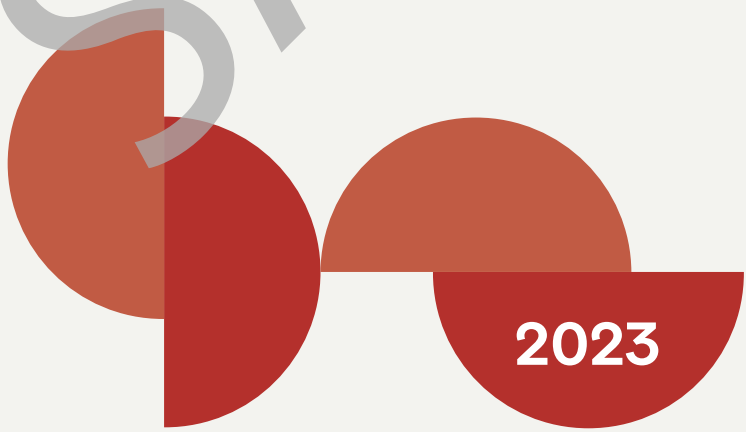
Optum

Desk Reference

Coders' Desk Reference for HCPCS Level II

Answers to your toughest HCPCS Level II coding questions



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Introduction to HCPCS

Coding is a complicated business. It is not enough to have current copies of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), *Current Procedural Terminology*, Fourth Edition (CPT®), and Healthcare Common Procedure Coding System (HCPCS Level II) books. Medical coders also need dictionaries and specialty texts if they are to accurately translate physicians' operative reports or patient charts into reimbursement codes.

That's why Optum360 has developed the *Coders' Desk Reference* series—to provide a one-stop resource with answers to a wide variety of coding questions. We polled the medical reimbursement community and our technical staff to determine the issues causing bottlenecks in a coder's workload.

We found that experienced coders are frustrated by limited definitions accompanying many CPT, ICD-10-CM, and HCPCS Level II codes. Beginning coders need guidelines on reporting ICD-10-CM, CPT, and HCPCS Level II codes and basic information about medical and reimbursement issues. Everyone requires up-to-date information about the anticipated changes to these coding systems.

Coders' Desk Reference for HCPCS answers the questions of both experienced and novice medical coders concerning medical supplies and equipment, as well as select services provided on an outpatient basis. It is a compendium of answers to a wide variety of coding questions and an introduction to new systems in coding structures. In order to code accurately, you must first have an understanding of the coding systems.

Coding Systems

Coding is the means by which providers and suppliers communicate their services with Medicare, Medicaid, third-party payers, and managed care organizations (MCOs). The correct use and reporting of modifiers and codes have become the defining elements in the reimbursement process for medical and surgical services, including services and items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Assignment of the appropriate codes and adequate medical record documentation are necessary to avoid or minimize risk of fraud and abuse charges.

Diagnosis Coding

Diagnostic statements contained within medical records and other medical documentation are assigned codes from ICD-10-CM. The correct use and reporting of ICD-10-CM codes is an important facet of the reimbursement process.

Diagnosis codes establish the necessity for which medical and surgical services, procedures, and DMEPOS items are furnished. Coding with ICD-10-CM is mandatory for all Medicare claims, Medicaid claims, third-party payer claims, and most other claims. In rare instances, claims for services or procedures submitted to self-funded insurance pools and workers' compensation carriers do not require ICD-10-CM codes, but do require a clearly descriptive diagnostic statement.

When reporting the appropriate diagnosis codes on claims for services, procedures, and DMEPOS items furnished to patients, ICD-10-CM diagnosis codes, CPT codes, and HCPCS Level II codes must be linked to identify the reason each service or procedure is rendered.

Providers and suppliers nationwide have discovered that many payers, including Medicare and Medicaid programs, will deny or delay claims because of incorrect or inappropriate ICD-10-CM code assignments. Many providers and suppliers have experienced these costly denials and delays. Following are some problem areas identified by payers in reporting ICD-10-CM codes:

- Invalid ICD-10-CM codes reported
- ICD-10-CM codes not reported to the highest level of specificity
- Additional digits, particularly zeroes, added to valid ICD-10-CM codes to make them seven-digit codes. This invalidates the ICD-10-CM codes
- No medical record or supplier documentation given to support reporting a particular ICD-10-CM code
- ICD-10-CM code reported does not match the sex of the patient
- ICD-10-CM code reported does not adequately support the service billed, or is not a diagnosis code recognized under medical necessity policy for the service reported

On October 1, 2015, the health care community began using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) coding system. Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since

Using Modifiers

The HCPCS Level II codes are alphanumeric codes developed by CMS as a complementary coding system to the AMA's CPT codes. HCPCS Level II codes describe procedures, services, and supplies not found in the CPT® manual.

Similar to the CPT coding system, HCPCS Level II codes contain modifiers that serve to further define services and items without changing the basic meaning of the HCPCS Level II code with which they are reported.

