



# HCPCS 2008

4th Quarter, Effective October 1

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***Appendix I – 2008 HCPCS Alphanumeric Index (pp 1-45)***

***Appendix II – 2008 Table of Drugs (pp 1-30)***

# HCPCS Background

Each year United States health care insurers process over 5 billion payment claims. The HCPCS Level II Code Set is one of the standard code sets used for this purpose. The HCPCS is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT® (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT to identify services and procedures for which they bill public or private health insurance programs. Decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items. The development and use of level II of the HCPCS began in the 1980's. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HCPCS is a system for identifying items and services. It is not a methodology or system for making coverage or payment determinations, and the existence of a code does not, of itself, determine coverage or non-coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or revision of HCPCS codes are made independent of the process for making determinations regarding coverage and payment.

Currently, there are national HCPCS codes representing over 4,000 separate categories of like items or services that encompass millions of products from different manufacturers. When submitting claims, suppliers are required to use one of these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. To avoid any appearance of endorsement of a particular product through HCPCS, the descriptors that are used to identify codes do not refer to specific products. For this reason, brand or trade names are not used to describe the products represented by a code.

There are several types of HCPCS level II codes depending on the purpose for the codes and who is responsible for establishing and maintaining them.

### **Permanent National Codes**

National permanent HCPCS level II codes are maintained by the CMS HCPCS Workgroup. The Workgroup is responsible for making decisions about additions, revisions, and deletions to the permanent national alpha-numeric codes. These codes are for the use of all private and public health insurers. Since HCPCS is a national coding system all payers will be represented in the Workgroup including representatives from private insurance agencies, the Statistical Analysis Durable Medical Equipment Regional Carriers (SADMERC), and Medicaid will participate in the workgroup meetings and provide input as to what is necessary to meet each party's program operating needs.

The permanent national codes serve the important function of providing a standardized coding system that is managed jointly by private and public insurers. This standardized approach to developing a set of uniform codes provides a stable environment for claims submission and processing.

### **Miscellaneous Codes**

National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. The importance of miscellaneous codes is that they allow suppliers to begin billing immediately for a service or item as soon as it is allowed to be marketed by the Food and Drug Administration (FDA) even though there is no distinct code that describes the service or item. A miscellaneous code can be used during the period of time a request for a new code is being considered under the HCPCS review process. The use of miscellaneous codes also helps us to avoid the inefficiency and administrative burden of assigning distinct codes for items or services that are rarely furnished or for which we expect to receive few claims.

Because of miscellaneous codes, the absence of a specific code for a distinct category of products does not affect a supplier's ability to submit claims to private or public insurers and does not affect patient access to products. Claims with miscellaneous codes are manually reviewed, the item or service being billed must be clearly described, and pricing information must be provided along with documentation to explain why the item or service is needed by the beneficiary.

Ordinarily, before using a miscellaneous code on a claim form, a supplier should check with the entity that will receive the payment claim to determine whether there is a specific code that should be used rather than a miscellaneous code. In the case of claims that are to be submitted to one of the four durable medical equipment regional carriers (DMERCs), suppliers that have coding questions should check with the statistical analysis durable medical equipment carrier (SADMERC) under contract to CMS. The SADMERC is responsible for providing suppliers and manufacturers with assistance in determining which HCPCS code should be used to describe DMEPOS items for the purpose of billing Medicare. The SADMERC has a toll free helpline for this purpose, (877) 735-1326, which is

operational during the hours of 9 AM to 4 PM (EST). In addition, The SADMERC publishes a product classification list on its website that lists individual items to code categories. More information about the SADMERC and the SADMERC's product classification list can be found at <http://www.palmettogba.com>.

If no code exists that describes the product category to which the item belongs, and if the item fits a Medicare Benefit Category, the SADMERC may instruct the supplier to submit claims using a "miscellaneous/not otherwise classified" code. If an item does not fit a Medicare Benefit Category, the SADMERC might assign a code that indicates that the product is not covered by Medicare such as code A9270, NON-COVERED ITEM OR SERVICE. If an item is included or bundled into another code and not separately reimbursed by Medicare, the SADMERC may assign the code that includes the item or a code that indicates that the item is included as a component of another code. In those cases in which a supplier or manufacturer has been advised to use a miscellaneous code because there is no existing code that describes a given product, and the supplier or manufacturer believes that the code is needed, it should submit a request to modify the HCPCS in accordance with the established process. The process for requesting a revision to the HCPCS level II codes is explained below.

