2020

Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 6

HCPCS Level II Concepts

Introduction

The Centers for Medicare & Medicaid Services (CMS) created a three-level coding system in 1983 known as the Healthcare Common Procedural Coding System (HCPCS). This system was developed to meet the operational needs of Medicare and Medicaid and to coordinate a uniform application of CMS policies for all government healthcare programs. As Medicare and other insurers cover a variety of services, supplies, and equipment not identified by CPT® codes, the HCPCS Level II codes were established for submitting claims for these items. Representatives from CMS, the Health Insurance Association of America (HIAA), and the Blue Cross/Blue Shield Association help maintain (additions, revisions, and deletions) the national permanent HCPCS Level II codes.

HCPCS Level II codes are in the public domain and free to use. They are available from the CMS website (public use files), the *Federal Register*, Medicare Administrative Contractor websites, and commercial publishers. See the CMS Quarterly Updates at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html.

The objectives for this chapter include:

- Understand an overview of HCPCS Level II
- List commonly used HCPCS Level II modifiers
- Explain appropriate reporting of discarded drugs/medication

HCPCS Level II Codes

HCPCS Level II codes are grouped according to type of service or supply within a section of the book. They are alphanumeric consisting of a single letter A-V followed by four digits versus CPT® codes that are identified using five digits. Understanding which letter precedes specific types of services, supplies, equipment/devices, and medications is helpful for accurate coding. In the HCPCS Level II code book, instructions and information that are applicable to a specific category of codes are found at the beginning of each major category. CMS has a decision tree to help the coder determine if the claim needs a HCPCS Level II code. See https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/HCPCS_Decision_Tree_and_Definitions.pdf.

HCPCS Level II codes are divided as follows:

A Codes Transportation services, medical and surgical supplies, and administrative, miscellaneous and investigational

B Codes Enteral and parenteral therapy

C Codes Temporary codes for use with Outpatient Prospective Payment System (OPPS) (pass-through)

E Codes Durable medical equipment (DME)

G Codes Procedures/professional services

H Codes Temporary national codes for governmental entities other than Medicare

J Codes Drugs administered other than oral method and chemotherapy drugs

K Codes Assigned to DME MAC (temporary)

L Codes Orthotic procedures and devices and prosthetic procedures

M Codes Medical services

P Codes Pathology and laboratory services

Q Codes Procedures, services, and supplies on a temporary basis

R Codes Diagnostic radiology services

S Codes Temporary national codes (non-Medicare)

T Codes National codes established for state Medicaid agencies

V Codes Vision services and hearing, which also includes speech-language pathology services

The beginning of each section contains information and instructions for proper use of codes applying to the specific section. Greater detail will be provided for each of these categories later in this chapter.

EXAMPLE

PROCEDURES/PROFESSIONAL SERVICES (TEMPORARY)

The G codes are used to identify professional healthcare procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes. The G codes are used for Medicare beneficiaries such as G0008 *Administration of influenza virus vaccine*, G0101 *Cervical or vaginal cancer screening; pelvic and clinical breast examination*, or G0102 *Prostate cancer screening; digital rectal examination.*

Please refer to your CPT® code book for possible alternate code(s).

Table of Drugs—The Table of Drugs (C, J, K, Q, and S codes) is designed to easily direct the coder to drug names and their corresponding codes based on an alphabetic list of drugs with cross-references to generic and commercial names. When looking in the index under the term Drugs, the coder is directed to see also Table of Drugs. Codes or ranges of codes are based on method of administration, delivery system, or specific to chemotherapy. When looking for codes specific to administration, disposable delivery systems, infusion supplies, or prescription of drugs, the index directs the coder to a code, which should be verified in the alphanumeric section or main body of the code book.

Other information pertaining to HCPCS Level II codes includes national coverage policy summaries. These policies indicate circumstances in which items or services are covered. They are published in the Department of Health and Human Services (HHS) portion of the *Federal Register* under CMS regulations. These statutory provisions, regulations, and national coverage policies should be applied when filing Medicare and other claims involving government programs. Also see the file at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html. These files contain the Level II alphanumeric HCPCS procedure and modifier codes, their long and short descriptions, and applicable Medicare administrative, coverage and pricing data.

