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On the topic:

HCPCS Coding in 2019

Maxine Collins, MBA, CPA, CMC, CMIS, CMOM
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INTRODUCTION – ITEMS DISCUSSED IN MPFS FOR 2019

- Patients over Paperwork
- Medical Record Documentation Supports Patient Care
- Documenting E/M Requires Choosing Appropriate Code
- Level of E/M visits
- How to Streamline E/M Payment and Reduce Clinician Burden
- Payment for E/M – Established & New
- Additional Payment Codes
- Advancing Virtual Care Information
INTRODUCTION

Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures:

“This information provides a description of the procedures CMS follows in processing HCPCS code applications and making coding decisions.”

For Further Information Contact:
Kimberlee Combs Miller (410) or Cindy Hale (410) 786-3404 for HCPCS Level II coding questions.

Introduction to HCPCS

Introduction to HCPCS

• Decisions regarding the addition, deletion, or modification of CPT® codes are made by the AMA.
  – Level 1: Does not include codes needed to report medical items or services that are regularly billed by suppliers other than physicians
  – Level 2: A standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® codes.

1. Example: Ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician’s office.
2. Permanent codes are maintained jointly by America’s Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA) and the Centers for Medicare and Medicaid Services (CMS)
THE HCPCS BACKGROUND

• As published by CMS:
  – “Each year, in the United States, health care insurers process over 5 billion claims for payment.”
  – Thus, the need for standardized coding systems as required by the Standard Transaction Code Sets under the HIPAA regulations.
  – HCPCS Level II Code Set is one of the standard code sets adopted under the law for the purpose of standardizing coding systems and claim filings.

THE OVERALL HCPCS SYSTEM (THE UMBRELLA SYSTEM)

• HCPCS is divided into two principal subsystems:
    • A numeric coding system maintained by the American Medical Association (AMA)
    • CPT is a uniform coding system consisting of:
      – Descriptive terms and
      – Identifying (corresponding) codes
    • Used primarily to identify medical services and procedures furnished by Physicians and other health care professionals.
    • “These health care professionals use CPT to identify services and procedures for which they bill public or private health insurance programs.”

Source: www.CMS.gov
HCPCS AND CPT® CONTRASTED

Healthcare Common Procedure Coding System (HCPCS)

A stand alone system - CPT® is one of two levels in HCPCS

• Level 1 - CPT®, 5 digits, all numeric
• Level 2 - National HCPCS, 5 digits, alpha-numeric, A-V + 4 numbers
  - The local Medicare carrier decides use of Level II.
  - The local Medicare carrier is responsible for providing instructions for their use.

<table>
<thead>
<tr>
<th>HCPCS Contrasted</th>
<th>Level 1 CPT®</th>
<th>Level 2 CPT®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes Used</td>
<td>American Medical Association</td>
<td>CMS</td>
</tr>
<tr>
<td>Responsible Agent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examples of Codes Used</td>
<td>96372</td>
<td>T1502</td>
</tr>
<tr>
<td>Example of Modifier</td>
<td>-22</td>
<td>TC</td>
</tr>
<tr>
<td>Coding Range</td>
<td>00100-99499</td>
<td>A0021-V5364</td>
</tr>
<tr>
<td>Modifier Range</td>
<td>-20-99</td>
<td>A-V</td>
</tr>
<tr>
<td>Updated</td>
<td>Annually</td>
<td>Annually</td>
</tr>
</tbody>
</table>

LEVEL I - CPT®

• Decisions regarding the addition, deletion or revision of CPT® codes are made by and are the copyright of the American Medical Association (AMA).
• 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
  – Regularly billed by suppliers other than Physicians.
LEVEL II OF THE HCPCS STANDARDIZED CODING SYSTEM

- Used primarily to identify:
  - Products;
  - Supplies; and
  - Services not included in the CPT code set jurisdiction such as:
    - Ambulance services;
    - Durable Medical Equipment (DME), 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.” ([www.CMS.gov](http://www.CMS.gov))

- Development and use of the Level II HCPCS began in the 1980’s.

- These are Alpha-numeric codes as they consist of a single alphabetical letter followed by 4 numeric digits, while CPT Category I codes are identified primarily using 5 numeric digits (while Level I Category II (Quality) codes end in an “F: and Category III codes (Temporary Codes) end in a “T”.

IMPACT OF HIPAA LEGISLATION

- October of 2003:
  - Secretary of the Department of Health and Human Services delegated authority under the HIPAA legislation to CMS to:
    - Maintain and Distribute HCPCS Level II Codes.
  - In 42 CFR Sec. 414.40(a) CMS established uniform national definitions of services, codes to represent services, and payment modifiers to the codes.
  - The CMS HCPCS Workgroup – an internal workgroup comprised of:
    - Federal government employees who represent the major components of CMS; and
    - Federal employees from pertinent Federal agencies, including, but not limited to the Department of Veteran’s Affairs and the Department of Defense.
  - When a recommendation for a revision to the HCPCS is received, it is reviewed at a regularly scheduled meeting of the CMS HCPCS Workgroup who normally meet monthly to discuss whether coding requests warrant a change to the national permanent codes.
  - CMS reviews the requests in conjunction with the Workgroup, issues preliminary decisions for public comment and holds public meetings before making final decisions on codes.
ONCE UPON A TIME

– Prior to December 31, 2003 there were Level III HCPCS codes that were developed and used by:
  • Medicaid State agencies;
  • Medicare Contractors; and
  • Private insurers

– Level III HCPCS codes were then used by insurers in their specific programs or local areas of jurisdiction and were referred to for Medicare purposes as “local codes”.
  • Local codes were established and used when an insurer preferred that suppliers use a local code to identify a service for which there was no Level I or Level II code, rather than use a “miscellaneous or not otherwise classified code”.
  • HIPAA of 1996 required CMS to adopt national standards for coding systems which were published in the Federal Register on August 17, 2000 (65FR 50312).
    – This legislation provided for the elimination of Level III HCPCS codes by October, 2002. However, use of Level III codes was postponed and use was continued until December 31, 2003.
  • At that time, the HCPCS Level II coding system was selected as the standardized coding system because of its wide acceptance among both public and private insurers.

HCPCS LEVEL II CODING SYSTEM

• “A comprehensive and standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing.”

• “HCPCS – a system for identifying items and certain 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 determination regarding coverage and payment.”

• “Currently, there are national HCPC codes representing approximately 6,000 separate categories of like items or services that encompass 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.”

Source: www.CMS.gov
## HCPCS Code Structure

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A codes</td>
<td>Ambulance and transportation services, medical and surgical&lt;br&gt;supplies, respiratory DME, administrative, miscellaneous and&lt;br&gt;investigational services/supplies.</td>
</tr>
<tr>
<td>B codes</td>
<td>Enteral and parenteral therapy services/supplies.</td>
</tr>
<tr>
<td>C codes</td>
<td>CMS Hospital Outpatient Payment System. Medicare ASC and OPPS claims.</td>
</tr>
<tr>
<td>D codes</td>
<td>Dental procedures.</td>
</tr>
<tr>
<td>E codes</td>
<td>Durable medical equipment such as walkers, hospital beds, infusion supplies, etc.</td>
</tr>
<tr>
<td>G codes</td>
<td>Temporary procedures/professional services. As these codes&lt;br&gt;are often changed to CPT codes within a given time period,&lt;br&gt;these codes should be reviewed and updated annually.</td>
</tr>
</tbody>
</table>

## HCPCS Code Structure

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H codes</td>
<td>Behavioral health and/or substance abuse treatment services.</td>
</tr>
<tr>
<td>J codes</td>
<td>Injectable drugs, which can be injected&lt;br&gt;subcutaneously, intramuscularly or intravenously.&lt;br&gt;Must specify the drug amount injected as these codes&lt;br&gt;specify dosage. Chemotherapy drugs.</td>
</tr>
<tr>
<td>K codes</td>
<td>Temporary codes assigned to durable medical equipment (DME) regional carriers.</td>
</tr>
<tr>
<td>L codes</td>
<td>Orthotic/prosthetic devices and procedures.</td>
</tr>
<tr>
<td>M codes</td>
<td>Medical services, which are either not covered by Medicare or have special coverage instructions.</td>
</tr>
</tbody>
</table>
HCPCS Code Structure

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P codes</td>
<td>Laboratory services, which are either not covered by Medicare or have special coverage instructions.</td>
</tr>
<tr>
<td>Q codes</td>
<td>Temporary procedures, services and supplies that have special coverage instructions for Medicare.</td>
</tr>
<tr>
<td>R codes</td>
<td>Diagnostic radiology services concerning portable x-rays/EKGs.</td>
</tr>
<tr>
<td>S codes</td>
<td>Temporary National Codes Established by Private Payers</td>
</tr>
<tr>
<td>T codes</td>
<td>Temporary National Codes Established by Medicaid – Not valid for Medicare</td>
</tr>
<tr>
<td>V codes</td>
<td>Vision, audiology and speech-language pathology services.</td>
</tr>
</tbody>
</table>

The Index

- All main terms are in boldface type
- Main term entries include tests, drugs, medical equipment, services, supplies, orthotics, prostheses, therapies and some medical and surgical procedures
- Sub-terms are listed under the main term
- When possible, entries are listed under a “common “ main term
- The “common” term may be a noun or a descriptor
Locating HCPCS Codes

To locate a code in the index:
1. Review the coding documentation and determine what description needs to be coded
2. Identify the main term
3. Locate the main term in the index
4. Look for sub-terms under the main term; look up the meaning of any unfamiliar abbreviations or terms
5. Note the code or code range found under the selected main term or sub-term
6. Locate the code in the alphanumeric list to ensure the specificity of the code. If a code range is provided, review all of the code narratives to determine the specific code
7. Some entries may be listed under more than one main term. If this is the case, review all codes choices
8. Never code directly from the index. Always verify the code in the alphanumeric list!