### **Temporary National Codes**

Temporary codes are for the purpose of meeting, within a short time frame, the national program operational needs of a particular insurer that are not addressed by an already existing national code. The CMS HCPCS Workgroup has set aside certain sections of the HCPCS code set to allow the Workgroup to develop temporary codes. Decisions regarding the number and type of temporary codes and how they are used are also made by the CMS HCPCS Workgroup. These codes are used at the discretion of CMS. This means that if, before the next scheduled annual update for permanent codes, the CMS HCPCS Workgroup needs a code in order to meet specific operating needs that pertain to its particular programs, it may establish a national temporary code. In the case of Medicare, decisions regarding temporary codes are made by the CMS HCPCS workgroup. For example, Medicare may need additional codes before the next scheduled annual HCPCS update to implement newly issued coverage policies or legislative requirements. Although we establish temporary codes to meet our specific operational needs, the temporary codes we establish can be used by other insurers. Temporary codes allow insurers the flexibility to establish codes that are needed before the next January 1 annual update for permanent national codes or until consensus can be achieved on a permanent national code. Permanent national codes are only updated once a year on January 1.

The CMS HCPCS Workgroup may decide to replace temporary codes with permanent codes. However, temporary codes do not have established expiration dates. Whenever a permanent code is established by the CMS HCPCS Workgroup to replace a temporary code, the temporary code is deleted and cross-referenced to the new permanent code.

In October of 2003, the Secretary of HHS delegated authority under the HIPAA legislation to CMS to maintain and distribute HCPCS Level II Codes. As stated in 42 CFR Sec. 414.40 (a) CMS establishes uniform national definitions of services, codes to represent services, and

payment modifiers to the codes. Within CMS there is a CMS HCPCS Workgroup which is an internal workgroup comprised of representatives of the major components of CMS, as well as other consultants from pertinent Federal agencies. Prior to December 31, 2003, Level III HCPCS were developed and used by Medicaid State agencies, Medicare contractors, and private insurers in their specific programs or local areas of jurisdiction. For purposes of Medicare, level III codes were also referred to as local codes. Local codes were established when an insurer preferred that suppliers use a local code to identify a service, for which there is no level I or level II code, rather than use a "miscellaneous or not otherwise classified code." The Health Insurance Portability and Accountability Act of 1996 required CMS to adopt standards for coding systems that are used for reporting health care transactions. To implement HIPAA, level III codes were eliminated December 31, 2003.

# Modifiers

Like CPT, HCPCS has national modifiers which are two letters (AA-VP). Each section of the HCPCS manual lists the modifiers typically reported with that section. Modifiers currently include:

In some instances, insurers instruct suppliers that a HCPCS code must be accompanied by code modifier to provide additional information regarding the service or item identified by the HCPCS code. Modifiers are used when the information provided by a HCPCS code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service. For example, a UE modifier is used when the item identified by a HCPCS code is "used equipment," a NU modifier is used for "new equipment." The level II HCPCS modifiers are either alpha-numeric or two letters.

## Ambulance Origin and Destination Modifiers

The modifiers listed below are used to designate the place of origin and destination of a transport. The first position identifies the place of origin and the second position identifies the destination.

Example: A patient is picked up at the scene of an accident and transported to a hospital. Place "S" (scene of accident or acute event) in the first modifier position, to indicate the place of origin. Place "H" (hospital) in the second modifier position to indicate the destination of the patient.

- D - Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes.
- E - Residential, Domiciliary, Custodial Facility (other than an 1819 facility).
- G - Hospital Based Dialysis Facility (hospital or hospital related).
- H - Hospital.
- I - Site of Transfer (e.g., airport or helicopter pad) between modes of ambulance transport.
- J - Non-Hospital Based Dialysis Facility.
- N - Skilled Nursing Facility (SNF) (1819 facility).
- P - Physician's office.
- R - Residence.
- S - Scene of Accident or Acute Event.
- X - (Destination code only) Intermediate stop at physician's office on the way to the hospital.