Medicare Exclusion Database (MED): Includes the CMS Publication 100 Internet Only Manual (IOM) references and references to the National Coverage Determinations (NCDs). These contain CMS regulations and rulings concerning coverage for procedures, services, and supplies. See the CMS website for the MED user manual: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/MED_UserManual_Final_V10_05202011.pdf.

EXAMPLE

Pub. 100-4, 18, 60.2

HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)

(Rev. 3848, Issued: 08-25-17, Effective: 09-26-17, Implementation: 09-26-17)

Effective for services furnished on or after January 1, 1998, the following codes are used for colorectal cancer screening services:

- 82270* (HCPCS G0107*)—Colorectal cancer screening; fecal-occult blood tests, 1–3 simultaneous determinations
- G0104 - Colorectal cancer screening; flexible sigmoidoscopy
- G0105—Colorectal cancer screening; colonoscopy on individual at high risk
- G0106—Colorectal cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy
- G0120—Colorectal cancer screening; barium enema; as an alternative to G0105, screening colonoscopy

Effective for services furnished on or after July 1, 2001 the following codes are added for colorectal cancer screening services:

- G0121—Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk.
- G0122—Colorectal cancer screening; barium enema (noncovered)

Effective for services for services furnished on or after January 1, 2004, the following code is used for colorectal cancer screening services as an alternative to 82270* (HCPCS G0107*):

- G0328—Colorectal cancer screening; immunoassay, fecal-occult blood test, 1-3 simultaneous determinations

Effective for services furnished on or after October 9, 2014, the following code is added for colorectal cancer screening services:

- HCPCS G0464—Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (eg, KRAS, NDRG4 and BMP3). Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT® 81528.

*NOTE: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS Level II code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT® code 82270.

- G0104—Colorectal Cancer Screening; Flexible Sigmoidoscopy

Screening flexible sigmoidoscopies (HCPCS G0104) may be paid for beneficiaries who have attained age 50, when performed by a doctor of medicine or osteopathy at the frequencies noted below.

Note: This is only a portion of this reference. Refer to your HCPCS Level II code book or the CMS Internet Only Manuals for the full reference. https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html.

HCPCS Level II codes were created by CMS to report supplies, materials, injections, and certain procedures and services not defined in the CPT® code book. CMS updates the codes continually, and they are recognized as a national set of standard alphanumeric codes and modifiers.

BILLING TIP

When a CPT® code and a HCPCS Level II code exist for the same service, check with the payer to determine which code to report. Medicare requires the HCPCS Level II code be reported rather than the CPT® code when a code exists in both for the same service. For example: G0010 *Administration of hepatitis B vaccine* versus 90471 *Immunization administration for percutaneous, intradermal, subcutaneous or intramuscular injections, initial.* The code G0010 is used for Medicare beneficiaries and 90471 is used by all other payers. See CMS website for more information on vaccinations at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf.

There can be more than one main entry term to locate a code in the HCPCS Level II code book index. Depending on the publisher, the index may be found toward the beginning or in the back of the code book.

For example, a patient receives an arch support for his right foot. This can be found by looking for Shoes/Arch support or Orthopedic shoes/Arch support.

Shoes
- Arch support
  - Nonremovable
    - Longitudinal L3070
    - Longitudinal/metatarsal L3090
    - Metatarsal L3080
  - Removable
    - Longitudinal L3040
    - Longitudinal/metatarsal L3060
    - Metatarsal L3050
  - or Orthopedic shoes
    - Arch support L3040-L3090

Once the code is located, all icons, color bars, symbols, notes, and references should be reviewed.

For example, look at G0105.