CMS HCPCS Categories

- A0021 - A0999  Transportation Services Including Ambulance
- A4206 - A8004  Medical & Surgical Supplies
- A9150 - A9999  Administrative, Miscellaneous And Investigational
- B4034 - B9999  Enteral & Parenteral Therapy
- C1713 - C9899  CMS Hospital Outpatient Payment System
- D0120 - D9999  Dental Procedures
- E0100 - E8002  Durable Medical Equipment
- F0000 - F9999  Reserved For Future Use
- G0008 - G9472  Temporary Procedures/Professional Services
- H0001 - H2037  Behavioral Health and/or Substance Abuse Treatment Services
- I0000 - I9999  Reserved For Future Use
- J0120 - J8999  Drugs Administered Other Than Chemotherapy Drugs
  (Exception: Oral Chemotherapy Drugs)
**HCPCS Modifiers**

- In some instances, insurers instruct suppliers that a HCPCS code be accompanied by a 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.

### HCPCS Modifiers

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9000 - J9999</td>
<td>Chemotherapy Drugs</td>
</tr>
<tr>
<td>K0001 - K0902</td>
<td>Temporary Codes Assigned to DME Regional Carriers</td>
</tr>
<tr>
<td>L0112 - L4631</td>
<td>Orthotics</td>
</tr>
<tr>
<td>L5000 - L9900</td>
<td>Prosthetics</td>
</tr>
<tr>
<td>M0075 - M0301</td>
<td>Other Medical Services</td>
</tr>
<tr>
<td>N0000 - N9999</td>
<td>Reserved For Future Use</td>
</tr>
<tr>
<td>O0000 - O9999</td>
<td>Reserved For Future Use</td>
</tr>
<tr>
<td>P2028 - P9615</td>
<td>Laboratory Services</td>
</tr>
<tr>
<td>Q0035 - Q9969</td>
<td>Temporary Codes Assigned by CMS</td>
</tr>
<tr>
<td>R0070 - R0076</td>
<td>Diagnostic Radiology Services</td>
</tr>
<tr>
<td>S0012 - S9999</td>
<td>Temporary National Codes Established for Private Payer</td>
</tr>
<tr>
<td>T1000 - T5999</td>
<td>Temporary National Codes Established by Medicaid</td>
</tr>
<tr>
<td>U0000 - U9999</td>
<td>Reserved For Future Use</td>
</tr>
<tr>
<td>V2020 - V5364</td>
<td>Vision, Hearing and Speech-Language Pathology Services</td>
</tr>
<tr>
<td>00000 - 99999</td>
<td>Reserved For CPT Services</td>
</tr>
</tbody>
</table>
Types of HCPCS Level II Codes

- Permanent National Codes
- Dental Codes
- Miscellaneous Codes
- Temporary Codes
- List of temporary codes:
  - C codes - S codes
  - Q codes - H codes
  - K codes - T codes

HCPCS PROCEDURE AND SUPPLY CODES

- Code(s) Description
  - A0021-A0999 Transportation Services
  - A4206-A5998 Medical And Surgical Supplies
  - A9150-A9999 Administrative, Miscellaneous and Experimental
  - B4034-B9999 Enteral And Parenteral Therapy
  - C1713-C9999 Temporary Hospital Outpatient PPS
  - D CODES - Dental Procedures
  - E0100-E8002 Durable Medical Equipment (DME)
  - G0008-G9997 Temporary Procedures & Professional Services
  - H0001-H2037 Rehabilitative Services
  - J0120-J9312 Drugs Administered
  - J8670-J9999 Oncology Drugs
  - K0001-K0900 Temporary Codes For DMERCS
  - L0172-L4631 Orthotic Devices & Services
  - L5000-L9999 Prosthetic Procedures
  - M0075-M1071 Medical Services
  - P2028-P9615 Pathology And Laboratory
  - Q0035-Q9992 Temporary Codes
  - R0070-R0076 Diagnostic Radiology Services
  - S0012-S9999 Private Payer Codes
  - T1000-T5999 State Medicaid Agency Codes
  - V2020-V5240 Vision Services
  - V5008-V5364 Hearing Services
  - A0800-V5220 -/+ Deleted, Replaced, Expanded Codes
HCPCS INDEX

- **Ambulance, A0021-A0999**
  - air, **A0430, A0431, A0435, A0436**
  - disposable supplies, **A0382-A0398**
  - non-emergency transport, fixed wing, **S9960**
  - non-emergency transport, rotary wing, **S9961**
  - oxygen, **A0422**

TRANSPORTATION SERVICES

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description Icons</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0021</td>
<td>Outside state ambulance serve</td>
</tr>
<tr>
<td>A0390</td>
<td>Advanced life support mileage</td>
</tr>
<tr>
<td>A0392</td>
<td>Als defibrillation supplies</td>
</tr>
<tr>
<td>A0394</td>
<td>Als iv drug therapy supplies</td>
</tr>
<tr>
<td>A0396</td>
<td>Als esophageal in tub suppl</td>
</tr>
<tr>
<td>A0398</td>
<td>Als routine disposable suppl</td>
</tr>
<tr>
<td>A0420</td>
<td>Ambulance waiting 1/2 hr</td>
</tr>
<tr>
<td>A0422</td>
<td>Ambulance G2 life sustaining</td>
</tr>
<tr>
<td>A0424</td>
<td>Extra ambulance attendant</td>
</tr>
<tr>
<td>A0425</td>
<td>Ground mileage</td>
</tr>
<tr>
<td>A0426</td>
<td>Als 1</td>
</tr>
<tr>
<td>A0427</td>
<td>Als1-emergency</td>
</tr>
<tr>
<td>A0080</td>
<td>Noninterest escort in non er</td>
</tr>
<tr>
<td>A0980</td>
<td>Interest escort in non er</td>
</tr>
<tr>
<td>A0100</td>
<td>Nonemergency transport taxi</td>
</tr>
<tr>
<td>A0110</td>
<td>Nonemergency transport bus</td>
</tr>
<tr>
<td>A0120</td>
<td>Noner transport mini-bus</td>
</tr>
<tr>
<td>A0130</td>
<td>Noner transport wheelch van</td>
</tr>
<tr>
<td>A0140</td>
<td>Nonemergency transport air</td>
</tr>
<tr>
<td>A0160</td>
<td>Noner transport case worker</td>
</tr>
</tbody>
</table>
LEVEL II NATIONAL CODES

A0427 - Ambulance service, advanced life support, emergency transport, level 1

- **Short Descr:** Als1-emergency
- **CMS 2013 Long Descriptor:** Ambulance service, advanced life support, emergency transport, level 1 (als1-emergency)
- **Medicare Physician Fee Schedule (MPFS) Indicators**
- **Medicare Coverage:** Carrier Determined
- **APC Status Indicator:** Service Paid under Fee Schedule or Payment System other than OPPS
- **Status Code:** X - Statutory Exclusion
- **Global Days:** XXX - Global Concept Does Not Apply
- **PC/TC Indicator (26):** 9 - Not Applicable
- **Multiple Procedures (51):** 9 - Concept does not apply.
- **Bilateral Surgery (50):** 9 - Concept does not apply.
- **Physician Supervisions: 09 - Concept does not apply.**
- **Assistant Surgeon (80, 82):** 9 - Concept does not apply.
- **Co-Surgeons (62):** 9 - Concept does not apply.
- **Team Surgery (66):** 9 - Concept does not apply.
- **Type of Service (TOS):** D - Ambulance
- **Berenson-Eggers TOS (BETOS):** 01A – Ambulance
- **Diagnostic Imaging Family:** 99 - Concept Does Not Apply
- **Non-Facility MUEs:** 2
- **Facility MUEs:** 2
- **OTS Orthotic:** No

HCPCS INDEX

- **Wheelchair, E0950-E1298, K0001-K0108**
  - accessories, E0192, E0950-E1030, E1065-E1069, E2211-E2230, E2300-E2309
  - amputee, E1170-E1200
  - back, fully reclining, manual, E1226
  - component or accessory, not otherwise specified, K0108
  - cushions, E2601-E2625
  - foot box, E0954
  - lateral thigh or knee support, E0953
  - narrowing device, E0969
  - power add-on, E0983-E0984
  - shock absorber, E1015-E1018
  - specially sized, E1220, E1230
  - stump support system, K0551
  - tire, E0999
  - transfer board or device, E0705
  - tray, K0107
  - van, non-emergency, A0130
  - youth, E1091
### HCPCS CODE E0950-E1298
#### DME - WHEELCHAIRS

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
<th>Icons</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0950-E1030</td>
<td>Wheelchair Accessories</td>
<td></td>
</tr>
<tr>
<td>E1031-E1039</td>
<td>Rollabout Chair</td>
<td></td>
</tr>
<tr>
<td>E1050-E1093</td>
<td>Wheelchair -- Fully Reclining</td>
<td></td>
</tr>
<tr>
<td>E1100-E1110</td>
<td>Wheelchair -- Semi-reclining</td>
<td></td>
</tr>
<tr>
<td>E1130-E1161</td>
<td>Wheelchair -- Standard</td>
<td></td>
</tr>
<tr>
<td>E1170-E1200</td>
<td>Wheelchair -- Amputee</td>
<td></td>
</tr>
<tr>
<td>E1220-E1229</td>
<td>Wheelchair -- Special Size</td>
<td></td>
</tr>
<tr>
<td>E1230</td>
<td>Power operated vehicle</td>
<td></td>
</tr>
<tr>
<td>E1231-E1239</td>
<td>Wheelchair -- Power Operated Vehicle</td>
<td></td>
</tr>
<tr>
<td>E1240-E1270</td>
<td>Wheelchair -- Lightweight</td>
<td></td>
</tr>
<tr>
<td>E1280-E1298</td>
<td>Wheelchair -- Heavy-duty</td>
<td></td>
</tr>
</tbody>
</table>

