Optum

Expert

HCPCS Level II Expert

HCPCS Level II codes with Medicare coverage essentials

2027

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Contents

Introduction

HCPCS Level II codes, except for the dental code series, are developed and maintained by a joint editorial panel consisting of the Centers for Medicare and Medicaid Services (CMS), the Blue Cross Blue Shield Association, and the Health Insurance Association of America. HCPCS Level II codes may be used throughout the United States in all Medicare regions. They consist of one alpha character (A through V) followed by four digits. Optum does not change the code descriptions other than correcting typographical errors. There are some codes that appear to be duplicates. CMS has indicated that each of the codes is used to report a specific condition or service. At press time, CMS had not provided further clarification regarding these codes. Additional information may be found on the CMS website, https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system.

Any supplier or manufacturer can submit a request for coding modification to the HCPCS Level II National codes. A document explaining the HCPCS modification process, as well as a detailed format for submitting a recommendation for a modification to HCPCS Level II codes, is available on the HCPCS website at https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system. Besides the information requested in this format, a requestor should also submit any additional descriptive material, including the manufacturer's product literature and information that is believed would be helpful in furthering CMS's understanding of the medical features of the item for which a coding modification is being recommended. The HCPCS coding review process is an ongoing, continuous process.

The dental (D) codes are not included in the official 2026 HCPCS Level II code set. The American Dental Association (ADA) holds the copyright on those codes and instructed CMS to remove them. As a result, Optum has removed them from this product; however, Optum has additional resources available for customers requiring the dental codes. Please visit www.optumcoding.com or call 1.800.464.3649.

Significant updates to this manual will be provided on our product updates page at Optumcoding.com, which can be accessed at the following: https://www.optumcoding.com/ProductUpdates/. Password: XXXXX

Note: The expanded Medically Unlikely Edit (MUE) tables containing HCPCS/CPT codes, MUE values, MUE adjudication indicators, and MUE rationale are no longer published in this book. The tables are updated quarterly and can be found on the CMS website at https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits.

Getting Started with *HCPCS Level II Expert*

Coders should keep in mind that the insurance companies and government do not base payment solely on what was done for the patient. They need to know why the services were performed. In addition to using the HCPCS coding system for procedures and supplies, coders must also use the ICD-10-CM coding system to denote the diagnosis. This book will not discuss ICD-10-CM codes, which can be found in a current ICD-10-CM code book for diagnosis codes. To locate a HCPCS Level II code, follow these steps:

1. Identify the services or procedures that the patient received.

   Example:

   Patient administered PSA exam.

2. Look up the appropriate term in the index.

   Example:

   Screening
   prostate specific antigen test (PSA)

   Coding Tip: Coders who are unable to find the procedure or service in the index can look in the table of contents for the type of procedure or device to narrow the code choices. Also, coders should remember to check the unlisted procedure guidelines for additional choices.

3. Assign a tentative code.

   Example:

   Code G0103

   Coding Tip: To the right of the terminology, there may be a single code or multiple codes, a cross-reference, or an indication that the code has been deleted. Tentatively assign all codes listed.

4. Locate the code or codes in the appropriate section. When multiple codes are listed in the index, be sure to read the narrative of all codes listed to find the appropriate code based on the service performed.

   Example:

G0103	**Prostate cancer screening; prostate specific antigen test (PSA)**

5. Check for color bars, symbols, notes, and references.

G0103	**Prostate cancer screening; prostate specific antigen test (PSA)**	A

6. Review the appendixes for the reference definitions and other guidelines for coverage issues that apply.
7. Determine whether any modifiers should be appended.
8. Assign the code.

   Example:

   The code assigned is G0103.

Coding Standards

Levels of Use

Coders may find that the same procedure is coded at two or even three levels. Which code is correct? There are certain rules to follow if this should occur.

When both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, the CPT code should be used. If, however, the narratives are not identical (e.g., the CPT code narrative is generic, whereas the HCPCS Level II code is specific), the Level II code should be used.

Be sure to check for a national code when a CPT code description contains an instruction to include additional information, such as describing a specific medication or supply. There are many HCPCS Level II codes that specify supplies in more detail.

Special Reports

Submit a special report with the claim when a new, unusual, or variable procedure is provided or a modifier is used. Include the following information:

- A copy of the appropriate report (e.g., operative, x-ray), explaining the nature, extent, and need for the procedure
- Documentation of the medical necessity of the procedure
- Documentation of the time and effort necessary to perform the procedure

Organization of Optum *HCPCS Level II Expert*

The Optum 2025 *HCPCS Level II* contains mandated changes and new codes for use as of January 1, 2026. Deleted codes have also been indicated and cross-referenced to active codes when possible. New codes have been added to the appropriate sections, eliminating the time-consuming step of looking in two places for a code. However, keep in mind that the information in this book is a reproduction of the 2026 HCPCS; additional information on coverage issues may have been provided to Medicare contractors after publication. All contractors periodically update their systems and records throughout the year. If this book does not agree with your contractor, it is either because of a mid-year update or correction, or a specific local or regional coverage policy.