It is important to note that HCPCS Level II modifiers may be reported in conjunction with both CPT and HCPCS Level II codes. In some cases, documentation may be required to accompany the claim to support the need for a particular modifier's use, especially in cases when the presence of a modifier causes suspension of the claim for manual review and pricing.

Ambulance Modifiers

For ambulance services modifiers, there are single alpha characters with distinct definitions that are paired together to form a two-character modifier. The first character indicates the origination of the patient (e.g., private residence, physician office, etc.) and the second character indicates the destination of the patient (e.g., hospital, skilled nursing facility, etc.). When reporting ambulance services, the name of the hospital or facility should be included on the claim. If reporting the scene of an accident or acute event (character S) as the origin of the patient, a written description of the actual location of the scene or event must be included with the claim.

Ambulance modifiers must be reported as two characters. For example, an ambulance transport from an accident scene to an acute care hospital would have modifier SH appended to the ambulance HCPCS code.

Ambulance Modifier Listing

- D Diagnostic or therapeutic site other than "P" or "H" when reported as origin codes
- E Residential, domiciliary, custodial facility (other than 1819 facility)
- G Hospital-based ESRD facility
- H Hospital
- I Site of transfer (for example, airport or helicopter pad) between modes of ambulance transport
- J Freestanding ESRD facility
- N Skilled nursing facility
- P Physician's office
- R Residence
- S Scene of accident or acute event
- X Intermediate stop at physician's office on way to hospital (destination code only). Note: Modifier X can only be reported as a designation code in the second position of a modifier

HCPCS Level II Modifiers

Alphabetical Listing

- A1 Dressing for one wound
- A2 Dressing for two wounds
- A3 Dressing for three wounds
- A4 Dressing for four wounds
- A5 Dressing for five wounds
- A6 Dressing for six wounds
- A7 Dressing for seven wounds
- A8 Dressing for eight wounds
- A9 Dressing for nine or more wounds
- AA Anesthesia performed personally by anesthesiologist
  - CPT codes approved for reporting with modifier AA are 00100–01999.
  - If an anesthetist assists the physician in the care of a single patient, the service is considered personally performed by the physician. The anesthesiologist should report this service with modifier AA and the appropriate CPT code from series 00100–01999.
  - Modifier AA affects Medicare payment.
- AD Medical supervision by a physician; more than four concurrent anesthesia procedures
  - Modifier AD affects Medicare payment as a distinct fee schedule amount exists.
- AE Registered dietitian
- AF Specialty physician
- AG Primary physician
- AH Clinical psychologist
- AI Principal physician of record
- AJ Clinical social worker
  - Medicare limits allowable to 75 percent of the physician fee schedule.
- AK Nonparticipating physician
- AM Physician, team member service

Documentation Standards

Medical Records Documentation for Providers

Documentation in the medical record must contain information justifying hospitalization, an observation stay, an encounter or visit, or services provided for a patient. It must indicate that services are provided using current medical knowledge and treatment for the condition or injury, and that the services are medically necessary. In addition, the documentation must stand up to the scrutiny of others.

To meet the requirements of medical necessity for all health care services reported to the Medicare program, the patient's medical record must reflect the nature and extent of the diagnosis or injury, with clear documentation of the following patient-specific facts:

- Physical examination findings
- Diagnostic tests/analyses results
- Relation of diagnosis to the DMEPOS item
- Complicating comorbidities
- Physical functional abilities and/or limitations (ability to ambulate or transfer, amount of time needed to be spent in a bed, extent of use of a wheelchair, types/frequencies of activities recommended for outside the home, etc.)
- Duration of the diagnosis (acute, acute but refractory to treatment, chronic)
- Overall expected course/prognosis
- Rehabilitation potentials

In most instances, an evaluation and management (E/M) service is rendered before or during the same session that an order for DMEPOS is given. Requirements for the correct reporting of E/M services are beyond the scope of this publication; however, in addition to the criteria listed above for medical record documentation, an appropriate patient history must be obtained.

In general, the following three criteria (known as key elements of E/M documentation) should appear in the patient's medical record to correctly report an E/M service:

- Patient history
- Physical examination
- Level of medical decision-making

This is a requirement under both the American Medical Association's (AMA) and the Centers of Medicare and Medicaid Services' (CMS) guidelines.

Providers who dispense DMEPOS should take note that during audits of E/M services, a prevalent finding is the lack of review of systems information. This is an integral part of the patient's history. The absence or inadequate documentation of this part of the patient's history will cause an auditor to downgrade the original level of E/M, resulting in an overpayment situation in which the provider will have to refund the reimbursement difference to the payer or the patient.

Providers may receive requests from DMEPOS suppliers for copies of patient medical records that support the medical necessity of the provider's order. This is generally in response to a direct demand made upon the supplier from the Medicare contractor to substantiate the need for DMEPOS items. Providers should respond promptly to any requests made by the DMEPOS supplier for additional information. Suppliers do report certain difficulties in obtaining copies of medical records from provider offices.

