



**COMMUNITY HEALTH PLAN**  
of Washington

*Committed to your health.®*



## **Provider Education Webinars**

Course 4:

**HCPCS Level II Coding Fundamentals**

# Housekeeping Items

## **Technical Difficulties**

If you experience technical difficulties, please

- utilize the “Chat” feature of the GoToWebinar application to let us know what kind of problem you’re having
- exit the application and try re-establishing your internet and phone connections
- call 1-888-206-2266 and enter Conferee pin number that came with your invitation/registration (if you cannot establish a webinar connection, this number will allow you to follow along with the conference using your handout). If you have to fall back on this method, please email us at the below email address and let us know what kind of problem you’re having.

## **Webinar Questions**

For questions concerning the content of this webinar, CHP has a dedicated email address: [providereducation@chpw.org](mailto:providereducation@chpw.org).

## **Questions about Specific Coding Scenarios**

If you have questions about particular documentation and coding questions (specific coding scenarios) please email it to us at [providereducation@chpw.org](mailto:providereducation@chpw.org).

## **Questions about Claims**

If you have questions about specific coding/claims processing issues, please use your usual route for claims queries (the webinar project isn’t set up to be the best forum to access claims information).

## **Continuing Education Credit**

At the end of each webinar, there are instructions detailing how to request Continuing Medical Education and/or Continuing Education Units, by using the dedicated email address that CHP has established for this activity: [providereducation@chpw.org](mailto:providereducation@chpw.org).

# Welcome

Welcome to this presentation of Community Health Plan's Provider Education Webinar, Course 4: HCPCS Level II Coding Fundamentals.

This webinar series is designed specifically for Community Health Plan's Physicians, Healthcare Professionals, and Administrative Staff who want to broaden their understanding and use of documentation and coding skills.

This webinar series consists of 10 one-hour courses.

Attendees may earn

- Continuing Medical Education (CME) through the AAFP\*, and/or
- Continuing Education Units (CEU) through AAPC\*\* and AHIMA\*\*\*

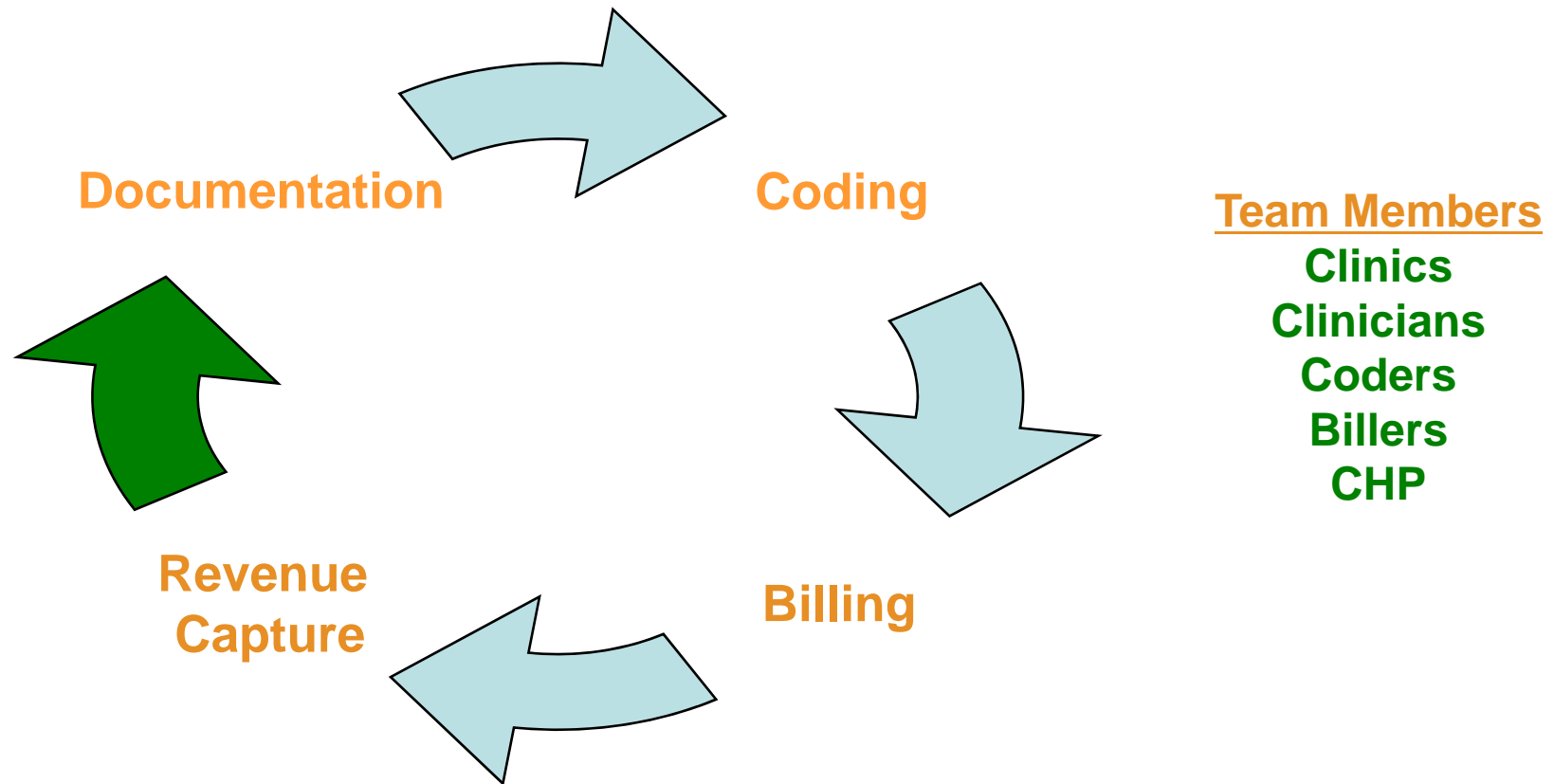
Courses and Self-Assessments must be completed to earn the CME/CEU credit.

