Chapter Eleven

HCPCS CODING FOR SUPPLIES, DRUGS & TEMPORARY PROCEDURES

Healthcare Common Procedural Coding System (HCPCS)

HCPCS is a coding system developed by the Center for Medicare and Medicaid Services (formally Heath Care Finance Administration or HCFA) in 1983 to report temporary professional services, procedures and supplies provided by physicians and supply companies not available in CPT. Generally, these codes are used by non-physician providers.

HCPCS Level II has more than 9,000 codes and is just one level of the three level procedural coding systems used to report medical services. The levels of HCPCS codes are listed below with a brief description of each coding system.

Level I - CPT is the Current Procedural Terminology for Physicians developed by the AMA and discussed previously in this manual. CPT is also known as HCPCS Level I.

Level II – HCPCS is the coding system designed to report medical services and supplies not utilized in CPT. The coding system consists of alpha-numeric (one letter followed by four numeric digits) codes for reporting these services. Medicare and Medicaid now require the use of HCPCS codes and many private commercial carriers are also encouraging and requiring their use as well. Some private carriers may not recognize the HCPCS codes, therefore when payment is denied for services billed using the HCPCS codes, send in supporting documentation to the carrier for the definition of the code and it may convince them to change their edits to recognize such codes. Workers Compensation carriers require the use of the CPT generic equivalent of HCPCS supply codes 99070 Supplies.

Level III – Local Codes are comprised of alphanumeric codes assigned by individual state Medicare carriers. These are assigned with the beginning letter series W-Z and are followed, like the level II codes, by four numeric digits. These codes are not common to all carriers. The Level III codes are developed by the state carriers when no code exists in the Level I or Level II categories to describe the service or supply. The codes are published at various times of the year depending on the need to create new codes throughout the year.

The various HCPCS coding systems also contain modifiers. Level I codes contain approximately 30 two-digit numeric modifiers, Level II codes contain more than 430 two-digit alphabetic/numeric and alpha/alpha modifiers, and Level III codes contain a variety of modifiers which are created on an as needed basis.

HCPCS Level II coding system is used much like the Level I (CPT) publication. The Index is utilized to look up the procedure or supply which in turn directs you to the appropriate alphanumeric code assignment. The Index for coding drugs can be found under its own section listed as Table of Drugs.

HCPCS Level II coding system consists of both permanent and temporary codes.

Permanent codes are maintained by the Center for Medicare and Medicaid (CMS) workgroup and are available for use by both government and commercial payers.

Temporary codes are created for specific payers (primarily Medicare). These codes are requested, approved and implemented within a short time frame (usually within 90 days from request) and if used consistently may become permanent codes.

Depending on the payer, procedures may be reported using CPT code or a HCPCS Level II code. One example is administration code; for Medicare an administration of a flu vaccine is coded G0008 whereas other payers require CPT code 90654-90668.

The HCPCS book is separated into three main sections

- ✓ **Index** – includes alphabetic listing of all services within HCPCS directing coder to the numeric code section for reporting the service.
- ✓ **Introduction** – provides instructions for how to use the HCPCS code book including defining symbols, modifiers and legends.
- ✓ **Code Chapters** – numeric codes separated by chapter (i.e. ambulance, DME supplies, etc.)

The major updates to the HCPCS coding are released annually; however, CMS releases quarterly updates throughout the year of codes that have been approved for immediate use by Medicare and Medicaid payers.