### Wheelchair Accessories

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
<th>Icons</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0950</td>
<td>Tray</td>
<td></td>
</tr>
<tr>
<td>E0951</td>
<td>Loop heel</td>
<td></td>
</tr>
<tr>
<td>E0952</td>
<td>Toe loop/holder, each</td>
<td></td>
</tr>
<tr>
<td>E0953</td>
<td>W/c lateral thigh/knee sup</td>
<td></td>
</tr>
<tr>
<td>E0954</td>
<td>Foot box, any type each foot</td>
<td></td>
</tr>
<tr>
<td>E0955</td>
<td>Cushioned headrest</td>
<td></td>
</tr>
<tr>
<td>E0956</td>
<td>W/c lateral trunk/hip support</td>
<td></td>
</tr>
<tr>
<td>E0957</td>
<td>W/c medial thigh support</td>
<td></td>
</tr>
<tr>
<td>E0958</td>
<td>Whlchr att- conv 1 arm drive</td>
<td></td>
</tr>
<tr>
<td>E0959</td>
<td>Amputee adapter</td>
<td></td>
</tr>
<tr>
<td>E0960</td>
<td>W/c shoulder harness/straps</td>
<td></td>
</tr>
<tr>
<td>E0961</td>
<td>Wheelchair brake extension</td>
<td></td>
</tr>
</tbody>
</table>
**WHEEL CHAIR ACCESSORIES**

E0953 - Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each

- **Short Descr:** W/c lateral thigh/knee sup
- **Medicare Physician Fee Schedule (MPFS) Indicators**
- **Medicare Coverage:** Carrier Determined
- **APC Status Indicator:** Non-Implantable Durable Medical Equipment
- **Type of Service (TOS):**
  - A - Used DME
  - P - Lump Sum Purchase of DME, Prosthetics, Orthotics
  - R - Rental of DME
- **Berenson-Eggers TOS (BETOS):**
- **Non-Facility MUEs:**
- **Facility MUEs:**
- Code deleted 01/01/2006 and reactivated with new description on 01/01/2018. For alternate use for years 2006-2017, see code E2211
- **OTS Orthotic:** No
- **Note:** Code deleted 01/01/2006 and reactivated with new description on 01/01/2018. For alternate use for years 2006-2017, see code E2211
- **CCS Clinical Classification:** 243 - DME and supplies


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**BCBSTX COVERAGE GUIDELINES**

**Wheelchair Options and Accessories:**

- Wheelchair options and accessories may be considered medically necessary when the patient’s wheelchair meets coverage criteria and the options/accessories are medically necessary for the patient to perform one or more of the following activities:
  - Function in the home; or
  - Perform instrumental activities of daily living.
- An option/accessory that is beneficial primarily in allowing the patient to perform leisure or recreational activities is considered not medically necessary.

**J3490 - Unclassified drugs**

- The following information is needed to process valid unlisted J-Codes such as **J3490**:
  - NDC Number
  - Drug Name
  - Dosage administered (e.g. 5 mg, 10 mg, etc.)
  - Include how the number of units being billed on the claim is being administered (e.g. 5 mg = 1 unit, 10 mg = 5 units, etc.)
  - Strength of drug administered (e.g. 25 mg/ml, 10 mg/10 ml, etc.)
  - Single dose vial or Multi-dose vial

*Source: https://www.findacode.com/medicare/pub100-manuals.html*

---

**INJECTIONS**

- According to WPS the following documentation is required:
  - Clear indication of patient name, date of birth, and date of service
  - Name of drug injected
  - Dosage of injection given
  - Route of administration
  - Signed and dated physician order to include the drug name, dosage, route of administration and duration of treatment
  - Progress notes to support the medical necessity of treatment and approach, details of what was injected, guidance utilized, epidurography (if performed), how the patient tolerated the procedure (i.e. blood loss, reaction, etc.), monitoring and to recovery with instructions.
  - Reminder: Certain injection procedures (i.e., epidural steroid injections) also require documentation of previous conservative therapies that were tried and failed.
  - Please be aware that this list is **not all inclusive**. Providers should submit all documentation to support the medical necessity and level of service(s) billed in accordance with Medicare regulations and policies.

*Source: https://www.WPS.com*
HCPCS MODIFIERS

Code(s) Description
• A1-ZA  HCPCS National Level II Modifiers
• DD-SX  Ambulance Service Modifiers
• PI-PS  PET Scan Modifiers
• JF-V9  +/- Deleted, Replaced, Expanded Codes

Patient Relationship Codes Required under MACRA - WHAT?

• In May 2017, CMS posted the operational list of patient relationship categories that are required under section 101(f) of MACRA.
• In this rule, we finalized certain Level II HCPCS modifiers to be used on claims to indicate these patient relationship categories (to determine which physician would be held accountable for a patients’ cost of care).
• Further, we finalized a policy that the reporting of these HCPCS modifiers may be voluntarily by clinicians associated with these patient relationship categories beginning January 1, 2018.
• We anticipate that there will be a learning curve with respect to the use of these modifiers, and we will work with clinicians to ensure their proper use.
MACRA & PATIENT RELATIONSHIP HCPCS MODIFIERS

- Section 1848(r)(4) of MACRA requires:
  - Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018 should include reporting for patient relationship categories.
  - The Act also mentioned Care episode groups and Patient condition groups which it appears they will continue to move forward on and/or considered in the future.

The Table on the next slide summarizes Table 27 found in the 2018 Physician Fee Schedule Final Rule (other information has been added to the Table from other references, including:
- CMS Patient Relationship Categories and Codes
- CMS Medicare Physician Fee Schedule for 2018 Final Rule"

### CMS

<table>
<thead>
<tr>
<th>N O.</th>
<th>HCPCS MODIFIER</th>
<th>Patient Relationship Categories</th>
<th>Notes (see CMS Patient Relationship Categories and Codes in References)</th>
<th>Examples include, but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 x</td>
<td>X1 Continuous/ broad services</td>
<td>“This category could include clinicians who provide the principal care for a patient, where there is not planned endpoint of the relationship. Care in this category is comprehensive, dealing with the entire scope of patient problems, either directly or in a care coordination role.”</td>
<td>“Primary care, specialists providing comprehensive care to patients in addition to specialty care, etc.”</td>
<td></td>
</tr>
<tr>
<td>2 x</td>
<td>X2 Continuous/ Focused services</td>
<td>“This category could include a specialist whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time.”</td>
<td>“A rheumatologist taking care of a patient’s rheumatoid arthritis longitudinally but not providing general primary care services.”</td>
<td></td>
</tr>
<tr>
<td>3 x</td>
<td>X3 Episodic/ wide services</td>
<td>“This category could include clinicians that have broad responsibility for the comprehensive needs of the patients, but only during a defined period and circumstance, such as a hospitalization.”</td>
<td>“A hospitalist providing comprehensive and general care to a patient while admitted to the hospital.”</td>
<td></td>
</tr>
<tr>
<td>4 x</td>
<td>X4 Episodic/ Focused services</td>
<td>“This category could include a specialist focused on particular types of time-limited treatment. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention.”</td>
<td>“An orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period.”</td>
<td></td>
</tr>
<tr>
<td>5 x</td>
<td>X5 Only as ordered by another clinician</td>
<td>“This category could include a clinician who furnishes care to the patient only as ordered by another clinician. This relationship may not be adequately captured by the alternative categories suggested above and may need to be a separate option for clinicians who are only providing care ordered by other clinicians.”</td>
<td>“A radiologist interpreting an imaging study ordered by another clinician.”</td>
<td></td>
</tr>
</tbody>
</table>
TO SUMMARIZE - STREAMLINING EVALUATION AND MANAGEMENT (E/M) AND REDUCING CLINICIAN BURDEN

• The 2019 Medicare Physician Fee Schedule Conversion Factor is:
  – $ 36.0391 – up from $ 35.996. - up $.0431!
• The 2019 Anesthesia Conversion Factor is:
• For CYs 2019 and 2020:
  – CMS will continue the current coding and payment structure for E/M office/outpatient visits; and
  – Practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare.

