



Get the H
Out of Here.

HCPCS Coding for
Hospitals



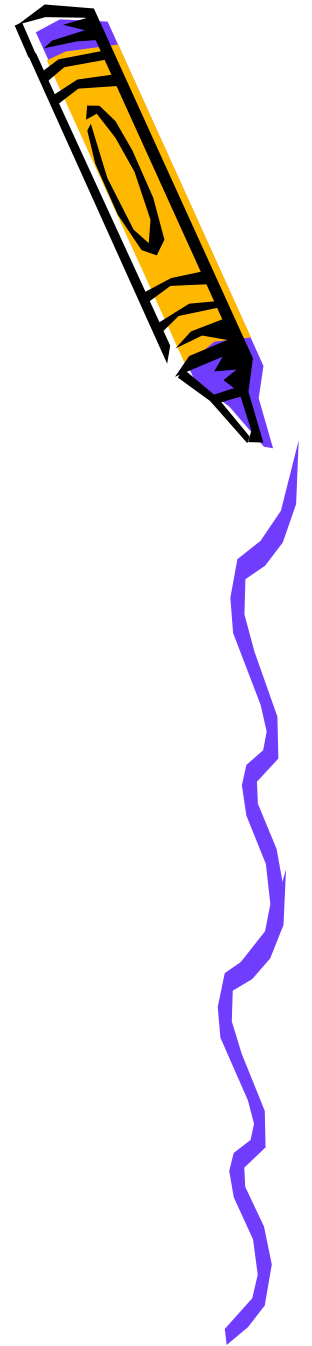
Presented by:
Candi McNew RN, CPC, CPC-H

What are HCPCS codes and how are they used?

Healthcare Common Procedure Coding System
Maintained by the Federal Government - Centers
for Medicare and Medicaid Services.

1. CPT
2. HCPCS
3. Medicare

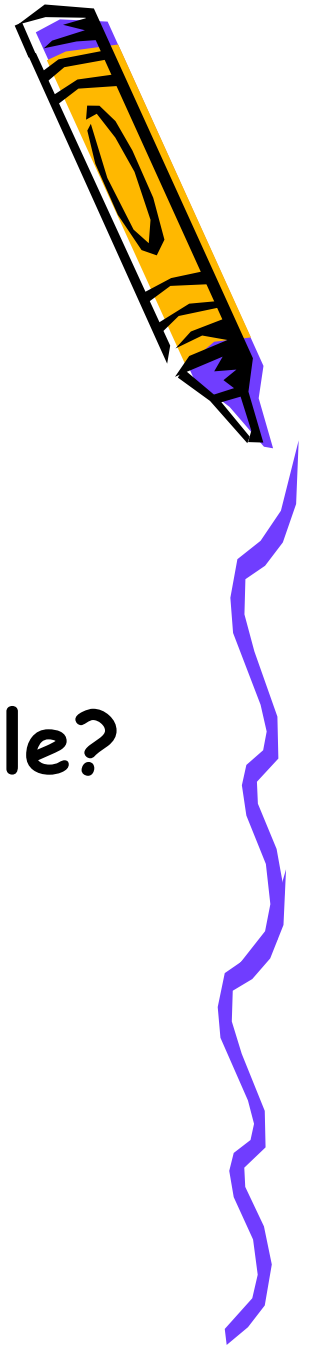
Always check the descriptions to make sure
they are the same or which code explains the
service the best.



Are HCPCS Codes paid?



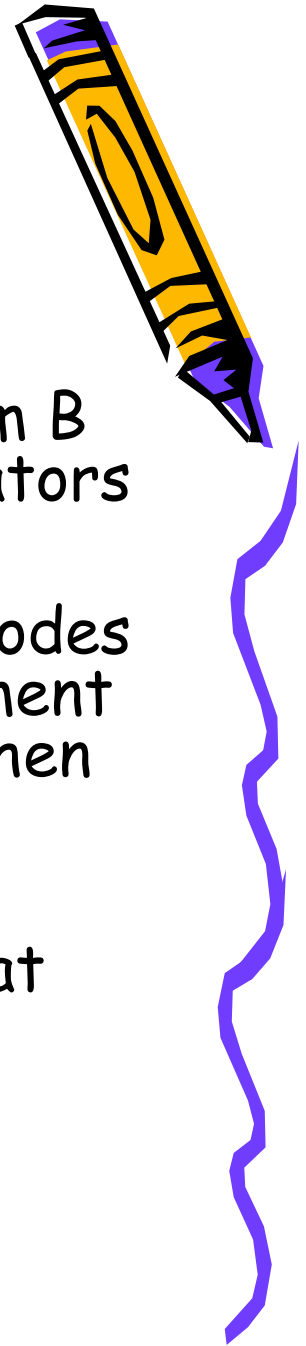
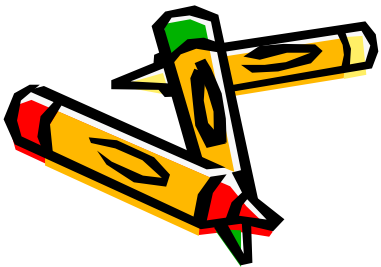
1. OPPS Payable: What fee schedule?
2. DME License
3. Private Payer Contract



Addendum B and Status Indicators

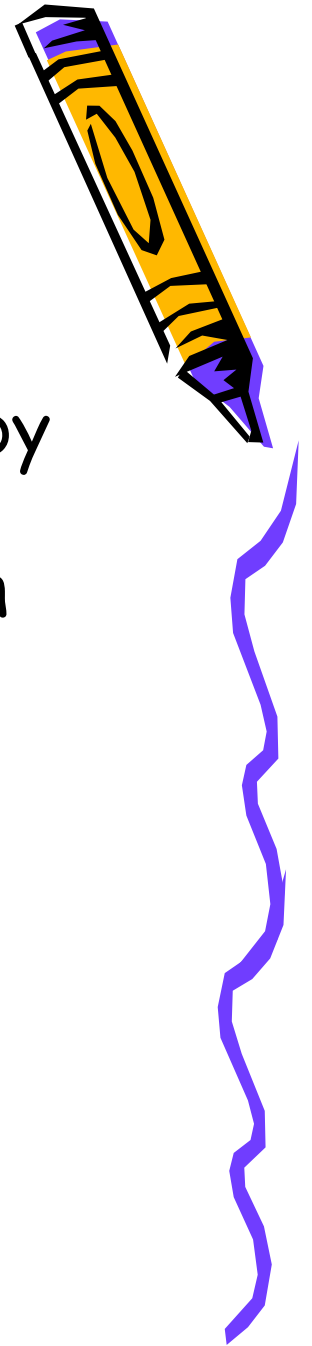
A very helpful resource to hospitals is Addendum B of the OPPS and the associated Status Indicators

- Status Indicator "A" identifies which HCPCS codes are separately payable under some other payment system, such as, the DMEPOS fee schedule when billed to the FI
- Status Indicator "Y" that identifies HCPCS that must be billed to the DMERC



What items are billable by OP departments to the FI/AB MAC?

- Some items that are DME are billable by Outpatient departments to the FI/AB MAC on a UBO4. These items have been exempted from the DME billing regulations.
 - Implanted DME
 - Surgical Dressings
 - Prosthetics/Orthotics
 - ESRD Home Supplies Method I payment



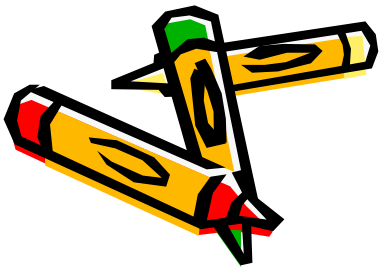
A is for Ambulance, Transportation and Medical Supplies

- A0434 - Specialty care transport (SCT):

Interfacility transportation of a critically injured or ill beneficiary by
A ground ambulance vehicle, including medically necessary supplies
And services, at a level of service beyond the scope of the EMT
Paramedic.

SCT is necessary when a beneficiary's condition requires ongoing
care that MUST be furnished by one or more health professionals
in an appropriate specialty area:

nursing, emergency medicine, respiratory care, cardiovascular
care, or a paramedic with additional training

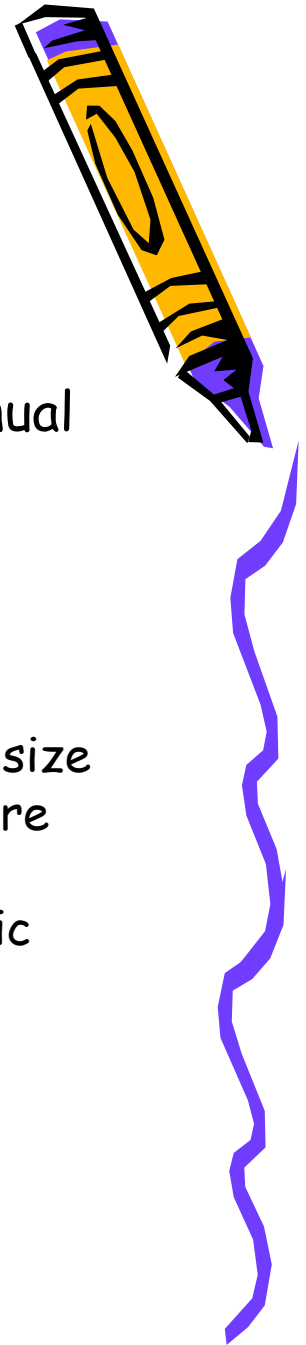


Medical Surgical Supplies

Medical Surgical Supplies • Provider Reimbursement Manual
HCFA Pub. 15,

Section 2203.2 states that to be separately chargeable,
a supply item must be:

- Directly identifiable to the individual patient with specific documentation or easily inferred documentation (e.g., documentation of a laceration repair specifying the location, size and type of suture would be sufficient for inferring the suture tray charge).
- Furnished at the direction of a physician because of specific medical needs (i.e., a specific physician order. The order may be a formal protocol or standing order.)
- Not reusable or represents a cost for each preparation



Take Home Surgical Dressings

Take home surgical dressings are a category of DME and would be supplied by an outpatient hospital clinic to its patients, typically from a wound care clinic.

The Take-home surgical dressing benefit is in the old hospital manual section 441 subsections O and P.

"If the hospital/clinic/OP departments are providing dressings to your outpatients to take home, bill your intermediary under revenue code 0623 "Surgical Dressings" along with the applicable surgical dressing HCPCS code. In this situation, payment will be made under the surgical dressing fee schedule

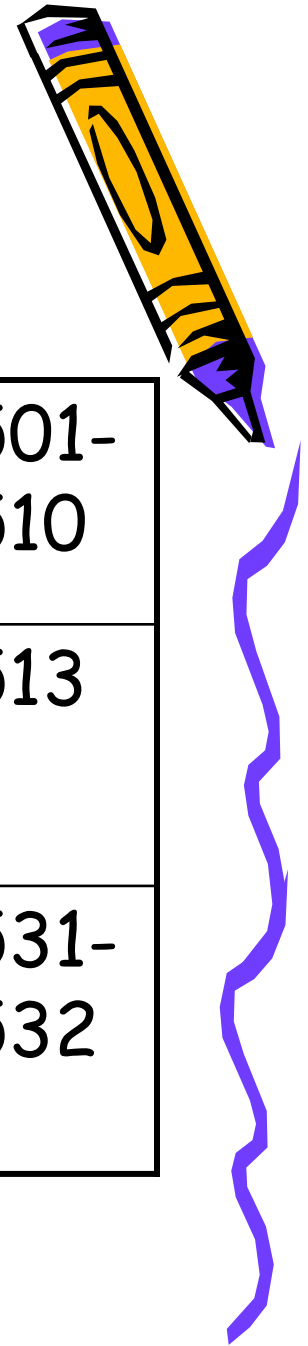


Surgical Procedure and Medical Supplies

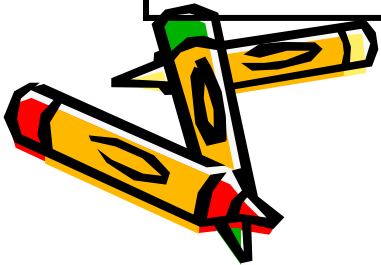
If hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPPS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim.