D G0105 Colorectal cancer screening; colonoscopy on individual at high risk A2 ASC T MIPS

CPT® Crosswalk: 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45395, 45397, 45398

BETOS: P8D Endoscopy – colonoscopy

Price established using national RVUs

Coding Clinic 2009, Q2; 2018, Q2

Pub: 100-4, Chapter 1, 30.3.1; 100-4, Chapter-18, 60.1; 100-4, Chapter-18, 60.6

The following information is found regarding this code:

1. A2 ASC indicates the ASC APC status indicator.
2. T indicates the OPPS APC status indicator.
3. CPT® Crosswalk is to list the correlating CPT® codes that exists.
4. The national RVU is used to price this code.
5. More information about using this code can be found in Coding Clinic: 2009, Q2 and 2018, Q2.
6. Next you see references for coverage:

   In this case, the references listed are: Pub: 100-4, Chapter 1, 30.3.1; 100-4, Chapter-18, 60.1; 100-4, Chapter-18, 60.6.

   100-4, Chapter 1, 30.3.1 discusses the mandatory accept assignment on Medicare claims.

   100-4, Chapter 18, 60.1 discusses the payment for colorectal screening services.

   100-4, Chapter 18, 60.6 discusses the billing requirements for facility claims sent to Medicare Part A MACs.

In most HCPCS Level II code books, there is a Table of Drugs and Biologicals which lists the brand and trade names alphabetically. Here is an excerpt from the table:

Drug Name	Per Unit (Dosage)	Route (Method of Administration)	HCPCS Code
Digoxin	up to 0.5 mg	IM, IV	J1160
Digoxin immune fab (ovine)	vial	IM, IV	J1162
Dihydrex, see Diphenhydramine HCL	—	—	—
Dihydroergotamine mesylate	1 mg	IM, IV	J1110
Dilaudid	up to 4 mg	SC, IM, IV	J1170
Diphedryl	50 mg	ORAL	Q0163
DMSO, Dimethyl sulfoxide	50%, 50 ml	OTH	J1212

The table contains the following columns:

Drug Name—The trade name or the generic name of the drug or biological.

Per Unit (Dosage)—Each code has an amount assigned to it for one unit. For example, Dihydroergotamine mesylate has 1 mg per unit while Diphedryl is 50 mg per unit.

Route (Method of Administration)—The route of administration is how the drug or biological is administered. For example, Digoxin shows IM, IV. This code is used when the drug is administered intravenously or intramuscularly. Common routes of administration are often abbreviated using the following terms:

IA—Intra-arterial administration—Administration of the drug is given within an artery

IV—Intravenous administration—Administration of the drug is given into the vein

IM—Intramuscular administration—Administration of the drug via an injection into a muscle

IT—Intrathecal—Administration of the drug is given into the subdural space of the spinal cord

SC—Subcutaneous administration—Administration of the drug via an injection just under the skin

INH—Administration by inhaled solution—Administration of the drug by breathing it

VAR—Various routes of administration—Administration of the drug by various routes commonly administered into, joints, cavities, tissues, or topical applications

OTH—Other routes of administration—Other administration methods like suppositories or catheter injections

ORAL—Administered orally—Administration of the drug via taking it by mouth

HCPCS Level II Code—The code to use to report the drug or biological. This code should be verified in the tabular section of the HCPCS Level II code book. For example, in the Table of Drugs, the drug Digoxin, J1160, is shown for up to 0.5 mg administered via IV or IM. In the tabular section, J1160 is for *Injection, digoxin, up to 0.5 mg.* There are several notes under the code dependent on the publisher.

Section Review 6.1

1. What abbreviation is used for a drug or biological given into the subdural space of the spinal cord?

   A. IV
   B. IM
   C. IT
   D. SC

2. When 8 mg of Dilaudid are given intravenously, how many units are reported?

   A. 1
   B. 2
   C. 3
   D. 4

3. What is the correct code and units to report for 80 mg of Depo-Medrol given IM?

   A. J1020 x 1
   B. J1020 x 4
   C. J1030 x 2
   D. J1040 x 1

4. What are C codes used for in the HCPCS Level II code book?

   A. Reporting ambulance services
   B. Reporting durable equipment
   C. Reporting procedures for professional services
   D. Reporting outpatient services by hospitals paid under the ACS and OPPS

