HCPCS in a Nutshell

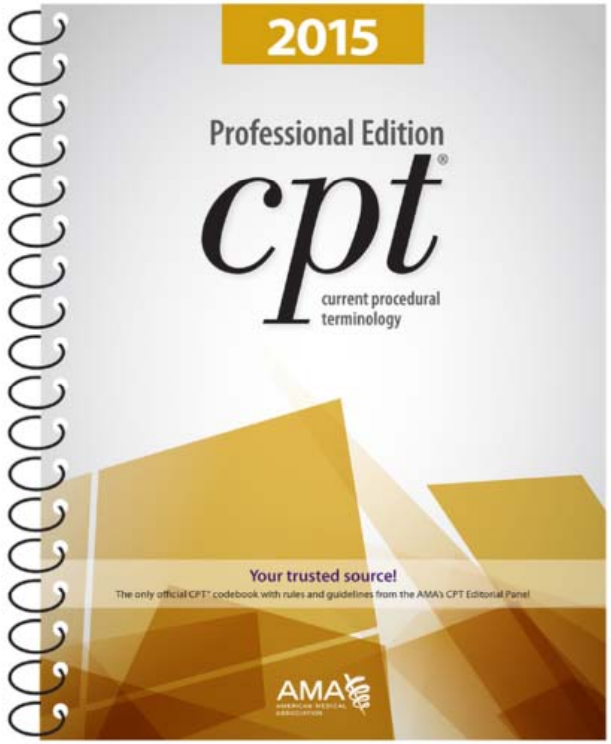
What is HCPCS?

HCPCS (Healthcare Common Procedure Coding System) is a standardized coding system created to ensure healthcare claims are processed in a consistent and orderly manner. HCPCS contains two code sets, published in two separate manuals:

- Level I: CPT (Current Procedural Terminology) – Developed in 1966, CPT is a coding system used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These codes are used to bill private or public health insurance plans. Most professional claims are billed utilizing the CPT code set. This set is maintained by the AMA and updated annually. This set does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

- Level II: HCPCS Level II – A coding system used to primarily identify products, supplies, and services not represented in the CPT code set. This set was developed in 1980, is maintained by CMS, and is updated quarterly based on feedback from providers, manufacturers, vendors, specialty societies, the ADA, BCBS, and others.