HCPCS codes billable to the FI/AB MAC



A4280 A4565	A6022- A6024	A6228- A6248	A6407	A6501- A6510
A4463 A4465	A6154	A6251- A6266	A6410 -A6411	A6513
A6010- A6011	A6196- A6224	A6402- A6404	A6441 - A6457	A6531- A6532



Ostomy Supplies

- Certain restrictions apply
 - Can be billed with the HCPCS code with revenue code 274, when associated with the surgery to create the opening or a revision to the opening.
 - If the ostomy supply is used for any other reason it does not qualify as exempt and can be billed without the HCPCS code and revenue code 272.



Medical Supplies



- Medical Supplies
 - If not separately payable but billable with a revenue code on the UB04.

<http://www.cms.hhs.gov/transmittals/downloads/R1702CP.pdf>



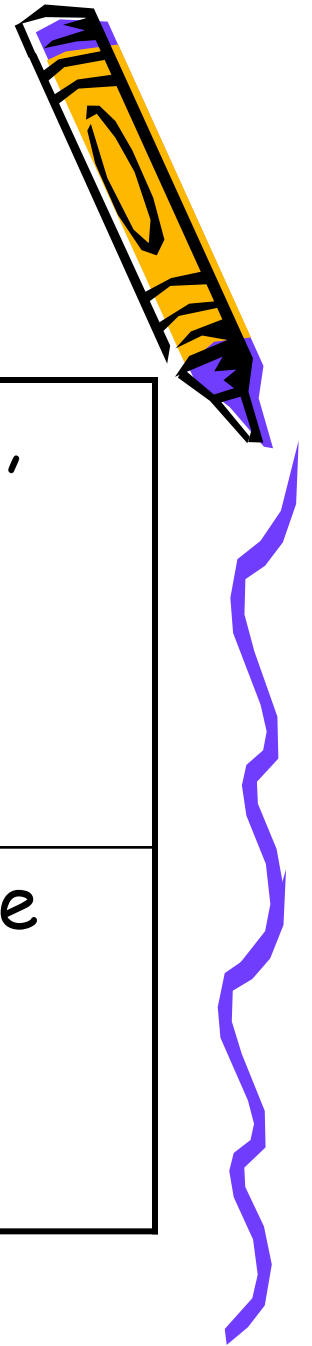
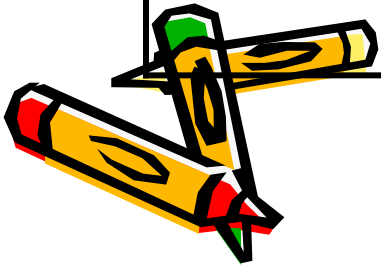
Implantable HCPCS Codes - A

A4262-Temporary,
Absorbable Lacrimal
Duct Implant, Each

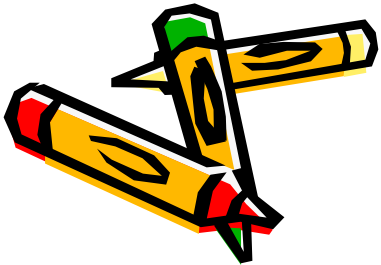
A4263-Permanent,
Long Term,
Nondissolvable
Lacrimal Duct
Implant, Each

A4300-Implantable
Access Catheter.
External Access

A4301-Implantable
Access Catheter.
Port/Reservoir



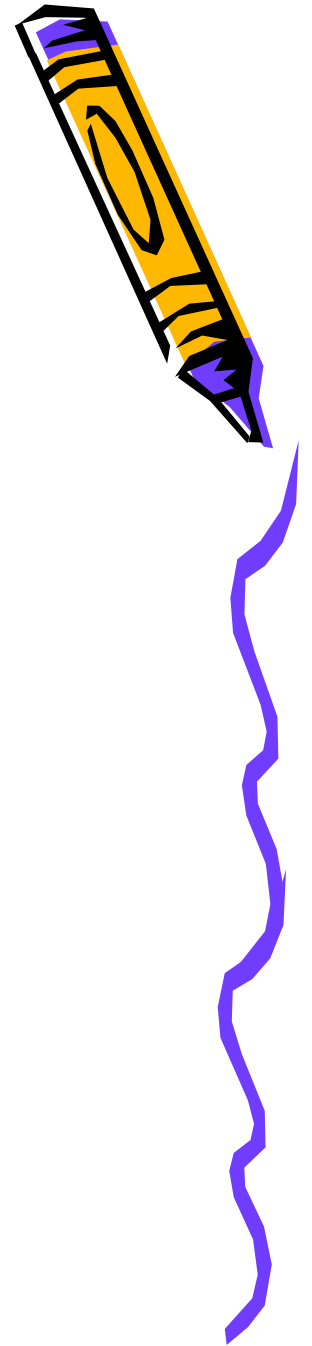
B is not for Bed Pan



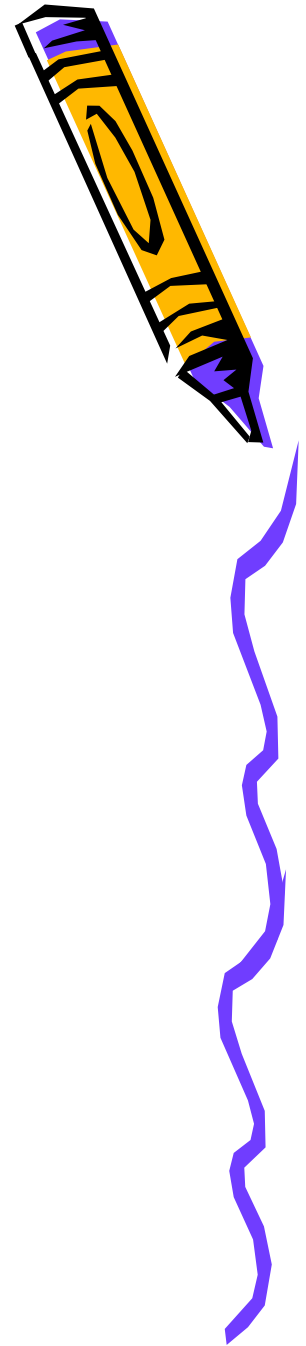
B is for Enteral & Parenteral Therapy

Codes are for supplies, formulae's, nutritional solutions and infusions pumps.

Billable to the DMERC.

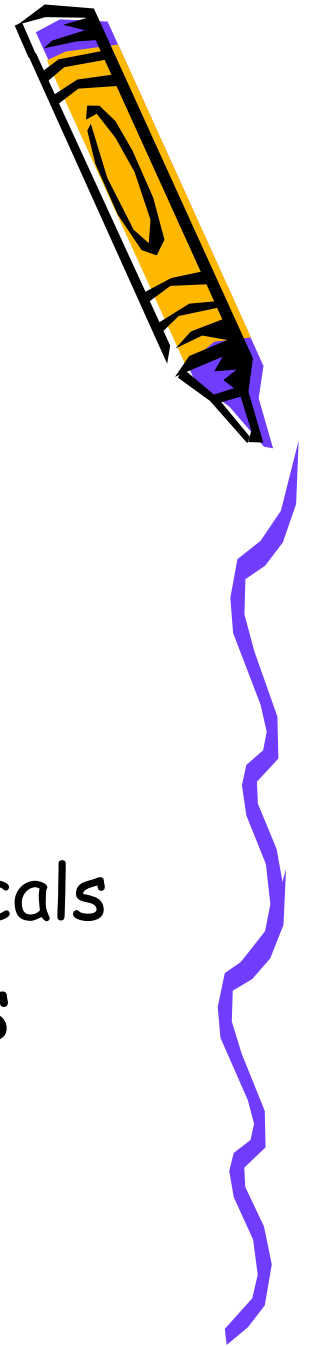


C is not for Coffee &
Cookies



C is for Outpatient PPS

- Only for Facilities
- Codes included in this category:
 - Devices
 - New Technology
 - Drugs/Biologicals/Radiopharmaceuticals
- Some have separate APC Payments



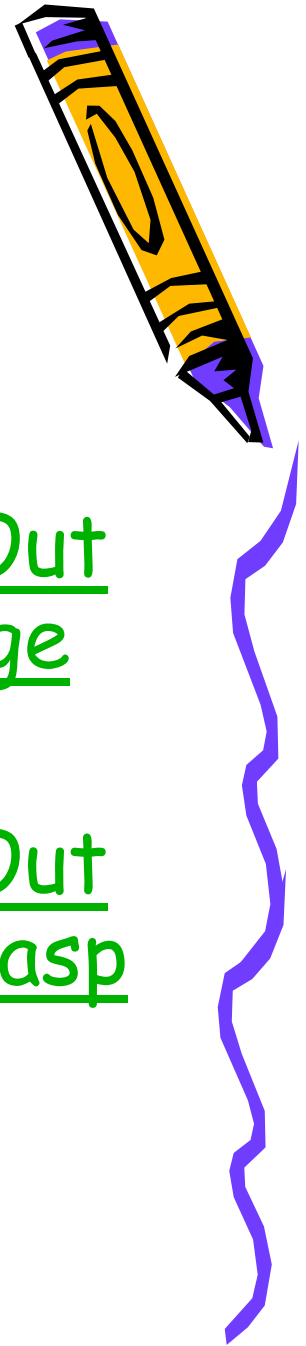
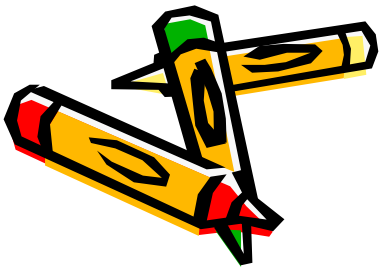
C is for Outpatient PPS

Addendum B:

- <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage>

Device to Procedure Edits:

- http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage



Report C codes for all Outpatient PPS Services



Hospitals are advised to continue to report all HCPCS codes that describe packaged items and services that were provided, unless CPT instructions or CMS provide other guidance. Further, hospitals should include charges for packaged items or services described and reported by those HCPCS codes with status indicator "N" on their claims when those codes can be appropriately reported, so that the costs associated with the packaged items or services can then be added to the costs of separately payable procedures on the same claims when establishing the annual payment rates for the separately payable services under the OPSS.