5. What codes are NOT reported by Medicare?

   A. A codes
   B. G codes
   C. J codes
   D. S codes

Types of Codes

There are national HCPCS Level II codes representing more than 4,000 separate categories of 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 assigned to a code represents the official definition of items and services that can be billed using that code. To avoid any appearance of endorsement of a product through HCPCS Level II, the descriptors used to identify codes do not refer to specific products. For this reason, brand or trade names are normally 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

Representatives from the Blue Cross Blue Shield Association (BCBSA), the Health Insurance Association of America (HIAA), and CMS maintain the national permanent HCPCS Level II codes. This panel makes decisions about additions, revisions, and deletions to the permanent national alphanumeric codes used by private and public health insurers. Since HCPCS Level II is a national coding system, none of the parties, including CMS, can make unilateral decisions regarding permanent Level II national codes. The Centers for Medicare & Medicaid Services (CMS) announces the release of a revised Quarterly Update Chart. The revised Quarterly HCPCS update includes new coding actions effective at the Quarter specified on the Update that were not included in the previously published file. The revised file has been posted to CMS' HCPCS website at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/medhcpcsgeninfo/. The coding changes are effective on the date indicated in the update.

Miscellaneous Codes

National codes also include miscellaneous/not otherwise classified codes, which are used when no existing national code describes the item or service being billed. 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 beneficiary needs the item or service.

Temporary National Codes

Temporary codes allow insurers to establish codes needed before the next January 1 annual update for permanent national codes or until consensus can be achieved on a permanent national code. These codes are updated quarterly.

Once established, temporary codes are usually implemented within 90 days which is the time needed to prepare and issue implementation instructions and to enter the new code in the CMS and contractors' computer systems and initiate user education. This time is needed to allow the instructions such as bulletins and newsletters to be sent out to suppliers to provide them with information and assistance regarding the implementation of temporary CMS codes. These can be found at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html.

Types of temporary HCPCS Level II codes:

1. C codes identify items that may qualify for pass-through payments under the Hospital Outpatient Prospective Payment System (OPPS). These codes are used on ACS and OPPS claims and are valid for Medicare claims submitted by hospital outpatient departments. As of October 1, 2006, non-OPPS providers were able to bill Medicare using C Codes. More information regarding HOPPS and the separate application process for C codes can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS.
2. G codes are used to identify professional healthcare procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.
3. Certain H codes are used by those state Medicaid agencies mandated by state law to establish separate codes for identifying mental health services such as alcohol and drug treatment services and no national code exists to meet the reporting needs of these agencies.
4. K codes were established for use by the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy.
5. Q codes identify services that would not be given a CPT® code. These include drugs, biologicals, and other types of medical equipment or services which are not identified by national level II codes but are needed for claims processing purposes.
6. S codes are used by private payers (BCBSA and the HIAA) to report drugs, services, and supplies for which there are no national codes but are needed by the private sector to implement policies, programs, or claims processing. They are for meeting the particular needs of the private sector. These codes may also be used by Medicaid programs, but they are not payable by Medicare.
7. T codes are for use primarily by Medicaid state agencies to identify items with no permanent national codes and are necessary to meet a national Medicaid program operating need. T codes may also be used by private insurance programs but are not payable by Medicare.

A Codes: Transportation Services including Ambulance; Medical and Surgical Supplies; Administrative, Miscellaneous, and Investigational

A codes are used to describe both emergency and non-emergency transportation services, supplies that are commonly used by physicians and facilities to complete the necessary treatment of each patient, and a miscellaneous category that includes non-prescription drugs and radiopharmaceutical diagnostic imaging agents. The transportation and medical supplies sections are further subcategorized to allow a greater level of specificity for more precise coding.

EXAMPLE

Transportation:

A0021 Ambulance service, outside state per mile, transport (Medicaid only)

Supplies:

A4230 Infusion set for external insulin pump, non-needle cannula type

Miscellaneous:

A4556 Electrodes (eg, apnea monitor), per pair

BILLING TIP

Read the code description completely, as many of these codes have specific quantities in each description. Be extremely mindful of terms such as each, per pair, per ounce, and per square inch. Units used are very important to observe in reviewing claims to ensure correct reimbursement.

B Codes: Enteral and Parenteral Therapy

B codes are used to describe enteral and parenteral therapy. This section of codes includes both the formula used and the supplies necessary to administer these types of services.