HCPCS Level II coding symbols

✔- Reinstated Code

➔ - Revised Code

✻- Carrier Discretion

◆- Not Covered or Valid by Medicare

❂- Special Coverage Instructions

X – Deleted Code

♀ Female only

♂ Male only

New Code

A Age

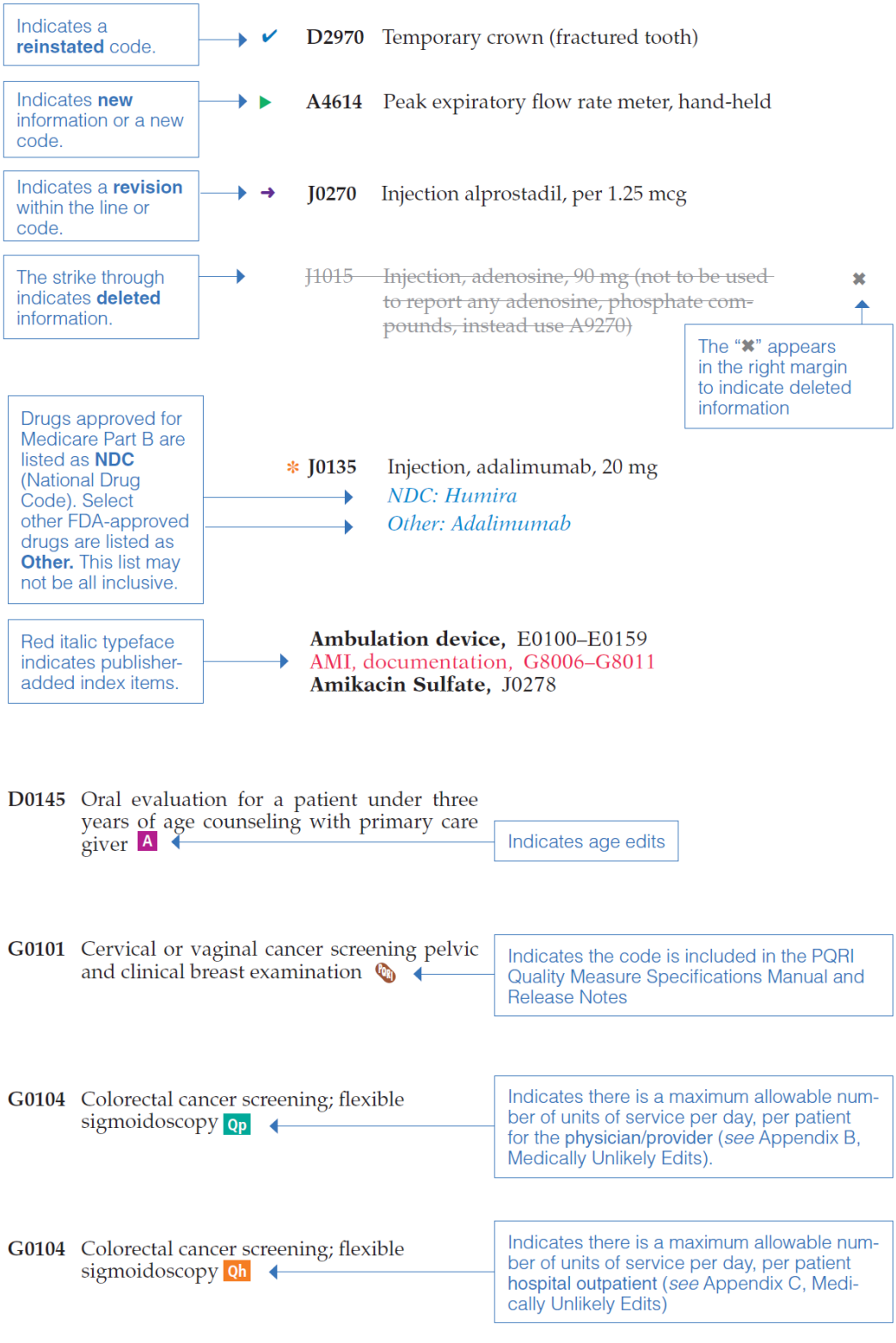
D DMEPOS

PQRI Physician Quality Reporting Initiative

Qp Quantity Physician Appendix B

Qh Quantity Hospital Appendix C

The illustrations below show how these symbols appear in the HCPCS manual.