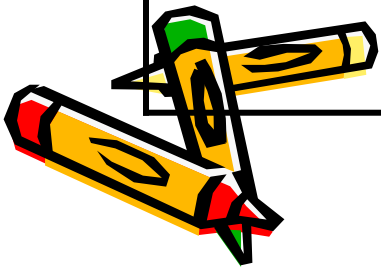
Transmittal: 1702

Effective Date: April 1, 2009

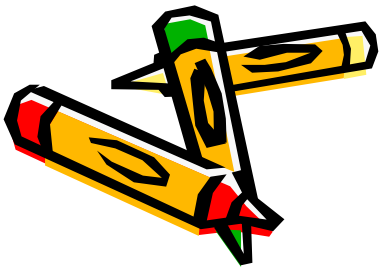
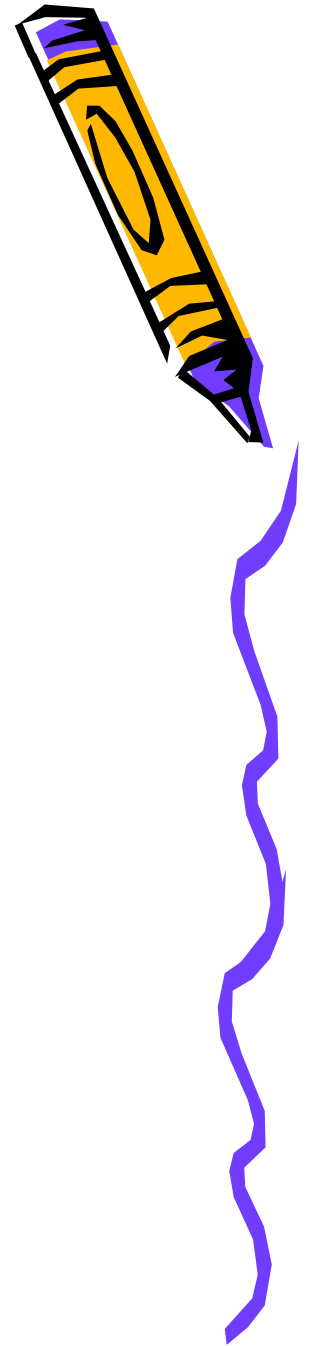
Implementation Date: April 6, 2009

Implantable HCPCS - C Code Descriptions

Brachytherapy Sources	Infusion Pumps, Catheters (?), Ports	Connective Tissue	Mesh, Vascular Grafts
Neurostimulator, Joint Devices, Anchors/Screws	Cardioverter-Defibrillator/Pacemakers/Event recorder	Leads Closure Device	Penile, Breast, Urinary Prosthesis
Ocular Implant, Intraocular Lens	Pulmonary Sealant	Stents/Vena Cava Filter	Urinary repair Device



D is for Dental

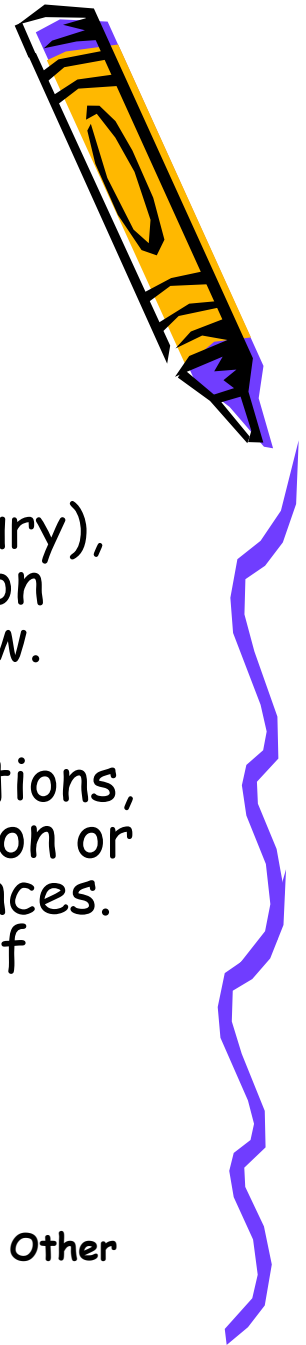


Medicare and Dental Services

- Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw.
- Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such examination would be covered under Part A if performed by a dentist on the hospital's staff



Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services



E is for Equipment but it
must be Durable



Durable Medical Equipment

- DME is covered under Part B as a medical or other health service (§1861(s)(6) of the Social Security Act [the Act]) and is equipment that:
 - Can withstand repeated use;
 - Is primarily and customarily used to serve a medical purpose;
 - Generally is not useful to a person in the absence of an illness or injury; and
 - Is appropriate for use in the home.
- All requirements of the definition must be met before an item can be considered to be durable medical equipment.

»EXCEPT:

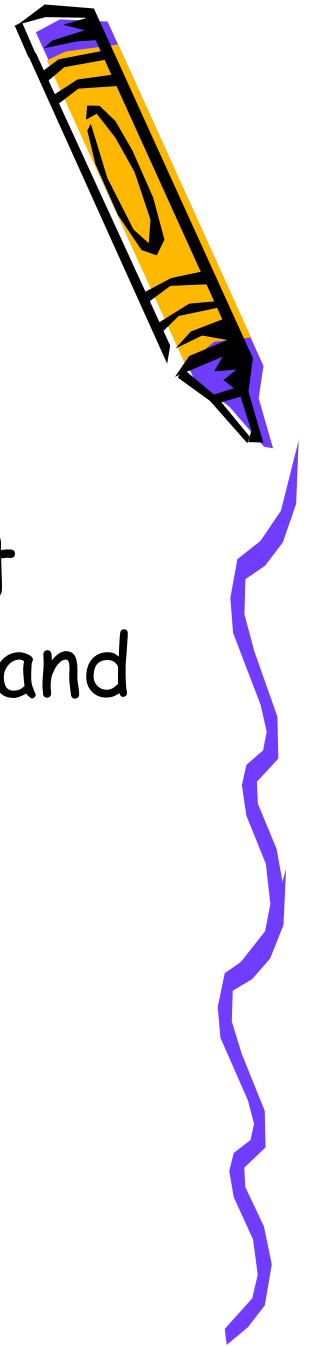


Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services



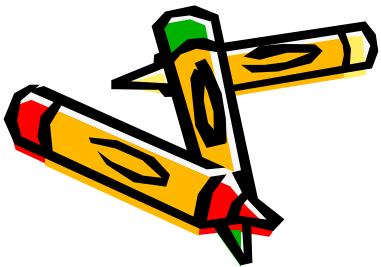
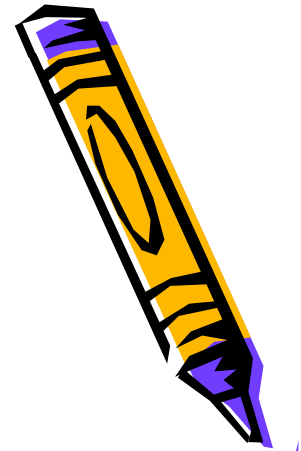
E is for Equipment that is Implantable

- E0616 - Implantable Cardiac Event Recorder with memory, activator, and programmer. SI-N
- C1764 - Event Recorder, Cardiac (Implantable). SI-N



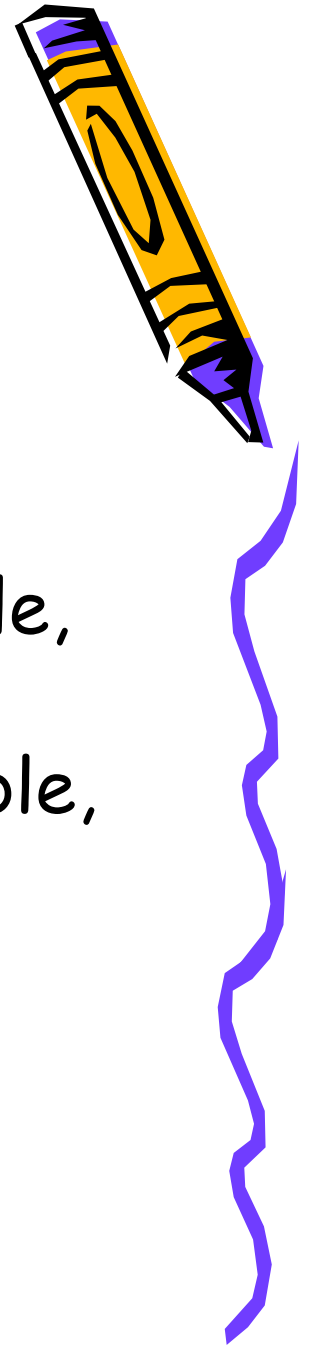
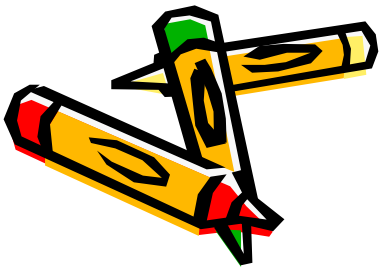
E is for Equipment that is Implantable

- E0782 - Infusion Pump Implantable non-programmable (includes all components, e.g. pump, catheter, connectors, etc) SI-N
- E0783 - Infusion Pump Implantable programmable (includes all components, e.g. pump, catheter, connectors, etc) SI-N
- E0785 - Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement. SI-N
- E0786 - Implantable Infusion Pump, replacement (excludes intraspinal catheter) SI-N



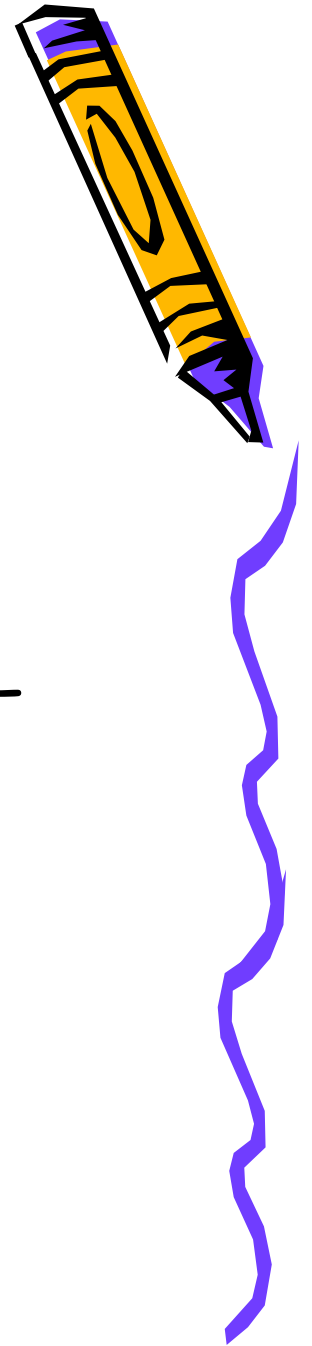
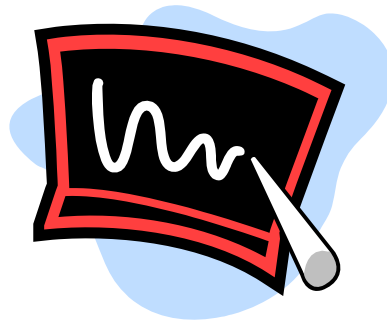
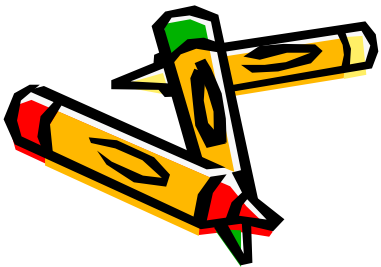
Comparable C codes: Always Use C codes First

- C1772 - Infusion Pump Implantable, programmable. SI-N
- C1891 - Infusion Pump, nonprogrammable, permanent (implantable) SI-N
- C2626 - Infusion pump, nonprogrammable, temporary (implantable) SI-N
- C1754 - Catheter interdiscal SI-N
- C1755 - Catheter intraspinal SI-N