- A1 DRESSING FOR ONE WOUND
- A2 DRESSING FOR TWO WOUNDS
- A3 DRESSING FOR THREE WOUNDS
- A4 DRESSING FOR FOUR WOUNDS
- A5 DRESSING FOR FIVE WOUNDS
- A6 DRESSING FOR SIX WOUNDS

- A7 DRESSING FOR SEVEN WOUNDS
- A8 DRESSING FOR EIGHT WOUNDS
- A9 DRESSING FOR NINE OR MORE WOUNDS

A modifiers (AA-AT) describe the individual providing a service such as AH used by a clinical psychologist to report services.

- AA ANESTHESIA SERVICES PERFORMED PERSONALLY BY ANESTHESIOLOGIST
  - AD MEDICAL SUPERVISION BY A PHYSICIAN: MORE THAN FOUR CONCURRENT ANESTHESIA PROCEDURES
  - AE REGISTERED DIETICIAN
  - AF SPECIALTY PHYSICIAN
  - AG PRIMARY PHYSICIAN
  - AH CLINICAL PSYCHOLOGIST
  - AJ CLINICAL SOCIAL WORKER
  - AK NON PARTICIPATING PHYSICIAN
  - AMPHYSICIAN, TEAM MEMBER SERVICE
  - AP DETERMINATION OF REFRACTIVE STATE WAS NOT PERFORMED IN THE COURSE OF DIAGNOSTIC OPHTHALMOLOGICAL EXAMINATION
  - AQ PHYSICIAN PROVIDING A SERVICE IN AN UNLISTED HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)
  - AR PHYSICIAN PROVIDER SERVICES IN A PHYSICIAN SCARCITY AREA
  - AS PHYSICIAN ASSISTANT, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST SERVICES FOR ASSISTANT AT SURGERY
  - AT ACUTE TREATMENT (THIS MODIFIER SHOULD BE USED WHEN REPORTING SERVICE 98940, 98941, 98942)
  - AU ITEM FURNISHED IN CONJUNCTION WITH A UROLOGICAL, OSTOMY, OR TRACHEOSTOMY SUPPLY
  - AV ITEM FURNISHED IN CONJUNCTION WITH A PROSTHETIC DEVICE, PROSTHETIC OR ORTHOTIC
  - AW ITEM FURNISHED IN CONJUNCTION WITH A SURGICAL DRESSING
  - AX ITEM FURNISHED IN CONJUNCTION WITH DIALYSIS SERVICES
  - BA ITEM FURNISHED IN CONJUNCTION WITH PARENTERAL ENTERAL NUTRITION (PEN) SERVICES
  - BL SPECIAL ACQUISITION OF BLOOD AND BLOOD PRODUCTS
  - BO ORALLY ADMINISTERED NUTRITION, NOT BY FEEDING TUBE
- B modifiers (BP-BU) describe beneficiary informed consent with respect to purchase/rental options.
- BP THE BENEFICIARY HAS BEEN INFORMED OF THE PURCHASE AND RENTAL OPTIONS AND HAS ELECTED TO PURCHASE THE ITEM

BR THE BENEFICIARY HAS BEEN INFORMED OF THE PURCHASE AND RENTAL OPTIONS AND HAS ELECTED TO RENT THE ITEM

BU THE BENEFICIARY HAS BEEN INFORMED OF THE PURCHASE AND RENTAL OPTIONS AND AFTER 30 DAYS HAS NOT INFORMED THE SUPPLIER OF HIS/HER DECISION

C modifiers describe a procedure code which was changed either for administrative reasons or because an incorrect code was filed.

CA PROCEDURE PAYABLE ONLY IN THE INPATIENT SETTING WHEN PERFORMED EMERGENTLY ON AN OUTPATIENT WHO EXPIRES PRIOR TO ADMISSION

CB SERVICE ORDERED BY A RENAL DIALYSIS FACILITY (RDF) PHYSICIAN AS PART OF THE ESRD BENEFICIARY'S DIALYSIS BENEFIT, IS NOT PART OF THE COMPOSITE RATE, AND IS SEPARATELY REIMBURSABLE

CC PROCEDURE CODE CHANGE (USE 'CC' WHEN THE PROCEDURE CODE SUBMITTED WAS CHANGED EITHER FOR ADMINISTRATIVE REASONS OR BECAUSE AN INCORRECT CODE WAS FILED)

CD AMCC TEST HAS BEEN ORDERED BY AN ESRD FACILITY OR MCP PHYSICIAN THAT IS PART OF THE COMPOSITE RATE AND IS NOT SEPARATELY BILLABLE