Indicates a **reinstated** code.
✔ D2970 Temporary crown (fractured tooth)
Indicates **new** information or a new code.
▶ A4614 Peak expiratory flow rate meter, hand-held
Indicates a **revision** within the line or code.
➔ J0270 Injection alprostadil, per 1.25 mcg
The strike through indicates **deleted** information.
J1015 ~~Injection, adenosine, 90 mg (not to be used to report any adenosine, phosphate compounds, instead use A9270)~~ ✖
The "✖" appears in the right margin to indicate deleted information
Drugs approved for Medicare Part B are listed as **NDC** (National Drug Code). Select other FDA-approved drugs are listed as **Other.** This list may not be all inclusive.
✻ J0135 Injection, adalimumab, 20 mg
NDC: Humira
Other: Adalimumab
Red italic typeface indicates publisher-added index items.
Ambulation device, E0100–E0159
AMI, documentation, G8006–G8011
Amikacin Sulfate, J0278
D0145 Oral evaluation for a patient under three years of age counseling with primary care giver A
Indicates age edits
G0101 Cervical or vaginal cancer screening pelvic and clinical breast examination PQRI
Indicates the code is included in the PQRI Quality Measure Specifications Manual and Release Notes
G0104 Colorectal cancer screening; flexible sigmoidoscopy Qp
Indicates there is a maximum allowable number of units of service per day, per patient for the physician/provider (*see* Appendix B, Medically Unlikely Edits).
G0104 Colorectal cancer screening; flexible sigmoidoscopy Qh
Indicates there is a maximum allowable number of units of service per day, per patient hospital outpatient (*see* Appendix C, Medically Unlikely Edits)

HCPCS Level II Table of Drugs and Chemicals

The table of drugs and chemicals is a table provided in the Index section of the HCPCS Level II code book to provide the coder with a simple means to code for drugs and chemical supplies. The table lists the narrative drug name (alphabetic listing), dosage, method of administration and the numeric HCPCS code for the drug.

IA	Intra-arterial administration
IV	Intravenous administration
IM	Intramuscular administration
IT	Intrathecal
SC	Subcutaneous administration
INH	Administration by inhaled solution
VAR	Various routes of administration
OTH	Other routes of administration
ORAL	Administered orally

Intravenous administration includes all methods, such as gravity infusion, injections, and timed pushes. The "VAR" posting denotes various routes of administration and is used for drugs that are commonly administered into joints, cavities, tissues, or topical applications, in addition to other parenteral administrations. Listings posted with "OTH" indicate other administration methods, such as suppositories or catheter injections.

DRUG NAME	DOSAGE	METHOD OF ADMINISTRATION	HCPCS CODE
A			
Abarelix	10 mg		**J0128**
Abatacept	10 mg		**J0129**
Abbokinase	5,000 IU vial	IV	**J3364**
	250,000 IU vial	IV	**J3365**
Abbokinase, Open Cath	5,000 IU vial	IV	**J3364**
Abciximab	10 mg	IV	**J0130**
Abelcet	10 mg	IV	**J0287**
	50 mg		**J0285**
Abilify	0.25 mg		**J0400**
ABLC	50 mg	IV	**J0285**
Abraxane	1 mg		**J9264**
Acetadote	100 mg		**J0132**
	per gram		**J7608**
Acetazolamide sodium	up to 500 mg	IM, IV	**J1120**
Acetylcysteine			
inhalation			**J7699**
injection	100 mg		**J0132**
unit dose form	per gram	INH	**J7604, J7608**
Achromycin	up to 250 mg	IM, IV	**J0120**
ACTH	up to 40 units	IV, IM, SC	**J0800**
Acthar	up to 40 units	IV, IM, SC	**J0800**
Acthib			**J3490**
Acthrel	1 mcg		**J0795**
Actimmune	0.25 mg	SC	**J1830**
	3 million units	SC	**J9216**
Actinomycin D	0.5 mg		**J9120**
Activase	1 mg	IV	**J2997**
Acutect	up to 20 millicuries		**A9504**
Acyclovir			**J8499**
Acyclovir Sodium	5 mg		**J0133**

HCPCS Level II Code Chapters

The following chapters are defined in the HCPCS Level II coding system:

Transportation Services Including Ambulance: A0000-A0999

Medical and Surgical Supplies: A4000-A8004

Administrative, Miscellaneous and Investigational: A9000-A9999

Enteral and Parenteral Therapy: B4000-B9999

CMS Hospital Outpatient Payment System: C1000-C9999

Dental Procedures: D0000-D9999

Durable Medical Equipment: E0100-E8002

Procedures/Professional Services (Temporary): G0000-G9999

Behavioral Health and/or Substance Abuse Treatment Services: H0001-H9999

Drugs Administered Other Than Chemotherapy: J0100-J8999

Chemotherapy Drugs: J9000-J9999

Temporary Codes Assigned to DME Regional Carriers: K0000-K9999

Orthotic Procedures: L0100-L4999

Prosthetic Procedures: L5000-L9999

Other Medical Services: M0000-M0301

Laboratory Services: P0000-P9999

Temporary Codes Assigned by CMS: Q0000-Q9999

Diagnostic Radiology Services: R0000-R9999

Temporary National Codes Established by Private Payers: S0000-S9999

Temporary National Codes Established by Medicaid: T1000-T9999

Vision Services: V0000-V2999

Hearing Services: V5000-V5999

The HCPCS level code ranges leave room for expanding codes within both code categories as well as allowing for additions of new categories in the future.

HCPCS Level II Modifiers

HCPCS Level II utilizes two-digit modifiers that may consist of two alpha or an alphanumeric digit. Modifiers are utilized for the purpose of changing, enhancing or modifying a procedure or service description being reported without changing the code description.

The most commonly used HCPCS Level II modifiers are listed in the table below. For a list of all modifiers refer to the introduction section of the HCPCS Level II code book.

HCPCS Level II Most Frequently Used Modifiers

HCPCS Modifier	HCPCS Modifier Description
AA	Anesthesia services personally furnished by an anesthesiologist.
AD	Medical supervision by physician: more than four concurrent anesthesia services.
AQ	Physician providing a service in a health professional shortage area (HPSA) (for dates of service on or after January 1, 2006).
AR	Physician provider services in a physician scarcity area.
AS	Physician assistant, nurse practitioner, or clinical nurse specialist service for assistant @ security.
AT	Acute or chronic active / corrective treatment (effective October 1, 2004)
CB	Services ordered by a dialysis-facility physician as part of the ESRD (end-stage renal disease) beneficiary's dialysis benefit; this is not part of the composite rate & is separately reimbursable.
CC	Procedure code change (the carrier uses CC when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed).
CR	Catastrophe / disaster related.
EJ	Subsequent claim for EPO (epoetin alfa) course of therapy.
E1	Upper left, eyelid.
E2	Lower left, eyelid.
E3	Upper right, eyelid.
E4	Lower right, eyelid.
FA	Left hand, thumb.
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.
GA	Advance Beneficiary Notification on file.
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.
GG	Performance & payment of screening mammogram & diagnostic mammogram on the same patient, same day (effective for dates of service on or after January 1, 2002).
GJ	"OPT OUT" physician or practitioner emergency or urgent service.
GM	Multiple patients on one ambulance trip.
GN	Service delivered under an outpatient speech-language pathology plan of care.
GO	Service delivered under an outpatient occupational therapy plan of care.
GP	Service delivered under an outpatient physical therapy plan of care.
GQ	Via asynchronous telecommunications system.
GT	Via interactive audio & video telecommunication system.
GV	Attending physician not employed or paid under arrangement by the patient's hospice provider (effective for dates of service on or after January 1, 2002).
GW	Service not related to the hospice patient's terminal condition (effective for dates of service on or after January 1, 2002).
GY	Item or service statutorily excluded or does not meet the definition of any Medicare benefit.
GZ	Item or service expected to be denied as not reasonable & necessary & Advance Beneficiary Notification has not been signed.
J1	Competitive acquisition program (CAP) no-pay submission for a prescription number.

