State of California—Health and Human Services Agency
Department of Health Care Services

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TO: COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS) ADMINISTRATORS, MEDICAL DIRECTORS, AND MEDICAL CONSULTANTS, STATE CHILDREN'S MEDICAL SERVICES (CMS) BRANCH STAFF, CCS-APPROVED SPECIAL CARE CENTERS, AND CCS-APPROVED HOSPITAL CHIEF EXECUTIVE OFFICERS

SUBJECT: CCS OUTPATIENT SPECIAL CARE CENTER (SCC) SERVICES

I. Purpose

The purpose of this Numbered Letter (NL) is to update and clarify the definition and usage of outpatient SCC services as well as provide appropriate billing codes and guidelines for these services.

II. Background

The Children's Medical Services Branch has oversight of a system of SCCs that provide comprehensive, coordinated specialty health care to CCS clients with complex, physically handicapping medical conditions, and to Genetically Handicapped Persons Program clients with specific genetically eligible medical conditions. SCCs consist of multi-disciplinary, multi-specialty teams that evaluate the child's/adult's medical condition and develop a comprehensive, family centered plan of health care that facilitates the provision of timely, coordinated treatment.

CCS-approved SCCs are located throughout the State, usually in conjunction with CCS-approved tertiary hospitals. Satellite SCCs, sponsored by SCCs at tertiary hospitals, are located in community hospital outpatient departments or local health departments. Though most SCCs are located in outpatient hospital departments/clinics, there is also inpatient SCCs: the neonatal intensive care units pediatric intensive care units and Rehabilitation SCCs. This Numbered Letter addresses only outpatient SCC services.

CCS-approved SCCs have been reviewed for meeting standards in the following areas: organization, facilities, staff, procedures and services. In addition, each SCC is required to provide and maintain a center directory that includes required core team members and specialty staff, who together comprise the multidisciplinary, multispecialty team. Core team members are defined as participants who are essential members of a multidisciplinary, multispecialty team. The minimum core team members for every SCC are the physician, nurse specialist, social worker and for most SCCs, dietitian.

The multidisciplinary, multispecialty team is defined as three or more health care professionals from diverse disciplines (such as pediatric subspecialist, nurse specialist, social worker, physical therapist, occupational therapist, dietitian, and respiratory care practitioner) who have expertise relevant to the medical condition of the pediatric patient receiving services. The health professionals work together in a coordinated and collaborative manner to assess the health needs of the patient and develop a treatment plan tailored to the identified needs. The patient and the patient's parent, legal guardian or primary caregiver are considered part of the team and joint participants in the assessment and treatment decision-making process.

Center Directories are to be reviewed annually and updated by the SCC. SCC Directories are online at http://www.dhcs.ca.gov/services/ccs and the form for updating Directories (DHS 4507) can be accessed by clicking on the tab for Forms, Laws, and Publications or by going directly to http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4507.pdf

III. Policy

A. The CCS program shall authorize SCC services for all CCS eligible clients who have a condition for which there is an SCC and who require at least annual multidisciplinary, multispecialty team services provided by the SCC.

B. The following HCPCS Level III codes for outpatient CCS SCC services are utilized for claiming for these services.

Z4300* Center coordinator, non-physician (team case conference and case reporting by coordinator who is either a nurse specialist, social worker, registered dietitian, or other allied health care professional)

Z4301 Assessment and intervention with instruction and education, nurse specialist.

Z4302* Team case conference, other allied health care professionals (physical therapist, occupational therapist, speech therapist/pathologist, genetic counselor, psychologist or audiologist who are participants).

Z4303 CCS required report of status of patient with complex medical condition, periodic, intermediate level report by physician or nurse specialist only.

Z4304 CCS required report of status of patient with complex medical condition, extensive, comprehensive level report by physician or nurse specialist only (This report is required annually and more often if clinically indicated).

Z4305 Center coordinator, physician (team case conference and case reporting coordinator).

Z4306 Team case conference, physician or dentist (participant).

Z4307 Interviewing, assessment, and intervention, medical social worker

Z4308 Assessment and intervention with instruction and education, registered dietitian.

Z4309* Assessment and intervention with instruction and education, other allied health care professional staff (physical therapist, occupational therapist, speech therapist/pathologist, genetic counselor, psychologist or audiologist).

Z4310 Team case conference, nurse specialist (participant).