\* American Academy of Family Physicians

\*\* American Academy of Professional Coders

\*\*\* American Health Information Management Association

# A Comprehensive Approach to Optimizing Documentation & Coding



## **Our Role – Clinical Components**

- Deliver timely comprehensive care....
- Document the care you deliver....
- Code the care you document....
- Capture the codes you document...

**Community Health Plan - Medicare Advantage**  
**Member HCC Report**



HEALTH CENTER - Clinic Name

Run Date: 10/27/2008

Patient Name: Doe, John  
 Address: 1234 Main Street, Anytown, US 98765  
 Phone: (555) 555-5555

Member ID: HP1000000000

**How To Use This Report**

Step 1: Please review the diagnoses (ICD9 codes) and conditions (Hierarchical Condition Categories (HCC Codes)) listed in Sections 1 and 2. If you believe that a diagnosis/condition listed here is not relevant to this patient, please circle the diagnosis/condition.

Step 2: After reviewing, please sign below and fax this form to our confidential fax: 206-652-7024, Attn: Member HCC Report.

Step 3: At your next visit with this patient, please check for the presence of these diagnoses/conditions and document each currently present diagnosis/condition accordingly in your visit note.

**Section 1 - Conditions (HCCs) Reported in Current Year**

(Reported diagnoses may come from multiple care settings, including primary care, specialty care and hospital providers. Only one HCC per patient is shown, with highest documented ICD9 code.)

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
250.00	Dmii Wo Cmp Nt St Uncntr	19	Diabetes without Complication	0.2

**Section 2 - Additional Conditions (HCCs) Reported in Prior Years**

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
291.81	Alcohol Withdrawal	51	Drug/Alcohol Psychosis	0.353
303.90	Alcoh Dep Nec/Nos-Unspec	52	Drug/Alcohol Dependence	0.265
780.39	Convulsions Nec	74	Seizure Disorders and Convulsions	0.269
428.0	Chf Nos	80	Congestive Heart Failure	0.417
		16	Diabetes with Neurologic or Other Specified Manifestation	0.552
		71	Polyneuropathy	0.268

*I have reviewed the diagnoses/conditions listed on this page, along with the medical history of this patient. With the exception of those codes that are circled, I attest that these diagnoses/conditions are present in this patient's medical history as available to me beginning \_\_\_\_\_ (mm/yyyy).*