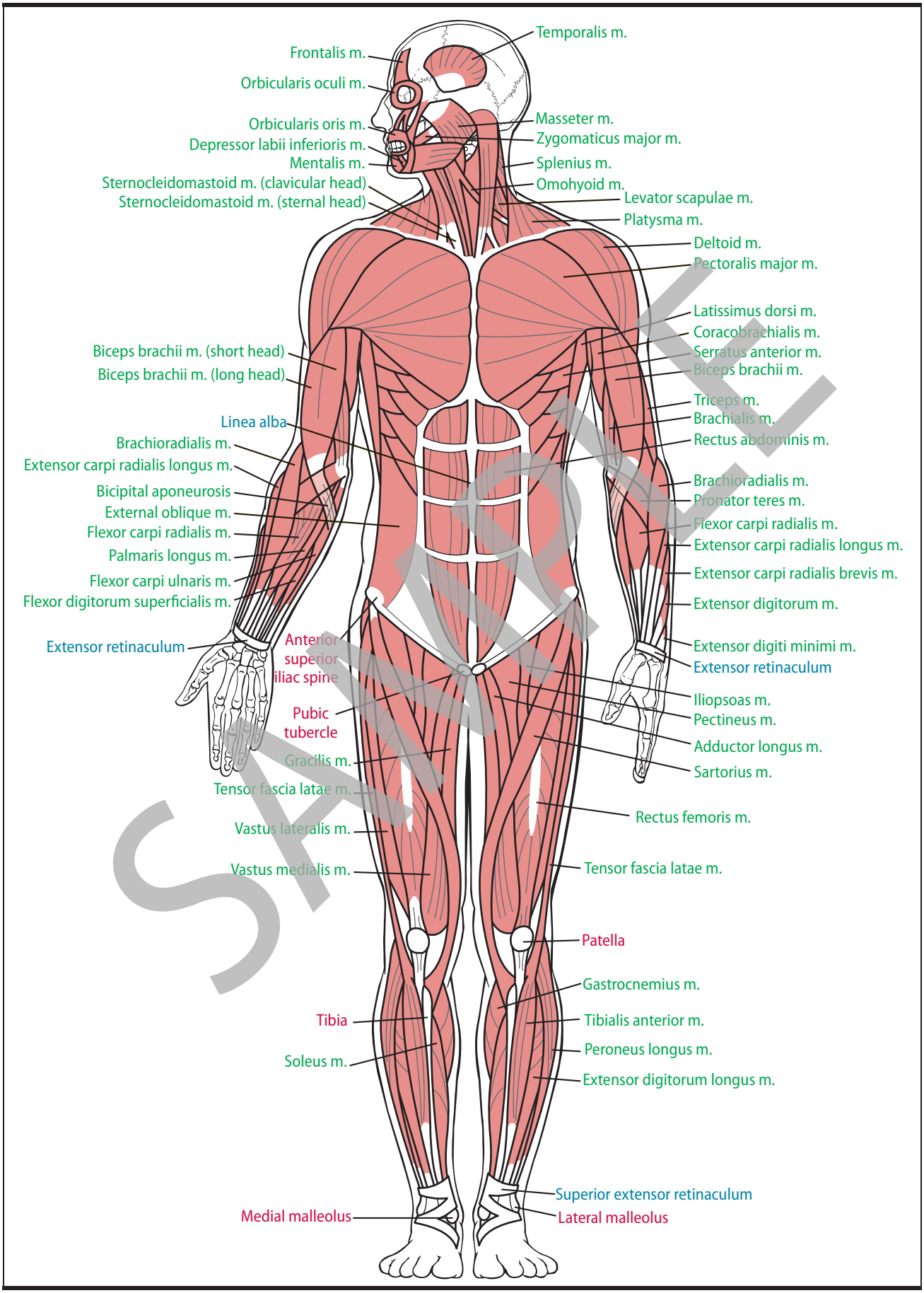
HCPCS Code Index

Because HCPCS is organized by code number rather than by service or supply name, the index enables the coder to locate any code without looking through individual ranges of codes. Just look up the medical or surgical supply, service, orthotic, or prosthetic in question to find the appropriate codes. This index also refers to many of the brand names by which these items are known.

Brand Name Drugs

Brand name drugs commonly reported with a code are listed underneath the code descriptor in blue font. This note will not appear if the brand name is part of the code descriptor.

Muscles



A4726 Dialysate solution, any concentration of dextrose, fluid volume greater than 5999 cc, for peritoneal dialysis

A4728 Dialysate solution, nondextrose containing, 500 ml

A4730 Fistula cannulation set for hemodialysis, each

A4736 Topical anesthetic, for dialysis, per g

A4737 Injectable anesthetic, for dialysis, per 10 ml

A4740 Shunt accessory, for hemodialysis, any type, each

A4750 Blood tubing, arterial or venous, for hemodialysis, each

A4755 Blood tubing, arterial and venous combined, for hemodialysis, each

A4760 Dialysate solution test kit, for peritoneal dialysis, any type, each

A4765 Dialysate concentrate, powder, additive for peritoneal dialysis, per packet

A4766 Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml

A4770 Blood collection tube, vacuum, for dialysis, per 50

A4771 Serum clotting time tube, for dialysis, per 50

A4772 Blood glucose test strips, for dialysis, per 50

A4773 Occult blood test strips, for dialysis, per 50

A4774 Ammonia test strips, for dialysis, per 50

A4802 Protamine sulfate, for hemodialysis, per 50 mg

A4860 Disposable catheter tips for peritoneal dialysis, per 10

A4870 Plumbing and/or electrical work for home hemodialysis equipment

A4890 Contracts, repair and maintenance, for hemodialysis equipment

A4911 Drain bag/bottle, for dialysis, each

A4913 Miscellaneous dialysis supplies, not otherwise specified

Pertinent documentation to evaluate medical appropriateness should be included when this code is reported. Determine if an alternative HCPCS Level II or a CPT code better describes the service being reported. This code should be used only if a more specific code is unavailable.