Z4311 Team case conference, medical social worker (participant).

Z4312 Team case conference, registered dietitian (participant).

Z4313 Group teaching, counseling, and support, physician.

Z4314* Group teaching, counseling and support, non-physician (nurse specialist, social worker, registered dietitian, or other allied health care professionals).

Z4315 Physician/parent conference.

X4700**Assessment and intervention, with instruction and education, respiratory care practitioner (RCP).

X4702**Team case conference, RCP (participant).

Z5406* Telephone consultation, non-physician (nurse specialist, social worker, registered dietitian, or other allied health care professionals).

*For the purposes of this numbered letter "other allied health care professionals" refers to physical therapists, occupational therapists, speech therapists/pathologists, genetic counselors, psychologists, or audiologists, who are CCS-approved. **Note:** Currently there is no CCS approval process for genetic counselors, but they can still participate in the SCC and bill the single asterisked codes.

Physical therapists, occupational therapists, speech therapists/pathologists, psychologists, and audiologists can bill their unique assessment codes (contained in SCG 02) instead of Z4309 if there is a formal accompanying report in the child's medical record and this report is submitted to the authorizing CCS program. Attachments B and C contain these specific codes.

**The RCP is an important participant in SCCs for the evaluation and care of children with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions. RCPs can only use the two codes X4700 and X4702.

C. SCC Service Code Grouping (SCG)

1. SCG Definition

   SCGs are groups of codes that are authorized to CCS-approved providers for the provision of medically necessary health care services related to the CCS client's eligible condition. The SCG contains a listing of codes that allows the provision of care for the CCS child without obtaining repeated single prior authorizations for services.

2. SCC SCG 02

   The SCC SCG includes the full range of "Physician SCG 01 codes," as well as the SCC billing codes. SCCs authorized with SCG 02 can bill for diagnostic and/or treatment services, and "team or center" services as listed in III.B. where applicable.

Note: Occasionally individual CCS-approved physicians who are part of an SCC are authorized with SCG 01 to provide ongoing physician specialty services for diagnosis and/or treatment. The reason for this is that full SCC team services are not needed. One example is the child with a very small ventriculoseptal defect (VSD) that is hemodynamically insignificant yet needs annual follow-up to monitor for any changes. In this example the cardiologist can be authorized individually with SCG 01 for the annual follow-up. Another example is when a child is already assigned to an SCC with an SCG 02 and needs physician consultative services from a physician at another SCC. The latter physician would receive an authorization with SCG 01.

The composition of SCGs is periodically updated by the CMS Branch as new codes become Medi-Cal benefits and other codes are terminated by Medi-Cal. The effective date for the changes to the SCGs is announced in "This Computes!" information notices available at http://www.dhcs.ca.gov/services/ccs and in Medi-Cal provider bulletins available at http://www.medi-cal.ca.gov.

A list of the Current SCGs and their codes are online at the CCS website. The most recent codes added are in bold, underlined, and given a symbol to indicate the effective-date in the SCG. Codes that are end-dated are bold, with a strike-through and a symbol indicating the end-date from the SCG. After one year from an effective-date, the symbol is removed, and after one year from an end-date, the code with the strike-through and symbol is removed completely from the manual page.

IV. Implementation

A. Referral of a Child to an SCC

1. A CCS client shall be referred to the appropriate CCS-approved SCC for evaluation, medical management and coordination of care when the child has or is suspected of having a CCS eligible medical condition requiring SCC evaluation and/or treatment and follow-up. These conditions include, but are not limited to:

   - complex congenital heart disease
   - inherited metabolic disorders
   - chronic renal disease
   - gastrointestinal and nutritional disorders

- chronic lung disease and cystic fibrosis
- malignant neoplasms
- hemophilia and coagulopathies
- sickle cell and other hemoglobinopathies
- craniofacial anomalies
- hearing loss
- myelomeningocele
- endocrine disorders including diabetes
- immunologic disorders
- infectious diseases
- rheumatologic disorders
- musculoskeletal/neuromusculoskeletal disorders
- amputations

2. Most children are assigned to one SCC. Infrequently a child may benefit from services of core team members from two SCCs. Both SCCs may be authorized as determined appropriate on a case-by-case basis with consultation of the County Medical Consultant or Regional Office Medical Consultant for dependent counties.