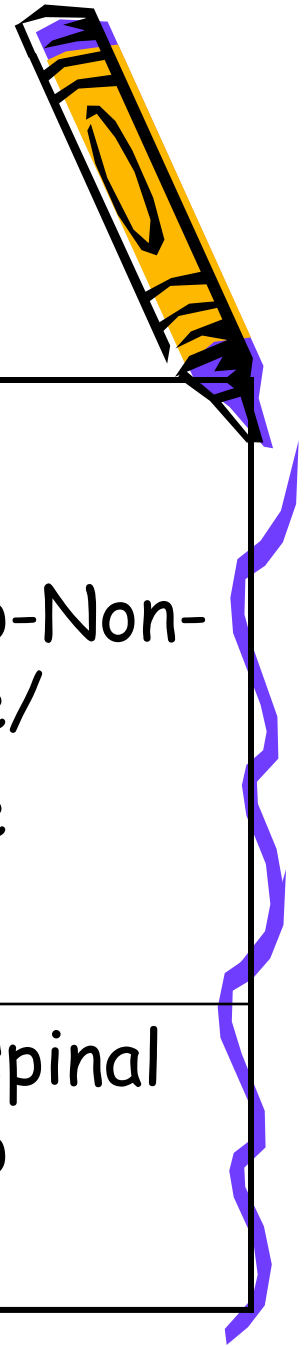


E is for Equipment but it
must be Durable

E1902 - Communication board, non-
electronic augmentative or
alternative communication device



Implantable HCPCS Codes - E

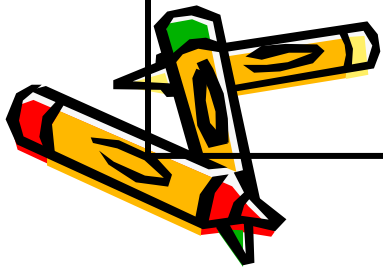


E0616-
Cardiac
Event
Recorder

E0749-
Osteogenesis
Stimulator-No
C Code exists

E0782-83-86
Implantable
Infusion Pump-Non-
Programmable/
Programmable
Replacement

E0785-Intraspinal
Infusion Pump

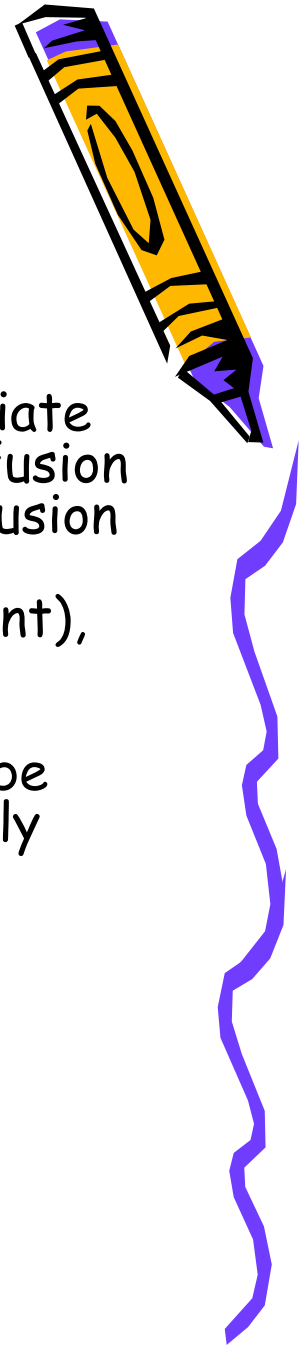


DME and Charging in the Hospital Setting

If the hospital staff in the emergency department initiate the intravenous administration of a drug through an infusion pump described by HCPCS code E0781 (Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient), complete the drug infusion, and discontinue use of the infusion pump before the patient leaves the hospital outpatient department, HCPCS code E0781 should not be reported because the infusion pump was used as a supply and would be paid through OPPS payment for the drug administration service. The hospital should include the charge associated with the infusion pump on the claim.



Medicare Claims Processing Manual
Chapter 4 - Part B Hospital

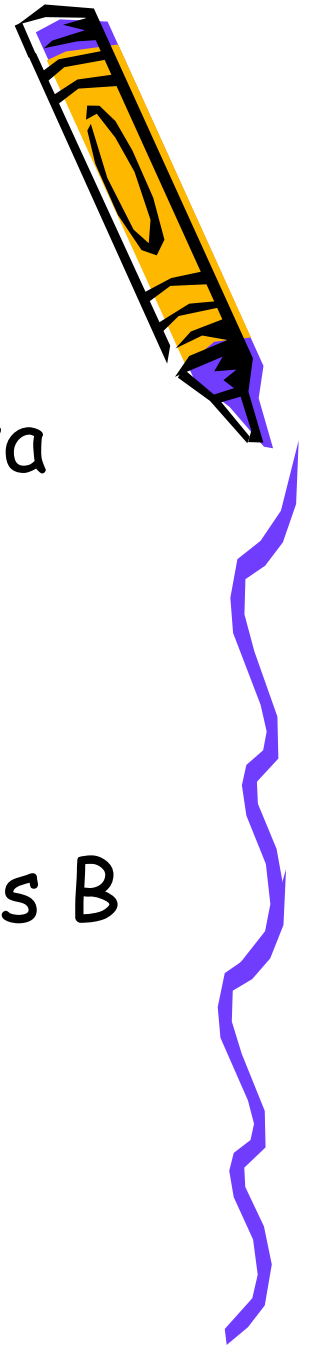


G is for
Procedures/Professional
Services (Temporary)



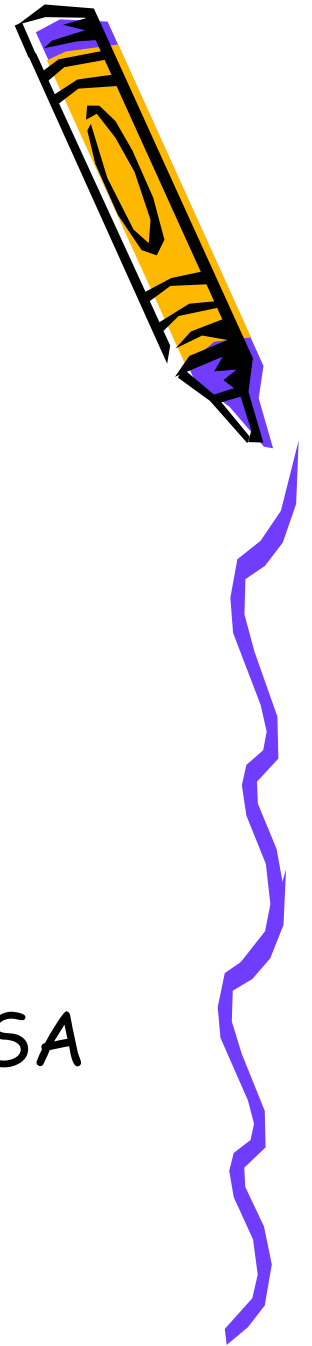
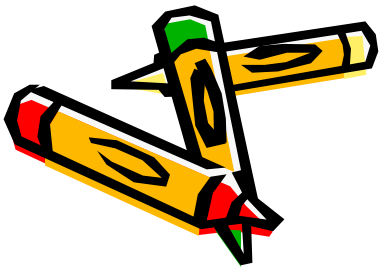
G is for
Procedures/Professional
Services (Temporary)

- G0008-Administration of Influenza Vaccine
- G0009-Administration of Pneumococcal Vaccine
- 90471- Administration of Hepatitis B Vaccine



G is for
Procedures/Professional
Services (Temporary)

- Screenings:
 - G0101- Cervical or Vaginal Cancer Screening; Pelvic and clinical Breast Examination
 - G0102-Prostate Cancer Screening; Digital Rectal Exam
 - G0103-Prostate Cancer Screening; PSA

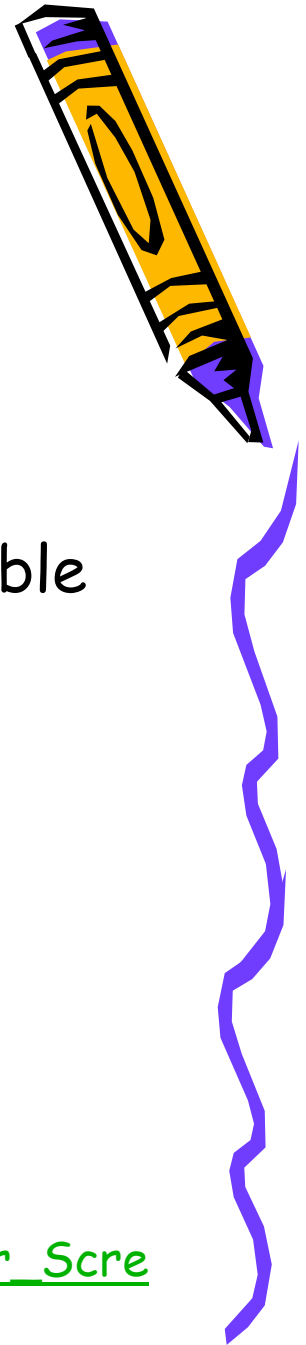


G is for Procedures/Professional Services (Temporary)

- Screenings:
 - G0104 - Colorectal Cancer Screening; Flexible Sigmoidoscopy
 - G0105 - Colorectal Cancer Screening; Colonoscopy, High Risk
 - G0121 Colorectal Cancer Screening; Colonoscopy, Not High Risk



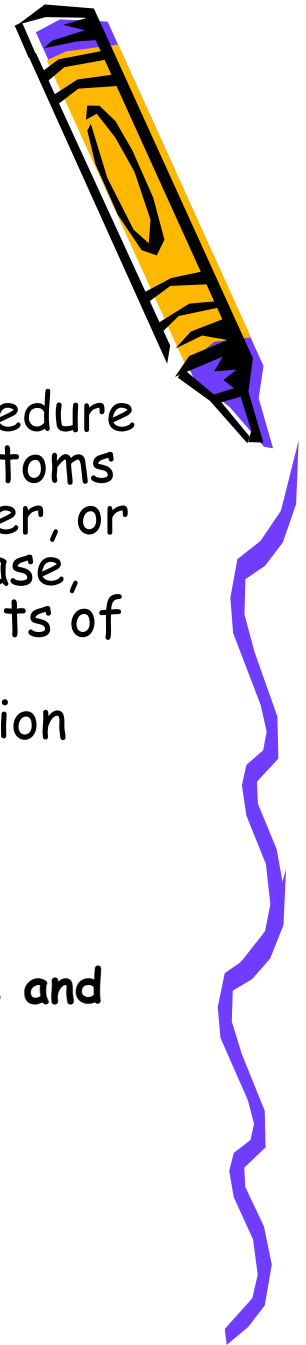
http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf



G is for Procedures/Professional Services (Temporary)

- A diagnostic mammogram is a covered radiological procedure that is furnished to a man or woman with signs or symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease, and it includes a physician's interpretation of the results of the procedure. Unlike the screening mammogram, the diagnostic procedure does require a doctor's prescription or referral in order for coverage to be available.