General DME Documentation Standards

The following documentation is necessary for DMEPOS items regardless of the payer:

- The provider should sign and date an order for the DMEPOS item.
- If the treating provider is also supplying the item, the clinical notes should substantiate the need for the item.
- The diagnosis establishing the medical necessity for the item must be documented in the medical record.
- If the medical necessity for the item, as determined by the payer, cannot be established due to the nature of the patient's condition, injury, or illness, then the patient must sign a waiver before receiving the item. For Medicare patients, this waiver is called the advance beneficiary notice (ABN). This document must be kept on file in case the Medicare contractor, Medicaid agency, third-party payer, or managed care plan requests proof of the advance notice.
- It is recommended that the provider keep a copy of the Certificate of Medical Necessity (CMN) in the patient's medical record. An order or CMN on its own will not justify medical necessity even if the physician signs it.
- If a DME Information Form (DIF) is used instead or in conjunction with the CME, a copy of the DIF should be kept in the patient's medical record. In some cases, the DIF replaces the CMN for certain

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

The DMEPOS Industry

Wheelchairs, artificial limbs, braces, surgical dressings, and medications are all examples of durable medical equipment, prosthetics, orthotics, and supplies, known by the acronyms DME and POS, or simply DMEPOS.

The DMEPOS industry includes manufacturers, pharmaceutical companies, medical equipment and supply companies (suppliers and vendors), and providers. Entities peripheral to the DMEPOS industry, but having direct impact on its operations, include the Food and Drug Administration (FDA), which approves the use of medical devices and pharmaceuticals in the United States, and federal and state health care programs such as Medicare and Medicaid, which provide DMEPOS coverage and/or reimbursement for millions of beneficiaries. Other third-party payers, various preferred provider organizations (PPOs), workers' compensation carriers, and managed care organizations (MCOs) also influence the DMEPOS industry.

Health insurance benefits for DMEPOS, in general, are entangled in a mesh of rules and regulations governing coverage and reimbursement. The Centers for Medicare and Medicaid Services (CMS) is the federal agency that runs the Medicare program and oversees the Medicaid program. CMS has strict criteria that must be met by both suppliers and providers of DMEPOS, as well as numerous rules and regulations covering every aspect of the DMEPOS reimbursement process. These include coding, claims preparation, provider and supplier certifications, options for equipment rental and purchase, and a host of other billing directives. CMS's model of DMEPOS reimbursement, viewed as generally effective even if somewhat cumbersome, has inspired a number of third-party payers to pattern their own reimbursement protocol after it to some degree. While a state Medicaid program has some degree of flexibility, many will follow the Medicare program guidelines.

Special Federal and Third-Party Payer Definitions

For federally funded health care programs, such as Medicare and the Children's Health Insurance Program (CHIP), and for programs that are partially funded by the federal government, such as state Medicaid programs, there are strict definitions of what constitutes DMEPOS. A number of commercial insurance plans also follow this same framework, or a similar one, constructed around the prescription, dispensation, reporting, and reimbursement of DMEPOS.

Defining DME

According to CMS, DME must meet specific criteria to be eligible for coverage. These criteria are shown here in the form of questions. The provider or supplier must be able to answer yes to all of these questions for the equipment or device to be recognized as eligible for reimbursement under the Medicare program:

- **Can the medical equipment withstand repeated use?** Medicare Fact: Many items, though durable in nature, such as braces (orthoses) and prostheses, are not considered DME. These items fall into different categories of DMEPOS classifications. Medical supplies such as incontinent pads, catheters, bandages, stockings, irrigating kits, sheets, and bags are expendable in nature and do not qualify as DME.
- **Is the medical equipment primarily and customarily used for medical purposes?** Medicare Fact: Certain types of medical equipment are considered "presumptively medical," meaning the sole purpose of the equipment is to provide medical benefits to the patient. A variety of devices and equipment fall into this category, including hospital beds, respirators, nebulizers, commodes, traction devices, and oxygen tents. Other types of medical equipment are considered "presumptively nonmedical," meaning that the devices and equipment are not only used for medical benefits, but also for purposes of personal comfort, ambient control, environmental enhancement, or convenience. For example, an

Reimbursement Guidelines

Many providers attempt to furnish items of DMEPOS as a convenience to their patients. Providers also furnish DMEPOS items to ensure that the proper application or fit of those items is achieved for maximum medical benefit to their patients. Very few providers actually proceed into DMEPOS dispensing with the idea that this activity will result in big profits. In this environment of stiff provider competition, however, the practice with an expansive service base will likely attract a larger and steadier patient base than a similar practice with a more limited scope of service. The one-stop shopping approach for medical services is a powerful tool in creating high patient volume and maintaining the fiscal health of the practice. This business principle is also true of DMEPOS supplier facilities.