B. Authorization of CCS SCC Services

1. SCG authorizations shall be provided via a Service Authorization Request (SAR) for counties in CMSNet. Requests from Los Angeles and Sacramento Counties will be issued using their legacy authorization processes until these counties make the transition to the Children's Medical Services Network (CMSNet) case management system.

2. An SCC SCG 02 authorization is to be issued to the CCS-approved SCC Directory number. The authorization is to be sent to the individual designated in the SCC Directory to receive authorizations. This designated individual in the SCC is responsible for providing copies of the SAR or providing the SAR number to all appropriate SCC team member(s), specialty consultant(s), and pharmacies involved in the CCS client's SCC care as well as to the administrative entity that provides billing services for the SCC.

3. While most SCCs will receive SCG 02 for their CCS clients as described in IV.B.2., there are some exceptions whereby SCCs have their own SCGs. For example, Transplant SCCs are issued SCG 03 (which includes all the codes in SCG 01 and SCG 02, plus codes unique to Transplant Centers); Communication Disorder SCCs and Cochlear Implant SCCs are issued SCG 04 and SCG 05 respectively; and High Risk Infant Follow-up (HRIF) SCCs are issued SCG 06. An authorization with the appropriate SCG is issued and sent to these SCCs as described in IV.B.2. and the responsibilities of the SCC are as described in IV.B.2., as applicable.

4. Individual procedure codes cannot be added to the SCC SCG 02, 03, 04, 05, or 06 authorizations. If additional codes are appropriately needed that are not in the SCG then these codes must be separately authorized to the individual provider or to the hospital outpatient provider number.

5. Infrequently, an SCC may be issued two SCGs.

    - If an outpatient chronic dialysis clinic is part of a tertiary facility, the Renal SCC receives both SCG 02 and SCG 09 (Dialysis SCG) for the CCS client who is receiving dialysis.

    - Both SCG 02 and SCG 04 are issued to a Craniofacial SCC for CCS clients who also have hearing loss and/or speech difficulties. Two SCC SCGs can be issued on the same authorization.

6. A time limited (e.g., three months) diagnostic authorization can be issued to an SCC to establish or rule out a CCS eligible medical condition for a child who is potentially CCS medically eligible when there is medical documentation that there is a suspected CCS eligible medical condition and one or more of the following apply:

- There is a signed CCS application for the child.
- The child is a full scope, no share of cost Medi-Cal beneficiary.
- The child is enrolled in a Healthy Families health plan.

The authorization may need to be extended one or more times depending on the time needed to complete the diagnostic evaluation.

7. An authorization for treatment of the child's confirmed CCS- eligible medical condition can be issued to an SCC when there is documentation of a CCS eligible medical condition requiring care under the supervision of a CCS-approved SCC and one or more of the following apply:

   - The child's parent or legal guardian has completed all CCS program requirements for the determination of residential and financial eligibility and has signed the Program Services Agreement.
   - The child is a full scope, no share of cost Medi-Cal beneficiary.
   - The child is enrolled in a Healthy Families health plan.

8. Each SCC treatment authorization must have a beginning and end date and conform to CCS program policy for authorization of medically necessary services.

9. A CCS authorization for SCC treatment services with SCG 02 or SCG 03 covers the following:

   a. All SCC codes for services, as described in III.B., such as:

   - Extensive and comprehensive chart reviews, multidisciplinary reports, and team case conferences by CCS-approved SCC core team members and other specialty consultants. These chart reviews/reports/case conferences may be provided and billed for at a minimum of once every 12 months.
   - Periodic and intermediate chart reviews, reports and team case conferences by core team health care professional(s) when determined to be medically necessary by the SCC core team physician(s). These chart/reviews/reports/case conferences may be provided and billed for as interim medically necessary services between annual visits, especially when the full core team is not needed.

b. Medically necessary health care services related to the management of the child's CCS-eligible medical condition.

10. A CCS authorization for SCC treatment services with SCG 04, 05, or 06 covers services specific to Communication Disorder SCC's, Cochlear Implant SCCs, and HRIF SCCs respectively and includes the appropriate codes for claiming for SCC team services

11. Medically necessary health care services not covered by an SCC authorization require a separate SAR. Examples of such services include, but are not limited to:

- Procedures only done at some specially approved SCCs, such as organ transplants, electrophysiological cardiac procedures, and invasive cardiac catheterizations.
- Major surgical procedures.
- Drugs and enteral products listed on the Restricted Drug Table.
- Non-benefits of the Medi-Cal program.