CE AMCC TEST HAS BEEN ORDERED BY AN ESRD FACILITY OR MCP PHYSICIAN THAT IS A COMPOSITE RATE TEST BUT IS BEYOND THE NORMAL FREQUENCY COVERED UNDER THE RATE AND IS SEPARATELY REIMBURSABLE BASED ON MEDICAL NECESSITY

CF AMCC TEST HAS BEEN ORDERED BY AN ESRD FACILITY OR MCP PHYSICIAN THAT IS NOT PART OF THE COMPOSITE RATE AND IS SEPARATELY BILLABLE

CR CATASTROPHE/DISASTER RELATED

E modifiers (E1-E4, EJ-ET) describe location (E1-E4--eyelid), ESRD services and emergency dental services.

E1 UPPER LEFT, EYELID

E2 LOWER LEFT, EYELID

E3 UPPER RIGHT, EYELID

E4 LOWER RIGHT, EYELID

EJ SUBSEQUENT CLAIMS FOR A DEFINED COURSE OF THERAPY, E.G., EPO, SODIUM HYALURONATE, INFLIXIMAB

EM EMERGENCY RESERVE SUPPLY (FOR ESRD BENEFIT ONLY)

EP SERVICE PROVIDED AS PART OF MEDICAID EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM

ET EMERGENCY SERVICES

EY NO PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE

F modifiers (FA-F9, FP) describe location (FA-F9-hands) or (FP-service provided as part of Medicaid Family Planning Program).

F1 LEFT HAND, SECOND DIGIT

F2 LEFT HAND, THIRD DIGIT

F3 LEFT HAND, FOURTH DIGIT

F4 LEFT HAND, FIFTH DIGIT

F5 RIGHT HAND, THUMB

F6 RIGHT HAND, SECOND DIGIT

F7 RIGHT HAND, THIRD DIGIT

F8 RIGHT HAND, FOURTH DIGIT

F9 RIGHT HAND, FIFTH DIGIT

FA LEFT HAND, THUMB

FB ITEM PROVIDED WITHOUT COST TO PROVIDER, SUPPLIER OR PRACTITIONER, OR CREDIT RECEIVED FOR REPLACED DEVICE (EXAMPLES, BUT NOT LIMITED TO COVERED UNDER WARRANTY, REPLACED DUE TO DEFECT, FREE SAMPLES)

FP SERVICE PROVIDED AS PART OF FAMILY PLANNING PROGRAM

G modifiers (G1-G6, GA-GX) describe most recent URR reading (G1-G5), G6 describes ESRD patient with <6 dialysis sessions in one month, waiver of liability statement on file (GA) and GC, GE which describes services performed by a resident under the supervision of a teaching physician.

G1 MOST RECENT URR READING OF LESS THAN 60

G2 MOST RECENT URR READING OF 60 TO 64.9

G3 MOST RECENT URR READING OF 65 TO 69.9

G4 MOST RECENT URR READING OF 70 TO 74.9

G5 MOST RECENT URR READING OF 75 OR GREATER

G6 ESRD PATIENT FOR WHOM LESS THAN SIX DIALYSIS SESSIONS HAVE BEEN PROVIDED IN A MONTH

G7 PREGNANCY RESULTED FROM RAPE OR INCEST OR PREGNANCY CERTIFIED BY PHYSICIAN AS LIFE THREATENING

G8 MONITORED ANESTHESIA CARE (MAC) FOR DEEP COMPLEX, COMPLICATED, OR MARKEDLY INVASIVE SURGICAL PROCEDURE

G9 MONITORED ANESTHESIA CARE FOR PATIENT WHO HAS HISTORY OF SEVERE CARDIO-PULMONARY CONDITION

GA WAIVER OF LIABILITY STATEMENT ON FILE

GB CLAIM BEING RE-SUBMITTED FOR PAYMENT BECAUSE IT IS NO LONGER COVERED UNDER A GLOBAL PAYMENT DEMONSTRATION

GC THIS SERVICE HAS BEEN PERFORMED IN PART BY A RESIDENT UNDER THE DIRECTION OF A TEACHING PHYSICIAN

GE THIS SERVICE HAS BEEN PERFORMED BY A RESIDENT WITHOUT THE PRESENCE OF A TEACHING PHYSICIAN UNDER THE PRIMARY CARE EXCEPTION

GF NON-PHYSICIAN (E.G. NURSE PRACTITIONER (NP), CERTIFIED REGISTERED NURSE