Medicare Claims Processing Manual Chapter 18 - Preventive and Screening Services



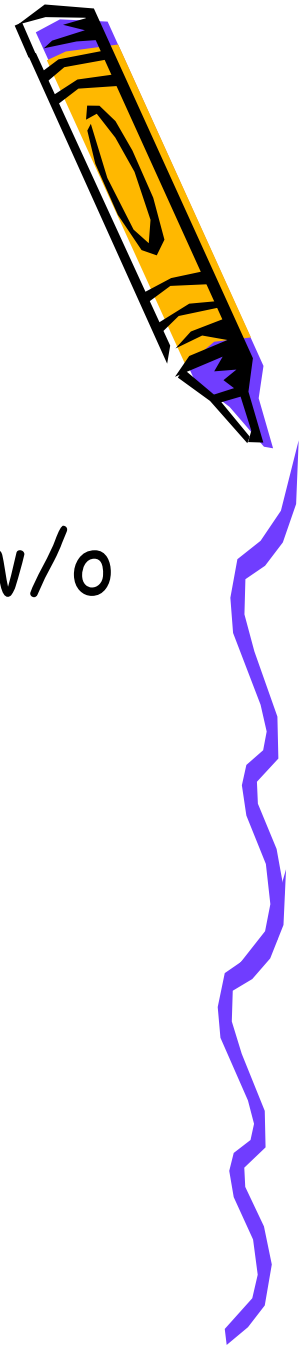
G is for
Procedures/Professional
Services (Temporary)

- Screening versus Diagnostic:
 - G0202 - Screening Mammography,
Direct Digital Image, Bilateral, All Views
 - G0204 - Diagnostic Mammography,
Direct Digital Image, Bilateral, All Views
 - G0206 - Diagnostic Mammography
Direct Digital Image, Unilateral, All
Views



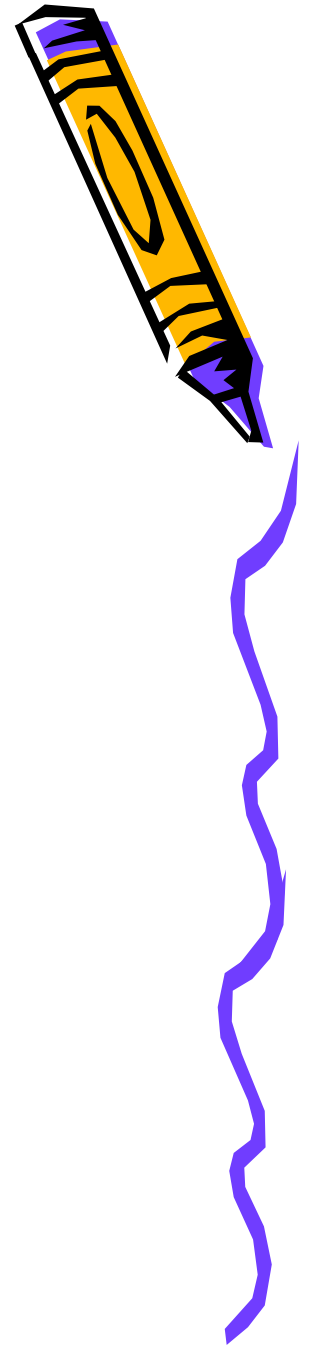
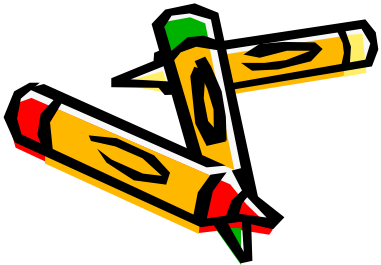
G is for
Procedures/Professional
Services (Temporary)

- G0260 - Injection SI Joint, w or w/o arthrography SI: T
- 27096 - Injection SI joint arthrography and/or anesthetic/steroid SI: B



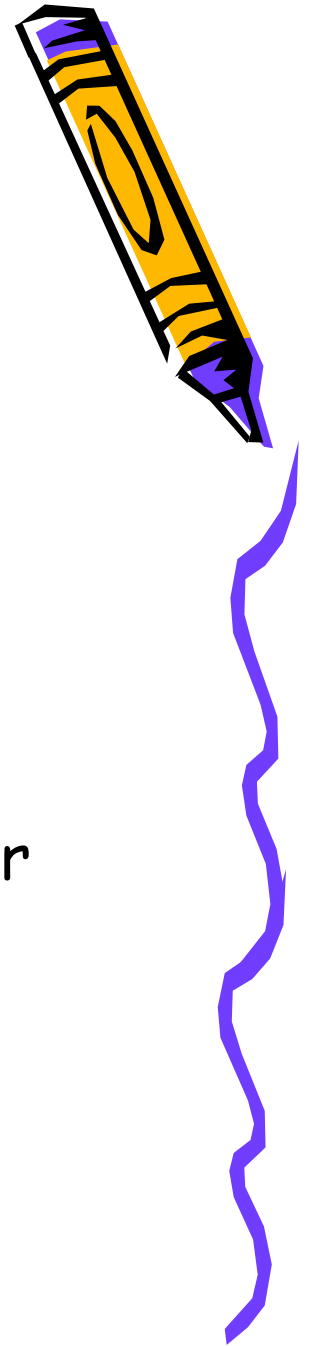
H Alcohol and Drug Abuse Treatment Services

- Not payable under OPPS



J Drugs Administered other than Oral Method

- Single versus Multidose Vial
- Mg, ml, gm's, units, mcg, IU
- Specific dosage versus UP TO
- Route of Administration
 - IM, IV, PO, Inhalation, Implant, Intraocular
- Formulation - i.e. Liposomal, protein bound, powder, solution, porcine, human

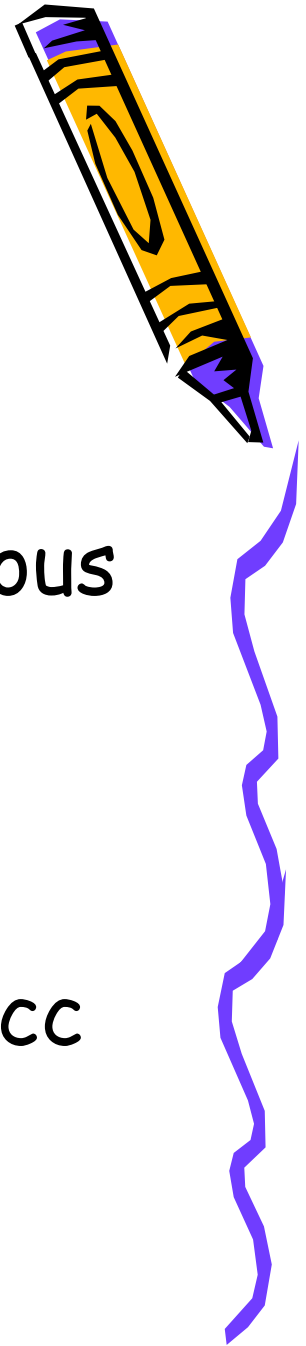


J Drugs Administered other than Oral Method

J2001 - Lidocaine HCL for Intravenous
Infusion, 10mg

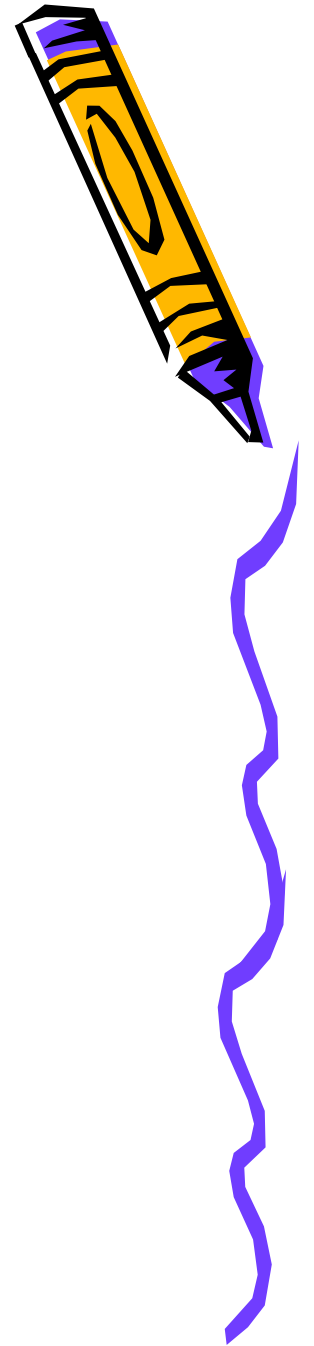
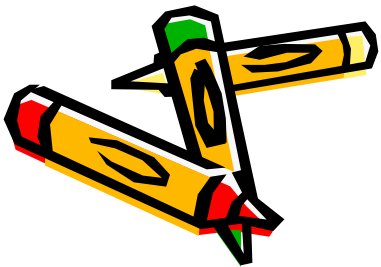
Is not interchangeable with deleted
HCPCS code