C. CCS SCC Provider Reimbursement.

1. CCS SCC services are reimbursable to CCS-approved SCC providers who are members of the SCC authorized to provide services to the CCS client. In addition, CCS SCC services are reimbursable to those CCS-approved consultants who have been requested by the CCS SCC approved physicians to evaluate their client. The current SAR number is to be provided to the specialty consultant to be used for billing services.

2. All physician providers rendering services to CCS clients must be enrolled as Medi-Cal providers.

V. Special instructions for SCCs, including SCC Directory and documentation requirements, and claims processing information are in Attachment A.

VI. SCC procedure code descriptions and requirements for billing are in Attachment B.

VII. SCC codes and units of service are in Attachment C.

If you have any questions, please contact your designated CMS Regional Office Consultant or the CMS Provider Services Unit Help Desk.

Original Signed by Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Chief
Children's Medical Services Branch

Enclosures

Attachment A
Instructions for Special Care Centers (SCCs)

I. SCC Directory Requirements

The SCC Directory provides County CCS Programs and Regional Offices with a list of approved providers working in the SCC who may be authorized for services. It is critical that these be current to ensure timely reimbursement.

A. New SCCs shall submit a SCC Directory, within seven days of receipt of the first CMS Branch approval letter, to the Regional Office staff indicated in the approval letter.

B. Approved SCCs shall review and update their SCC Directory at a minimum annually and whenever new staff join or leave the SCC team.

1. The SCC listings and directories are located on the CMS website at http://www.dhcs.ca.gov/services/ccs and the SCC Directory Update Fax Cover Sheet (DHS 4507) with instructions for updating directories can be accessed at http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4507.pdf

2. A completed DHS 4507 (including the six digit SCC directory number) and copy of a downloaded SCC Directory with signature of the SCC Medical Director shall be faxed to the CMS Provider Services Unit (PSU), at (916) 322-8798. The PSU help desk at (916) 322-8702 is available to respond to questions.

3. It is the responsibility of the SCC Medical Director or designee to ensure the SCC Directory is up to date.

II. Documentation Requirements for billed Z codes

The CCS program requires that providers maintain documentation of the services provided for billing SCC codes. Reports that are generated (Z4303 and Z4304) from SCC visits must be sent to the local CCS program where a child lives, NOT with the claim (documentation should

continue to be sent to LA and Sacramento Counties with claims until they are on CMSNet).

III. Claims Processing

A. Claims for services authorized with a SAR should be forwarded directly to the Medi-Cal Fiscal Intermediary, Electronic Data Systems (EDS), either by electronic or hard copy submission

> **Note: Claims for services provided to CCS clients residing in Los Angeles, and Sacramento counties cannot be submitted directly to EDS until these counties are on CMSNet.** All claims for CCS clients residing in these counties must be sent hard copy to the county CCS office for review and approval.

B. Providers should refer to the Medi-Cal website http://www.medi-cal.ca.gov concerning use of their National Provider Identifier (NPI) in lieu of their Medi-Cal legacy provider number.

C. The SCC's authorization number, an 11 digit number beginning with "97" or "91", must be placed in the designated SAR field.