Source: www.cms.gov

HCPCS LEVEL II MODIFIERS

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1-AX</td>
<td>A Modifiers</td>
</tr>
<tr>
<td>BA-BU</td>
<td>B Modifiers</td>
</tr>
<tr>
<td>CA-CP</td>
<td>C Modifiers</td>
</tr>
<tr>
<td>DA-DA</td>
<td>D Modifiers</td>
</tr>
<tr>
<td>E1-EY</td>
<td>E Modifiers</td>
</tr>
<tr>
<td>F1-FY</td>
<td>F Modifiers</td>
</tr>
<tr>
<td>G1-GZ</td>
<td>G Modifiers</td>
</tr>
<tr>
<td>H9-HZ</td>
<td>H Modifiers</td>
</tr>
<tr>
<td>J1-JW</td>
<td>J Modifiers</td>
</tr>
<tr>
<td>K0-KZ</td>
<td>K Modifiers</td>
</tr>
<tr>
<td>LC-LT</td>
<td>L Modifiers</td>
</tr>
<tr>
<td>M2-MS</td>
<td>M Modifiers</td>
</tr>
<tr>
<td>NR-NJ</td>
<td>N Modifiers</td>
</tr>
<tr>
<td>P1-PX</td>
<td>P Modifiers</td>
</tr>
<tr>
<td>Q0-QZ</td>
<td>Q Modifiers</td>
</tr>
<tr>
<td>R0-RT</td>
<td>R Modifiers</td>
</tr>
<tr>
<td>S0-SZ</td>
<td>S Modifiers</td>
</tr>
<tr>
<td>T1-TW</td>
<td>T Modifiers</td>
</tr>
<tr>
<td>U1-UZ</td>
<td>U Modifiers</td>
</tr>
<tr>
<td>V1-VP</td>
<td>V Modifiers</td>
</tr>
<tr>
<td>X1-XU</td>
<td>X Modifiers</td>
</tr>
<tr>
<td>Z1-ZZ</td>
<td>Z Modifiers</td>
</tr>
</tbody>
</table>
### “A” HCPCS MODIFIERS

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>DRESSING FOR ONE WOUND</td>
</tr>
<tr>
<td>A2</td>
<td>DRESSING FOR TWO WOUNDS</td>
</tr>
<tr>
<td>A3</td>
<td>DRESSING FOR THREE WOUNDS</td>
</tr>
<tr>
<td>A4</td>
<td>DRESSING FOR FOUR WOUNDS</td>
</tr>
<tr>
<td>A5</td>
<td>DRESSING FOR FIVE WOUNDS</td>
</tr>
<tr>
<td>A6</td>
<td>DRESSING FOR SIX WOUNDS</td>
</tr>
<tr>
<td>A7</td>
<td>DRESSING FOR SEVEN WOUNDS</td>
</tr>
<tr>
<td>A8</td>
<td>DRESSING FOR EIGHT WOUNDS</td>
</tr>
<tr>
<td>A9</td>
<td>DRESSING FOR NINE OR MORE WOUNDS</td>
</tr>
<tr>
<td>AA</td>
<td>ANESTHESIA PERF BY ANESTGST</td>
</tr>
<tr>
<td>AD</td>
<td>MD SUPERVISION, &gt;4 ANES PROC</td>
</tr>
<tr>
<td>AE</td>
<td>REGISTERED DIETICIAN</td>
</tr>
<tr>
<td>AF</td>
<td>SPECIALTY PHYSICIAN</td>
</tr>
<tr>
<td>AG</td>
<td>PRIMARY PHYSICIAN</td>
</tr>
<tr>
<td>AH</td>
<td>CLINICAL PSYCHOLOGIST</td>
</tr>
<tr>
<td>AI</td>
<td>Principal physician of rec</td>
</tr>
<tr>
<td>AJ</td>
<td>CLINICAL SOCIAL WORKER</td>
</tr>
<tr>
<td>AJ</td>
<td>NON PARTICIPATING PHYSICIAN</td>
</tr>
<tr>
<td>AK</td>
<td>PHYSICIAN TEAM MEMBER SVC</td>
</tr>
<tr>
<td>AL</td>
<td>Prov declined alt pm method</td>
</tr>
<tr>
<td>AM</td>
<td>NO STIM OF REFRACTIVE STATE</td>
</tr>
<tr>
<td>AN</td>
<td>PHYSICIAN SERVICE HPSA ARE</td>
</tr>
<tr>
<td>AO</td>
<td>PHYSICIAN SCARCITY AREA</td>
</tr>
<tr>
<td>AP</td>
<td>ASSISTANT AT SURGERY SERVICE</td>
</tr>
<tr>
<td>AQ</td>
<td>PRINCIPAL PHYSICIAN OF RECORD</td>
</tr>
<tr>
<td>AR</td>
<td>ACUTE TREATMENT</td>
</tr>
<tr>
<td>AS</td>
<td>URO, OSTOMY OR TRACH ITEM</td>
</tr>
<tr>
<td>AT</td>
<td>ITEM W PROSTHETIC/ORTHOTIC</td>
</tr>
<tr>
<td>AU</td>
<td>ITEM W A SURGICAL DRESSING</td>
</tr>
<tr>
<td>AV</td>
<td>ITEM W DIALYSIS SERVICES</td>
</tr>
<tr>
<td>AW</td>
<td>Item/service not for ESRD</td>
</tr>
<tr>
<td>AX</td>
<td>Physician serv in dent HPSA</td>
</tr>
<tr>
<td>AY</td>
<td>Item/service not for ESRD</td>
</tr>
</tbody>
</table>

**AI - PRINCIPAL PHYSICIAN OF RECORD**

- **Appropriate Usage (AI MODIFIER FACT SHEET)**
  - To identify the admitting or attending physician who oversees the patient’s care while in an inpatient or nursing facility setting.
  - Appended to the initial inpatient hospital visit procedure code.
  - Appended to the initial nursing facility procedure code.
  - Valid for services January 1, 2010, and after.

- **Inappropriate Usage:**
  - Appended to procedure codes other than the initial inpatient visit or initial nursing facility care services.
  - Appended by physicians other than the attending or admitting physician who oversees the patient’s care.
  - Appended to services dated December 31, 2009, and before.

- **Additional Information**
  - Medicare will allow services when a provider uses this modifier incorrectly on an office or other outpatient service. Medicare will allow services when someone other than the principal physician of record uses this modifier. Medicare can allow services provided by a physician called in to see the patient even though the principal physician of record does not append this modifier to his/her claim or he/she has not yet submitted the claim to Medicare.
  - This is an informational only modifier. The modifier will not make any changes in processing or amounts payable. Therefore, append any payment modifiers before the AI modifier.

- **Documentation**
  - The patient’s medical record indicates the physician overseeing the patient’s care in an inpatient or nursing facility setting.

- **Unassigned Claim**
  - The use of the modifier does not change the processing of unassigned claims.
  - RECORD

Source: WPS GHA Portal Content for Jurisdiction 25 Part B
EXAMPLE OF HCPCS “G” MODIFIERS

- GA Liability waiver ind case
- GB CLAIM RESUBMITTED
- GC RESIDENT/TEACHING PHYS SERV
- GD UNIT OF SERVICE > MUE VALUE
- GE RESIDENT PRIM CARE EXCEPTION
- GF NONPHYSICIAN SERV C.A HOSP
- GG PAYMENT SCREEN MAM + DIAGMAM
- GH DIAG MAMMO TO SCREENING MAMO
- GI Opt out provider of er svc
- GJ ACTUAL ITEM/SERVICE ORDERED
- GK UPGRADED ITEM, NO CHARGE
- GL Multiple transports
- GM OP SPEECH LANGUAGE SERVICE
- GN OP OCCUPATIONAL THERAPY SERV
- GO OP PT SERVICES
- GP TELEHEALTH STORE AND FORWARD
- GQ SERVICE BY VA RESIDENT
- GR Epo/darbepoietin reduced 25%
- GS INTERACTIVE/TELECOMMUNICATION
- GT Liability waiver rout notice
- GU ATTENDING PHYS NOT HOSPICE
- GV SERVICE UNRELATED TO TERM CO
- GW VOLUNTARY LIABILITY NOTICE
- GX STATUTORILY EXCLUDED
- GY NOT REASONABLE AND NECESSARY

“S” HCPCS MODIFIERS

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description Icons</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA</td>
<td>NURSE PRACTITIONER W PHYSICI</td>
</tr>
<tr>
<td>SB</td>
<td>NURSE MIDWIFE</td>
</tr>
<tr>
<td>SC</td>
<td>MEDICALLY NECESSARY SERV/SUP</td>
</tr>
<tr>
<td>SD</td>
<td>SERV BY HOME INFUSION RN</td>
</tr>
<tr>
<td>SF</td>
<td>STATE/FED FUNDED PROGRAM/SER</td>
</tr>
<tr>
<td>SG</td>
<td>2ND OPINION ORDERED BY PRO</td>
</tr>
<tr>
<td>SH</td>
<td>ASC FACILITY SERVICE</td>
</tr>
<tr>
<td>SI</td>
<td>2ND CONCURRENT INFUSION THER</td>
</tr>
<tr>
<td>SJ</td>
<td>3RD CONCURRENT INFUSION THER</td>
</tr>
<tr>
<td>SK</td>
<td>HIGH RISK POPULATION</td>
</tr>
<tr>
<td>SL</td>
<td>STATE SUPPLIED VACCINE</td>
</tr>
<tr>
<td>SM</td>
<td>SECOND OPINION</td>
</tr>
<tr>
<td>SN</td>
<td>THIRD OPINION</td>
</tr>
<tr>
<td>SQ</td>
<td>ITEM ORDERED BY HOME HEALTH</td>
</tr>
<tr>
<td>SS</td>
<td>HIT IN INFUSION SUITE</td>
</tr>
<tr>
<td>ST</td>
<td>RELATED TO TRAUMA OR INJURY</td>
</tr>
<tr>
<td>SU</td>
<td>PERFORMED IN PHYS OFFICE</td>
</tr>
<tr>
<td>SV</td>
<td>DRUGS DELIVERED NOT USED</td>
</tr>
<tr>
<td>SW</td>
<td>SERV BY CERT DIAB EDUCATOR</td>
</tr>
<tr>
<td>SY</td>
<td>CONTACT W/HIGH-RISK POP</td>
</tr>
</tbody>
</table>
**“SA” MODIFIER**

- **SA - NURSE PRACTITIONER** Rendering Service in Collaboration With a Physician

**BCBSTX – Supervision of Physician Assistant, Advanced Nurse Practitioner or Certified Registered Nurse First Assistant**

