174 (nursery, newborn, Level IV): newborn 0 thru 28 days
- 202 (medical intensive care): adults
- 203 (pediatric intensive care): infants and children

These revenue codes are billed in conjunction with ICD-10-PCS extracorporeal oxygenation procedure codes 5A1522F, 5A1522G and 5A1522H.

Hospital Reimbursement DRG-Reimbursed Facilities

ECMO/ECLS 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/ECLS 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-10-PCS procedure code 3E0F7SD (introduction of nitric oxide gas into respiratory tract, via natural or artificial opening).

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 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 code 96912 to bill psoralen with ultraviolet light (PUVA) treatments for vitiligo. Code 96900 is used to bill ultraviolet treatment alone for psoriasis. CPT codes 96900, 96910 (ultraviolet treatment Goeckerman type) and 96912 do not require authorization.

Esophageal Acid Reflux Testing

CPT codes 91030 thru 91040 are used to bill for esophageal acid reflux testing. Within this range, CPT 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.

‹‹**Table of CPT Codes for Esophageal Acid Reflux Testing**››

CPT Code	Description
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
91035	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation 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	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)
91040*	Esophageal balloon distention study, diagnostic, with provocation when performed. Do not report more than once per session.

Capsule Endoscopy

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

‹‹CPT code 91113 (gastrointestinal tract imaging, intraluminal [eg, capsule endoscopy], colon, with interpretation and report)

91113 requires a *Treatment Authorization Request* (TAR) and is approved only for patients with incomplete colonoscopy.››

Claims for codes 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 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

The PIEE procedure is contraindicated in the presence of the following:

- Colon surgery within the past year

- Evidence of an acute abdomen
- Evidence of acute diverticular disease
- Significant rectal or lower gastrointestinal bleeding

TAR Requirement

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

Table of HCPCS Codes for PIEE Equipment and Supplies

HCPCS Code	Description
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:

‹‹**Table of HCPCS Codes and Limitations for NPWT Devices and Supplies**››

HCPCS Code	Description	Limitations
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.
K0743	Suction pump, home model, portable, for use on wounds	Maximum rental period is 120 days. Reimbursement is “By Report.
K0744	Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less	Reimbursement is “By Report.” Frequency is limited to 2 per day with a maximum of 10 in 30 days.
K0745	Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 square inches but less than or equal to 48 square inches	Reimbursement is “By Report.” Frequency is limited to 2 per day with a maximum of 10 in 30 days.
K0746	Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 square inches	Reimbursement is “By Report.” Frequency is limited to 2 per day with a maximum of 10 in 30 days.

Note: CPT codes 97605 thru 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

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.

- 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

NPWT coverage will be denied as not medically necessary if any of the following contraindications are present:

- 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

Evidence of significant wound improvement must be demonstrated. Date of assessment and description of the wound must be provided, together with interventions implemented.

‹‹Gender Affirming Care

For detailed policy information on the treatment of gender affirming care refer to the *Surgery* section in the appropriate Part 2 provider manual.››

Extracorporeal Photopheresis

For detailed policy information on the process of extracorporeal photopheresis (ECP), refer to the *Blood and Blood Derivatives* section in the appropriate Part 2 provider manual.

Liver Elastography

This service is used to distinguish hepatic cirrhosis from non-cirrhosis in recipients with hepatitis C or other chronic liver diseases. 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
K70.30
K70.31
K70.40
K70.41
K70.9
K73.0 thru K73.9
‹‹K74.00 thru K74.69››
K75.4
K75.81
K76.0
K76.89
K76.9

Authorization

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Billing

CPT code 91200 (liver elastography, mechanically induced shear wave, without imaging, with interpretation and report).

Intensive Behavioral Therapy for Obesity

HCPCS code G0446 (annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes).

For more information regarding Intensive Behavioral Therapy (IBT), including IBT frequency and services, billing requirements and TAR and SAR requirements, providers should refer to the *Preventive Services* section of the appropriate Part 2 provider manual.

Diabetes Self-Management

Diabetes self-management training (DSMT) HCPCS codes G0108 Training (DSMT) (diabetes outpatient self-management training services, individual, per 30 minutes) and G0109 (diabetes outpatient self-management training services, group session [2 or more], per 30 minutes) have the following billing instructions.

Frequency Restrictions

Claims paid in the first continuous 12 months (one year) have the following frequency restrictions:

HCPCS Code	Frequency Restriction
G0108	One (1) hour of individual assessment
G0109	Up to nine (9) hours of group sessions

Claims paid in subsequent years are restricted to two (2) hours per calendar year, combined, as listed in the following units:

HCPCS Code	Frequency Restriction
G0108	Each unit is 30 minutes
G0109	Each unit is 30 minutes

Authorization

Claims with additional number of hours are to be billed with a TAR, California Children's Services/Genetically Handicapped Persons Program (CCS/GHPP) stamp or CCS Service Authorization Request (SAR).

Billing

HCPCS codes G0108 and G0109 may not be billed on the same date of service as CPT codes 97802 through 97804.

Medical Nutrition Therapy (MNT)

Medical nutrition therapy (MNT) is billed with the following codes and billing instructions:

CPT Code	Description
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes group (2 or more individuals), each 30 minutes

Frequency Restrictions

Frequency is limited to three hours for the first calendar year and two hours per calendar year in each subsequent year.

Authorization

Claims with additional number of hours are to be billed with a TAR, CSS/GHPP stamp, or CCS SAR.

Billing

CPT codes 97802 thru 97804 may not be billed on the same date of service as HCPCS codes G0108 and G0109.

Pasteurized Donor Human Breast Milk

HCPCS code T2101 (human breast milk processing, storage and distribution only), to be billed per 3 ounces per unit, 35 ounces per day, only good for 30 days; can be used for medically necessary pasteurized donor human milk (PDHM) when obtained from a licensed and approved facility. Coverage may be up to 12 months of age. For more information, refer to the *Pregnancy: Postpartum and Newborn Referral Services* section in this manual.

‹‹HCPCS code A4287 (disposable collection and storage bag for breast milk, any size, any type, each).››

‹‹Legend››

‹‹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.
*	Do not report more than once per session