ATTACHMENT B
SCC PROCEDURE CODE DESCRIPTIONS AND REQUIREMENTS FOR BILLING

Provider Type	Procedure Code(s)	Description and Requirements
Physician	Z4303	For development of a "periodic, intermediate level" chart review and preparation of the SCC team case conference report per patient. To claim for this intermediate code, the visit could include the full core team or a partial core team as deemed appropriate. The report shall include a brief summary of the chart review (e.g., what was reviewed in the chart - labs, radiology reports, etc. - and what of importance was identified), history and physical examination, and shall describe important team findings and recommendations. The report shall be maintained in the client's chart and a copy submitted to the authorizing CCS program. Core team assessments may be attached to the team report. A SCC can only bill for one report (from either the Physician or Nurse Specialist) per patient visit. The completed report is documentation of this activity. The preparer of the report (physician or nurse) must be indicated on the report and does not have to be the coordinator.
Physician	Z4304	For development of an "extensive, comprehensive level" chart review and preparation of the SCC team case conference report per patient. This chart review and report are required once per year (minimum) per patient. To claim for this comprehensive code, the full core team should participate in the visit and if a member is not present, the reason should be included in the report. Other specialists may participate as appropriate. The report shall include a summary of the chart review (e.g., what was reviewed in the chart - labs, radiology reports, etc. - and what of importance was identified), history and physical examination, the case conference team members' evaluations or a summary thereof, and recommendations. The report shall be maintained in the client's chart and a copy submitted to the authorizing CCS program. Core team assessments may be attached to the team report. A SCC can only bill for one report (from either the Physician or Nurse Specialist) per patient multidisciplinary team visit. Documentation of this activity is the completed report. The preparer of the report (physician or nurse) must be indicated on the report and does not have to be the coordinator.
Physician	Z4305	For physician coordinating activities of the SCC per patient per date of service (including coordinating team case conference discussion and recommendations after team member evaluations and case reporting). A SCC can only bill for the time of one coordinator per patient per date of service (i.e., either Z4300 or Z4305). Also, a physician cannot bill for both serving as the coordinator for a patient and as a case conference participant (i.e., Z4305 and Z4306) per date of service.
Physician/dentist	Z4306	For physician/dentist participation in the SCC team case conference per patient. This code is used on a per case basis. Z4305 cannot be claimed in addition to Z4306 for the same patient on the same date of service. All physicians/dentists participating in the case conference may bill for this code. There is no limit to the number of physicians/dentists who may participate or bill but the expectation is that they are all contributing to the case conference. The SCC team case conference report shall include a summary of the chart review (e.g., what was reviewed in the chart - labs, radiology reports, etc. - and what of importance was identified), history and physical examination, the case conference team members' evaluations or a summary thereof, and recommendations. (Note: This code is not to be used for physician/dentist participation in "Grand Rounds" or some other type of medical professional case conference.) A log shall be maintained of all the participants in the case conference, with the coordinator identified. This log (which shall include the client's name, date of the conference, participant names, participant signatures, and participant disciplines) shall be located in the SCC facility.

Physician	Z4313	For physician leadership of group counseling, group teaching, or support group for the SCC client/family. A SCC can only bill for one such leadership (from either the physician [Z4313], nurse specialist [Z4314], or other allied health care professional [Z4314]) per patient per session per day. There should be a progress note in the patient chart describing the teaching provided and the response of the individuals to the teaching. A record must be kept of the counseling session including the name of the physician, the names of the clients in the group and notation as to which family members were present. This record should be kept in a log which shall be located in the SCC facility.
Physician	Z4315	For the physician conference with the client, client's family, or both. This code is billed per patient per 0.5 hrs up to a total of 2 hrs per physician per client. More than one physician can bill for this code per patient if each physician participates in the conference. A record must be kept of the conference including time spent and name of physician(s) participating. The record can be in a log located in the SCC facility or can be an entry in the client's chart.
Physician	99201-99205	One of these codes is utilized by the physician per patient visit for the history and physical for new patients. The comprehensiveness and length of time spent determine the code billed.
Physician	99211-99215	One of these codes is utilized by the physician per patient visit for follow-up services as clinically indicated for established patients. The complexity and length of time spent determine the code billed.
Nurse Specialist	Z4300	For non-physician coordinating activities for the SCC per patient per date of service (including coordinating team case conference discussion and recommendations after team member evaluations and case reporting). A SCC can only bill for the time of one coordinator per patient per date of service (i.e., either Z4300 or Z4305). Also, a nurse specialist cannot bill for both serving as the coordinator (which includes coordinating the case conference) and as a case conference participant (i.e., Z4300 and Z4310).
Nurse Specialist	Z4301	For nurse specialist comprehensive assessment/intervention and instruction/education per patient and family (per 0.5 hrs). Requires a comprehensive assessment containing assessment elements recognized by the discipline, generally in a standardized format (form). This visit should be on, or within 30 days of, the day of the team case conference. This code is also used for nurse specialist assessment/intervention and instruction/education per patient and family (per 0.5 hrs) for intermittent SCC visits between annual visits as clinically indicated. Requires a progress note.