DMEPOS Utilization and Authorization

Utilization, one of the most significant factors in the cost of medical care, is the primary focus of managed care and DMEPOS industry interface. To help control member utilization, the typical managed care policy requires the MCO member to obtain a provider order for any DMEPOS item. Under some MCO stipulations, this order can be generated by the treating specialist, who in turn must notify the MCO and receive authorization to either (1) dispense the item directly to the patient, or (2) allow the patient to obtain the item from a supplier. Under other MCO rules, the order for the DMEPOS must be routed from the specialist to the provider for approval, and then the MCO must be notified by the provider for final approval.

Prior authorizations, preauthorizations, and precertifications are mandatory (and many times burdensome) communications with the MCO generally required for performing special services (such as surgical procedures), making referrals, treating a patient in the emergency department (ED) admitting a patient to a skilled nursing facility, and ordering DMEPOS. This policy mandate affects all participating provider offices and involved suppliers as well.

Once approval is obtained from the MCO for the DMEPOS item, an authorization number or form is given to the provider. Providers should insist on receiving the MCO's permission in writing to obtain the DMEPOS item. The provider, whether a PCP or a specialist, must then contact the approved supplier and furnish the information necessary for DMEPOS dispensation. The supplier will need the patient's personal data (name, date of birth, address, etc.) and insurance information. In many cases, the supplier may also need information such as the following:

- Type of DMEPOS item with specific characteristics, if appropriate
- Patient's diagnosis
- Patient's prognosis
- Length of time the DMEPOS is needed (for items such as oxygen)
- Written physician order, personally signed and dated

These special reimbursement provisions clarify three basic facts:

- Which services and items are covered when pre-authorization is obtained from the plan
- Which services and items are specifically excluded
- Who is responsible for payment for excluded or noncovered items or services, and for covered items or services denied as not medically necessary when the patient has been given advance written notice of the probable denial

By signing the advance notice (similar to the Medicare program's ABN), the patient waives the provider's or supplier's liability and acknowledges financial responsibility for the item or service furnished. Obtaining the signed advance notice form ahead of time also ensures smoother claims processing and patient billing, as all facets of the process are known. If the claim is submitted to the carrier for a noncovered or not medically necessary item or service, a denial will ensue. Patients who signed the liability waiver notice in advance are aware of their financial obligation and can be billed on the date of service (for noncovered items) or after the carrier's denial is received (for items deemed not medically necessary).

PPS and Consolidated Billing

In an effort to contain costs, CMS has been instituting prospective payment systems (PPS) for each of its covered types of services. Acute care hospital stays are reimbursed by diagnosis-related groups (DRGs). The payment is based on the patient's diagnoses, age, and procedures performed. The majority of the services provided to the hospital inpatient are covered in that one payment to the hospital.

CMS has expanded its cost containment efforts. A prospective payment system based on resource utilization was put into place for Skilled Nursing

HCPCS Lay Descriptions

A

A0021

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

This code represents a per mile charge for ambulance transportation outside of the state where the ambulance provider is based and is reported only for Medicaid claims. Consult the local Medicaid office in the state that the provider is located for further definition and usage requirements.

A0080-A0210

A0080 Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest

A0090 Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest

A0100 Nonemergency transportation; taxi

A0110 Nonemergency transportation and bus, intra- or interstate carrier

A0120 Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems

A0130 Nonemergency transportation: wheelchair van

A0140 Nonemergency transportation and air travel (private or commercial) intra- or interstate

A0160 Nonemergency transportation: per mile - caseworker or social worker

A0170 Transportation ancillary: parking fees, tolls, other

A0180 Nonemergency transportation: ancillary: lodging-recipient

A0190 Nonemergency transportation: ancillary: meals, recipient

A0200 Nonemergency transportation: ancillary: lodging, escort

A0210 Nonemergency transportation: ancillary: meals, escort

These codes provide for reporting nonemergency transportation and related ancillary services. Different types of vehicles used and/or the areas traveled, as well as additional fees are specified in these codes. This range reports nonemergency transport services such as a vehicle provided by a volunteer or family member; wheelchair van, taxi, bus, or air transport (private or commercial); mountainous area transport, or transportation outside the state. Examples of ancillary services include parking fees and tolls, lodging or meals for the recipient or for the escort, and per mile transportation of a caseworker or social worker.

A0225

A0225 Ambulance service, neonatal transport, base rate, emergency transport, one way

Report this code for the emergency transport of a neonate by ambulance, one way only, at base rate.

A0380

A0380 BLS mileage (per mile)

A basic life support (BLS) ambulance provides transportation plus the equipment and staff needed for basic life support services, such as controlling bleeding, splinting fractures, treating shock, delivering babies, and performing cardio-pulmonary resuscitation (CPR). BLS transport is reported on a per mile basis.