J2	CAP restocking of emergency drugs after emergency administration.
J3	CAP drug not available through CAP as written; reimbursed under average sales price methodology.
KD	Infusion drugs furnished through implanted durable medical equipment (effective January 1, 2004).
KX	Claims for therapy services that have exceeded therapy caps (either by automatic exception or by approved request), for which specific required documentation is on file.
KZ	New coverage not implemented by managed care.
LC	Left circumflex coronary artery.
LD	Left anterior descending coronary artery.
LR	Laboratory round trip.
LT	Left side (use to identify procedures performed on the LEFT side of the body).
QA	FDA investigational device exemption.
QB	Physician providing service in a rural HPSA.
QC	Single-channel monitoring (recording device for Holter monitoring).
QD	Recording & storage in solid-state memory by a digital recorder (digital recording / storage for Holter monitoring).
QJ	Services / items provided to a prisoner or patient in state or local custody. However, the state or local government, as applicable, meets the requirements in 42 C.F.R.S 411.4.
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
QL	Patient pronounced dead after ambulance called.
QP	Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes.
QR	Services that are covered under a clinical study / trial.
QS	Monitored anesthesia care service.
QT	Recording & storage on tape by an analog tape recorder.
QU	Physician providing services in an urban HPSA (for dates of service prior to January 1, 2006).
QV	Item or service provided as routine care in a Medicare qualifying clinical trial.
QW	CLIA waived test.

QX	Certified registered nurse anesthetist (CRNA) service with medical direction by a physician.
QY	Medical direction of one CRNA by an anesthesiologist.
QZ	CRNA service without medical direction by a physician.
Q3	Live kidney donor surgery & related services.
Q5	Service furnished by a substitute physician under a reciprocal billing arrangement.
Q6	Service furnished by a locum tenens physician.
Q7	One class "A" finding.
Q8	Two class "B" findings. Class "B" findings: Absent posterior tibial pulse; advanced tropic changes (hair growth, nail changes, pigmentary changes, or skin texture–three required); absent dorsalis pedis pulse.
Q9	One class "B" & two class "C" findings. Class "C" findings: Claudication; temperature changes, edema, paresthesia; burning.
RC	Right coronary artery.
RT	Right side (use to identify procedures performed on the RIGHT side of the body).
SG	Ambulatory surgical center (ASC) facility charges. This modifier is used only by the ASC for identifying the facility charge. It should not be reported by the physician when reporting the physician's professional service rendered in an ASC.
TA	Left foot, great toe.
T1	Left foot, second digit.
T2	Left foot, third digit
T3	Left foot, fourth digit.
T4	Left foot, fifth digit.
T5	Right foot, great toe.
T6	Right foot, second digit.
T7	Right foot, third digit.
T8	Right foot, fourth digit.
T9	Right foot, fifth digit.

TC	Technical component. Under certain circumstances, a charge may be made for the technical component of a diagnostic test only. Under those circumstances, the technical component charge is identified by adding modifier TC to the usual procedure number.
TS	Pre-diabetic screening is paid twice within a rolling 12-month period. Second screening should be billed with TS modifier.
UN	Transportation of portable X-rays, two patients served.
UP	Transportation of portable X-rays, three patients served.
UQ	Transportation of portable X-rays, four patients served.
UR	Transportation of portable X-rays, five patients served.
US	Transportation of portable X-rays, six or more patients served.
V5	Vascular catheter (alone or with any other vascular access)
V6	Arteriovenous graft (or other vascular access not including a vascular catheter)
V7	Arteriovenous fistula only (in use with two needles)
VP	Aphakic patient

The **Correct Coding Initiative (CCI)** was developed by the Center for Medicare and Medicaid as part of the HCPCS Level II coding system and is defined by CMS as follows:

"The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits."

CCI consists of two edit categories:

Code pair edits also called "bundling" edits, are used to report procedures that may not be paid by Medicare if reported during the same session, for the same patient on the same date of service. In cases where the codes may be reported and paid separately, a modifier may be used when documentation supports the separate procedural services.

CCI code pair edit are guidelines for billing and payment and are different from coding bundling guidelines within the CPT code book.

The CCI code pair table has six columns all described by the corresponding number shown below.