\_\_\_\_\_  
 Printed Name & Credentials

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

# Community Health Plan of Washington Provider Education Webinar

## Course 4: HCPCS Level II Coding Fundamentals (Healthcare Common Procedural Coding System)

Marvel Gray, CPC, CCS-P, MCS-P, PCS, CCP, CCO, CMPM  
Cost Reimbursement and Research Analyst

Kate Parman, CPC, CCS, CCS-P, MCS-P  
Cost Recovery Analyst

# Learning Objectives

## Webinar Learning Objective:

Community Health Plan's goal is that our Providers will apply this career training and best practices information across their care spectrum, regardless of Patients' ability to pay or insurance type.

## Course 4 Learning Objective: HCPCS Level II Coding Defined

Focus on proper use of HCPCS Level II codes to meet various coding and descriptive requirements.

## Participants' learning objectives for Course 4 are:

- Understand the purpose of the HCPCS coding classification
- Learn that there are instructions that affect proper coding in this HCPCS classification
- Recognize how proper use of HCPCS codes can help drive documentation and coding accuracy

# HCPCS Code Set Definition and Purpose

- HCPCS stands for Health Care Procedure Coding System, aka HCPCS (hic-pics)
- Level I is the CPT coding classification (CPT-4)
- Level II is the HCPCS coding classification, which defines supplies and services not included in Level I CPT-4 codes
- Level II (HCPCS) codes have been in use since 1983
- The HCPCS code set is updated annually on January 1<sup>st</sup> (except the Temporary HCPCS codes, which are updated throughout the year as necessary)
- Instructional and Informational Notes assist in proper HCPCS code selection
- The primary purpose of the HCPCS code set is to bill Medicare and Medicaid, however it has come to apply to many other payers as well. Check with individual payers regarding their policies about HCPCS proper code usage.

# HCPCS Modifiers

HCPCS codes are modifiable in that there is a set of alpha and alpha-numeric 2-digit codes that are appendable to the HCPCS codes.

Right/Left Example: L4396-RT

L4396 Static Ankle-Foot Orthotic (AFO), prefabricated, incl. fitting & adjstmt.  
-RT Right

Fingers/Toes Example: A4570-F2

A4570 Splint  
-F2 Left hand, third digit

(Because the modifier description states “left hand”, it would not be appropriate to append –LT to the code.)

Payers have different requirements regarding the use of HCPCS and their modifiers: check with the individual payer for requirements.

# Examples of Services & Supplies Described in the HCPCS Code Classification

## Services / Procedures

- Dental procedures, Tobacco Counseling, Bladder Catheterization for Specimen Collection

## DME – Durable Medical Equipment

- Wheelchairs, Canes, Walkers, Crutches, Sitz Bath, CPAP machine, Nebulizers, Home Blood Glucose Monitor

## Prosthetics

- Artificial limb, Post-mastectomy breast implant, Artificial Larynx

## Orthotics

- Knee, Wrist, Shoulder, Lumbar, Elbow Brace, Orthotic Footwear

## Supplies

- Incontinence garment, Ostomy pouch, Enteral Feeding Tubes and Formulas

**(Refer to the description in the References slide of this presentation for the official and more precise descriptions.)**

# Codes Sometimes Transition from being a HCPCS code to being a CPT code

Smoking and tobacco-use cessation counseling visit:

July 2005 – December 2007

January 2008-2009

HCPCS

CPT

G0375

99406

G0376

99407

Tobacco Counseling *for the control and prevention of oral disease:*

2004-2009

HCPCS

D1320

# HCPCS Code Selection Procedure & Helpful Tips

## Code Selection Process (used for the ICD-9-CM and CPT code sets as well as HCPCS)

1. Identify the main term for the service or supply that the Patient received.
2. Locate the main term in the Index
3. Make note of the potential code choices listed in the Index
4. Locate the potential code in its respective section
5. Compare the different potential codes (if any)
6. Select the code which most specifically describes the service or supply that the Patient received
7. Review the Appendices to check for additional information that may apply to the code selected
8. Determine if one or more modifiers should be appended to the selected code to further describe the circumstance

## Helpful Tips

When a CPT and a HCPCS code have nearly identical descriptions for a procedure or service, use the CPT code

>>>>Unless the HCPCS code is more specific, then use the HCPCS more specific code. Always code to the highest level of specificity

Don't use CPT 99070 (generic, unspecified HCPCS code) if there is a more specific code available. There are many HCPCS codes which describe services in detail.