J2000 - Injection, lidocaine hcl, 50 cc

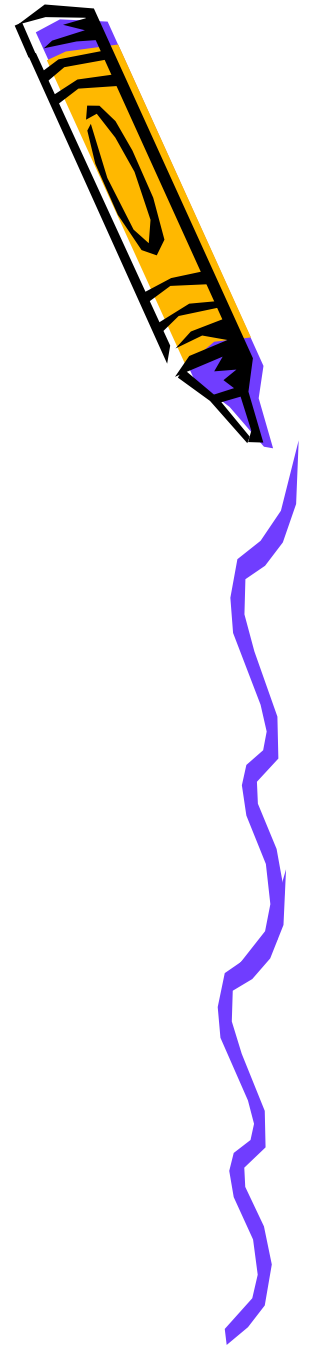


K Temporary Codes

- DMERC billing

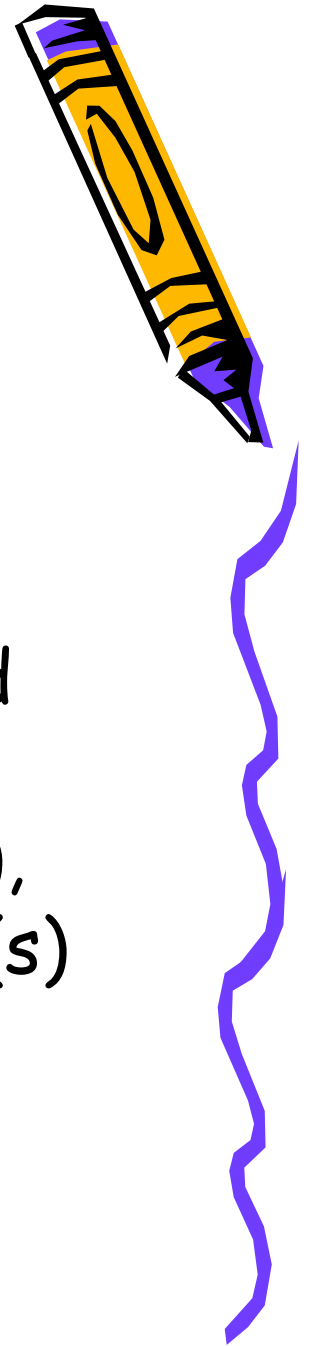


L is for Orthotic Procedures



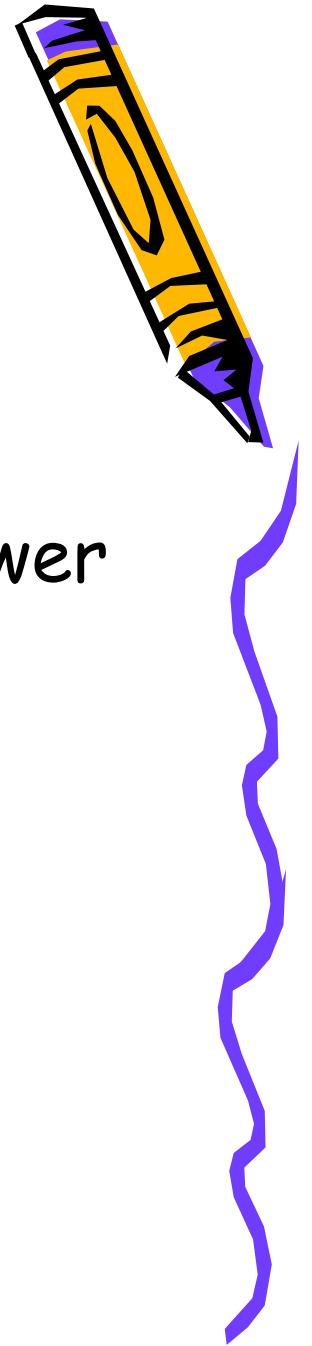
L is for Orthotic Procedures

- Prefabricated versus Fabricated
- ALWAYS THERAPY CODES
 - 97760 - Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes



L is for Orthotic Procedures

- ALWAYS THERAPY CODES
 - 97761 - Prosthetic training upper/lower extremity(s), each 15 minutes
 - 97762 - Checkout for orthotic/prosthetic use, established patient, each 15 minutes

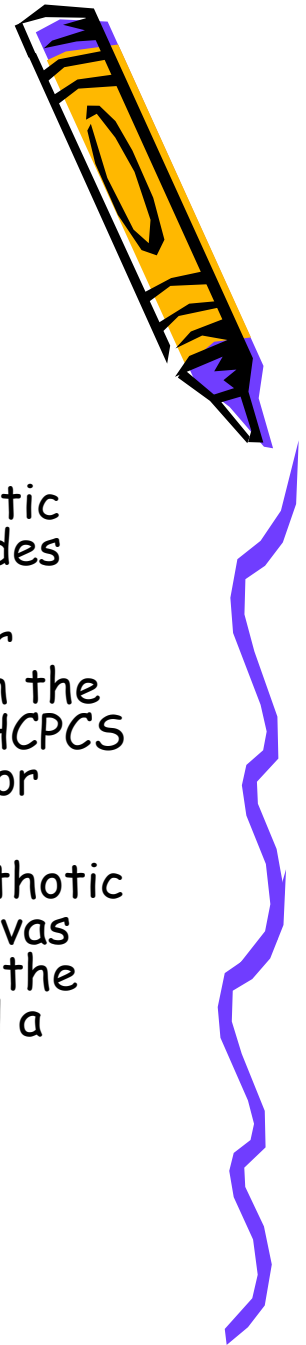


Charging for a Visit and an L Code

- Controversial in the ED setting
- When hospital outpatient staff provide a prosthetic or orthotic device, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient's use of the item, the hospital should not bill a visit or procedure HCPCS code to report the charges associated with the fitting, adjustment, or other related services. Instead, the HCPCS code for the device already includes the fitting, adjustment or other similar services.
- For example, if the hospital outpatient staff provides the orthotic device described by HCPCS code L1830 (KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment), the hospital should only bill HCPCS code L1830 and should not bill a visit or procedure HCPCS code to describe the fitting and adjustment.



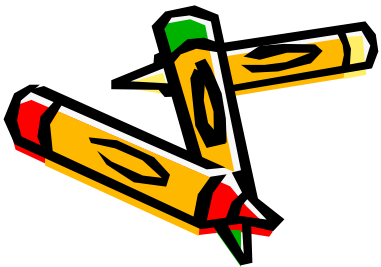
**Medicare Claims Processing Manual
Chapter 4 - Part B Hospital**



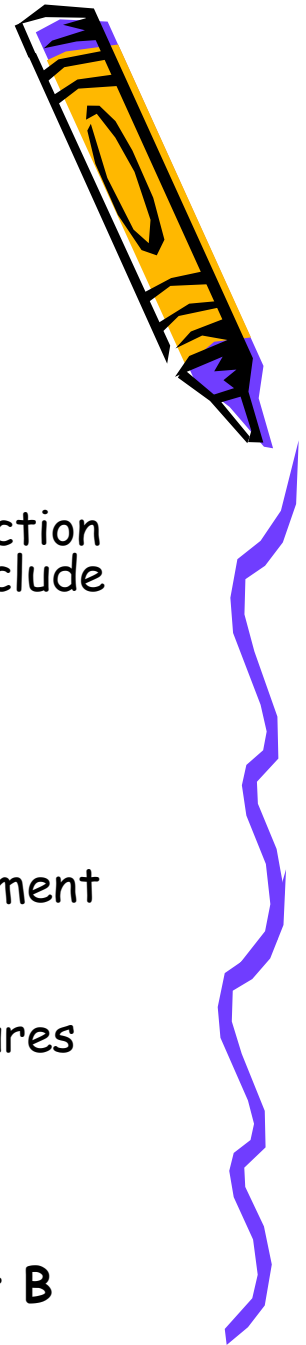
L is for Orthotic Procedures

40 - Other Covered Services and Items
(Rev. 1, 10-01-03) A3-3112.4.C, HO-230.4.D

- Covered services and items provided by the hospital in connection with a clinic visit or a physician's treatment of outpatients include the use of the following:
- Hospital facilities, including the use of the emergency room;
- Services of nurses, nonphysician anesthetists, psychologists, technicians, therapists, and other aides; and
- Medical supplies such as gauze, oxygen, ointments, and other supplies used by physicians or hospital personnel in the treatment of outpatients.
- Additional examples of covered items are surgical dressings; splints, casts, and other devices used for reduction of fractures and dislocations; prosthetic devices; leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes

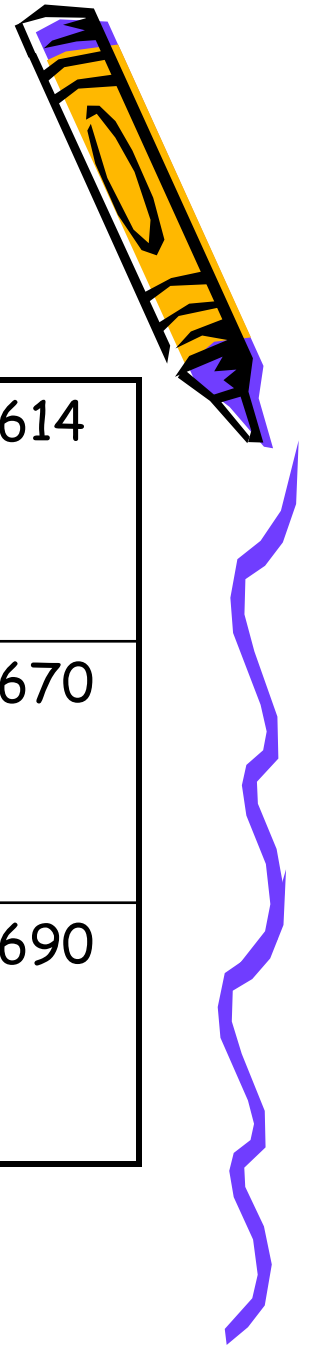


Medicare Benefit Policy Manual
Chapter 6 - Hospital Services Covered Under Part B

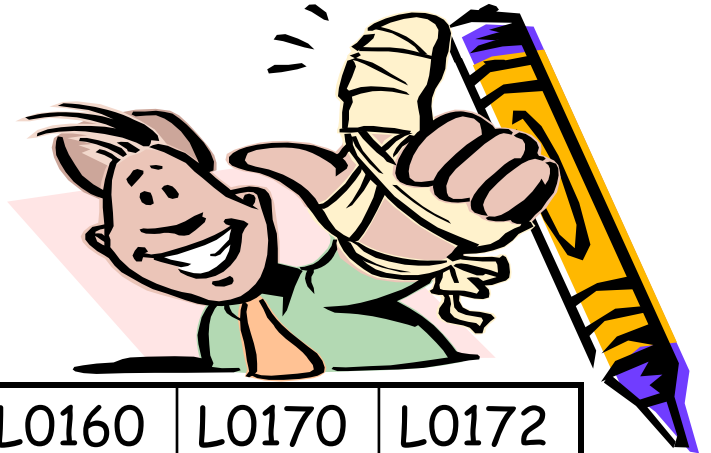


Implantable HCPCS Codes L

L8600	L8603	L8606	L8609	L8612	L8613	L8614
L8630	L8631	L8641	L8642	L8658	L8659	L8670
L8680	L8682	L8685	L8686	L8687	L8688	L8690



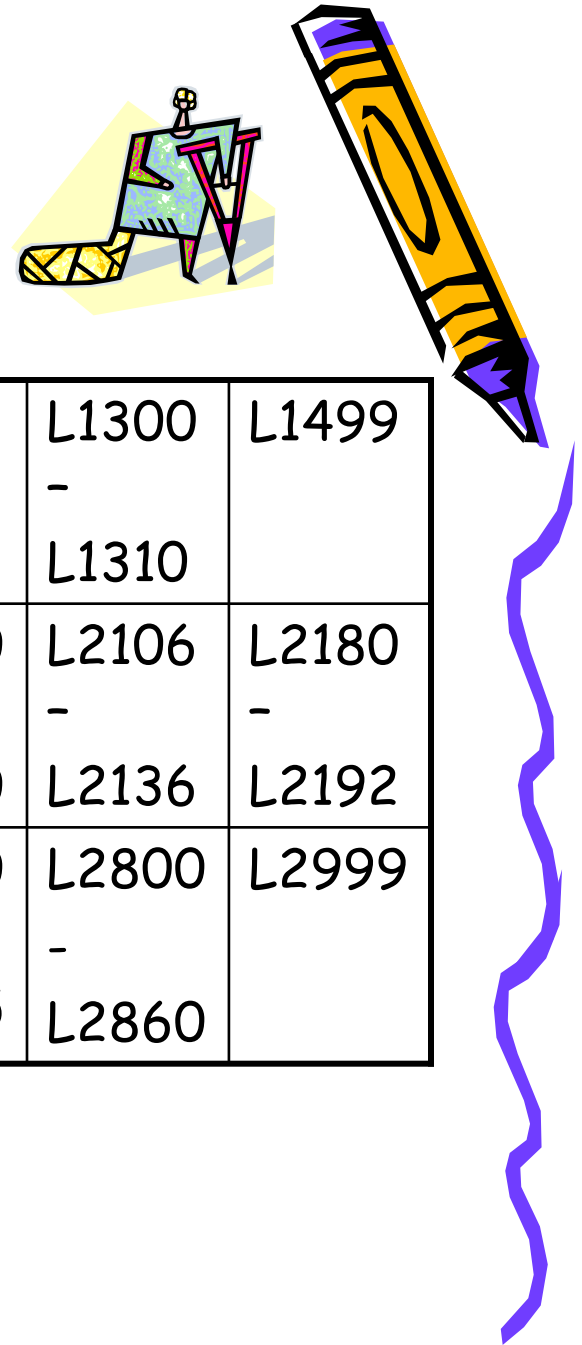
Payable L Codes



L0112	L0120	L0130	L0140	L0150	L0160	L0170	L0172
L0174	L0180	L0190	L0200	L0210	L0220	L0430	L0450
L0452	L0454	L0456	L0458	L0460	L0462	L0464	L0466
L0470	L0472	L0480	L0482	L0484	L0486	L0488	L0490
L0491	L0492	L0621 - L0640	L0700	L0810	L0820	L0830	L0830
L0859	L0861	L0861	L0970	L0972	L0974	L0976	L0978