A	B	C	D	E	F
Column1/Column 2 Edits					
1 Column 1	2 Column 2	3 * = In existence prior to 1996	4 Effective Date	5 Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable 6
99215	G0101		19980401	19980401	9
99215	G0102		20000605	*	0
99215	G0104		19980401	19980401	9

Figure 2: Column 1/Column 2 table with 99215 in Column 1

1. Column 1 indicates the payable code.
2. Column 2 contains the code that is not payable with this particular Column 1 code, unless a modifier is permitted and submitted.
3. This third column indicates if the edit was in existence prior to 1996.
4. The fourth column indicates the effective date of the edit (year, month, date).
5. The fifth column indicates the deletion date of the edit (year, month, date).
6. The sixth column indicates if use of a modifier is permitted. This number is the modifier indicator for the edit. (The Modifier Indicator Table, shown on page 7 of this booklet, provides further explanation.)

CMS also created **as part of the HCPCS Level II coding system Medically Unlikely Edits (MUE)** system. The MUE system designates the number of times a procedure will be paid by Medicare if performed on the same patient on the same date of service by the same or a different provider. To avoid denials for duplication of a CPT or HCPCS code, a modifier would be utilized if the edit allows a service to

Medical necessity and appropriate application of modifiers to a procedure or HCPCS code performed outside of these parameters must be established and documented in the medical record for payment to be made for procedures reported above the MUE standard.

These MUE edits are applied to the unit field in box 24G of the CMS 1500 billing form for professional services and box 46 of the UB-04 billing form for hospital services.

MUE guidelines are used as part of billing and payment rules for Medicare and are not considered part of CPT or HCPCS coding system, albeit, they were designed by CMS and have been adopted by many commercial payers as well.

Commercial payers have created their own additional customized edits in addition to building on the foundation of the CMS CCI and MUE edits.

Note that coding modifiers such as -59, -76, -77, and -91 may be used to override CCI and MUE rules. Documentation MUST be present to show that the services are distinct and separate before modifiers are applied. Coders, not billers, should be responsible for reviewing documentation to support the use of any modifier used for CCI and MUE edits presented.

Example of CMS HCPCS MUE Table

HCPCS/CPT Code	Practitioner Services MUE Values
G0464	1
G6030	2
G6031	2
G6032	2
G6034	2
G6035	2
G6036	2
G6037	2
G6039	2
G6040	2
G6041	1
G6042	2
G6043	2
G6044	2
G6045	1
G6046	1
G6047	1
G6048	1

The National Correct Coding Initiative (NCCI/CCI) is an edit system utilized by CMS as part of the HCPCS coding system as well. NCCI edits affect physicians and outpatient hospital settings and each have their own categories for bundling edits. MUE's affect physicians, durable medical equipment suppliers and hospital outpatient settings.

Code Pair Edits

(1) NCCI Edits-Physicians

These code pair edits are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Centers (ASCs).

(2) NCCI Edits-Hospital

This set of code pair edits is applied to the following Types of Bills (TOBs) subject to the Outpatient Code Editor (OCE): Hospitals (TOB 12X and 13X), Skilled Nursing Facilities (SNFs) (TOB 22X and 23X), Home Health Agencies (HHAs) Part B (TOB 34X), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPTs) (74X), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) (TOB 75X).

MUEs

(1) Practitioner MUEs

All physician and other practitioner claims are subject to these edits.

(2) Durable Medical Equipment (DME) Supplier MUEs

These edits are applied to claims submitted to DME MACs. (At this time, this file includes HCPCS A-B, D-H, K-V codes in addition to HCPCS codes under the DME MAC jurisdiction.)

(3) Facility Outpatient MUEs

Claims for TOB 13X, 14X, and Critical Access Hospitals (85X) are subject to these edits.

 The entire Correct Coding Initiative and the guide for determining the accurate code pair edits and MUE for procedures can be found at the CMS website at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd

 For more information on HCPCS, CCI and MUE Guidelines visit the Center for Medicare and Medicaid (CMS) website at http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html