A0382

A0382 BLS routine disposable supplies

Basic life support (BLS) routine disposable supplies include such items as cervical collar, gauze, dressings, and ice packs. Report a unit of one for all routine disposable supplies that are used.

A0384

A0384 BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)

Specialized disposable basic life support (BLS) defibrillation supplies include such items as defibrillator electrodes (AED), pacing pads, combination pads, and gel pads. This code is reported in jurisdictions where defibrillation is permitted in BLS ambulances.

A0390

A0390 ALS mileage (per mile)

Advanced life support (ALS) mileage is paid on a per mile basis based on the patient's condition. Some local governments may require an ALS response for all calls, but Medicare pays only for the level of service provided, and only when the service is medically necessary. This applies to ground and air transports.

C1818

C1818 Integrated keratoprosthesis

An integrated keratoprosthesis is a flexible, one-piece biocompatible polymer lens. It is used to replace diseased native corneas in conditions where traditional corneal transplantation is not indicated or possible.

C1819

C1819 Surgical tissue localization and excision device (implantable)

A lesion localization device is an implantable radiofrequency guide that allows for stabilization, dissection, and excision of a lesion or foreign objects. Used with stereotactic, alphanumeric grid imaging techniques and ultrasound, this device may include radiofrequency, laser, or ultrasonic components. Implantation within the body proximate to the suspect tissue or object is done prior to surgery with one or more integrated transponder tags. At the time of surgery, scanning of the body with a radiofrequency scanner or reader activates the tag or tags and provides the surgeon with signals indicative of the location.

C1820

C1820 Generator, neurostimulator (implantable), with rechargeable battery and charging system

An implantable rechargeable neurostimulator generator is a device that creates small electrical impulses that are transmitted to electrodes implanted near the spinal cord or a peripheral nerve. The small electrical impulses interrupt pain signals sent to the brain. This type of generator contains a battery that can be recharged. This code represents a non-high-frequency system and includes the generator, rechargeable battery, and its charging system.

C1821

C1821 Interspinous process distraction device (implantable)

Interspinous process distraction implantable devices are implants placed between vertebral spinous processes. They aim to restrict painful motion while enabling normal motion. The implant is inserted between the spinous processes through a small incision and acts as a spacer between the spinous processes. After implantation, the device is opened or expanded to distract (open) the neural foramen and decompress the nerves. Reduction of vertebral motion may prevent pain caused by compression of blood vessels and nerves in the spine.

C1822

C1822 Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system

An implantable rechargeable neurostimulator generator is a device that creates small electrical impulses that are transmitted to electrodes implanted near the spinal cord or a peripheral nerve. The small electrical impulses interrupt pain signals sent to the brain. This type of generator contains a battery that can be recharged. This code represents a high-frequency system and includes the generator, rechargeable battery, and its charging system.

C1823

C1823 Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads

An implantable neurostimulator generator is a device that creates small electrical impulses that are transmitted to electrodes implanted near the spinal cord or a peripheral nerve. The small electrical impulses interrupt pain signals sent to the brain. This type of generator contains a battery that does not require recharging. This code includes the generator and battery.

C1824

C1824 Generator, cardiac contractility modulation (implantable)

A cardiac contractility modulation generator is a small implantable device, similar to a pacemaker, intended for the treatment of chronic heart failure in patients who are symptomatic despite appropriate medical treatment. In contrast to a pacemaker or a defibrillator, the system is designed to modulate the strength of contraction of the heart muscle rather than the rhythm. Typically implanted in the right pectoral region, this minimally invasive device is connected to three standard leads (electrodes) that are used to sense atrial and ventricular activity. An electrode in the right atrium and two in the right ventricle of the heart ensure the precise timing of the cardiac contractility modulation (CCM) signals, delivering them just after the heart contracts (the absolute refractory period). The U.S. Food and Drug Administration (FDA) granted breakthrough device exemption for the OPTIMIZER® Smart Implantable Pulse Generator (Impulse Dynamics, Orangeburg, NY) with approved use in the treatment of individuals with chronic, moderate-to-severe (New York Heart Failure [NYHA] Class III or ambulatory Class IV) heart failure (HF) who remain symptomatic despite guideline directed medical therapy (GDMT). Recipients must be in normal sinus rhythm with left ventricular ejection fraction (LVEF) from 25 to 45 percent and not considered a candidate for cardiac resynchronization therapy (CRT) to restore normal heart rhythm. The

H2015-H2016

H2015 Comprehensive community support services, per 15 minutes

H2016 Comprehensive community support services, per diem

Comprehensive community support services consist of mental health and substance abuse services. These services assist individuals in achieving their recovery and rehabilitation goals. The program aims to reduce psychiatric and addiction symptoms and to assist in developing community living skills. The services may include coordination of services, support during a crisis, development of system monitoring and management skills, monitoring medications, and help in developing independent living skills. Report H2015 for comprehensive community support services per each 15 minutes or H2016 for per diem.