Regarding the Table of Drugs section of HCPCS, both the generic name and brand name of drug is listed. Either name will “cross-walk” to the appropriate tentative code in the appropriate section of the HCPCS manual. Only after referencing the detailed description of the code in the appropriate section is a tentative code selected.

# Organizations that Utilize HCPCS Codes:

- Medical Providers
  - Durable Medical Equipment (DME) Vendors
  - Dentists
  - Optical Suppliers
  - Hospitals
  - Nursing Homes
  - Pharmacies
  - Payers
  - Government Programs
- 
- An important caution: ALWAYS research the correct HCPCS code/s to use for the products you dispense and services you supply.

# Structure of the HCPCS Classification

## HCPCS National Level II Codes

5 digit alphanumeric code

A letter followed by four numbers: A0000-V0000

## HCPCS National Level II Modifiers

Some Modifier purposes:

indicate services or supplies are part of a government program  
services supervised by anesthesiologist  
specific side of the body  
equipment purchased vs. rented

# About the HCPCS Code Classification

## About HCPCS:

- The HCPCS code set exists as a separate code set, and is used in conjunction with the CPT-4 and ICD-9-CM code sets.
- The HCPCS code set is maintained by the American Medical Association (AMA).

## Useful Websites:

- The majority of the HCPCS code set is updated yearly, and the CMS Web site to view the annual HCPCS update:  
<http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp>
- CMS's Guide to the HCPCS Code Classification website:  
<http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp>



# HCPSC Codes & Medicare ABN Forms

Medicare's new Advance Beneficiary Notice of Noncoverage (ABN) form will be required starting March 1, 2009.

The new ABN form (Form# CMS-R-131) replaces three previously used ABN forms:

ABN-G (general use)

ABN-L (lab use)

NEMB (Notice of Exclusion from Medicare Benefits)

The hope is to eliminate one source of confusion for Beneficiaries and for Notifiers (Providers of Services and Supplies).

(A) Notifier(s): \_\_\_\_\_ (C) Identification Number: \_\_\_\_\_  
 (B) Patient Name: \_\_\_\_\_

**ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**  
**NOTE:** If Medicare doesn't pay for (D) \_\_\_\_\_ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) \_\_\_\_\_ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) \_\_\_\_\_ listed above.  
 Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**(G) OPTIONS:** Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the (D) \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the (D) \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

**OPTION 3.** I don't want the (D) \_\_\_\_\_ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**(H) Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature: \_\_\_\_\_ (J) Date: \_\_\_\_\_

According to the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0166. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0166

# Avoid HCPCS Common Errors

## Example 1: Orthotic Devices

1. Use the ICD-9-CM that is appropriate for the HCPCS service or supply.

HCPCS codes require use of ICD-9-CM diagnosis codes to illustrate the medical necessity.: They are reported together and are therefore “linked” to one another on the claim form. To insure integrity of claims data, the chart documentation must be specific enough to precisely describe services and supplies (to coders, billers, reviewers, payers, regulators, etc).

In this example, Wyle E. Coyote saw the Provider for follow up on his hypertension, which is stable, and during the visit requested a prefabricated neoprene wrist brace for his tendonitis which was discussed (and documented!) at his last visit.

If documentation criteria is met, the visit’s coding should look like:

99211-99215 (CPT code range) E/M Office Visit should be linked to:  
ICD-9-CM 401.9 Hypertension AND 726.90 Tendonitis.  
CPT modifier -25 should be appended to E/M Office Visit code.

L3908 (HCPCS code) Wrist Orthotic should only be linked to:  
ICD-9-CM 726.90 Tendonitis

Use the appropriate HCPCS and ICD-9-CM codes to “paint a picture” of the service/supply and diagnosis that is/are documented. Code what is true: don’t code strictly for reimbursement.