- The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Nurse Practitioner (APN) or Certified Registered Nurse First Assistant (CRNFA):
  - **AS Modifier**: A physician should use this modifier when billing on behalf of a PA, ANP or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. *(Modifier AS to be used ONLY if they assist at surgery)*
  - **SA Modifier**: A supervising physician should use this modifier when billing on behalf of a PA, ANP, or CRNFA for non-surgical services. *(Modifier SA is used when the PA, ANP, or CRNFA is assisting with any other procedure that DOES NOT include surgery.)*
  - **-80 Modifier**: PA’s, ANP’s, and CRNFA’s who are billing with their own provider number will not need to bill a modifier, unless they are billing as an Assistant Surgeon, then they must use the –80 modifier.
<table>
<thead>
<tr>
<th>Reimbursement Guide for Nurse Practitioners (NPs) and Physician Assistants (PAs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definitions:</strong></td>
</tr>
<tr>
<td>Incident to - Are services provided strictly as a follow up to the physician's plan of care. Incident to services are provided by a nurse practitioner or physician assistant the physician must be on site, and the visit cannot be with a new patient or with an old patient with a new problem. The services for incident to should be billed under the supervising physician's credentials. Please see attached link for more detail. Please verify each payer's policy to verify their incident to billing rules as they are subject to change.</td>
</tr>
<tr>
<td>Direct Supervision - The physician is physically present in the building (in-office), where the service is being rendered.</td>
</tr>
<tr>
<td>Indirect Supervision - The physician is not physically present in the building (not in-office) where the service is being rendered.</td>
</tr>
<tr>
<td><strong>Provider Name</strong></td>
</tr>
<tr>
<td><strong>Reimbursement</strong></td>
</tr>
<tr>
<td><strong>Incident to</strong></td>
</tr>
<tr>
<td><strong>Direct Billing</strong></td>
</tr>
</tbody>
</table>

| **Aetna** |
| Required modifier: No modifier is required. |
| Reimbursement: 100% of the physician's contracted rate. |
| Underlying required: If the supervising physician has an Active group contract, undercoding is not required. If the supervising physician has an individual contract, undercoding is required. |
| Follow CMS's guidelines regarding "incident to"? Yes. |
| **BlueCross BlueShield of Texas** |
| Required modifier: Modifier "SA" is required. |
| Reimbursement: No modifier is required. |
| Underlying required: No credentialing or provider record needed. Forms are required. |
| Follow CMS’s guidelines regarding "incident to"? No. |
| **Cigna** |
| Required modifier: Modifier "SA" is required. |
| Reimbursement: 100% of the physician's contracted rate. |
| Underlying required: Per Cigna's prior authorization guidelines, forms must be submitted to the Cigna InterQual Office. |
| Follow CMS’s guidelines regarding "incident to"? No. |
| **Humana** |
| Required modifier: No modifier is required. |
| Reimbursement: 100% of the physician's contracted rate. |
| Underlying required: NA. |
| Follow CMS’s guidelines regarding "incident to"? Yes. |
| **United Healthcare** |
| Required modifier: Modifier "SA" is required. |
| Reimbursement: No modifier is required. |
| Underlying required: NA. |
| Follow CMS’s guidelines regarding "incident to"? Yes. |

Note: This information is subject to change. Please verify with your payor representative for verification.
PET Scan Modifiers

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PI</td>
<td>PET tumor init tx strat</td>
</tr>
<tr>
<td>PS</td>
<td>PET tumor subsq tx strategy</td>
</tr>
</tbody>
</table>
Anatomical Modifiers

- 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
- LC – Left circumflex coronary artery
- LD – Left anterior descending coronary artery
- LM – Left main coronary artery
- LT – Left Side
- RC – Right coronary artery
- RI – Ramus intermedius coronary artery
- RT – Right Side
- 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

X Modifiers

- XE – (Separate encounter) a service that is distinct because it occurred during a separate encounter.
- XS – (Separate structure) A service that is distinct because it was performed on a separate organ/structure
- XP – (Separate practitioner) A service that is distinct because it was performed by a different practitioner.
- XU – (Unusual non-overlapping service) The use of a service that is distinct because it does not overlap usual components of the main service
TYPES OF HCPCS LEVEL II CODES

- **Permanent National Codes:**
  - Maintained by CMS
  - CMS responsible for making decisions about additions, revisions, and deletions for the permanent national alpha-numeric codes.
  - Codes for use by all private and public health insurers
  - Serve important function of providing standardization – set of uniform codes provides stable environment for claims submissions and processing.

Source: [www.cms.gov](http://www.cms.gov)

---

TYPES OF HCPCS LEVEL II CODES

- **Dental Codes** - A separate category of national codes.
- **Current Dental Terminology (CDT)** is a publication copyrighted by the American Dental Association (ADA):
  - Lists codes for billing:
    - Dental procedures and
    - Supplies
  - While CDT codes are considered HCPCS Level II codes, decisions regarding their use is made by the ADA and not CMS. CDT codes are published and copyrighted by the ADA.
TYPES OF HCPCS LEVEL II CODES

• **Miscellaneous Codes:**
  – Codes 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**.
  – Allow suppliers to begin billing immediately for a service or item as soon as it is allowed to be marketed by the FDA, even though there is no distinct code that currently exists to describe service or item.
  – A miscellaneous code may be assigned by insurers for use during the period of time a request for a new code is being considered under the HCPCS review process.
  – Claims with miscellaneous codes are manually reviewed. Therefore, the item or service 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.
  – When such a claim is submitted to one of the four DME MACs, suppliers that have coding questions should contact the Pricing, Data Analysis, and Coding (PDAC) contractor of CMS. PDAC is responsible for providing assistance in determining which HCPCS code should be used for billing to Medicare.
    • PDAC has a toll free helpline for this purpose – 877-735-1326.
    • In addition, PDAC publishes a product classification list on its website that lists individual items to code categories.
    • More information about the PDAC and the PDACs product classification list can be found at: [http://www.dmepdac.com](http://www.dmepdac.com)

• **Temporary National Codes:**
  – Serve the purpose of meeting, within a short time frame, the national program operational needs of particular insurance sector that are not already addressed by an existing national code.
  – CMS has set aside certain sections of HCPCS code set for development of temporary codes.
  – Decisions about the use of temporary codes are made by CMS.
  – Temporary(?) - codes do not have established expiration dates, although it can be changed to a permanent code status by CMS.
TYPES OF TEMPORARY HCPCS CODES

• “C” codes – (Pass-Through)
  – Established to permit implementation of section 201 of the Balanced Budget Refinement Act of 1999.
  – Utilized to report drugs, biologicals, magnetic resonance angiography (MRA), and devices that must be used by OPPS hospitals.
  – Reported for device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS code assignments.
  – Non-OPPS hospitals, Critical Access Hospitals (CAHs), Indian Health Service Hospitals (IHS), hospitals located in American Samoa, Guam, Saipan, or the Virgin Islands, and Maryland waiver hospitals may report these codes at their discretion.
  – Additional information concerning HOPPS and the separate application process for C codes can be found at: http://www.cms.gov/HospitalOutpatientPPS/.

TYPES OF TEMPORARY HCPCS CODES

• “G” codes:
  – Used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT codes.
  – CMS does not have an external application process for “G” codes.
  – CMS’ standard Level II HCPCS coding program does not maintain “C” or “G” codes.
TYPES OF TEMPORARY HCPCS CODES

• “Q” codes:
  – Used to identify services that would not be given a CPT code:
    • Such as drugs, biologicals, and other types of medical equipment or services, and
    • Which are not identified by national level II codes but for which codes are needed for claims processing services.

• “K” codes:
  – Established for use by DME MACs when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy.
  – For example, codes other than the permanent national codes may be needed by DME MACs to identify certain product categories and supplies necessary for establishing appropriate regional medical review coverage policies.

• “S” codes:
  – Primarily used by private insurers to report drugs, services and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs or claims processing.
  – These codes serve the purpose of meeting the particular needs of the private sector.
  – They may also be used by Medicaid programs, but they are not payable by Medicare.
TYPES OF TEMPORARY HCPCS CODES

- Certain “H” codes are used by State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services.
- The “T” codes are for use primarily by Medicaid State agencies to identify items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need.
- “T” codes may also be used by private insurance programs, but they are not payable by Medicare.

HCPCS UPDATES

- Permanent National Codes:
  - Updated annually, according to the following schedule:
    1. Coding requests must be received by the specified deadline in January of the current year in order to be considered for possible coding accuracy by January 1 of the subsequent year.
    2. Computer tapes and instructions, that include an updated list of codes and identify which codes have been changed or deleted, are updated and sent to our contractors and Medicaid State agencies at least 60 days in advance of the January 1 implementation date for the annual update.

    - In addition, the CMS HCPCS Workgroup’s final decisions on all public requests for changes will be published on the official HCPCS website at [www.cms.gov/Medicare/Coding?Medhcpcsgeninfo/index.html](http://www.cms.gov/Medicare/Coding?Medhcpcsgeninfo/index.html) in November of each year.
HCPCS UPDATES

**Temporary Codes:**
- CMS has flexibility to add, change or discontinue these codes on a quarterly basis.
- Once established, temporary codes and effect dates for their use are posted on CMS’ HCPCS website at http://www.cms.gov/Medicare/Coding/Medhcpcsgeninfo/Index.html. This website enables us to quickly disseminate information on coding requests and decisions.
- Newly established Temporary codes are usually implemented within 90 days of publication, the time needed to prepare and issue.

**Telehealth Services Modifiers**
- **GQ** – via asynchronous telecommunications system (Alaska or Hawaii)

**Therapy Modifiers**
- **96** – Habilitative Services
- **97** – Rehabilitative Services

**Advance Beneficiary Notice of Noncoverage (ABN) Modifiers**
- **GA** – waiver of liability statement issued as required by payer policy, individual case
- **GX** – notice of liability issued, voluntary under payer policy
- **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 and necessary
2018 CMS FINALIZES THE ADDITION OF SEVERAL CODES TO TELEHEALTH SERVICES

• HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
• CPT code 90785 (Interactive Complexity);
• CPT codes 96160 and 96161 (Health Risk Assessment);
• HCPCS code G0506 (Care Planning for Chronic Care Management); and
• CPT codes 90839 and 90840 (Psychotherapy for Crisis).