CMS: 100-04,8,20; 100-04,8,60.2.1

A4918 Venous pressure clamp, for hemodialysis, each

A4927 Gloves, nonsterile, per 100

A4928 Surgical mask, per 20

A4929 Tourniquet for dialysis, each

A4930 Gloves, sterile, per pair

A4931 Oral thermometer, reusable, any type, each

A4932 Rectal thermometer, reusable, any type, each

Ostomy Pouches and Supplies

A5051 Ostomy pouch, closed; with barrier attached (one piece), each

A5052 Ostomy pouch, closed; without barrier attached (one piece), each

A5053 Ostomy pouch, closed; for use on faceplate, each

A5054 Ostomy pouch, closed; for use on barrier with flange (two piece), each

A5055 Stoma cap

A5056 Ostomy pouch, drainable, with extended wear barrier attached, with filter, (one piece), each

A5057 Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (one piece), each

A5061 Ostomy pouch, drainable; with barrier attached, (one piece), each

A5062 Ostomy pouch, drainable; without barrier attached (one piece), each

A5063 Ostomy pouch, drainable; for use on barrier with flange (two-piece system), each

A5071 Ostomy pouch, urinary; with barrier attached (one piece), each

A5072 Ostomy pouch, urinary; without barrier attached (one piece), each

A5073 Ostomy pouch, urinary; for use on barrier with flange (two piece), each

A5081 Stoma plug or seal, any type

A5082 Continent device; catheter for continent stoma

A5083 Continent device, stoma absorptive cover for continent stoma

A5093 Ostomy accessory; convex insert

Incontinence Supplies

A5102 Bedside drainage bottle with or without tubing, rigid or expandable, each

A5105 Urinary suspensory with leg bag, with or without tube, each

A5112 Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each

A5113 Leg strap; latex, replacement only, per set

A5114 Leg strap; foam or fabric, replacement only, per set

A5120 Skin barrier, wipes or swabs, each (AU, AV)

A5121 Skin barrier; solid, 6 x 6 or equivalent, each

A5122 Skin barrier; solid, 8 x 8 or equivalent, each

A5126 Adhesive or nonadhesive; disk or foam pad

A5131 Appliance cleaner, incontinence and ostomy appliances, per 16 oz

A5200 Percutaneous catheter/tube anchoring device, adhesive skin attachment

Diabetic Shoes, Fitting, and Modifications

According to Medicare, documentation from the prescribing physician must certify the diabetic patient has one of the following conditions: peripheral neuropathy with evidence of callus formation; history of preulcerative calluses; history of ulceration; foot deformity; previous amputation; or poor circulation. The footwear must be fitted and furnished by a podiatrist, pedorthist, orthotist, or prosthetist.

A5500 For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multidensity insert(s), per shoe

CMS: 100-02,15,140

A5501 For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe

CMS: 100-02,15,140

Durable Medical Equipment E0100-E8002

E codes include durable medical equipment such as canes, crutches, walkers, commodes, decubitus care, bath and toilet aids, hospital beds, oxygen and related respiratory equipment, monitoring equipment, pacemakers, patient lifts, safety equipment, restraints, traction equipment, fracture frames, wheelchairs, and artificial kidney machines.

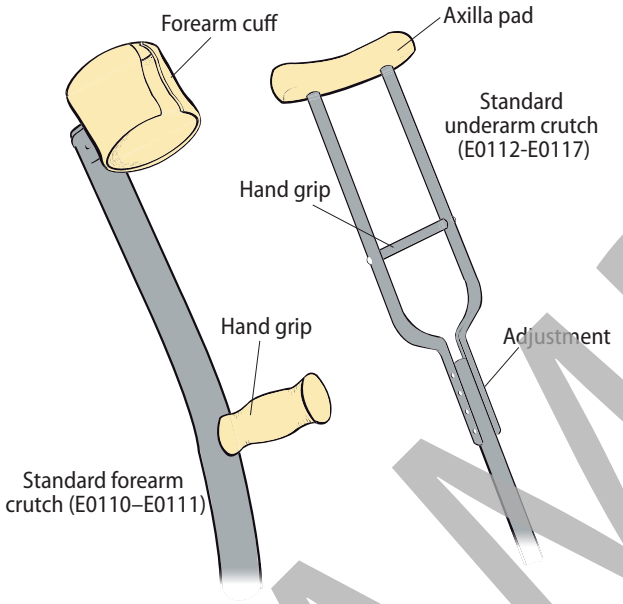
Canes

E0100 **Cane, includes canes of all materials, adjustable or fixed, with tip** Y (NU, RR, UE)
White canes for the blind are not covered under Medicare.

E0105 **Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips** Y (NU, RR, UE)

Crutches

E0110 **Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips** Y ☑ (NU, RR, UE)



E0111 **Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips** Y ☑ (NU, RR, UE)

E0112 **Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips** Y ☑ (NU, RR, UE)

E0113 **Crutch, underarm, wood, adjustable or fixed, each, with pad, tip, and handgrip** Y ☑ (NU, RR, UE)

E0114 **Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrips** Y ☑ (NU, RR, UE)

E0116 **Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each** Y ☑ (NU, RR, UE)

E0117 **Crutch, underarm, articulating, spring assisted, each** Y ☑ (RR)

E0118 **Crutch substitute, lower leg platform, with or without wheels, each** E1 ☑
Medicare covers walkers if patient's ambulation is impaired.