# Avoid HCPCS Common Errors

## Example 2: Services

2. Refer to both Level II (HCPCS) and Level I (CPT) code sets for the code/s which best describe the service/s being performed.

In this example, Olive Oyl saw her Provider to follow up her DM2, and her lower extremity loss of protective sensation. Both conditions were stable, but Olive's right great and 2<sup>nd</sup> digit dystrophic toe nails needed to be trimmed, which was done.

If documentation criteria is met, the visit's coding should look like:

99211-99215 (CPT code range) E/M Office Visit should be linked to:  
ICD-9-CM 250.00 DM2 AND 703.8 Other specified diseases of nails.  
CPT modifier -25 should be appended to E/M Office Visit code.

G0127 (HCPCS code) Trimming of dystrophic nails, (any number) should only be linked to:  
ICD-9-CM 703.8 Other specified diseases of nails.\*  
HCPCS modifiers –T5 and –T6 should be appended to the HCPCS code.

Note that in order to arrive at the correct code, both the HCPCS and CPT code sets would have to be referenced. The HCPCS code is specific to trimming of dystrophic nails and the CPT is specific to non-dystrophic nails.

Compare codes for services in the CPT as well as the HCPCS classifications to be certain that the correct, most specific code is chosen.

\*The Provider's medical chart documentation doesn't specify whether the nail and sensory conditions are due to the Diabetes, therefore those conditions shouldn't be coded as a complication/manifestation of Diabetes.

# Avoid HCPCS Common Errors

## Example 3: Injectables

3. Follow these steps to find the correct code when coding injectable drugs, biologicals, and substances.

In this example, Road Runner came to his Provider's office to get his Vitamin B-12 injection (standing order) for his long-standing pernicious anemia.

In addition to the Injection CPT code 96372 +281.0 pernicious anemia

### Code the substance (the drug/biological/substance)

Identify the name of the injectable drug and find it in HCPCS Appendix 1 (Table of Drugs).

The crosswalk indicates that J3420 is a *possible* or *tentative* code.

Find J3420 in the HCPCS "J" Section: DRUGS ADMINISTERED OTHER THAN ORAL METHOD.

Verify that J3420 is the correct code by comparing the brand/generic name, dosage amount, etc.

Apply any instructional and informational notes in the code designation.

### Code the service (administration of the injection)

Identify the type of injection (Sub-Q, IM, IV Push, etc.) and reference Indexes in both the HCPCS and CPT manuals: main terms are injection and administration.\*

Injections and administration HCPCS codes are found throughout the HCPCS manual, while CPT codes are usually in a range of codes in the medicine section.

\*\*Injection" and "Administration" differ from the main terms for Immunization, Vaccination. Infusion, Instillation, Introduction, and other routes and types of administration of drugs, biologicals, and substances.

# Finding the Proper HCPCS Code

- HCPCS Manuals give instructions on how to use the manual, usually in the Introduction section. Reference this section regularly, and look for updated information on how to properly document and code for HCPCS.
- Identify the main term for the service/supply the Patient received, and find the term in the index (i.e. screening, cervical or vaginal)
- When the main term is found in the Index, select a '*tentative*' or '*candidate*' code (i.e.G0101) and find that code in the Alphanumeric Listing.
- In the Alphanumeric Listing, find specifics that further define the item. Be certain that the code specifics accurately describe the item exactly. If there is not a HCPCS code that is completely specific for the item, you may need to query the HCPCS resource (see slide 16).
- Don't code directly from the Index: always look both places.
- Use the Index and the Alphanumeric Listing together.
- When the code is located, refer to the symbols, colors, and/or instructions that denote special information, and make a final choice of code accordingly.

# HCPCS Temporary Codes

HCPCS Temporary Codes are updated throughout the year as necessary. (The rest of the HCPCS codes are updated annually.)

As with the ICD-9-CM and CPT-4 code sets, the HCPCS code set includes instructional and informational notes about how to utilize this code set.

Although (depending on the publisher) a lot of documentation, coding, and reimbursement information is contained in the HCPCS manual, please remember that the services & supplies that were provided are what should be coded and reported. Code for accuracy and with integrity. Never code for reimbursement alone: this can't be understated.