EXAMPLE

Kit:

B4220 Parenteral nutrition supply kit; premix, per day

Solution:

B4185 Parenteral nutrition solution, per 10 grams lipids

BILLING TIP

Take care to note the units of measure when using these codes. The unit value may be 100 calories per unit, 500 ml per unit or in some instances the units are dependent on the grams of protein.

C Codes: CMS Hospital Outpatient Prospective Payment System (OPPS)

C codes describe services, drugs, and supplies reported in the outpatient hospital setting. These codes include supplies, drugs, biologicals, radiopharmaceuticals, and radiology procedures.

EXAMPLE

Device:

C1725 Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)

Radiology procedure:

C8934 Magnetic resonance angiography with contrast, upper extremity

BILLING TIP

C codes are always billed on a UB-04 as they are exclusively used in the outpatient hospital setting for facility (technical) services.

D Codes: Dental Procedures

D codes are used to describe all dental services and are a separate category of national codes that are developed and copyrighted by the American Dental Association (ADA). The Current Dental Terminology code set is commonly referred to as CDT® codes. Types of dental services characterized by these codes include diagnostic, preventive, endodontic, periodontal, and surgical services. These categories are subdivided for added specificity. Because the ADA requires publishers to pay a significant royalty, D codes are no longer listed in every HCPCS Level II code book; they are available through the ADA. D codes are not included on the CPB certification exam.

BILLING TIP

D codes are always submitted on an ADA form. Each service is listed separately. For more information, visit http://www.ada.org/en.

E Codes: Durable Medical Equipment

E codes are used to describe durable medical equipment (DME) that include canes, crutches, commodes, decubitus care equipment, bath and toilet aids, hospital beds and accessories, monitoring equipment, and wheelchairs.

DME is covered under Part B as a medical or other health service (§1861(s) (6) of the Social Security Act [the Act]) and is equipment that:

a. Can withstand repeated use;

b. Is primarily and customarily used to serve a medical purpose;

c. Generally is not useful to a person in the absence of an illness or injury; and

d. Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment. These codes are used by the physician office or entity other than a DME Medicare administrative contractor (MAC). See CMS website for more information at https://www.medicare.gov/what-medicare-covers/what-part-b-covers/durable-medical-equipment-dme.

EXAMPLE

Equipment:

E1221 Wheelchair with fixed arm, footrests

E1590 Hemodialysis machine

BILLING TIP

The coder must ensure that the code chosen best describes the equipment to its greatest level of specificity.

G Codes: Procedures/Professional Services (Temporary)

Generally, G codes are assigned by CMS to identify professional healthcare procedures and services that would otherwise be coded in the CPT® code book but for which no CPT® code exists or are not reimbursed by Medicare. G codes are under Medicare's jurisdiction.

EXAMPLE

When a Medicare patient has a screening for cancer of the rectum and lower colon a HCPCS Level II code is reported.

G0104 Colorectal cancer screening; flexible sigmoidoscopy

When a patient is new to Medicare (within the first 12 months) and presents for an initial preventive physical exam (IPPE), G0402 is reported instead of preventive visit codes or office or outpatient visit codes from CPT®. See CMS website for more information at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.

BILLING TIP

When the patient's primary insurance is Medicare, the G codes take precedence over the use of similar CPT® codes for correct billing. Be mindful that many of these codes will have frequency limitations and may require completion of Advanced Beneficiary Notice (ABN). When this is the case, modifier GA should be reported with the correct service code when an ABN is completed and signed.

H Codes: Alcohol and Drug Abuse Treatment Services

H codes are used by state Medicaid agencies mandated by state law to have separate codes for identifying mental health services including alcohol and drug abuse treatment services, as well as at-risk prenatal care. These services are described as physician or non-physician services, short-term services, or long-term services.

EXAMPLE

Prenatal Care:

H1004 Prenatal care, at-risk enhanced service; follow-up home visit

Alcohol or drug:

H0014 Alcohol and/or drug services; ambulatory detoxification

BILLING TIP

H codes are not billable to Medicare.