Walkers

E0130 **Walker, rigid (pickup), adjustable or fixed height** Y (NU, RR, UE)
CMS: 100-04,36,50.15

E0135 **Walker, folding (pickup), adjustable or fixed height** Y (NU, RR, UE)
Medicare covers walkers if patient's ambulation is impaired.
CMS: 100-04,36,50.15

E0140 **Walker, with trunk support, adjustable or fixed height, any type** Y (RR)
CMS: 100-04,36,50.15

E0141 **Walker, rigid, wheeled, adjustable or fixed height** Y (NU, RR, UE)
Medicare covers walkers if patient's ambulation is impaired.
CMS: 100-04,36,50.15

E0143 **Walker, folding, wheeled, adjustable or fixed height** Y (NU, RR, UE)
Medicare covers walkers if patient's ambulation is impaired.
CMS: 100-04,36,50.15

E0144 **Walker, enclosed, four-sided framed, rigid or folding, wheeled with posterior seat** Y (RR)
CMS: 100-04,36,50.15

E0147 **Walker, heavy-duty, multiple braking system, variable wheel resistance** Y (NU, RR, UE)
Medicare covers safety roller walkers only in patients with severe neurological disorders or restricted use of one hand. In some cases, coverage will be extended to patients with a weight exceeding the limits of a standard wheeled walker.
CMS: 100-04,36,50.15

E0148 **Walker, heavy-duty, without wheels, rigid or folding, any type, each** Y ☑ (NU, RR, UE)
CMS: 100-04,36,50.15

E0149 **Walker, heavy-duty, wheeled, rigid or folding, any type** Y (RR)
CMS: 100-04,36,50.15

○ **E0152** **Walker, battery powered, wheeled, folding, adjustable or fixed height** E1
AHA: 2Q,24

Attachments

E0153 **Platform attachment, forearm crutch, each** Y ☑ (NU, RR, UE)

E0154 **Platform attachment, walker, each** Y ☑ (NU, RR, UE)
CMS: 100-04,36,50.14; 100-04,36,50.15

E0155 **Wheel attachment, rigid pick-up walker, per pair** Y ☑ (NU, RR, UE)
CMS: 100-04,36,50.15

E0156 **Seat attachment, walker** Y (NU, RR, UE)
CMS: 100-04,36,50.14; 100-04,36,50.15

E0157 **Crutch attachment, walker, each** Y ☑ (NU, RR, UE)
CMS: 100-04,36,50.14; 100-04,36,50.15

E0158 **Leg extensions for walker, per set of four** Y ☑ (NU, RR, UE)
CMS: 100-04,36,50.14; 100-04,36,50.15

E0159 **Brake attachment for wheeled walker, replacement, each** Y ☑ (NU, RR, UE)
CMS: 100-04,36,50.15

Commodes

E0160 **Sitz type bath or equipment, portable, used with or without commode** Y (NU, RR, UE)
Medicare covers sitz baths if medical record indicates that the patient has an infection or injury of the perineal area and the sitz bath is prescribed by the physician.

Appendix 1 — Table of Drugs and Biologicals

INTRODUCTION AND DIRECTIONS

The HCPCS 2027 Table of Drugs and Biologicals is designed to quickly and easily direct the user to drug names and their corresponding codes. Both generic and brand or trade names are alphabetically listed in the "Drug Name" column of the table. The associated A, C, J, K, Q, or S code is given only for the generic name of the drug. While every effort is made to make the table comprehensive, it is not all-inclusive.

The "Unit Per" column lists the stated amount for the referenced generic drug as provided by CMS. "Up to" listings are inclusive of all quantities up to and including the listed amount. All other listings are for the amount of the drug as listed. The editors recognize that the availability of some drugs in the quantities listed is dependent on many variables beyond the control of the clinical ordering clerk. The availability in your area of regularly used drugs in the most cost-effective quantities should be relayed to your third-party payers.

The "Route of Administration" column addresses the most common methods of delivering the referenced generic drug as described in current pharmaceutical literature. The official definitions for Level II drug codes generally describe administration other than by oral method. Therefore, with a handful of exceptions, oral-delivered options for most drugs are omitted from the Route of Administration column.

Intravenous administration includes all methods, such as gravity infusion, injections, and timed pushes. When several routes of administration are listed, the first listing is simply the first, or most common, method as described in current reference literature. The "VAR" posting denotes various routes of administration and is used for drugs that are commonly administered into joints, cavities, tissues, or topical applications, in addition to other parenteral administrations. Listings posted with "OTH" alert the user to other administration methods, such as suppositories or catheter injections.

Please be reminded that the Table of Drugs and Biologicals, as well as all HCPCS Level II national definitions and listings, constitutes a post-treatment medical reference for billing purposes only. Although the editors have exercised all normal precautions to ensure the accuracy of the table and related material, the use of any of this information to select medical treatment is entirely inappropriate. Do not code directly from the table. Refer to the tabular section for complete information.

See Appendix 3 for abbreviations.