• Additionally, we are finalizing our proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners.
• We are also finalizing separate payment for CPT code 99091, which describes certain remote patient monitoring, for CY 2018.
• Lastly, we will consider the stakeholder input we received in response to the proposed rule’s comment solicitation on how CMS could expand access to telehealth services, within the current statutory authority.

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-02.html

HCPCS Procedure & Supply Codes - G0296

Code Information:
• Reactivated code for 2015
• T = Telehealth service (Medicare)

• G0296 - Counseling visit to discuss need for lung cancer screening (ldct) using low dose ct scan (service is for eligibility determination and shared decision making)
G0296

- **Use place of service code 02-Telehealth** - The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)

- **Use the GQ modifier if you performed telehealth services for Federal programs in Alaska or Hawaii, “via an asynchronous telecommunications system”** (for example, GQ01).

- An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs.

- Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:
  - Physicians.
  - Nurse practitioners (NPs).
  - Physician assistants (PAs).
  - Nurse-midwives.
  - Clinical nurse specialists (CNs).
  - Certified registered nurse anesthetists.
  - Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90791, 90831, 90838, and 90838.
  - Registered dietitians or nutrition professionals.

Source: CMS.gov

HCPCS G0506

- **G0506 - Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service**

- Code Information – T = Telehealth Service (Medicare); + = Add-on code

- CMS has established separate payment under billing codes for the additional time and resources providers spend caring for Medicare and dual eligible (Medicare and Medicaid) patients with chronic conditions.

- Click on the "References" link to review their toolkit which includes information for health care professionals, including tips for getting started, fact sheets on the requirements for implementing a CCM program, and educational materials to share with patients.

Source: CMS Chronic Care Management Health Care Professional Tool Kit
### -/+ Deleted, Replaced, Expanded Codes in 2018

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
<th>Icons</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP</td>
<td>C-apc adjunctive service</td>
<td></td>
</tr>
<tr>
<td>JF</td>
<td>Compounded Drug</td>
<td></td>
</tr>
<tr>
<td>L1</td>
<td>Separately payable lab test</td>
<td></td>
</tr>
<tr>
<td>QU</td>
<td>MD PROVIDING SVC URBAN HPSA</td>
<td></td>
</tr>
<tr>
<td>QV</td>
<td>ITEM OR SERVICE PROVIDED</td>
<td></td>
</tr>
<tr>
<td>RP</td>
<td>REPLACEMENT &amp; REPAIR(DMEPOS)</td>
<td></td>
</tr>
<tr>
<td>SZ</td>
<td>Habilitative services</td>
<td></td>
</tr>
<tr>
<td>V8</td>
<td>Infection present</td>
<td></td>
</tr>
<tr>
<td>V9</td>
<td>No infection present</td>
<td></td>
</tr>
<tr>
<td>ZA</td>
<td>Novartis/sandoz</td>
<td></td>
</tr>
<tr>
<td>ZB</td>
<td>Pfizer/hospira</td>
<td></td>
</tr>
<tr>
<td>ZC</td>
<td>Merck/samsung bioepis</td>
<td></td>
</tr>
</tbody>
</table>

**HCPCS 2019**

**TABLE OF DRUGS**
### 2019 Table of Drugs

Questions regarding coding and billing guidance should be submitted to the insurer in whose jurisdiction a claim is being filed. For private sector health insurance carriers, please contact the individual private insurance entity. For Medicare systems, please contact the Medicare Agency in the state in which the claim is being filed. For Medicare, contact the Medicare contractors.

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 laminated tubes. The "VAR" posting denotes various routes of administration and is used for drugs that are administered into joints, cavities, tissues, or topical application, in addition to other parenteral administrations. Listings posted with "OTH" indicate other administration methods, such as suppositories or catheter injections.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Form</th>
<th>Route</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abatecap</td>
<td>10 mg</td>
<td>IV</td>
<td>J0129</td>
</tr>
<tr>
<td>Abikoikine, see Urokinase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abikoinase, Open Cast, see Urokinase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abrikokin</td>
<td>10 mg</td>
<td>IV</td>
<td>J0130</td>
</tr>
<tr>
<td>Alben, see Angiotensin B Lipid Complex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABMC, see Angiotensin B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albutololpresaivetaxel</td>
<td>6 units</td>
<td>IM</td>
<td>J0505</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>16 mg</td>
<td>IV</td>
<td>J0131</td>
</tr>
<tr>
<td>Acetamidamide sodium</td>
<td>up to 500 mg</td>
<td>IM, IV</td>
<td>J1120</td>
</tr>
<tr>
<td>Acetylcysteine, in a dry form</td>
<td>100 mg</td>
<td>IV</td>
<td>J0132</td>
</tr>
<tr>
<td>Acetylcysteine, in a liquid form</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetylcysteine, unit dose form</td>
<td>per gram</td>
<td>INH</td>
<td>J7604, J7605</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HCPCS Procedure & Supply Codes - J7620

Code Information - J7620 - Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, fda-approved final product, non-compounded, administered through dme

- HCPCS Chapter/Section Guidelines & Notes
- HCPCS Procedure & Supply Codes
- Drugs Administered
- Inhalation Solutions
- Code(s) Description Icons
  - J7604 Acetylcysteine comp unit
  - J7605 Arformoterol non-comp unit
  - J7606 Formoterol fumarate, inh
  - J7607 Levalbuterol comp con
  - J7608 Acetylcysteine non-comp unit
  - J7609 Albuterol comp unit
  - J7610 Albuterol comp con
  - J7611 Albuterol non-comp con
  - J7612 Levalbuterol non-comp con
  - J7613 Albuterol non-comp unit
  - J7614 Levalbuterol non-comp unit
  - J7615 Levalbuterol comp unit
  - J7620 Albuterol ipratrop non-comp
  - J7622 Beclomethasone comp unit
  - J7624 Betamethasone comp unit
  - J7626 Budesonide non-comp unit

- J7620 - Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, fda-approved final product, non-compounded, administered through dme
Short Descr: Albuterol ipratrop non-comp

- CMS 2013 Long Descriptor: Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, non-compounded, administered through DME
- Related Drugs: Ipratropium Bromide and Albuterol Sulfate
- Medicare Physician Fee Schedule (MPFS) Indicators:
- Medicare Coverage: Special Coverage Instructions Apply
- APC Status Indicator: Items and Services Not Billable to the Fiscal Intermediary/MAC
- Status Code: E - Excluded from Physician Fee Schedule by Regulation
- Global Days: XXX - Global Concept Does Not Apply
- PC/TC Indicator (26): 9 - Not Applicable
- Multiple Procedures (51): 9 - Concept does not apply.
- Bilateral Surgery (50): 9 - Concept does not apply.
- Physician Supervisions: 09 - Concept does not apply.
- Assistant Surgeon (80, 82): 9 - Concept does not apply.
- Co-Surgeons (62): 9 - Concept does not apply.
- Team Surgery (66): 9 - Concept does not apply.
- Type of Service (TOS): 1 - Medical Care
- Berenson-Eggers TOS (BETOS): D1G - Drugs Administered through DME
- Diagnostic Imaging Family: 99 - Concept Does Not Apply
- Non-Facility MUEs: 6
- Facility MUEs: 0
- OTS Orthotic: No
- CCS Clinical Classification: 240 - Medications (Injections, infusions and other forms)

How ASP pricing works

- Because Drugs are not a part of the Medicare fees schedule, Drug pricing by Medicare is done according to Average Sales pricing (ASP) and is used to pay Part B claims.
- Average Wholesale pricing was used for part B Medicare payments until 2005, then ASP pricing/payment structure was implemented.
- For each billing code, CMS calculates a weighted average sales price using the Average Sales Price (ASP) data submitted by manufacturers.
- Manufacturers submit ASP data at the 11-digit National Drug Code (NDC) level.
- Manufacturers submit the number of units of the 11-digit NDC sold and the ASP for those units.
BILLING UNITS

• The number of billing units in an NDC is determined by the amount of drug in the package. For example:
  – A manufacturer sells a box of 4 vials of a drug.
  – Each vial contains 20 milligrams (mg).
  – The billing code is per 10 mg.
  – The number of billing units in this NDC for this billing code is \((4 \text{ vials} \times 20 \text{ mg})/10 \text{ mg} = 8\) billable units.

Beginning April 1, 2008, CMS uses the following weighting methodology to determine the payment limit:  
(Say what?)

1. CMS sums the product of the manufacturer’s ASP and the number of units of the 11-digit NDC sold for each NDC assigned to the billing and payment code, and
2. Then divides this total by the sum of the product of the number of units of the 11-digit NDC sold and the number of billing units in that NDC for each NDC assigned to the billing and payment code.
3. CMS weights the ASP for an NDC by the number of billing units sold for that NDC.

Prior to April 1, 2008, the following weighting methodology applies:

1. CMS converts the manufacturer’s ASP for each NDC into the average sales price per billing unit by dividing the manufacturer’s ASP for that NDC by the number of billing units in that NDC.
2. CMS sums the product of the ASP per billing unit and the number of units of the 11-digit NDC sold for each NDC assigned to the billing code, and then divides this total by the sum of the number of units of the 11-digit NDC sold for each NDC assigned to the billing code.
3. CMS weights the ASP per billing units equally for each NDC regardless of package size.