J Codes: Drug Administered Other than Oral Method

J codes include injectable as well as inhalation solution drugs. Types of drugs include chemotherapy and immunosuppressive drugs and are usually not self-administered. Each HCPCS Level II code book includes a Table of Drugs, which includes the code, drug name, recommended dosing, and route of administration.

The dosage of the medication can be listed as milligrams (mg), milliliters (ml), grams (g), and micrograms (mcg) and will be listed with a dosage per unit.

EXAMPLE

J2270 Injection, morphine sulfate, up to 10 mg

J2560 Injection, phenobarbital sodium, up to 120 mg

EXAMPLE

Inhalation drugs:

J7638 Dexamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per mg

It is critical to read the description, dosing, and method of administration when selecting the J codes. Lack of attention may lead to billing errors. See CMS website for more information at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2019ASPFiles.html.

K Codes: Durable Medical Equipment (DME) Medicare Administrative Contractors (MACS)

K codes are temporary codes used by the DME MACs. This section of codes is primarily used for wheelchairs and wheelchair accessories.

EXAMPLE

Wheelchair:

K0005 Ultra lightweight wheelchair

Accessory:

K0046 Elevating leg rest, lower extension tube, replacement only, each

L Codes: Orthotic and Prosthetic Procedures

L codes are used to report orthotic and prosthetic procedures and devices. These codes are categorized by body area and subdivided for a greater level of specificity.

Prosthetic devices (other than dental) are covered under Part B as a medical or other health service (§1861(s)(8) of the Act) and are devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ.

EXAMPLE

Cervical: L0170 Cervical, collar, molded to patient model

Foot: L3070 Foot, arch support, non-removable attached to shoe, longitudinal, each

BILLING TIP

The codes submitted should identify the correct anatomical area of the prosthetic.

M codes: Other Medical Services

M codes are used to report other medical services. There are a limited number of codes in this section.

EXAMPLE

M0076 Prolotherapy

P Codes: Pathology and Laboratory Services

P codes are used to report pathology and laboratory services. This code section is subdivided into four sections that include chemistry and toxicology tests, pathology screening tests, microbiology tests, and miscellaneous pathology.

EXAMPLE

P7001 Culture, bacterial, urine; quantitative, sensitivity study

P9048 Infusion, plasma protein fraction (human), 5%, 250 ml

Q Codes: Miscellaneous Services (Temporary)

Q codes are temporary codes for supplies, procedures and services that include contrast material, screening Papanicolaou (Pap) smears, chemotherapy administration, lab tests, and pharmacy dispensing fees.

EXAMPLE

Screening:

Q0091 Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Cast Supplies:

Q4018 Cast supplies, long arm splint, adult (11 years +), fiberglass

R Codes: Diagnostic Radiology Services

R codes are used to describe the transportation and set up of portable equipment from a facility to a home or nursing home for the purpose of performing diagnostic tests such as X-rays or EKGs.

EXAMPLE

X-ray:
R0075 Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen

EKG:
R0076 Transportation of portable EKG to facility or location, per patient

BILLING TIP

Claims will be denied if there is an office visit on the same day as the portable equipment is used. These services could be performed at the office during the visit.

S Codes: Temporary National Codes (Non-Medicare)

S codes are developed by the Blue Cross/Blue Shield Association (BCBSA) and the HIAA to report drugs, supplies, and services for which there are no national codes. S codes are needed by the private sector to implement policies, programs, or claims processing. State Medicaid agencies may use these codes. Rationale for establishing these codes includes circumstances related to case rates, increased dosing of medication, new surgical services, refinement of laboratory and infertility testing, and added specificity for mental health services.

EXAMPLE

Home visits:
S0274 Nurse practitioner visit at member's home, outside of a capitation arrangement

Education:
S9470 Nutritional counseling, dietitian visit

Mental health:
S9484 Crisis intervention mental health services, per hour

BILLING TIP

S codes must NEVER be submitted to Medicare for payment.