Drug Name	Units Per	Route	Code
10% LMD	500 ML	IV	J7100
5% DEXTROSE AND .45% NORMAL SALINE	1000 ML	IV	S5010
5% DEXTROSE IN LACTATED RINGERS	1000 CC	IV	J7121
5% DEXTROSE WITH POTASSIUM CHLORIDE	1000 ML	IV	S5012
5% DEXTROSE/.45% NS WITH KCL AND MAG SULFATE	1000ML	IV	S5013
5% DEXTROSE/.45% NS WITH KCL AND MAG SULFATE	1500 ML	IV	S5014
5% DEXTROSE/NORMAL SALINE	5%	VAR	J7042
5% DEXTROSE/WATER	500 ML	IV	J7060
A-HYDROCORT	100 MG	IV, IM, SC	J1720
~~A-METHAPRED~~	~~125 MG~~	~~IM, IV~~	~~J2930~~
~~A-METHAPRED~~	~~40 MG~~	~~IM, IV~~	~~J2920~~
ABATACEPT	10 MG	IV	J0129
ABCIXIMAB	10 MG	IV	J0130
ABECMA	UP TO 510 MILLION CELLS	IV	Q2055
ABELCET	10 MG	IV	J0287
ABILIFY	0.25 MG	IM	J0400
ABILIFY ASIMTUFII	1 MG	IM	J0402
ABILIFY MAINTENA KIT	1 MG	IM	J0401
ABLAVAR	1 ML	IV	A9583
ABOBOTULINUMTOXINA	5 UNITS	IM	J0586
ABRAXANE	1 MG	IV	J9264
~~ABRILADA~~	~~10 MG~~	~~SC~~	~~Q5132~~
ABRILADA	1 MG	SC	Q5145
AC5 ADVANCED WOUND SYSTEM (AC5)	SQ CM	OTH	A2020
ACAPATCH	SQ CM	OTH	Q4325
ACCELULAR PERICARDIAL TISSUE MATRIX NONHUMAN	SQ CM	OTH	C9354
ACCUNEB NONCOMPOUNDED, CONCENTRATED	1 MG	INH	J7611
ACCUNEB NONCOMPOUNDED, UNIT DOSE	1 MG	INH	J7613
ACESSO	SQ CM	OTH	Q4311
ACESSO AC	SQ CM	OTH	Q4312
ACESSO DL	SQ CM	OTH	Q4293
ACESSO TL	SQ CM	OTH	Q4300
ACETADOTE	1 G	INH	J7608
ACETADOTE	100 MG	IV	J0132
ACETAMINOPHEN (B. BRAUN), NOT THERAPEUTICALLY EQUIVALENT TO J0131	10 MG	IV	J0136
ACETAMINOPHEN (FRESENIUS KABI), NOT THERAPEUTICALLY EQUIVALENT TO J0131	10 MG	IV	J0134
ACETAMINOPHEN (HIKMA) NOT THERAPEUTICALLY EQUIVALENT TO J0131	10 MG	IV	J0137
ACETAMINOPHEN/IBUPROFEN	10 MG/3 MG	ORAL	J0138
ACETAZOLAMIDE SODIUM	500 MG	IM, IV	J1120
ACETYLCYSTEINE COMPOUNDED	PER G	INH	J7604
ACETYLCYSTEINE NONCOMPOUNDED	1 G	INH	J7608
ACTEMRA	1 MG	IV	J3262
ACTEMRA	1 MG	IV	Q0249
ACTHAR GEL	UP TO 40 UNITS	IM/SC	J0801
ACTHAR GEL (ANI)	UP TO 40 UNITS	IM/SC	J0802
ACTHREL	1 MCG	IV	J0795
ACTIMMUNE	3 MU	SC	J9216
ACTIVASE	1 MG	IV	J2997
ACTIVATE MATRIX	SQ CM	OTH	Q4301
ACUTECT	STUDY DOSE UP TO 20 MCI	IV	A9504
ACYCLOVIR	5 MG	IV	J0133
ADAGEN	25 IU	IM	J2504
ADAKVEO	5 MG	IV	J0791
~~ADALIMUMAB~~	~~20 MG~~	~~SC~~	~~J0135~~
ADALIMUMAB	1 MG	SC	J0139
ADALIMUMAB-AACF	1 MG	SC	Q5144
~~ADALIMUMAB-AACF, BIOSIMILAR~~	~~20 MG~~	~~SC~~	~~Q5131~~
ADALIMUMAB-AATY	1 MG	SC	Q5141
ADALIMUMAB-ADBM	1 MG	SC	Q5143
~~ADALIMUMAB-AFZB~~	~~10 MG~~	~~SC~~	~~Q5132~~
ADALIMUMAB-AFZB	1 MG	SC	Q5145
ADALIMUMAB-FKJP	1 MG	SC	Q5140
ADALIMUMAB-RYVK	1 MG	SC	Q5142
~~ADAMTS13, RECOMBINANT-KRHN~~	~~10 IU~~	~~IV~~	~~C9167~~
ADAMTS13, RECOMBINANT-KRHN	10 IU	IV	J7171
ADASUVE	1 MG	INH	J2062
ADCETRIS	1 MG	IV	J9042
ADENOCARD	1 MG	IV	J0153

HCPCS Modifiers

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

Modifiers A1, A2, A3, A4, A5, A6, A7, A8, and A9 wound dressings:

- Modifiers A1–A9 indicate that a primary or secondary dressing on a surgical or debrided wound is being applied. Primary dressings are defined as therapeutic or protective coverings, and secondary dressings are materials applied for a therapeutic or protective function.
- Documentation must indicate the number of wounds being dressed.
- The modifier number reported must correspond to the number of wound dressings applied, not necessarily the number of wounds treated. For example, a patient with three previously debrided wounds may require a secondary dressing on only two wounds, which would be reported with modifier A2.
- Gradient compression stockings are not considered wound dressing and would not be reported with modifiers A1–A9 although A6531 and A6532 are covered for open venous stasis ulcers.

AA Anesthesia services performed personally by anesthesiologist

- Modifier AA has no effect on payment.

AB Audiology service furnished personally by an audiologist without a physician/NPP order for nonacute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary

- This modifier can be appended to certain audiology service codes to indicate that the service was provided without an order by a physician or nonphysician practitioner. Services without an order are allowed once every 12 months per patient for nonacute hearing conditions.

AD Medical supervision by a physician: more than four concurrent anesthesia procedures

- Modifier AD is appended to physician claims when a physician supervised four or more concurrent procedures.
- Payment is made on a 3 base unit amount.
- Base units are assigned by CMS or payers, and the lowest unit value is 3.