Nurse Specialist	Z4303	For development of a “periodic, intermediate level” chart review and preparation of the SCC team case conference report per patient. This chart review and report preparation may include the full core team or a partial core team, and other specialists, as deemed appropriate. The report shall include a brief summary of the chart review (e.g., what was reviewed in the chart - labs, radiology reports, etc. - and what of importance was identified), history and physical examination, and shall describe important team findings and recommendations. The report shall be maintained in the client’s chart and a copy submitted to the authorizing CCS program. Core team assessments may be attached to the team report. A SCC can only bill for one report (from either the Physician or Nurse Specialist) per patient visit. The completed report is documentation of this activity. The preparer of the report (physician or nurse) must be indicated on the report and does not have to be the coordinator.
Nurse Specialist	Z4304	For development of an “extensive, comprehensive level” chart review and preparation of the SCC team case conference report per patient. This chart review and report are required once per year (minimum) per patient. To claim for this comprehensive code, the full core team should participate in the visit and if a member is not present, the reason should be included in the report. Other specialists may participate as appropriate. The report shall include a summary of the chart review (e.g., what was reviewed in the chart - labs, radiology reports, etc. - and what of importance was identified), history and physical examination, the case conference team members’ evaluations or a summary thereof, and recommendations. The report shall be maintained in the client’s chart and a copy submitted to the authorizing CCS program. Core team assessments may be attached to the team report. A SCC can only bill for one report (from either the Physician or Nurse Specialist) per patient multidisciplinary team visit. Documentation of this activity is the completed report. The preparer of the report (physician or nurse) must be indicated on the report and does not have to be the coordinator.
Nurse Specialist	Z4310	For nurse specialist participation in the SCC team case conference per patient (per 0.25 hrs, maximum 0.5 hrs). Z4300 cannot be claimed in addition to Z4310 for the same patient on the same date of service. (Note: This code is not to be used for nurse participation in “Grand Rounds” or some other type of medical professional case conference.)
Nurse Specialist	Z4314	For nurse specialist leadership of group counseling, group teaching, or support group for the SCC client/family. A SCC can only bill for one such leadership (from either the physician [Z4313], nurse specialist [Z4314], or allied health care professional [Z4314]) per patient per session per day. There should be a progress note in the patient chart describing the teaching provided and the response of the individuals to the teaching. A record must be kept of the counseling session including the name of the nurse specialist, the names of the clients in the group and notation as to which family members were present. This record should be kept in a log which shall be located in the SCC facility.
Nurse Specialist	Z5406	For telephone consultation(s) for case management and coordination of care per patient per date of service (per 0.25 hrs, maximum 0.75 hrs). This code is not to be utilized for scheduling appointments or appointment-reminder notifications.

Social Worker	Z4300	For non-physician coordinating activities for the SCC per patient (including coordinating team case conference discussion and recommendations after team member evaluations and case reporting). A SCC can only bill for the time of one coordinator per patient per date of service (i.e., either Z4300 or Z4305). Also, a social worker cannot bill for both serving as the coordinator (which includes coordinating the case conference) and as a case conference participant (i.e., Z4300 and Z4311).
Social Worker	Z4307	For social worker comprehensive assessment/intervention and interviewing per patient and family per date of service (per 0.5 hrs, maximum 2 hrs). Requires a progress note or a standardized form completed. This visit should be on, or within 30 days of, the day of the team case conference. This code is also used for social worker assessment/intervention and interviewing per patient and family (per 0.5 hrs, maximum 2 hrs) for intermittent SCC visits between annual visits as clinically indicated. Requires a progress note.
Social Worker	Z4311	For social worker participation in the SCC comprehensive team case conference (per 0.25 hrs, maximum 0.5 hrs). Z4300 cannot be claimed in addition to Z4311 for the same patient on the same date of service. (Note: This code is not to be used for social worker participation in "Grand Rounds" or some other type of medical professional case conference.)
Social Worker	Z4314	For allied health care professional leadership of group counseling, group teaching, or support group for the SCC client/family. A SCC can only bill for one such leadership (from either the physician [Z4313], nurse specialist [Z4314], or allied health care professional [Z4314]) per patient per session per day. There should be a progress note in the patient chart describing the teaching provided and the response of the individuals to the teaching. A record must be kept of the counseling session including the name of the social worker, the names of the clients in the group and notation as to which family members were present. This record should be kept in a log which is located in the SCC facility.
Social Worker	Z5406	For telephone consultations for case management and coordination of care per patient per date of service (per 0.25 hrs, maximum 0.75 hrs). This code is not to be utilized for scheduling appointments or appointment reminders.
Registered Dietitian	Z4300	For non-physician coordinating activities for the SCC per patient (including coordinating team case conference discussion and recommendations after team member evaluations and case reporting). A SCC can only bill for the time of one coordinator per patient per date of service (i.e., either Z4300 or Z4305). Also, a Registered Dietitian cannot bill for both serving as the case conference coordinator and as a conference participant (i.e., Z4300 and Z4312).