T Codes: National Codes Established for State Medicaid Agencies

T codes are national codes established and used by all state Medicaid agencies. These codes were founded upon the implementation of HIPAA to establish one code set and to eliminate all local state codes. These codes represent nursing and home health-related services, substance abuse treatment, and training-related procedures. Requests for new T codes are limited to state Medicaid directors.

EXAMPLE

T1013 Sign language or oral interpretive services, per 15 minutes

T5001 Positioning seat for persons with special orthopedic needs

BILLING TIP

T codes are not reimbursed by Medicare.

V Codes: Vision Services, Hearing Services & Speech-Language Pathology Services

V codes are used to describe vision, hearing, and limited speech language pathology services.

Goods and services include lenses, contacts, vision aids, ocular prosthetics, speech language pathology, and various hearing services. These codes are under Medicare's jurisdiction and are for non-physician services.

EXAMPLE

Vision:
V2020 Frames, purchases

Hearing aids:
V5008 Hearing screening

HCPCS Level II Reimbursement

HCPCS Level II reimbursement is at the discretion of the local MAC. If a CPT® code and a HCPCS Level II code exist for the same service, make sure that each code encompasses the same procedure, and then refer to your payer policies for guidance about which code to report for each patient.

EXAMPLE

27215 Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed

G0412 Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral or bilateral, for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed

The code description is slightly different. Coders should report the HCPCS Level II G code for patients who are covered by Medicare according to Medicare guidelines.

HCPCS Level II National Modifiers

Level I modifiers of CPT® are two numeric digits appended to procedure and service codes to specify special circumstances. For example, a provider performs a service involving increased technical difficulty beyond those normally required (modifier 22 *Unusual procedural services*) or when a physician decides to reduce or eliminate a certain portion of the service or procedure usually provided (modifier 52 *Reduced services*).

The physical status of a patient who is receiving anesthesia is reported using a two-digit alphanumeric modifier appended to the five-digit CPT® anesthesia code. The numeric portion of the modifier indicates a normal healthy patient (P1), a patient with mild systemic disease (P2), a patient with severe systemic disease (P3), a patient with severe systemic disease that is a constant threat to life (P4), a moribund patient who is not expected to survive the operation (P5), or a declared brain-dead patient whose organs are being removed for donor purposes (P6).

Level II modifiers are two alpha characters (AA–VP) or an alpha character followed by a digit. They are divided into subsections for services related to anatomy, transportation (ambulance), anesthesia, coronary arteries, ophthalmology, professional services, end-stage renal disease, and dental care. All the alpha modifiers are listed in the HCPCS Level II code book. Examples include:

Modifier	Description
AI	Principal physician of record
CC	Procedure code change (Use cc when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed.)
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
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	Waiver of liability statement issued as required by payer policy, individual case (this modifier is appended when an ABN has been signed and is on file for the service)
GG	Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
GH	Diagnostic mammogram converted from screening mammogram on same day
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
NR	New when rented (use modifier when the DME was new at the time of rental is subsequently purchased)
NU	New equipment
Q6	Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area
QS	Monitored anesthesia care service
RC	Right coronary artery
RR	Rental (use modifier when DME is to be rented.)
SG	Ambulatory surgical center (ASC) facility service
TC	Technical component.

Ambulance Origin and Destination Modifiers

When certain single-character modifiers are combined, they easily specify circumstances of a service. One example is the characters of modifiers appended to ambulance service HCPCS Level II codes. The first character denotes the origin of the ambulance service, and the second character reports the destination. (Note: The ambulance modifiers may not be listed in all HCPCS Level II code books) Origin and destination codes and their descriptions are as follows:

D	Diagnostic or therapeutic site other than P or H when these codes are used as origin codes
E	Residential, domiciliary, custodial facility (other than an 1819 facility)
G	Hospital-based dialysis facility
H	Hospital
I	Site of transfer (eg, airport or helicopter pad) between modes of ambulance transport
J	Free standing ESRD facility

N	Skilled nursing facility (SNF)
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on the way to the hospital (destination code only)

Combinations of single-character modifiers are appended to HCPCS Level II ambulance service codes.