# HCPCS Coding Help

The American Hospital Association (AHA) and the Centers for Medicare & Medicaid Services (CMS) are collaborating in the establishment of the AHA clearinghouse to handle coding questions on established HCPCS usage.

If you have a HCPCS coding question, you may want to reference the CMS website: [http://www.cms.hhs.gov/MedHCPCSGenInfo/20\\_HCPCS\\_Coding\\_Questions.aspx](http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.aspx)

HCPCS-related questions must be submitted in the approved form, which you can download from the AHA website (<http://www.ahacentraloffice.org/>) listed below, and either faxed or mailed directly to the AHA Central Office.

Central Office on HCPCS  
American Hospital Association  
One North Franklin  
Chicago, IL 60606  
Fax: 312-422-4583

# Building a Bridge, and Using it

## Ethical Responsibility

Guessing about where to find rules that apply to documentation and coding questions is not necessary, is unethical, and wastes your valuable time and energy.

CHP is here to help you build a foundation for understanding this valuable career skill, and to assist you with official references when questions about proper documentation and coding arise.

## Feedback about the Webinar

Community Health Plan chose this enterprise-wide, long-term approach of online training to serve our Providers, achieve our training objectives, and optimize the delivery of this information (which ultimately benefits the Patients, the Providers, and the Plan).

To that end, CHP has created a dedicated email address for our Providers and their Staff to send questions and comments about this training: please email us at: [providereducation@chpw.org](mailto:providereducation@chpw.org). CHP encourages our Providers to give us feedback about this educational webinar, so that it may be continuously improved.

# Continuing Education Credit Requirements

CHP has arranged to award CMEs (through AAFP) and CEUs (through AAPC and AHIMA) for Participants who:

- attend this webinar,
- are counted as present,
- complete a brief Self-Assessment and Quality Survey at the end of the webinar, and
- request the continuing, education credit in the manner described in the steps in the next slide.

# Obtaining Continuing Education Credits

1. Send an email to [providereducation@chpw.org](mailto:providereducation@chpw.org) with “Continuing Education Credit Request” in the subject line.
2. Be sure to let us know which organization/s you’re requesting continuing education credit from, and
3. Include your contact information in the body of the email.
4. A *brief* Self-Assessment will be emailed to requesters. The brief Self-Assessment is evidence of learning objectives met (and is a requirement of the continuing education granting organizations), and
5. Upon completion of your Self-Assessment, email it back to CHP at the above email address.
6. CHP will process and send the continuing education certificates to the Participants at the contact information provided in Step 3 (above).
7. As always, it’s the responsibility of the Participant to submit and/or make available proof of continuing education credit earned (CME/CEU certificates) to the AAFP, AAPC, and AHIMA on demand. CHP doesn’t submit certificates to these organizations on behalf of webinar Attendees.

Additional Resources: much of the information in the Webinar is available in a more comprehensive form at CMS’s website: <http://www.cms.hhs.gov/MLNGenInfo/> and click on the Web-Based Training Modules. There are additional CMS web-based training courses there as well.

# Thank You for Participating

Community Health Plan would like to thank you for taking time out of your busy schedule to participate in today's Provider Education Course 4 Webinar: HCPCS Level II Coding Fundamentals.

Community Health Plan has arranged for documentation and coding resources to be made available to you by email for questions about the materials covered in this webinar series. We cannot address specific, individual claims processing queries. There are other resources available for reimbursement questions, and the usual route for claims questions should be used for them.

This concludes CHP's HCPCS Level II Coding Fundamentals Course #4.

The Provider Education Team is looking forward to delivering the next course in this webinar series, and it will reinforce the concepts and complement the content of this course.

# References

## Slide 11

For formal descriptions of DMEPOS: See Medicare A News Issue 2067  
Mar 6 2008

## Slide 17 and 18

Annual HHS OIG Work Plan: <http://oig.hhs.gov/publications/workplan.asp>  
CMN and ABN Information at CMS: <http://www.cms.hhs.gov/>

## Slide 27

CMS web-based Training Module: <http://www.cms.hhs.gov/MLNGenInfo/>