Registered Dietitian	Z4308	For registered dietitian comprehensive assessment/intervention and instruction/education as clinically indicated per patient and family per date of service (per 0.5 hrs, maximum 2 hrs). Requires a progress note or a standardized form completed. This visit should be on, or within 30 days of, the day of the team case conference. This code is also used for registered dietitian assessment/intervention and instruction/education per patient and family (per 0.5 hrs, maximum 2 hrs) for intermittent SCC visits between annual visits as clinically indicated. Requires a progress note.
Registered Dietitian	Z4312	For participation in the SCC comprehensive team case conference (per 0.25 hrs, maximum 0.5 hrs). Z4300 cannot be claimed in addition to Z4312 for the same patient on the same date of service.
Registered Dietitian	Z4314	For allied health care professional leadership of group counseling, group teaching, or support group for the SCC client/family. A SCC can only bill for one such leadership (from either the physician [Z4313], nurse specialist [Z4314], or allied health care professional [Z4314]) per patient per session per day. There should be a progress note in the patient chart describing the teaching provided and the response of the individuals to the teaching. A record must be kept of the counseling session including the name of the dietitian, the names of the clients in the group and notation as to which family members were present. This record should be kept in a log which is located in the SCC facility.
Registered Dietitian	Z5406	For telephone consultations for case management and coordination of care per patient per date of service (per 0.25 hrs, maximum 0.75 hrs). This code is not to be utilized for scheduling appointments or appointment reminders. This code requires a progress note in the patient chart.
Other Allied Health Care Professional	Z4300	For non-physician coordinating activities for the SCC per patient per date of service (including coordinating team case conference discussion and recommendations after team member evaluations and case reporting). A SCC can only bill for the time of one coordinator per patient per date of service (i.e., either Z4300 or Z4305). Also, an allied health care professional cannot bill for both serving as the coordinator (which includes coordinating the case conference) and as a case conference participant (i.e., Z4300 and Z4310).
Other Allied Health Care Professional	Z4302	For participation in the SCC comprehensive team case conference (per 0.25 hrs). Z4300 cannot be claimed in addition to Z4302 for the same patient on the same date of service.
Other Allied Health Care Professional	Z4309	For a comprehensive assessment/intervention and instruction/education as clinically indicated per patient and family per date of service (per 0.5 hrs, maximum 2 hrs). Requires a progress note or a standardized form completed. This visit should be on, or within 30 days of, the day of the team case conference. This code is also used for other allied health care assessment/intervention and interviewing per patient and family (per 0.5 hrs, maximum 2 hrs) for intermittent SCC visits between annual visits as clinically indicated. Requires a progress note.

Other Allied Health Care Professional	Z4314	For health care professional leadership of group counseling, group teaching, or support group for the SCC client/family. A SCC can only bill for one such leadership (from either the physician [Z4313] or allied health care professional [Z4314]) per patient per session per day. There should be a progress note in the patient chart describing the teaching provided and the response of the individuals to the teaching. A record must be kept of the counseling session including the name of the allied health care professional, the names of the clients in the group and notation as to which family members were present. This record should be kept in a log which is located in the SCC facility.
Other Allied Health Care Professional	Z5406	For telephone consultations for case management and coordination of care per patient per date of service (per 0.25 hrs, maximum 0.75 hrs). This code is not to be utilized for scheduling appointments or appointment reminders.
Respiratory Care Practitioner	X4700	For an assessment/intervention and instruction/education as clinically indicated per client and family per date of service. Requires a progress note or a standardized form completed.
Respiratory Care Practitioner	X4702	For participation in the SCC comprehensive team case conference per client.
Facility Codes	Z7500	For the SCC that is hospital-based, for the examining room or treatment room charge per patient per date of service.
Facility Codes	Z7610	For the SCC facility that is hospital-based for any non-surgical miscellaneous medical supplies and/or drugs per patient per date of service.