EXAMPLE

HH	Ambulance trip from discharge/transfer from one hospital to another hospital
RH	Ambulance trip from the patient's residence to a hospital
SH	Ambulance trip from scene of accident to a hospital
RP	Ambulance trip from the patient's residence to a physician's office

Reporting for Discarded Drugs/Medications

Single-use vials or other single use packages of drugs may contain more medication than is administered to the patient. When a provider administers only a portion of the vial to the patient and must discard the remaining medication, according to the Medicare Claims Processing Manual (Pub. 100-04, Chapter 17, Section 40), the provider may bill for the remaining portion of medication discarded with HCPCS Level II modifier JW. This policy does not apply to drugs and biologicals provided under the Competitive Acquisition Program for Part B drugs and biologics (CAP) or when a multi-dose vial is used.

The claim should be reported with one line item indicating the amount of drug used. A second line item should be reported with the amount of drug discarded with modifier JW *Drug amount discarded/not administered to any patient* appended. The reporting of discarded drugs/administration is at the discretion of the MAC.

EXAMPLE

A provider sees three patients for botulinum toxin type A. This drug is currently only available in a 100-unit size and, once reconstituted in the provider's office, must be used within a four-hour period. The provider administers 30 units to each patient within the appropriate time period but has no other patients that need this medication scheduled for the day. This means that 10 units of the drug will be wasted. The correct code for this drug is J0585 *Botulinum toxin A, per unit*, and would be billed as follows:

Patient 1: J0585 x 30

Patient 2: J0585 x 30

Patient 3: J0585 x 30
J0585-JW x 10

BILLING TIP

JW is not to be used with discarded amounts from a multi-dose vial (MDV) or when the remaining amount is used on another patient instead of discarded.

Section Review 6.2

1. What HCPCS Level II code and unit(s) is reported for 4 boxes of alcohol wipes?

   A. A4245 x 4
   B. A4245 x 1
   C. A4244 x 1
   D. A4244 x 4

2. Patient is given 15 mg of methotrexate sodium IM for rheumatoid arthritis given from 5 mg vials. What HCPCS Level II code and unit(s) is reported?

   A. J8610 x 6
   B. J9260
   C. J9250 x 5
   D. J9250 x 3

3. Select the supply code for an insertion tray that has a two way all silicone Foley catheter with a drainage bag?

   A. A4312
   B. A4314
   C. A4315
   D. A4311

4. An audiologist provides a battery for a hearing device to a patient. What HCPCS Level II code is reported for the battery?

   A. A4601
   B. L8622
   C. L8624
   D. V5266

5. A female patient is getting a right and left breast mastectomy bra with integrated form breast prosthesis. What HCPCS Level II code is reported?

   A. L8002
   B. L8002-50
   C. L8001-50
   D. L8000

Abbreviations

g	grams
IM	Intramuscular
IV	Intravenous
mcg	micrograms
mg	milligrams
ml	milliliters
SQ	subcutaneous

Glossary

Advanced Beneficiary Notice (ABN)—A standardized form that explains to the patient why Medicare may deny the particular service or procedure. An ABN protects the provider's financial interest by creating a paper trail that CMS requires before a provider can bill the patient for payment if Medicare denies coverage for the stated service or procedure.

Enteral Nutrition—Nutrients for patients with impaired ability to chew/swallow or ingest food, typically delivered by gastric or nasogastric tube.

Healthcare Common Procedure Coding System (HCPCS) Level II HCPCS Level II is the national procedure code set for healthcare practitioners, providers, and medical equipment suppliers when filing insurance claims for medical devices, medications, transportation services, and other items and services.

Injection—A fluid introduced into tissue, cavity, or vessel, usually by needle.

Intramuscular (IM)—Within a muscle.

Intravenous (IV)—Within a vein.

Locum Tenens—Substitute physician who takes over the professional practice of a physician who is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. When a locum tenens fills in, the regular physician submits the claim with modifier Q6 appended to the services.

Orthotic—A custom-made mechanical appliance used in orthopedics.

Parenteral Nutrition—Nutrients delivered intravenously to patients who are postoperative, in shock, or otherwise unresponsive.

Prosthetic—An artificial body part.

Subcutaneous (SQ)—Beneath the skin.