Example:
The anesthesiologist is supervising five CRNAs whose services overlapped. The anesthesiologist reports each of these services with modifier AD appended. Each of these services will be reimbursed at the base rate of 3 units regardless of the actual base units assigned.

AE Registered dietician

- Append modifier AE when reporting nutritional services to indicate that an appropriate provider performed the service.

AF Specialty physician
AG Primary physician

Modifiers AF and AG physician designation:

- These modifiers are appended as a physician designation for outpatient services provided in a critical access hospital (CAH) in a designated physician scarcity area (PSA) or health professional shortage area (HPSA).
- Primary care physicians are defined as general practice, family practice, internal medicine, and obstetrics/gynecology for modifier AG.
- Specialty care physicians are defined as specialties other than dental, optometry, chiropractic, or podiatry for modifier AF.

AH Clinical psychologist

- Modifier AH may be appended for services provided by a clinical psychologist who has met the required level of education (PhD) and hours of practice.

AI Principal physician of record

- CMS policies regarding the use of consultation and inpatient services codes were revised in 2010. Under these guidelines the inpatient and office/outpatient consultation services as described by these codes in the CPT book are not covered services. For Medicare patients, inpatient services will be reported only with the initial and subsequent hospital care codes.
- Medicare requires that the initial hospital care code be reported for each physician's first visit with a patient during a specific hospitalization.
- As only one physician may be the admitting physician, CMS has added HCPCS Level II modifier AI Principal physician of record, to be appended to the initial hospital care code reported by the attending physician. All other physicians and consultants report just the initial hospital or nursing facility care code without appending a modifier.
- Subsequent inpatient encounters by any physician are reported using appropriate CPT codes.

AJ Clinical social worker

- Modifier AJ may be appended for services provided by a clinical psychologist who has met the required level of education (MSW) and hours of practice.

AK Nonparticipating physician

- Modifier AK is appended by physicians who are not participating providers with Medicare and are not "opt-out" physicians.
- Nonparticipating providers may see patients in their offices or when providing on-call coverage.
- This is separate from modifier GJ Opt-out physician or practitioner emergency or urgent service.

AM Physician, team member service

- The physician member of a team is required to perform one out of every three visits made by a team member.
- Modifier AM should be appended to indicate a team member visit was performed by the physician.
- Team member visits are denied if only one person rendering services is billing for team services, as this is inappropriate billing practice.
- Modifier AM has no effect on payment.

AO Alternate payment method declined by provider of service
AP Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
AQ Physician providing a service in an unlisted health professional shortage area (HPSA)

- Physician services furnished in a health professional shortage area (HPSA) qualify for a quarterly incentive payment. Global surgery packages may also qualify for these payments. The following guidelines apply for the HPSA incentive payment:
  - If the entire global surgery package is furnished in an HPSA, the procedure code for the surgery should be reported with the applicable HPSA procedure code modifier.
  - If only a portion of the global surgical package is performed in an HPSA, only the portion that is furnished in the HPSA should be reported with the HPSA modifier.
- Only physician services are eligible for the HPSA incentive payment. Do not report nonphysician services with modifier AQ.
- Modifier AQ has no effect on individual claim payment but generates a quarterly bonus payment.
- The name, address, and ZIP code where the service was provided must be included on the electronic or paper billing to be considered for HPSA bonus payment.

AR Physician provider services in a physician scarcity area

- Modifier AR is appended when a physician provides services in an area designated as a physician scarcity area.
- A health scarcity area may be urban or any other area as designated.

AS Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery

- Medicare will pay assistant-at-surgery services directly at 85 percent of 16 percent of the amount a physician gets under the physician fee schedule (PFS). This is equal to 13.6 percent of the physician amount under the PFS.
- See the PFS for a list of services where modifier AS can be appended.
- Check with third-party payers for their guideline regarding modifier AS.

Determining Correct Use

Determining correct modifier assignment can be confusing at times. If the medical record documentation does not support the use of a specific modifier, the provider risks denial of the claim based on lack of medical necessity and possible fraud and/or abuse penalties if/when the medical record documentation is reviewed by federal, state, and other third-party payers.

It is important to validate the final modifier determination against the medical record documentation. First, the special circumstance that warrants the use of a modifier must be identified in the medical record. Keep in mind, a modifier provides the way a provider or facility can indicate a service provided to the patient has been changed by some distinctive situation yet the code description itself remains the same. Therefore, the medical record should contain pertinent information and an adequate definition of the service or procedure performed that supports the use of the assigned modifier. If the service is not documented or a special circumstance is not indicated, it is not appropriate to report the modifier.

HCPCS Level II modifiers may be appended to any HCPCS Level I or Level II code. Because the CPT book lists a subset of the Level II modifiers, some incorrectly assume only those modifiers may be appended to CPT codes.

For example, a pediatrician receives free flu vaccine for children under age 3 from the state health department. When the vaccine is administered, the procedure code is reported with modifier SL State supplied vaccine, appended. Although modifier SL is not listed in the CPT book, it would be incorrect to report the service without modifier SL.

Appropriate Use of Professional/Technical Component Modifiers

- Modifier 26 is appended:
  - to the procedure code to report only the professional component.
  - when a physician is providing the interpretation of the diagnostic test/study performed. The interpretation of the diagnostic test/study is a patient-specific service that is separate, distinct, written, and signed.
- Modifier TC is appended:
  - to the procedure code to report only the technical component. Payment includes both the practice and malpractice expenses.
  - to stand-alone procedure codes to describe the technical component only (e.g., staff and equipment costs) of diagnostic tests.
  - to the procedure code by portable x-ray suppliers to report only the technical component.
  - to procedures with a "1" indicator in the PC/TC field of the MPFSDB.
- Modifier TC payment rule: Payment is based solely on the technical value of each individual procedure.
  - Modifier TC is appropriate for use with the following types of services:

    1 = Medical care/injections

    2 = Surgery

    4 = Radiology

    5 = Lab

    6 = Radiation therapy

    8 = Assistant surgeon

    When both the professional and technical components are performed, and the technical component was purchased by an outside entity, report the two components on separate lines on the CMS-1500 claim form.