		Other Allied Health Professional Evaluation Codes*
Provider Type	**Procedure Code(s)**	**Description and Requirements**
		*The following codes (in SCG 02) can be used instead of Z4309. These codes require a formal report for the patient chart and for submission to the CCS program.
Physical Therapist	X3920	For physical therapy evaluation first 30 minutes plus report.
Physical Therapist	X3922	For physical therapy evaluation each additional 15 minutes.
Occupational Therapist	X4100	For occupational therapy evaluation first 30 minutes plus report.
Occupational Therapist	X4102	For occupational therapy evaluation each additional 15 minutes.
Speech Therapist	X4300	For speech therapy language evaluation plus report.
Speech Therapist	X4301	For speech therapy speech evaluation plus report.
Psychologist	X9514	For psychodiagnostic test admininstration including pre-interview, one complete hour.
Psychologist	X9526	For psychodiagnostic test admininstration including pre-interview, two complete hours.
Psychologist	X9528	For psychodiagnostic group test admin. per person – over one, add

Psychologist	X9530	For psychodiagnostic test scoring, one complete hour.
Psychologist	X9532	For psychodiagnostic test scoring, two complete hours (maximum).
Psychologist	X9534	For psychodiagnostic test scoring, partial hour, each 15 minutes.
Psychologist	X9536	For psychodiagnostic computer scored test, per test at computer – firm's usual charge up to maximum of this rate.
Psychologist	X9538	For psychodiagnostic written test report, one complete hour.
Psychologist	X9540	For psychodiagnostic written test report, two complete hours (maximum).
Psychologist	X9542	For psychodiagnostic written test report, partial hour, each 15 minutes.

ATTACHMENT C
CODES AND UNITS OF SERVICE

Code	Description	Units Of Service
Z4300	Center coordinator, non-physician	Case
Z4301	Assessment, intervention, with instruction, education, nurse specialist	30 minutes
Z4302	Team case conference, other allied health care professional	15 minutes
Z4303	Report of status of patient, periodic, physician or nurse specialist	Case
Z4304	Report of status of patient, comprehensive, physician or nurse specialist	Case
Z4305	Center coordinator, physician	Case
Z4306	Team case conference, physician/dentist	Case
Z4307	Interview, assessment, intervention, social worker	30 minutes
Z4308	Assessment, intervention, with instruction, education, registered dietitian	30 minutes
Z4309	Assessment, intervention, with instruction, education, other allied health care professional	30 minutes
Z4310	Team case conference, nurse specialist	15 minutes
Z4311	Team case conference, medical social worker	15 minutes
Z4312	Team case conference, registered dietitian	15 minutes
Z4313	Group teaching, counseling, and support, physician	Person/ session
Z4314	Group teaching, counseling and support, other allied health care professional	Person/ session
Z4315	Physician/parent conference	30 minutes

Codes And Units Of Service

Code	Description	Units Of Service
Z5406	Telephone consultation, non-physician	15 minutes
Z7500	Use of hospital examining or treatment room	Case
Z7610	Non-surgical misc. drugs and medical supplies administered	By report
X3920	Physical therapy evaluation first 30 minutes plus report	30 minutes
X3922	Physical therapy evaluation each additional 15 min.	15 minutes
X4100	Occupational therapy evaluation first 30 minutes plus report	30 minutes
X4102	Occupational therapy evaluation each additional 15 minutes	15 minutes
X4300	Speech therapy language evaluation plus report	Person
X4301	Speech therapy speech evaluation plus report	Person
X4700	Assessment, evaluation and/or intervention, respiratory care practitioner	Person/ session
X4702	Team case conference, respiratory care practitioner	Case
X9514	Psychodiagnostic test admin. incl pre-interview one complete hour	60 minutes
X9516	Psychodiagnostic test admin. incl pre-interview two complete hours	120 minutes
X9526	Psychodiagnostic test admin. partial hour, ea 15 minutes	15 minutes
X9528	Psychodiagnostic group test admin. per person – over one, add	Person

Codes And Units Of Service

Code	Description	Units Of Service
X9532	Psychodiagnostic test scoring, two complete hours (maximum)	120 minutes
X9534	Psychodiagnostic test scoring, partial hour – ea 15 minutes	15 minutes
X9536	Psychodiagnostic computer scored test, per test at computer – firm's usual charge up to maximum of this rate	Per Test
X9538	Psychodiagnostic written test report, one complete hour	60 minutes
X9540	Psychodiagnostic written test report, two complete hours (maximum)	120 minutes
X9542	Psychodiagnostic written test report, partial hour – each 15 minutes	15 minutes