HCPCS Level I CPT Code Book



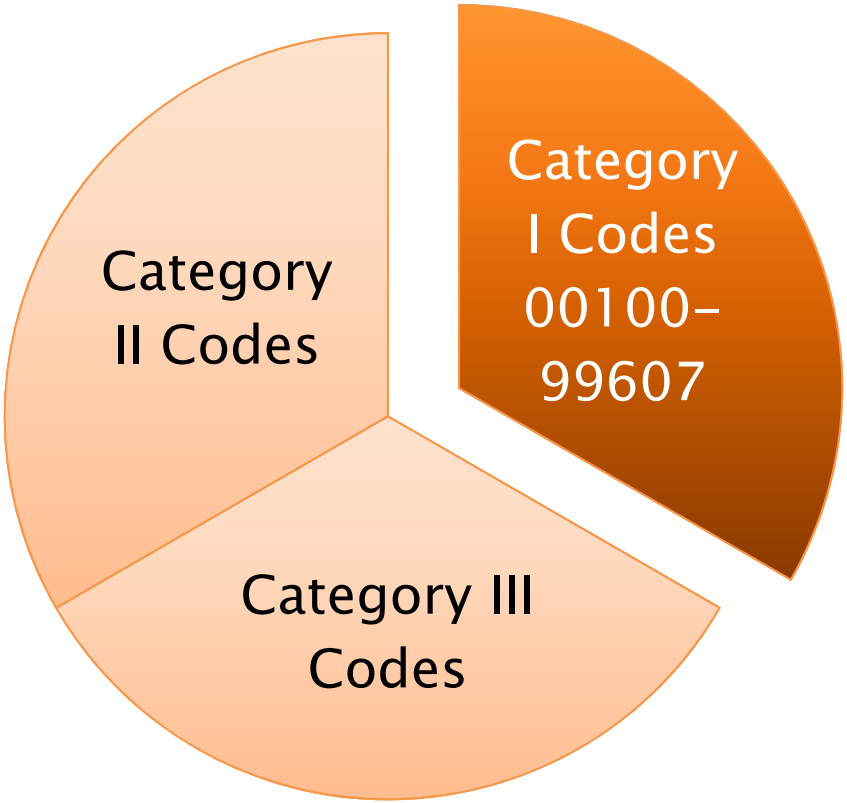
HCPCS Level I (CPT) Breakdown

The CPT codebook is comprised of the following sections, in the following order:

- **E/M** *(Evaluation and Management) (99201-99499)*
- **Anesthesia** *(00100-01999)*
- **Surgery** *(10021-69990)*
- **Radiology** *(70010-79999)*
- **Pathology and Laboratory** *(80047-89398)*
- **Medicine** *(Vaccines, Drugs, Psychiatry, Ophthalmology, Testing, and Procedures not Considered Surgical) (90281-99607)*
- **Category II** *(Supplemental tracking codes used for performance measurement)(0001F-9007F)*
- **Category III** *(Temporary codes for emerging technology, services and procedures)(0019T-0380T)*

The CPT codes and guidelines serve as the national coding standard for all physician and other heath care professional services and procedures performed in all places of service.

HCPCS Level I (CPT) Breakdown–cont'd



CPT codes 00100–99607 are the most frequently used and can be found on most professional claims. Samples of these frequently used codes are:

- 99201– Office or other outpatient visit, new patient, problem focused
- 99477– Initial hospital care, per day, for the evaluation and management of neonate
- 27134– Revision of total hip arthroplasty
- 70490– Computed tomography(CT), soft tissue neck
- 85002– Blood count, automated
- 90688– Influenza virus vaccine, over 3 years of age

CPT Breakdown

Defining Category II Codes

- Category II CPT codes are supplemental tracking alphanumeric codes, four digits followed by the letter F, that can be used for performance measurement. The use of these codes is usually optional; the codes are not required for correct coding and may not be used as a substitute for Category I codes. Examples include:
  - 5005F Patient counseled on self-examination for new or changing moles
  - 4004F Patient screened for tobacco use **and** received tobacco cessation intervention, if identified as a tobacco user
  - 2001F Weight recorded
  - 0500F Initial prenatal care visit; report also date of visit and date of last menstrual period (Medicaid requires this code)
- The use of the Category II codes is rapidly decreasing as providers are moving towards EHR and Registry submission of their quality measures. These codes were intended for reporting quality measures via claims submission.
- They are also intended to decrease the time spent by physicians and other health professionals on chart review to verify that the measures were performed. For example, if you are trying to track the use of statin therapy in your practice, reporting code *00067F, Statin therapy, prescribed,* will allow you to do this through your coding or billing rather than through chart review.
- These codes may typically describe services that are included in an evaluation and management (E/M) service. Therefore the Category II CPT codes will not have relative value units (RVUs) and are not reimbursable. Category II codes are not recognized in hospital outpatient billing of Medicare patients. They may be used for internal tracking and reporting, however it is important that these codes not be included on Medicare OPPS claims.

CPT Breakdown

Defining Category II Modifiers

- The Category II Modifiers are broken into two categories: Exclusion Modifiers (1P, 2P, 3P) and Inclusion Modifier (8P).
- Exclusion modifiers may only be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Some measures do not allow performance exclusions. Reasons for appending a performance measure exclusion modifier fall into one of three categories:
  - 1P Exclusion modifier due to medical reasons
    Examples include: not indicated (absence of organ/limb, already received/performed, other); contraindicated (patient allergic history, potential adverse drug interaction, other); other medical reasons.
  - 2P Exclusion modifier due to patient reasons
    Examples include: patient declined; economic, social, or religious reasons; other patient reasons.
  - 3P Exclusion modifier due to system reasons
    Examples include: resources to perform the services not available (e.g., equipment, supplies); insurance coverage or payer-related limitations; other reasons attributable to health care delivery system.