• For further information: Go to CMS FAQs at: 

CMS LCD Document Information for NEBULIZERS

- LCD ID: L33370
- LCD Title: Nebulizers
- LCD Determination ID:
- Original Effective Date: For services performed on or after 10/01/2015
- Revision Effective Date: For services performed on or after 01/01/2016
- Revision Ending Date: N/A
- Retirement Date:
- Notice Period Start Date: N/A
- Notice Period End Date: N/A
- Jurisdiction:
  - Not Specified.

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SMALL VOLUME NEBULIZER LOCAL COVERAGE DETERMINATION -

- A small volume nebulizer (A7003, A7004, A7005), related compressor (E0570) and FDA-approved inhalation solutions of the drugs listed below are covered when:
  1. It is reasonable and necessary to administer albuterol (J7611, J7613), arformoterol (J7605), budesonide (J7626), cromolyn (J7631), formoterol (J7606), ipratropium (J7644), levalbuterol (J7612, J7614), or metaproterenol (J7669) for the management of obstructive pulmonary disease. (Reference the Diagnosis Codes that Support Medical Necessity Group 8 Codes section for applicable diagnoses); or
  2. It is reasonable and necessary to administer dornase alpha (J7639) to a beneficiary with cystic fibrosis (Reference the Diagnosis Codes that Support Medical Necessity Group 9 Codes section for applicable diagnoses); or
  3. It is reasonable and necessary to administer pentamidine (J2545) to a beneficiary with HIV, pneumocystosis, or complications of organ transplants (Reference the Diagnosis Codes that Support Medical Necessity Group 4 Codes section for applicable diagnoses); or
  4. It is reasonable and necessary to administer acetylcysteine (J7608) for persistent thick or tenacious pulmonary secretions (Reference the Diagnosis Codes that Support Medical Necessity Group 7 Codes section for applicable diagnoses).

NEBULIZER LCD – HCPCS MODIFIERS

- The appearance of a code in this section does not necessarily indicate coverage.

- **HCPCS MODIFIERS:**
  - **EY** - No physician or other licensed health care provider order for this item or service
  - **GA** - Waiver of liability statement issued as required by payer policy, individual case
  - **GZ** - Item or service expected to be denied as not reasonable and necessary
  - **KO** - Single drug unit dose formulation
  - **KP** - First drug of a multiple drug unit dose formulation
  - **KQ** - Second or subsequent drug of a multiple drug unit dose formulation
  - **KX** - Requirements specified in the medical policy have been met

---

LCD - NEBULIZERS

- **HCPCS CODES:**

**EQUIPMENT**
- **E0565** - Compressor, air power source for equipment which is not self-contained or cylinder driven
- **E0570** - Nebulizer, with compressor
- **E0572** - Aerosol compressor, adjustable pressure, light duty for intermittent use
- **E0574** - Ultrasonic/electronic aerosol generator with small volume nebulizer
- **E0575** - Nebulizer, ultrasonic, large volume
- **E0585** - Nebulizer, with compressor and heater
- **K0730** - Controlled dose inhalation drug delivery system
LCD NEBULIZERS

ACCESSORIES
• A4619 - Face tent
• A7003 - Administration set, with small volume nonfiltered pneumatic nebulizer, disposable
• A7004 - Small volume nonfiltered pneumatic nebulizer, disposable
• A7005 - Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable
• A7006 - Administration set, with small volume filtered pneumatic nebulizer
• A7007 - Large volume nebulizer, disposable, prefilled, used with aerosol compressor
• A7008 - Large volume nebulizer, disposable, prefilled, used with aerosol compressor
• A7009 - Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer
• A7015 - Aerosol mask, used with dmie nebulizer
• A7016 - Dome and mouthpiece, used with small volume ultrasonic nebulizer
• A7017 - Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen
• A7026 - Tracheostomy mask, each
• E0580 - Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
• E1372 - Immersion external heater for nebulizer

LCD – PARTIAL LISTING OF INHALATION DRUGS AND SOLUTIONS

INHALATION DRUGS AND SOLUTIONS
• A4216 - Sterile water, saline and/or dextrose, diluent/flush, 10 ml
• A4217 - Sterile water/saline, 500 ml
• A4218 - Sterile saline or water, metered dose dispenser, 10 ml
• A7018 - Water, distilled, used with large volume nebulizer, 1000 ml
• E0333 - Pharmacy dispensing fee for inhalation drug(s); initial 30-day supply as a beneficiary
• J2545 - Pentamidine isethionate, inhalation solution, fda-approved final product, non-compounded, administered through dmie, unit dose form, per 300 mg
• J7604 - Acetylcysteine, inhalation solution, compounded product, administered through dmie, unit dose form, per gram
• J7605 - Arformoterol, inhalation solution, fda approved final product, non-compounded, administered through dmie, unit dose form, 15 micrograms
• J7606 - Formoterol fumarate, inhalation solution, fda approved final product, non-compounded, administered through dmie, unit dose form, 20 micrograms
• J7607 - Levalbuterol, inhalation solution, compounded product, administered through dmie, concentrated form, 0.5 mg
• J7608 - Acetylcysteine, inhalation solution, fda-approved final product, non-compounded, administered through dmie, concentrated form, per gram
• J7609 - Albuterol, inhalation solution, compounded product, administered through dmie, unit dose, 1 mg
• J7610 - Albuterol, inhalation solution, compounded product, administered through dmie, concentrated form, 1 mg
• J7611 - Albuterol, inhalation solution, fda-approved final product, non-compounded, administered through dmie, concentrated form, 1 mg
• J7612 - Levalbuterol, inhalation solution, fda-approved final product, non-compounded, administered through dmie, concentrated form, 0.5 mg
• J7613 - Albuterol, inhalation solution, fda-approved final product, non-compounded, administered through dmie, unit dose, 1 mg
• J7614 - Levalbuterol, inhalation solution, fda-approved final product, non-compounded, administered through dmie, unit dose, 0.5 mg
• J7615 - Levalbuterol, inhalation solution, compounded product, administered through dmie, unit dose, 0.5 mg
• J7620 - Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, fda-approved final product, non-compounded, administered through dmie
• J7622 - Beclomethasone, inhalation solution, compounded product, administered through dmie, unit dose form, per milligram
• J7624 - Betamethasone, inhalation solution, compounded product, administered through dmie, unit dose form, per milligram
PARTIAL LISTING OF ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY FOR NEBULIZER TREATMENT

- ICD-10-CM Codes that support Medical Necessity:
  - The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on "Coverage Indications, Limitations and/or Medical Necessity" for other coverage criteria and payment information.

For HCPCS codes A4619, E0565, E0572:
- A15.0 - Tuberculosis of lung
- B20 - Human immunodeficiency virus [HIV] disease
- B59 - Pneumocystosis
- B84.0 - Cystic fibrosis with pulmonary manifestations
- J09.6 - Other specified diseases of upper respiratory tract
- J47.0 - Bronchiectasis with acute lower respiratory infection
- J47.1 - Bronchiectasis with (acute) exacerbation
- J47.9 - Bronchiectasis, uncomplicated
- J86.09 - Other diseases of bronchus, not elsewhere classified
- Q33.4 - Congenital bronchiectasis
- T86.00 - Unspecified complication of bone marrow transplant
- T86.01 - Bone marrow transplant rejection
- T86.02 - Bone marrow transplant failure
- T86.03 - Bone marrow transplant infection
- T86.09 - Other complications of bone marrow transplant
- T86.10 - Unspecified complication of kidney transplant
- T86.11 - Kidney transplant rejection
- T86.12 - Kidney transplant failure
- T86.13 - Kidney transplant infection
- T86.19 - Other complication of kidney transplant
- T86.20 - Unspecified complication of heart transplant

GENERAL INFORMATION

- DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

- PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL (PIM 5.2.1); All items billed to Medicare require a prescription.
- An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request.
- Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.
GENERAL INFORMATION

• DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

• Description of the item
  – Beneficiary's name
  – Prescribing physician's name
  – Date of the order

• Physician signature (if a written order) or supplier signature (if verbal order)

• For the “Date of the order” described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

ORDER

• In some cases, the physician may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of service (DOS) entered on the claim, Medicare-required forms (e.g., CMN, DIF) or refill/delivery timelines. As long as the supplier has a properly completed prescription with a correctly determined prescription date, an item may be shipped or delivered on or after the prescription date (except for items that require written orders prior to delivery).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.
WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.4)

- ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS codes specified in the table contained in the Policy Specific Documentation Requirements Section below.
- The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.
- Refer the related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about the statutory requirements associated with a WOPD.

DETAILED WRITTEN ORDERS (PIM 5.2.3)

- A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:
  - Beneficiary's name
  - Physician's name
  - Date of the order
  - Detailed description of the item(s) (see below for specific requirements for selected items)
  - Physician signature and signature date
WRITTEN ORDER

• For items provided on a periodic basis, including drugs, the written order must include:
  – Item(s) to be dispensed
  – Dosage or concentration, if applicable
  – Route of Administration
  – Frequency of use
  – Duration of infusion, if applicable
  – Quantity to be dispensed
  – Number of refills

• For the “Date of the order” described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

DWO/WOPD

With respect to the date on the DWO/WOPD:

• If the prescriber creates a complete and compliant DWO/WOPD, only a single date - the “order date” - is required. This order date may be the date that the prescriber signs the document (either wet signature or electronic signature).

• If someone other than the prescriber (e.g., DME supplier) creates the DWO/WOPD then the prescription must be reviewed and, “…personally signed and dated…” by the prescriber. In this scenario two (2) dates are required: an “order date” and a prescriber-entered “signature date”.