Inappropriate Use of Professional/Technical Component Modifiers

- Appending modifier 26 for a reread of results of an interpretation initially provided by another provider.
- Appending both modifier 26, indicating that only the professional portion of the service was provided, and modifier 52 for reduced services. It is not necessary to report 52 because the professional component modifier already indicates that only a portion of the complete service was performed.
- Appending modifiers 26 and TC (except for purchased diagnostic tests) when a diagnostic test or radiology service is performed globally (both components are performed by the same provider). When a global service is performed, the code representing the complete service should be reported without modifiers. The payment for the global service reflects the allowances for both components.
- Appending modifier TC to identify procedures that are covered only as diagnostic tests and, therefore, do not have a related professional component. The use of modifier TC on these codes is not appropriate, nor is it correct coding.

Do not append these modifiers to:

- Professional component-only procedure codes, identified in the MPFSDB by an indicator "2" in the PC/TC column.
- Global-only procedures, identified in the MPFSDB with an indicator "4" in the PC/TC column.
- Technical-component-only procedure codes, assigned an indicator "3" in the MPFSDB PC/TC column.

Appropriate Use of Other Modifiers

- Append modifier 59, XE, XP, XS, or XU when reporting a combination of codes that would normally not be reported together. This modifier indicates the ordinarily bundled code represents a service done at a different anatomic site or at a different session on the same date. This may represent a:
  - different session or patient encounter (XE)
  - different practitioner/physician (XP)
  - different site or organ system (e.g., a skin graft and an allograft in different locations) (XS)
  - separate incision/excision (XS)
  - separate lesion (e.g., a biopsy of skin on the neck is performed at the same session as an excision of a 1.0 cm benign lesion of the face) (XS)
  - separate injury (XU)
- Append modifier 59, XE, XP, XS, or XU only on the procedure designated as a separate procedural service. The physician needs to document that the procedure or service was independent of other services rendered on the same day.
- Ensure the medical record documentation is clear as to the separate and distinct procedure before appending modifier 59, XE, XP, XS, or XU to a code. This modifier allows the code to bypass edits; therefore, appropriate documentation must be present in the record.

  Note: Medicare uses the Correct Coding Initiative (CCI) screens when editing claims for possible unbundling. Under CCI screens, specific codes have been identified that should not be reported together, and not all edits allow modifier 59, XE, XP, XS, or XU to override the CCI edit.
- When multiple approaches are taken to obtain a tissue sample (cytological or surgical), report the most invasive procedure performed at the same session/site in order to obtain a specimen. For example, if a fine-needle aspiration is attempted and is unsuccessful and the same physician proceeds to obtain a core biopsy using a cutting needle and ultimately finds it necessary to perform an open biopsy, all occurring at the same session, report only the open biopsy. If different lesions are biopsied using different methodologies, even at the same session, append modifier 59, XE, XP, XS, or XU. If different biopsy procedures are necessary for different reasons (e.g., fine-needle aspiration for diagnosis and needle biopsy for receptors in breast carcinoma), report both procedures.
- When a recurrent hernia requires repair (herniorrhaphy, hernioplasty), report the appropriate recurrent hernia repair code. A code for incisional hernia repair is not to be reported in addition to the recurrent hernia repair unless a medically necessary incisional hernia repair is performed at a different site. In this case, attach modifier 59 or XS to the incisional hernia repair code.
- Modifier 59 is appended only if another modifier such as XE, XS, XP, or XU does not more accurately describe the situation.
- For Medicare reporting purposes, it may be necessary to report one of the more specific X{EPSU} modifiers (XE, XS, XP, or XU) in lieu of appending the general modifier 59.

ESRD. End stage renal disease. Progression of chronic renal failure to lasting and irreparable kidney damage that requires dialysis or renal transplant for survival.

EVAR. Endovascular aortic repair. Deployment of a prosthetic stent via a catheter into the site of an abdominal aortic aneurysm (AAA). The stent provides a safe conduit for blood flow to relieve pressure on the aneurysm as the blood flows through the stent instead of continuing to bulge the sac formed by the aorta wall dilation.

event recorder. Portable, ambulatory heart monitor worn by the patient that makes electrocardiographic recordings of the length and frequency of aberrant cardiac rhythm to help diagnose heart conditions and to assess pacemaker functioning or programming.

fecal microbiota transplant (FMT). Procedure in which healthy bacteria (microbiota) is extracted from the feces of a screened donor and transferred to the colon of the recipient via colonoscopy or upper endoscopy, most often to treat persistent *C. difficile* infections.

Food and Drug Administration (FDA). Federal agency responsible for protecting public health by substantiating the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, national food supply, cosmetics, and items that give off radiation.