Payable L Codes



L0980	L0999	L1000	L1005	L1100	L1210	L1300	L1499
-		-	-	-	-	-	
L0984		L1001	1090	L1120	L1290	L1310	
L1510	L1600	L1700	L1800	L1900	L2000	L2106	L2180
-	-	-	-	-	-	-	-
L1520	L1690	L1755	L1860	L1990	L2090	L2136	L2192
L2200	L2300	L2405	L2500	L2600	L2750	L2800	L2999
-	-	-	-	-	-	-	
L2280	L2397	L2492	L2580	L2680	L2795	L2860	



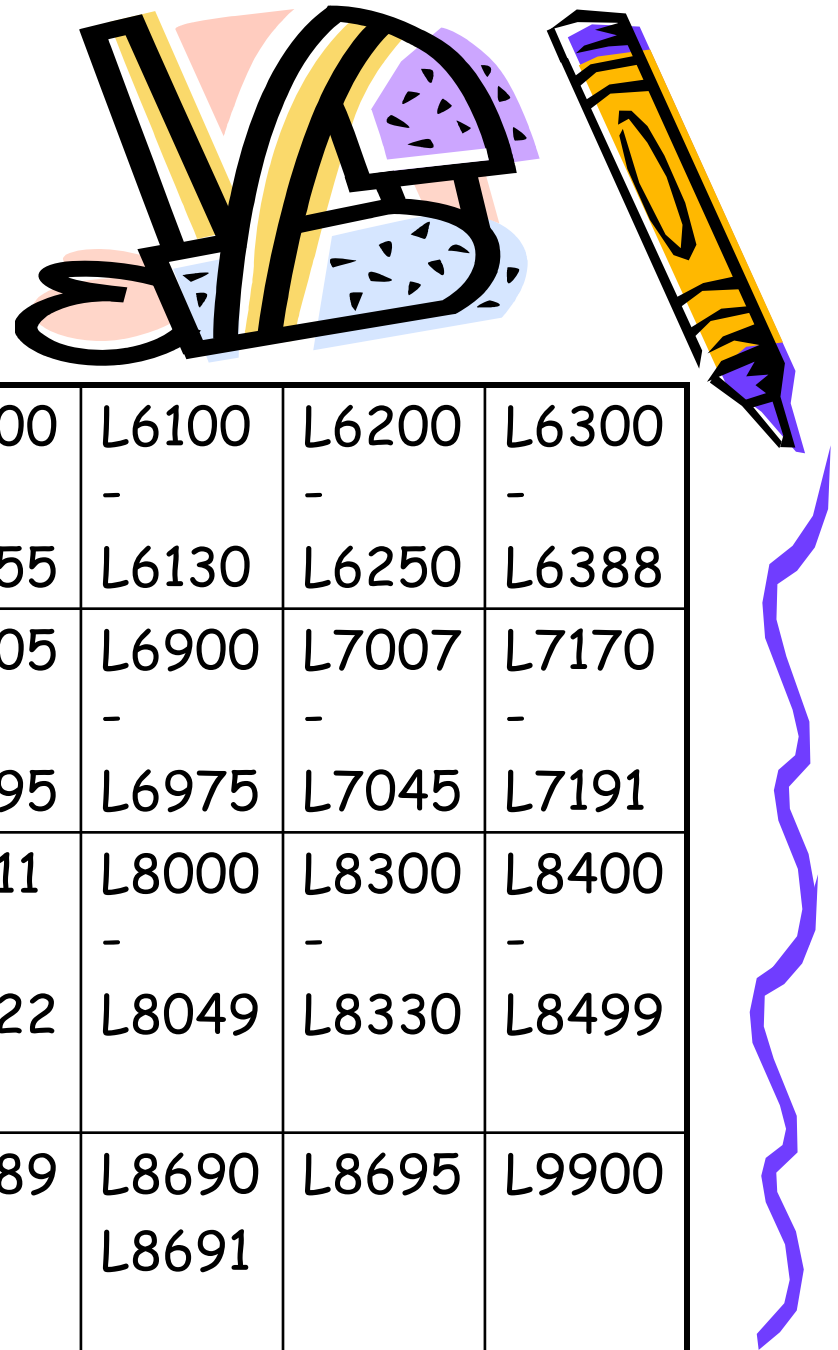
Payable L Codes



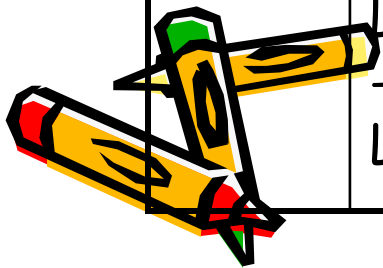
L3000	L3100	L3201	L3224	L3300	L3400	L3500	L3600
-	-	-	-	-	-	-	-
L3090	L3170	L3214	L3265	L3390	L3485	L3595	L3675
L3700	L3806	L3900	L3967	L3971	L3975	L4000	L4100
-	-	-		AND	-	-	-
L3766	L3890	L3962		L3973	L3999	L4090	L4130
L4205	L4350	L5000	L5100	L5200	L5301	L5400	L5500
-	-	-	-	-	-	-	-
L4210	L4398	L5060	L5160	L5280	L5341	L5460	L5595



Payable L Codes

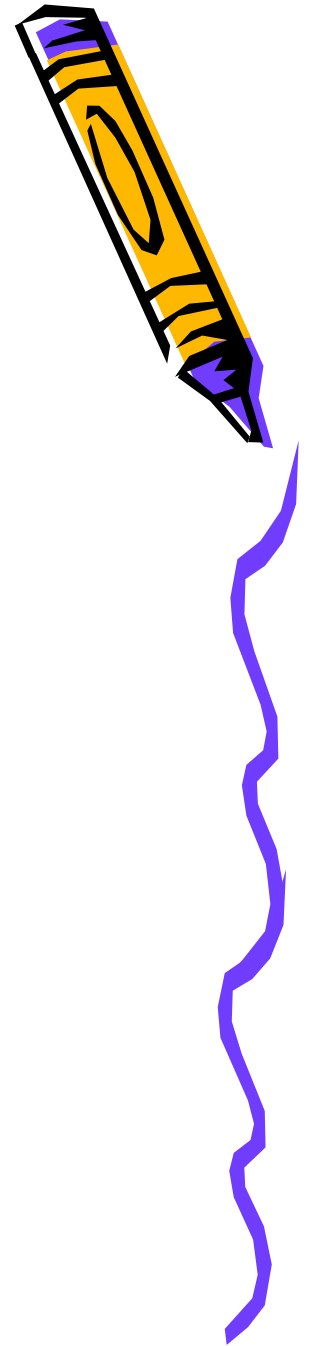


L5600	L5700	L5810	L5910	L6000	L6100	L6200	L6300
-	-	-	-	-	-	-	-
L5699	L5795	L5858	L5999	L6055	L6130	L6250	L6388
L6400	L6500	L6600	L6703	L3805	L6900	L7007	L7170
-	-	-	-	-	-	-	-
L6450	L6590	L6698	L6709	L6895	L6975	L7045	L7191
L7260	L7360	L7400	L7500	L7611	L8000	L8300	L8400
-	-	-	-	-	-	-	-
L7274	L7368	L7499	L7520	L7622	L8049	L8330	L8499
	L8500	L8615	L8681	L8689	L8690	L8695	L9900
	-	-	L8683		L8691		
	L8515	L8624	L8684				



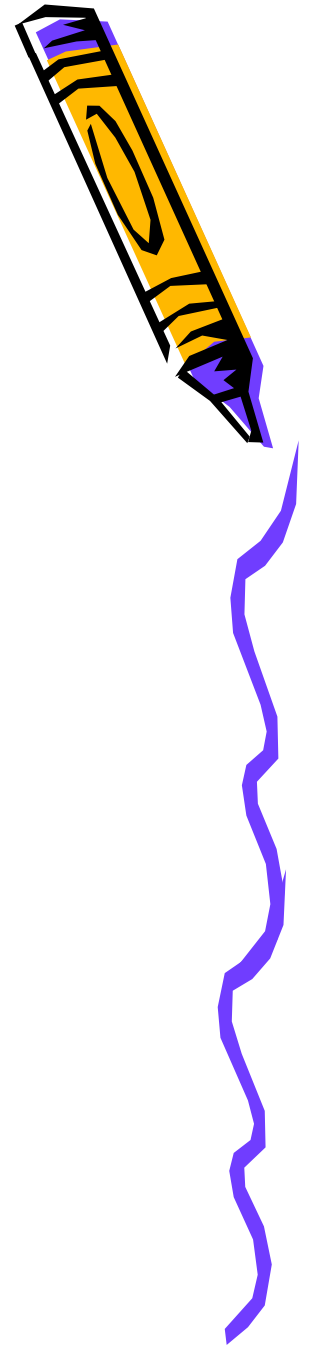
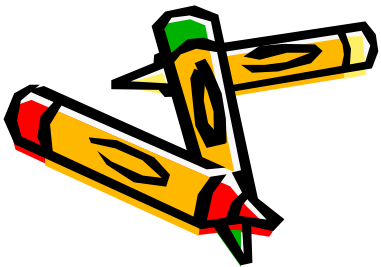
M IS FOR Medical Services

- Not paid for by Medicare



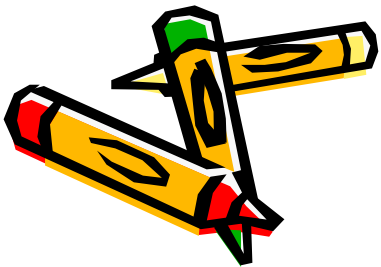
P Pathology and Laboratory Services

- Paid Under OPPPS
 - Blood and Blood Products
- Paid from the Laboratory Fee Schedule
 - Laboratory Test Check
 - Check Addendum B



Q Temporary Services

- Medicare will add Q codes quarterly.
- Check Transmittals
- Some have been temporary for years