CPT Breakdown

Defining Category II Modifiers–cont'd

- Inclusion modifier 8P is available for use only with CPT II codes to facilitate reporting a denominator eligible case when an action described in a measure is not performed and the reason is *not specified*.
- 8P reporting modifier – action not performed, reason not otherwise specified
- Use of the 8P reporting modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.
- The 8P reporting modifier facilitates reporting an eligible case on a given measure when the quality action does not apply to a specific encounter. EPs can use the 8P reporting modifier to receive credit for satisfactory reporting but will not receive credit for performance.

As with Category II codes, these modifiers are used typically for physicians reporting via claims. Most EHR's have features that alert the physician when the patient is eligible, and if exclusion applies, physician can check to exclude that patient. This data is recorded in the patient chart and extracted for submission.

CPT Breakdown

Defining Category III Codes

- Category III is a set of temporary codes for reporting emerging procedures, services, and technology. These codes where created to provide a description for a service that previously could only be coded as *Unlisted/Other* in Category I CPT. Therefore, if a Category III code is available, it must be used in place of a Category I unlisted code.

- Because these services are emerging they may not have received FDA approval. Utilizing Category III codes is critically important in the evaluation of health care delivery and the formation of public and private policy.

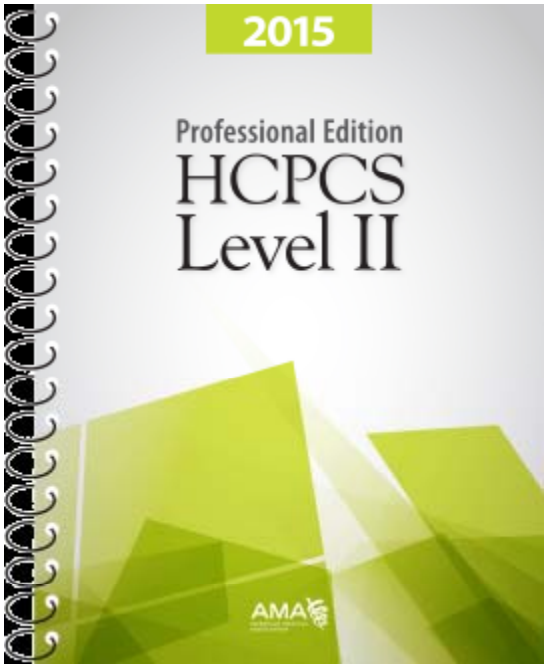
- All Category III codes are four digits followed by the letter T.

  Examples include:

  - 0188T Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient, from a remote location; first 30-74 minutes
  - 0329T Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report.

- These temporary codes may or may not eventually receive CPT Category I designation and will fall off of the Category III list five years after initial publication.

HCPCS Level II Code Book



HCPCS Level II Breakdown

The HCPCS Level II code book consists of the following sections, in the following order:

- Level II Modifiers
- Medical and Surgical Supplies (A)
- CMS Hospital Outpatient Payment System
- Dental Procedures
- Durable Medical Equipment (DME)
- Temporary Procedures/Professional Services (G)
- Drugs and Chemotherapy Drugs (J)
- Temporary DME for Regional Carriers (K)
- Orthotics and Prosthetics (L)
- Temporary Codes assigned by CMS (Q)
- Temporary National Codes by Private Payors (S)
- Temporary Codes by Medicaid (T)
- Vision and Hearing Services (V)

HCPCS Level II Breakdown- cont'd

- Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the Level II codes were established for submitting claims for these items. Although RVU's are not assigned these codes, they are billable and reimbursable by most payors.
- Hospitals utilize HCPCS Level II codes much more frequently than physician practices since medications, as well as surgical and medical supplies make up most of this code set.
- The development and use of HCPCS Level II began in the 1980's. In 2003 HHS delegated authority under the HIPAA legislation to CMS to maintain and distribute Level II codes.
- The BCBS Association and the American Dental Association(ADA) post their procedure codes as part of HCPCS Level II.
- CMS regularly uses HCPCS Level II to post codes for the tracking of demonstration projects and new technologies.

Thank you

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