H2017-H2018

H2017 Psychosocial rehabilitation services, per 15 minutes

H2018 Psychosocial rehabilitation services, per diem

Psychosocial rehabilitation services are intended to help individuals to compensate for or to eliminate functional deficits and environmental and interpersonal barriers associated with mental illness. The goal of the program is to help individuals achieve the fullest possible integration as an active and productive member of their family and community with the least possible ongoing professional intervention. Activities are done to achieve the goals for the individual. This is a face-to-face intervention and the services may be provided in a group or an individual setting. Report these codes for psychosocial rehabilitation services in 15-minute increments or a per diem charge.

H2019-H2020

H2019 Therapeutic behavioral services, per 15 minutes

H2020 Therapeutic behavioral services, per diem

Therapeutic behavioral services are treatments that attempt to change unhealthy, potentially dangerous, or self-destructive behaviors. It focuses on helping an individual understand how the behavior affects life and emotions. Behavioral therapy is usually action-based, using techniques of classical conditioning and operant conditioning. The behavior itself is the problem and the goal is to minimize or eliminate the problem. Each payer, agency, or organization has their own definition and categorization of therapeutic behavioral services. Consult the appropriate party for addition information.

H2021-H2022

H2021 Community-based wrap-around services, per 15 minutes

H2022 Community-based wrap-around services, per diem

Wrap-around community services are provided for a short period of time for seriously emotionally disabled youth. These services are provided for children/adolescents with a rate classification level (RCL) placement higher than 12. These codes include support and training for family members as an integral part of services provided.

H2023-H2024

H2023 Supported employment, per 15 minutes

H2024 Supported employment, per diem

Supported employment services are available to individuals with serious mental illness. Employment specialists assist in obtaining and maintaining employment in the community and in continuing treatment for the client to ensure rehabilitation and productive employment.

H2025-H2026

H2025 Ongoing support to maintain employment, per 15 minutes

H2026 Ongoing support to maintain employment, per diem

Ongoing support to maintain employment services are available to individuals with serious mental illness. Employment specialists provide supportive counseling and interventions within the work environment when needed to ensure the continued employment and self-sufficiency of the client.

H2027

H2027 Psychoeducational service, per 15 minutes

The National Library of Medicine, within the National Institutes of Health, defines a psychoeducational service as an item, action, or procedure "of or relating to the psychological aspects of education; specifically: relating to or used in the education of children with behavioral disorders or learning disabilities." Each payer, agency, or organization has its own definition and categorization of psychoeducational services. Consult the appropriate party for addition information.

H2028-H2029

H2028 Sexual offender treatment service, per 15 minutes

H2029 Sexual offender treatment service, per diem

Sexual offender treatment services provide rehabilitation services that vary depending on the type of treatment facility, security level, and staffing ratios available.

J7680-J7681

J7680 Terbutaline sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per mg

J7681 Terbutaline sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per mg

Terbutaline sulfate is a beta$_2$-adrenergic agonist that functions as a bronchodilator. It works, in part, by stimulating the conversion of adenosine triphosphate (ATP) to cyclic 3',5'-adenosine monophosphate, which relaxes bronchial muscles. Terbutaline sulfate is indicated for the prevention and reversal of bronchospasm in asthma, bronchitis, and emphysema.

J7682

J7682 Tobramycin, inhalation solution, FDA-approved final product, noncompounded, unit dose form, administered through DME, per 300 mg

Tobramycin is an aminoglycoside antibiotic, which is derived from various species of *Streptomyces* bacteria or produced synthetically. Aminoglycosides inhibit bacterial protein synthesis by binding with the 30S ribosomal subunit and are bactericidal. Streptomycin is derived from *Streptomyces tenebrarius* and inhibits protein synthesis, causing cell death. Susceptibility studies should be performed prior to the administration of tobramycin. It is indicated in the treatment of infections caused by gram-negative bacillary bacteria, including *Pseudomonas aeruginosa*, *Staphylococcus aureus*, *Escherichia coli*, *Klebsiella* species, *Enterobacter* species, *Serratia* species, *Proteus* species, *Providencia* species, and *Citrobacter* species. The inhalation form is indicated in the treatment of *Pseudomonas aeruginosa* in patients with cystic fibrosis.

J7683-J7684

J7683 Triamcinolone, inhalation solution, compounded product, administered through DME, concentrated form, per mg

J7684 Triamcinolone, inhalation solution, compounded product, administered through DME, unit dose form, per mg

Triamcinolone is a synthetic corticosteroid, which is analogous to corticosteroids produced by the adrenal cortex. The drug is one to two times more potent than prednisone. Its mechanism of actions is not clearly defined. Triamcinolone does decrease inflammation by stabilizing leukocytes, suppress the chemicals normally released in immune response, and stimulate bone marrow. Inhaled triamcinolone is a local anti-inflammatory delivering the drug directly to the lungs. The drug has no effect on acute bronchospasms, but is indicated for prophylactic and maintenance therapy of asthma.