FOTO. Focus on therapeutic outcomes.

gait. Manner in which a person walks.

gene. Basic unit of heredity that contains nucleic acid. Genes are arranged in different and unique sequences or strings that determine the gene's function. Human genes usually include multiple protein coding regions such as exons separated by introns which are nonprotein coding sections.

genetic test. Test that is able to detect a gene mutation, either inherited or caused by the environment.

gingivoplasty. Repair or reconstruction of the gum tissue, altering the gingival contours by excising areas of gum tissue or making incisions through the gingiva to create a gingival flap.

glaucoma. Rise in intraocular pressure, restricting blood flow and decreasing vision.

habilitative services. Procedures or services provided to assist a patient in learning, keeping, and improving new skills needed to perform daily living activities. Habilitative services assist patients in acquiring a skill for the first time.

halo. Tool for stabilizing the head and spine.

health care provider. Entity that administers diagnostic and therapeutic services.

hemodialysis. Cleansing of wastes and contaminating elements from the blood by virtue of different diffusion rates through a semipermeable membrane, which separates blood from a filtration solution that diffuses other elements out of the blood.

home health services. Services furnished to patients in their homes under the care of physicians. These services include part-time or intermittent skilled nursing care, physical therapy, medical social services, medical supplies, and some rehabilitation equipment. Home health supplies and services must be prescribed by a physician, and the beneficiary must be confined at home in order for Medicare to pay the benefits in full.

hospice. Organization that furnishes inpatient, outpatient, and home health care for the terminally ill. Hospices emphasize support and counseling services for terminally ill people and their families, pain relief, and symptom management. When the Medicare beneficiary chooses hospice benefits, all other Medicare benefits are discontinued, except physician services and treatment of conditions not related to the terminal illness.

hypertrophic. Enlarged or overgrown from an increase in cell size of the affected tissue.

implant. Material or device inserted or placed within the body for therapeutic, reconstructive, or diagnostic purposes.

implantable cardioverter-defibrillator. Implantable electronic cardiac device used to control rhythm abnormalities such as tachycardia, fibrillation, or bradycardia by producing high- or low-energy stimulation and pacemaker functions. It may also have the capability to provide the functions of an implantable loop recorder or implantable cardiovascular monitor.

in situ. Located in the natural position or contained within the origin site, not spread into neighboring tissue.

incontinence. Inability to control urination or defecation.

infusion. Introduction of a therapeutic fluid, other than blood, into the bloodstream.

infusion pump. Device that delivers a measured amount of drug or intravenous solution through injection over a period of time.

intra-arterial. Within an artery or arteries.

intramuscular. Within a muscle.

intraocular lens. Artificial lens implanted into the eye to replace a damaged natural lens or cataract.

intravenous. Within a vein or veins.

introducer. Instrument, such as a catheter, needle, or tube, through which another instrument or device is introduced into the body.

keratoprosthesis. Surgical procedure in which the physician creates a new anterior chamber with a plastic optical implant to replace a severely damaged cornea that cannot be repaired.

LDS. Lipodystrophy syndrome. Syndrome which involves the partial or total absence of fat and/or the abnormal deposition and distribution of fat in the body due to a disturbance of the lipid metabolism.

magnetic resonance angiography. Diagnostic technique utilizing magnetic fields and radio waves rather than radiation to produce detailed, cross-sectional images of internal body structures.

multiple-lead device. Implantable cardiac device (pacemaker or implantable cardioverter-defibrillator [ICD]) in which pacing and sensing components are placed in at least three chambers of the heart.

mutation. Alteration in gene function that results in changes to a gene or chromosome. Can cause deficits or disease that can be inherited, can have beneficial effects, or result in no noticeable change.

nasogastric tube. Long, hollow, cylindrical catheter made of soft rubber or plastic that is inserted through the nose down into the stomach, and is used for feeding, instilling medication, or withdrawing gastric contents.

nebulizer. Latin for mist, a device that converts liquid into a fine spray and is commonly used to deliver medicine to the upper respiratory, bronchial, and lung areas.

negative pressure dressing. Adjunctive therapy used to speed wound healing in skin grafts or large wounds. It has been shown to increase blood flow, decrease bacterial count, and increase formation of granulation tissues. A foam pad is placed on the defect and covered with an occlusive drape. A small tube that is non-collapsible is placed into the foam and attached to a disposable pump that provides negative pressure up to -125 mmHg.

NMES. Neuromuscular electrical stimulation. Technology that uses percutaneous stimulation to deliver electrical impulses for muscle flexion to trigger action. NMES can, in some cases, create an ability to ambulate among paraplegic patients.

obturator. Prosthesis used to close an acquired or congenital opening in the palate that aids in speech and chewing.

occult blood test. Chemical or microscopic test to determine the presence of blood in a specimen.

occupational therapy. Training, education, and assistance intended to assist a person who is recovering from a serious illness or injury perform the activities of daily life.

ocular implant. Implant inside muscular cone.

omnicardiogram. Method of mathematically interpreting the usual linear form of the electrocardiogram in a different, roughly circular shape. This interpretation is then compared to a normal template and an analysis is performed on two randomly selected cycles from leads I, II, V4, V, and/or V6.

oral. Pertaining to the mouth.

ordering physician. Physician who orders nonphysician services (e.g., laboratory services, pharmaceutical services, imaging services, or durable medical equipment) for a patient.

orphan drugs. Drugs that treat diseases that affect fewer than 200,000 people in the United States, as designated by the FDA. Orphan drugs follow a varied process from other drugs regulated by the FDA.

orthosis. Derived from a Greek word meaning "to make straight," it is an artificial appliance that supports, aligns, or corrects an anatomical deformity or improves the use of a moveable body part. Unlike a prosthesis, an orthotic device is always functional in nature.

orthotic. Associated with the making and fitting of an orthosis(es).

osteo-. Having to do with bone.

osteogenesis stimulator. Device used to stimulate the growth of bone by electrical impulses or ultrasound.

ostomy. Artificial (surgical) opening in the body used for drainage or for delivery of medications or nutrients.