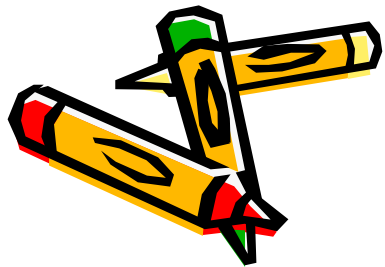


Implantable HCPCS Codes - Q

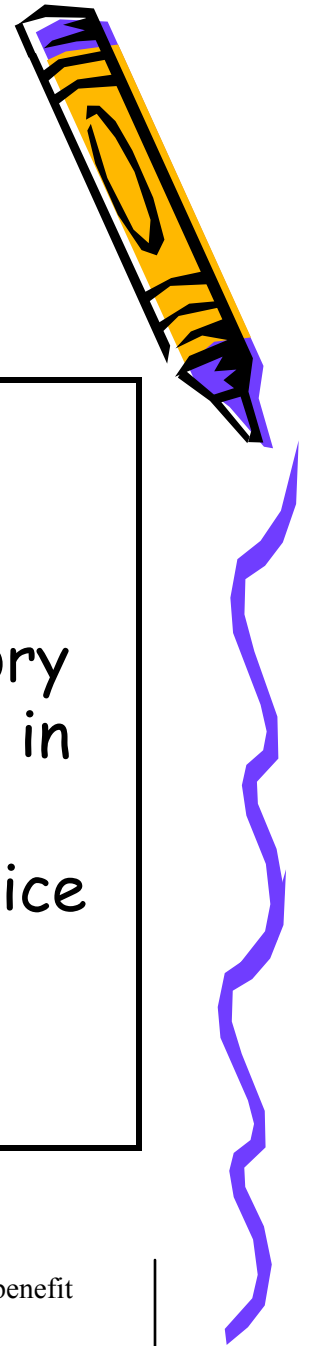
Q1003-New
Technology,
Intraocular
Lens, Category 3
as defined in the
Federal Register
notice Vol 65,
May 3, 2000

Q1004-New
Technology,
Intraocular
Lens, Category
4 as defined in
the Federal
Register notice
SI-E

Q1005-New
Technology,
Intraocular
Lens, Category
5 as defined in
the Federal
Register notice
SI-E



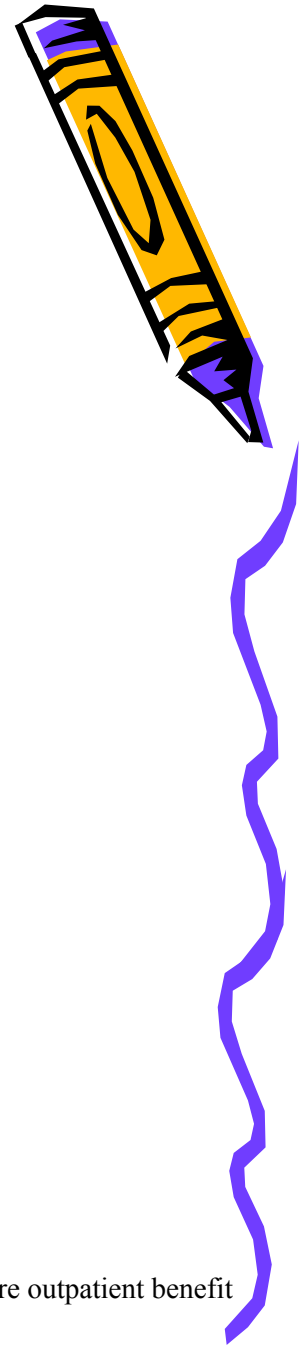
- That are not covered by any Medicare outpatient benefit based on statutory exclusion.



HCPCS Codes - Q Payable by FI AB/MAC

Q0480-Q0505

Items associated with Ventricular Assist
Device



- That are not covered by any Medicare outpatient benefit based on statutory exclusion.

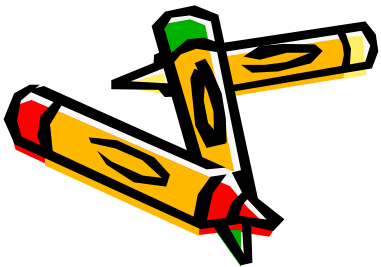
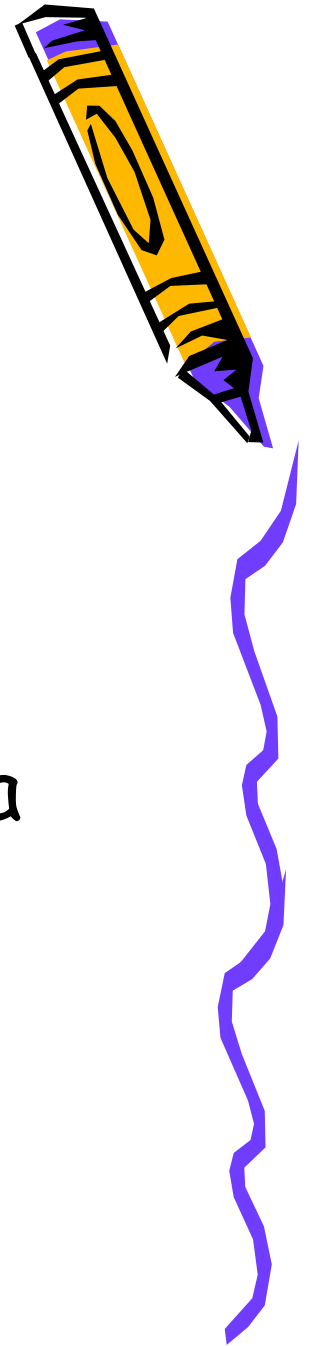
S is for Temporary National Codes (Non-Medicare)

- Medicaid will accept these codes depending on the state.
- Some Private Payers accept these codes. Blue Cross and Blue Shield
- Usually codes of last resort if another CPT/HCPCS code does not describe the service/procedure/medication

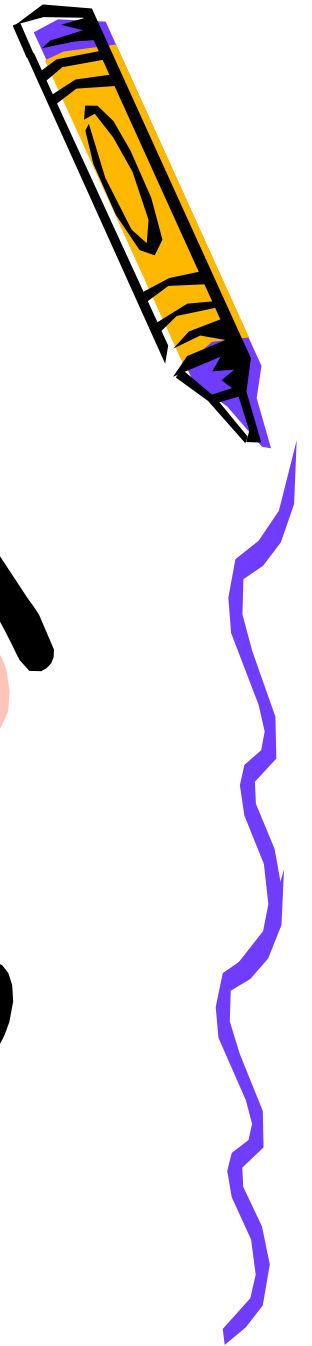
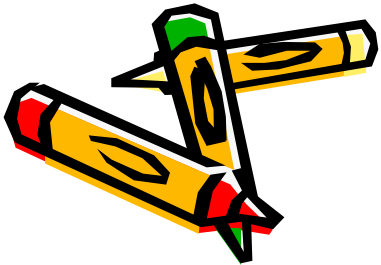


T Codes are for State Medicaid Agencies

- Medicaid will accept these codes
- Some Private payers will accept these codes if they are built into a contract.

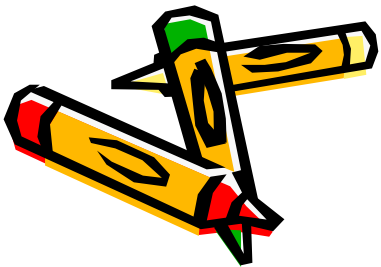


V is for Vision and
Hearing

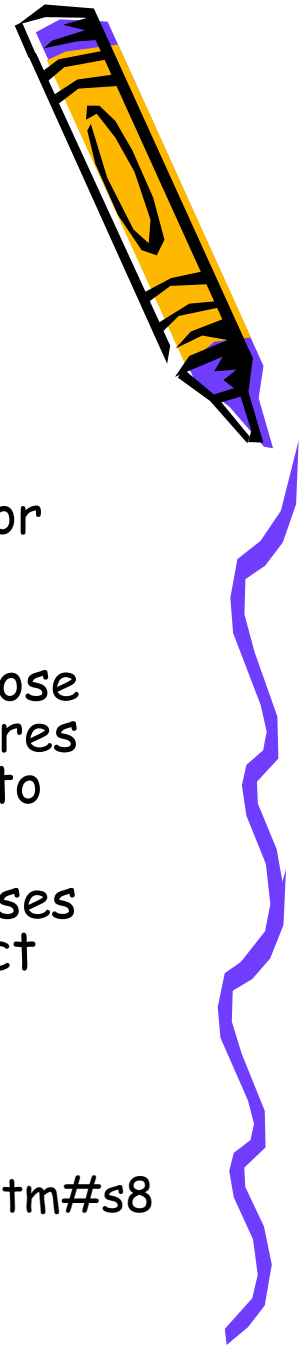


Eyeglass/Contact Lens Coverage

- Section 1862(a)(7) where notwithstanding any other provision of this title, no payment may be made under Medicare Part A or Part B for any expenses incurred for items or services where such expenses are for . . .
.eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes
Section 1861(s)(8) for one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens.



http://www.ssa.gov/OP_Home/ssact/title18/1861.htm#s8

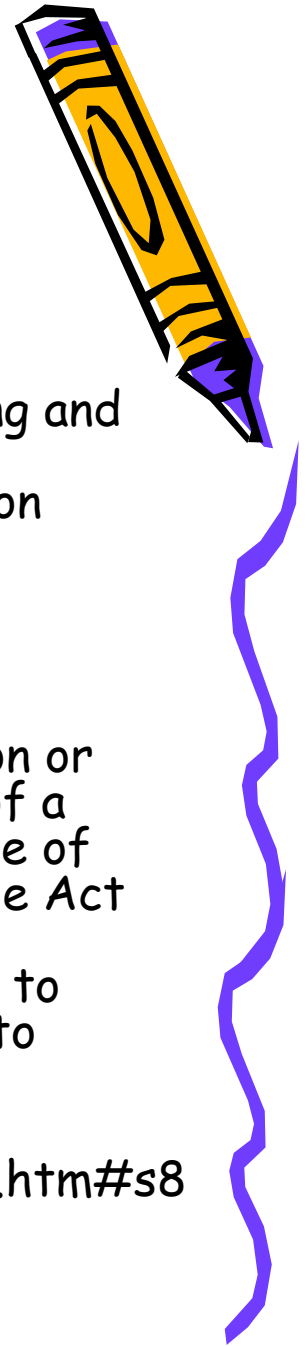


Hearing Aid Testing

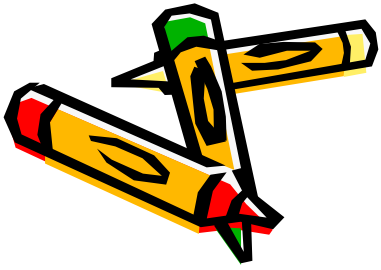
Medically necessary diagnostic hearing tests, including hearing and balance assessment services, performed by a qualified audiologist are covered as other diagnostic tests under section 1861(s)(3) of the Act and would be

separate from the new IPPE benefit. These services may be appropriate when a physician or other qualified NPP orders a diagnostic hearing test for the purpose of obtaining information necessary for the physician's diagnostic evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. However, coverage of this testing is excluded by virtue of section 1862 (a)(7) of the Act when the diagnostic information required to determine the appropriate medical or surgical arrangement is already known to the physician, or the diagnostic services are performed only to determine the need for the appropriate type of hearing aid.

http://www.ssa.gov/OP_Home/ssact/title18/1861.htm#s8



THE END



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