J7685

J7685 Tobramycin, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg

Tobramycin is an aminoglycoside antibiotic, which is derived from various species of Streptomyces bacteria or produced synthetically. Aminoglycosides inhibit bacterial protein synthesis by binding with the 30S ribosomal subunit and are bactericidal. Streptomycin is derived from *Streptomyces tenebrarius* and inhibits protein synthesis, causing cell death. Susceptibility studies should be performed prior to the administration of tobramycin. It is indicated in the treatment of infections caused by gram-negative bacillary bacteria, including *Pseudomonas aeruginosa*, *Staphylococcus aureus*, *Escherichia coli*, *Klebsiella* species, *Enterobacter* species, *Serratia* species, *Proteus* species, *Providencia* species, and *Citrobacter* species. The inhalation form is indicated in the treatment of *Pseudomonas aeruginosa* in patients with cystic fibrosis.

J7686

J7686 Treprostinil, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, 1.74 mg

Treprostinil inhalation solution is used for the treatment of pulmonary arterial hypertension to improve exercise activities. Treprostinil is a prostacyclin analogue and provides direct vasodilation of pulmonary and systemic arterial vascular beds and inhibition of platelet aggregation. Recommended dose is an initial treatment of three breaths per treatment session, four times daily. The dose is increased by an additional three breaths at approximately one to two week intervals, if tolerated, until nine breaths are reached per treatment session, four times daily. The medication is administered through an ultrasonic, pulsed-delivery nebulizer.

J7699

J7699 NOC drugs, inhalation solution administered through DME

Use this code to represent an inhalation drug that has been administered through DME and is not represented by any other level I or level II HCPCS code.

J7799

J7799 NOC drugs, other than inhalation drugs, administered through DME

Use this code to represent a drug that has been administered through DME, but is not an inhalation drug. Be sure the drug does not have any other specified level I or level II HCPCS code to represent it.

L5974-L5975

L5974 All lower extremity prostheses, foot, single axis ankle/foot

L5975 All lower extremity prostheses, combination single axis ankle and flexible keel foot

These codes report the supply of specific types of prosthetic feet. A single axis ankle is capable of dorsiflexion and plantarflexion only (the movement of the foot up and down). This is among the more fundamental designs of prosthetic feet. The keel is the component of a prosthetic foot that generally runs from heel to toe near the footplate. A flexible keel may be made of carbon reinforced fibers, metal, or resilient materials. The flexible keel absorbs impact and transfers energy as weight rolls from heel strike to "toe-off," the moment when weight is released from the forefoot. Flexible keels are integral components of many energy storing prosthetic feet.

L5976

L5976 All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)

This code refers to the supply of a specific level of energy-storing prosthetic foot, whereby some type of material deforms with weight pressure but then resumes its original shape as pressure is removed with a consequent release of energy. The keel is the component of a prosthetic foot that generally runs from heel to toe near the footplate. A flexible keel, which may be made of carbon-reinforced fibers, metal, or resilient materials, absorbs impact and transfers energy as weight rolls from heel strike to "toe-off" the moment when weight is released from the forefoot. Flexible keels are integral components of many energy-storing prosthetic feet.

L5978-L5979

L5978 All lower extremity prostheses, foot, multiaxial ankle/foot

L5979 All lower extremity prostheses, multiaxial ankle, dynamic response foot, one-piece system

These codes report the supply of a specific type of foot prosthesis. A multiaxial ankle is capable of dorsiflexion and plantarflexion (the movement of the foot up and down), as well as limited twisting motion, medial and lateral movement, and internal and external rotation. This offers stability and allows the user to better negotiate uneven terrain. The dynamic response foot is a type of energy storing prosthetic foot. It falls well within the range of active use, but somewhat short of the high-end athletic prostheses. The keel in this type of foot is energy absorbing with good transfer upon "toe-off." Sure-Flex, Genesis II, and Seattle Lite are considered in this category.

L5980-L5981

L5980 All lower extremity prostheses, flex-foot system

L5981 All lower extremity prostheses, flex-walk system or equal

These codes report the supply of a specific type of foot prosthesis. The original flex-foot system was a unique design to accommodate active users. The foot was developed in the early 1980s using a single L-shaped strip of carbon fiber, which at the time was a material new to prosthesis fabrication. The lower horizontal portion was fitted to sole material, and the upper vertical part was attached to the pylon. A separate strip was attached to the rear of the footplate like a leaf spring to act as the heel. The design provides springlike compression action, as well as some torque and flexibility properties. The foot is known for high flexibility and good energy-storing capabilities and remains in widespread use. The flex-walk system is a second generation of the flex-foot design and addresses the needs of amputees with longer residual limbs with moderate activity levels, as well as pediatric applications. Both versions adapt well to both endoskeletal and exoskeletal shank designs.