• In some cases, the physician may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of service (DOS) entered on the claim, Medicare-required forms (e.g., CMN, DIF) or refill/delivery timelines. As long as the supplier has a properly completed prescription with a correctly determined prescription date, an item may be shipped or delivered on or after the prescription date (except for items that require written orders prior to delivery).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state “PRN” or “as needed” utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

The detailed description in the written order may be either a narrative description or a brand name/model number. Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record. (PIM 5.2.3)
MEDICAL RECORD INFORMATION

• GENERAL (PIM 5.7 - 5.9)

• The Coverage Indications, Limitations and/or Medical Necessity section of this LCD contains numerous reasonable and necessary (R&N) requirements.

• The Non-Medical Necessity Coverage and Payment Rules section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that: Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.

• Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.
  – Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs.
  – The medical record is not limited to physician’s office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive).
  – Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

CONTINUED MEDICAL NEED

• For all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription.

• For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period.

• Entries in the beneficiary’s medical record must have been created prior to, or at the time of, the initial date of service (DOS) to establish whether the initial reimbursement was justified based upon the applicable coverage policy.
• For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review.

• Any of the following may serve as documentation justifying continued medical need:
  A recent order by the treating physician for refills
  A recent change in prescription
  A properly completed CMN or DIF with an appropriate length of need specified
  Timely documentation in the beneficiary's medical record showing usage of the item
  Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

CONTINUED USE

• Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.
• Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.
• Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:
  - Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies
  - Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements (This is deemed to be sufficient to document continued use for the base item, as well)
  - Supplier records documenting beneficiary confirmation of continued use of a rental item
  - Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.
PROOF OF DELIVERY
(PIM 4.26, 5.8)

- Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files.
- For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement.
- Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.
- Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.
- For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary.
- Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

POD

- Suppliers are required to maintain POD documentation in their files. For the items addressed in this policy, there are two methods of delivery:
  1. Delivery directly to the beneficiary or authorized representative
  2. Delivery via shipping or delivery service
MODIFIERS

KX, GA, AND GZ MODIFIERS:

• Suppliers must add a KX modifier to codes for E0574, J7686, K0730 and Q4074 only if all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity” section of this policy have been met.

• If all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code.

• When there is an expectation of a medical necessity denial, suppliers must enter GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or GZ modifier if they have not obtained a valid ABN.

• Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

Table: HCPCS Procedure & Supply Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4563</td>
<td>Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each</td>
</tr>
<tr>
<td>A5514</td>
<td>For diabetics only, multiple density insert, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each</td>
</tr>
<tr>
<td>A6460</td>
<td>Synthetic resorbable wound dressing, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing</td>
</tr>
<tr>
<td>A6461</td>
<td>Synthetic resorbable wound dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing</td>
</tr>
<tr>
<td>A9589</td>
<td>Instillation, hexaminolevulinate hydrochloride, 100 mg</td>
</tr>
</tbody>
</table>


NOTE - There are 185 codes in this list.
## ADDITIONAL EXAMPLES OF NEW 2019 HCPCS CODES

- **E0447** Portable oxygen contents, liquid, 1 month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute (lpm)
- **E0467** Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions
- **G0068** Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, and/or inotropic infusion drug(s) for each infusion drug administration calendar day in the individual's home, each 15 minutes
- **G0069** Professional services for the administration of subcutaneous immunotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes
- **G0070** Professional services for the administration of chemotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes
- **G0071** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only
- **G0076** Brief (20 minutes) care management home visit for a new patient, for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)
- **G0077** Limited (30 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)

## ADDITIONAL NEW HCPCS CODES – PARTIAL LISTING 2019

- **G2010** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment
- **G2011** Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes
- **G2012** Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- **J0185** Injection, aprepitant, 1 mg
- **J0517** Injection, benralizumab, 1 mg
- **J0567** Injection, cerliponase alfa, 1 mg
- **J0584** Injection, burosumab-twza 1 mg
- **J0599** Injection, c-1 esterase inhibitor (human), (haegarda), 10 units
- **J0841** Injection, crotalidae immune f(ab')2 (equine), 120 mg
- **J1095** Injection, dexamethasone 9 percent, intraocular, 1 microgram
### Alert: Changed Code for 2019- REVISED HCPCS CODES – PARTIAL LIST ONLY

**NOTE - There are 89 codes in this list.**

**HCPCS Procedure & Supply Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9273</td>
<td>Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type</td>
</tr>
<tr>
<td>C1889</td>
<td>Implantable/insertable device, not otherwise classified</td>
</tr>
<tr>
<td>E0218</td>
<td>Fluid circulating cold pad with pump, any type</td>
</tr>
<tr>
<td>E0483</td>
<td>High frequency chest wall oscillation system, includes all accessories and supplies, each</td>
</tr>
<tr>
<td>G0499</td>
<td>Hepatitis b screening in non-pregnant, high risk individual includes hepatitis b surface antigen (hbsag), antibodies to hbsag (anti-hbs) and antibodies to hepatitis b core antigen (anti-hbc), and is followed by a neutralizing confirmatory test, when performed, only for an initially reactive hbsag result</td>
</tr>
<tr>
<td>G8647</td>
<td>Risk-adjusted functional status change residual score for the knee impairment successfully calculated and the score was equal to zero (0) or greater than zero (&gt; 0)</td>
</tr>
<tr>
<td>G8648</td>
<td>Risk-adjusted functional status change residual score for the knee impairment successfully calculated and the score was less than zero (&lt; 0)</td>
</tr>
</tbody>
</table>

### Alert: Deleted Code for 2019

**PARTIAL LISTING OF DELETED HCPCS CODES 2019**

**NOTE - There are 46 codes in this list.**

**HCPCS Procedure & Supply Codes :**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C8904</td>
<td>Magnetic resonance imaging without contrast, breast; unilateral</td>
</tr>
<tr>
<td>C8907</td>
<td>Magnetic resonance imaging without contrast, breast; bilateral</td>
</tr>
<tr>
<td>C9014</td>
<td>Injection, cerliponase alfa, 1 mg</td>
</tr>
<tr>
<td>C9015</td>
<td>Injection, c-1 esterase inhibitor (human), haegarda, 10 units</td>
</tr>
<tr>
<td>C9016</td>
<td>Injection, triptorelin extended release, 3.75 mg</td>
</tr>
</tbody>
</table>
### PARTIAL LISTING OF DELETED HCPCS CODES 2019

- **J0833** Injection, cosyntropin, not otherwise specified, 0.25 mg
- **J9310** Injection, rituximab, 100 mg
- **K0903** For diabetics only, multiple density insert, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each
- **Q2040** Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion
- **Q4131** Epifix or epicord, per square centimeter
- **Q4172** Puraply or puraply am, per square centimeter
- **Q9993** Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
- **Q9994** In-line cartridge containing digestive enzyme(s) for enteral feeding, each
- **Q9995** Injection, emicizumab-kxwh, 0.5 mg
- **V5170** Hearing aid, cros, in the ear
- **V5180** Hearing aid, cros, behind the ear
- **V5210** Hearing aid, bicros, in the ear
- **V5220** Hearing aid, bicros, behind the ear

### Alert: Reactivated Codes for 2019

**NOTE - There are 3 codes in this list.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9513</td>
<td>Lutetium lu 177, dotatate, therapeutic, 1 millicurie</td>
</tr>
<tr>
<td>J3245</td>
<td>Injection, tildrakizumab, 1 mg</td>
</tr>
<tr>
<td>Q2042</td>
<td>Tisagenlecleucel, up to 600 million car-positive viable t cells, including</td>
</tr>
<tr>
<td></td>
<td>leukapheresis and dose preparation procedures, per therapeutic dose</td>
</tr>
</tbody>
</table>
Example of Improper Payments due to Insufficient Documentation – CERT REVIEW

- Missing clinical documentation of wound evaluation:
  - A supplier billed for Healthcare Common Procedure Coding System (HCPCS) code A6212 (Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing) and in response to the CERT review contractor’s request for documentation, the following was submitted:
    - Treating physician’s detailed written order
    - Treating physician’s clinical records (dated two weeks prior to the order date) documenting beneficiary with a stage two pressure ulcer with no exudate
    - Treating physician’s clinical record (dated three days after the order date) documenting stage two pressure ulcer with light exudate
    - Proof of delivery Additional requests to the treating physician for documentation to support the HCPCS code billed returned no documentation.
  - The clinical records submitted were insufficient to support that the beneficiary had a full thickness wound with moderate to heavy exudate as required by the LCD for the billed HCPCS code.
- The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the billing provider.
Example of Improper Payments due to Insufficient Documentation –

- **Missing a valid order as required by regulation**, Medicare program manuals, and MAC specific guidelines A physician billed for HCPCS A6021 (Collagen dressing, sterile, size 16 sq. in. or less, each) and in response to the CERT review contractor’s request for documentation, the following was submitted:
  - Treating physician’s clinical records documenting a debrided sacral wound with wound measurements
  - Treating physician’s written order that is not detailed (such as, missing frequency of dressing change)
  - Proof of delivery Additional requests to the provider for documentation to support the HCPCS code billed returned no documentation.

- The provider failed to submit medical record documentation that was sufficient to support the claim per LCD and Medicare requirements.

- The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the billing provider.

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- **Resources**: You may want to review the following information to help avoid insufficient documentation errors:
  - SSA 1861 (e) (5), which is available at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
  - The CERT provider website, which is available at https://certprovider.admedcorp.com
  - The CERT Program website, which is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html
2017 NATIONAL IMPROPER PAYMENT STATISTICS

Common Causes of Improper Payments

Figure 2: Improper Payment Rate Error Categories by Percentage of 2017 National Improper Payments

QUESTIONS

• QUESTIONS???

• THANK YOU!!!

• CONTACT INFO: mcollins@pmimd.com
  940-631-4279