L5982-L5984

L5982 All exoskeletal lower extremity prostheses, axial rotation unit

L5984 All endoskeletal lower extremity prostheses, axial rotation unit, with or without adjustability

When the prosthesis incorporates an axial rotation device, this net torque acting about the long axis of the socket is able to rotate the socket externally, the only resistance to such rotation being the relatively weak return spring in the axial rotation device. The axial rotation tends to relieve the contact pressures that caused the torque and thus reduces pressures in the critical anteromedial region of the brim. With an axial rotation device, the socket is free to respond to the demands of the stump and relieve the pressures and torque caused by cyclic action of the musculature.

L5985

L5985 All endoskeletal lower extremity prostheses, dynamic prosthetic pylon

This code reports the supply of a dynamic pylon for a lower-extremity prosthesis system. A pylon is a post-like structure fitted to the residual limb socket on one end and the prosthetic foot component on the other. The pylon may be a tube made of aluminum, titanium, steel, or carbon fiber-reinforced plastic. A dynamic pylon has energy-storing properties, typically provided by an internal spring or series of springs. Some models, such as the Endolite telescopic torsion pylon, also allow for some twisting movement. The energy-return feature absorbs shock and in some users provides gait efficiency with less energy outlay.

T2007

T2007 Transportation waiting time, air ambulance and nonemergency vehicle, one-half (1/2) hour increments

This code represents the idle or unloaded waiting time that a transport, air ambulance, or nonemergency vehicle spends waiting for a particular patient.

T2010-T2011

T2010 Preadmission screening and resident review (PASRR) Level I identification screening, per screen

T2011 Preadmission screening and resident review (PASRR) Level II evaluation, per evaluation

Preadmission screening and resident review (PASRR) is a protection for patients with serious mental illness or mental retardation. PASRR is intended to prevent patients from being inappropriately admitted to nursing facilities that cannot provide the specialized care they require. Federal law requires all patients, regardless of payer source, be given a level I identification screening to identify mental illnesses or mental retardation. Level I screens are generally forms completed by hospital discharge planners, community health nurses, or other practitioners defined by state law. Patients who do or may have a mental illness or mental retardation are then referred for a level II evaluation. The level II evaluation is provided to all patients identified in level I and any resident who has experienced a significant change in condition. This level II evaluation is the resident review that is conducted according to federal delineated criteria. Once it is determined that a patient has a mental illness or mental retardation, it must be determined what specialized services are needed and whether the nursing home can provide those services. Types of specialized services and their definition may vary by state.

T2012-T2021

T2012 Habilitation, educational; waiver, per diem

T2013 Habilitation, educational, waiver; per hour

T2014 Habilitation, prevocational, waiver; per diem

T2015 Habilitation, prevocational, waiver; per hour

T2016 Habilitation, residential, waiver; per diem

T2017 Habilitation, residential, waiver; 15 minutes

T2018 Habilitation, supported employment, waiver; per diem

T2019 Habilitation, supported employment, waiver; per 15 minutes

T2020 Day habilitation, waiver; per diem

T2021 Day habilitation, waiver; per 15 minutes

Habilitation is the act of making an individual capable of fitting into and/or functioning in society. The codes indicated here generally refer to people who have disabilities that initially prevent them from functioning independently in society. Habilitation provides the assistance that these people need to attain their goals, wants, and/or needs. Paraprofessionals and professionals usually provide support, training, and any required therapy. Day habilitation may be a full day of directed services or may be an alternate day where recreational activities are the main body of the day.

T2022-T2023

T2022 Case management, per month

T2023 Targeted case management; per month

Case management is an effort to improve care and to contain costs by having one party manage or coordinate all care delivered to patients who have certain complex illnesses or injuries, including mental and behavioral health issues. Case management may include, but is not limited to, the evaluation of a condition, the development and implementation of a plan of care, the coordination of medical resources, and the appropriate communication to all parties. Targeted case management targets a specific population subgroup.

T2024-T2025

T2024 Service assessment/plan of care development, waiver

T2025 Waiver services; not otherwise specified (NOS)

Medicaid may choose to wave certain requirements in conjunction with specialized programs. In these cases, waivers usually refer to permission from the federal government to waive or change certain requirements.

T2026-T2027

T2026 Specialized childcare, waiver; per diem

T2027 Specialized childcare, waiver; per 15 minutes

Specialized childcare usually refers to childcare provided to an individual who has special physical or developmental needs. It may also refer to childcare needed during nonstandard hours, such as overnight, or care for a mildly ill child who cannot attend school or regular daycare. Most states require providers of specialized childcare to be certified, licensed, or otherwise deemed qualified to care for the child. The waiver refers to permission from the federal government to state Medicaid plans to finance services that are not in compliance with federal regulations.