AAPC

HCPCS LEVEL II EXPERT

Service/Supply Codes for Caregivers & Suppliers

2021

Benefiting

susan G. komen®

See back for details

Table of Contents

Introduction

This Healthcare Common Procedure Coding System (HCPCS) Level II code book goes beyond the basics to help you to code accurately and efficiently. In addition to including a customized Alphabetic Index and Tabular List for services, supplies, durable medical equipment, and drugs which the Centers for Medicare and Medicaid Services (CMS) developed, we include the following features:

Features

We've crafted a select set of bonus features based on requests from coders in the field as well as the recommendations of our core group of veteran coding educators. Features that you'll benefit from page after page include:

- HCPCS Level II Coding Procedures guide from CMS to help you to better understand HCPCS Level II codes
- Comprehensive list of new/revised/deleted codes for 2021
- CPT® crosswalk codes for select HCPCS Level II G codes
- Deleted codes crosswalk for 2021
- 60 stick-on tabs to mark specific sections of the book
- Symbols showing which codes have restrictions based on age or sex of the patient
- Medicare coverage and reimbursement alerts
- APC status indicators and ASC payment indicators
- HCPCS Level II modifiers with lay descriptions and coding tips
- Updated and enhanced illustrations of body systems at the front of the book so you don't have to search the code book for these large color images of body systems
- Highlighted coding instructional and informational notes help you recognize important code usage guidance for specific sections
- Intuitive color-coded symbols and alerts identify new and revised codes and critical coding and reimbursement issues quickly
- Symbols in Index showing each new code
- A user-friendly page design, including dictionary-style headers, color bleed tabs, and legend keys

Additionally, our dedicated team drew on their years of experience using code books to develop this book's user friendly symbols, highlighting, color coding, and tabs, all designed to help you find the information you need quickly.

Let Us Know What You Think

Our goal for this code book is to support those involved in the business side of healthcare, helping them to do their jobs and do them well. We'd appreciate your feedback, including your suggestions for what you'll need in a HCPCS Level II resource, so we can be sure our code books serve your needs.

HCPCS Level II Coding Procedures

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) LEVEL II CODING PROCEDURES

This information provides a description of the procedures CMS follows in processing HCPCS code applications and making coding decisions.

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A. HCPCS BACKGROUND INFORMATION

Each year in the United States, health care insurers process over 5 billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. The Healthcare Common Procedure Coding System (HCPCS) Level II Code Set is one of the standard, national medical code sets specified by the Health Insurance Portability and Accountability Act (HIPAA) for this purpose. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II of the HCPCS. Level I of the HCPCS is comprised of CPT® (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT® is a uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT® to identify services and procedures for which they bill public or private health insurance programs. The CPT® codes are republished and updated annually by the AMA.

HCPCS Level II is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® code set jurisdiction, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT® codes, the HCPCS Level II codes were established for submitting claims for these items. Level II codes are also referred to as alpha- numeric codes because they consist of a single alphabetical letter followed by four numeric digits, while CPT® codes primarily are identified using five numeric digits.

B. HISTORY

The development and use of Level II of the HCPCS began in the 1980s. Concurrent to the use of Level II codes, there were also Level III codes. HCPCS Level III were developed and used by Medicaid State agencies, Medicare contractors, and private insurers in their specific programs or local areas of jurisdiction. For purposes of Medicare, Level III codes were also referred to as local codes. Local codes were established when an insurer preferred that suppliers use a local code to identify a service, for which there is no Level I or Level II code, rather than use a "miscellaneous or not otherwise classified code."

HIPAA required the Secretary to adopt standards for coding systems that are used for reporting health care transactions. Thus, regulations were published in the Federal Register on August 17, 2000 (65 FR 50312), to implement standardized coding systems under HIPAA. These regulations provided for the elimination of Level III local codes by October 2002, at which time, the Level I and Level II code sets could be used. The elimination of local codes was postponed, as a result of section 532(a) of BIPA, which continued the use of local codes through December 31, 2003.

The regulation that was published on August 17, 2000 (45 CFR 162.1002), to implement the HIPAA requirement for standardized coding systems established the HCPCS Level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions that are not within the CPT® code set jurisdiction. The HCPCS Level II coding system was selected as the standardized coding system because of its wide acceptance among both public and private insurers.

C. AUTHORITY

The Secretary of the Department of Health and Human Services has delegated authority under HIPAA to CMS to maintain and distribute HCPCS Level II codes. As stated in August 17, 2000 (45 CFR 162.1002), CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes.

D. HCPCS LEVEL II CODES

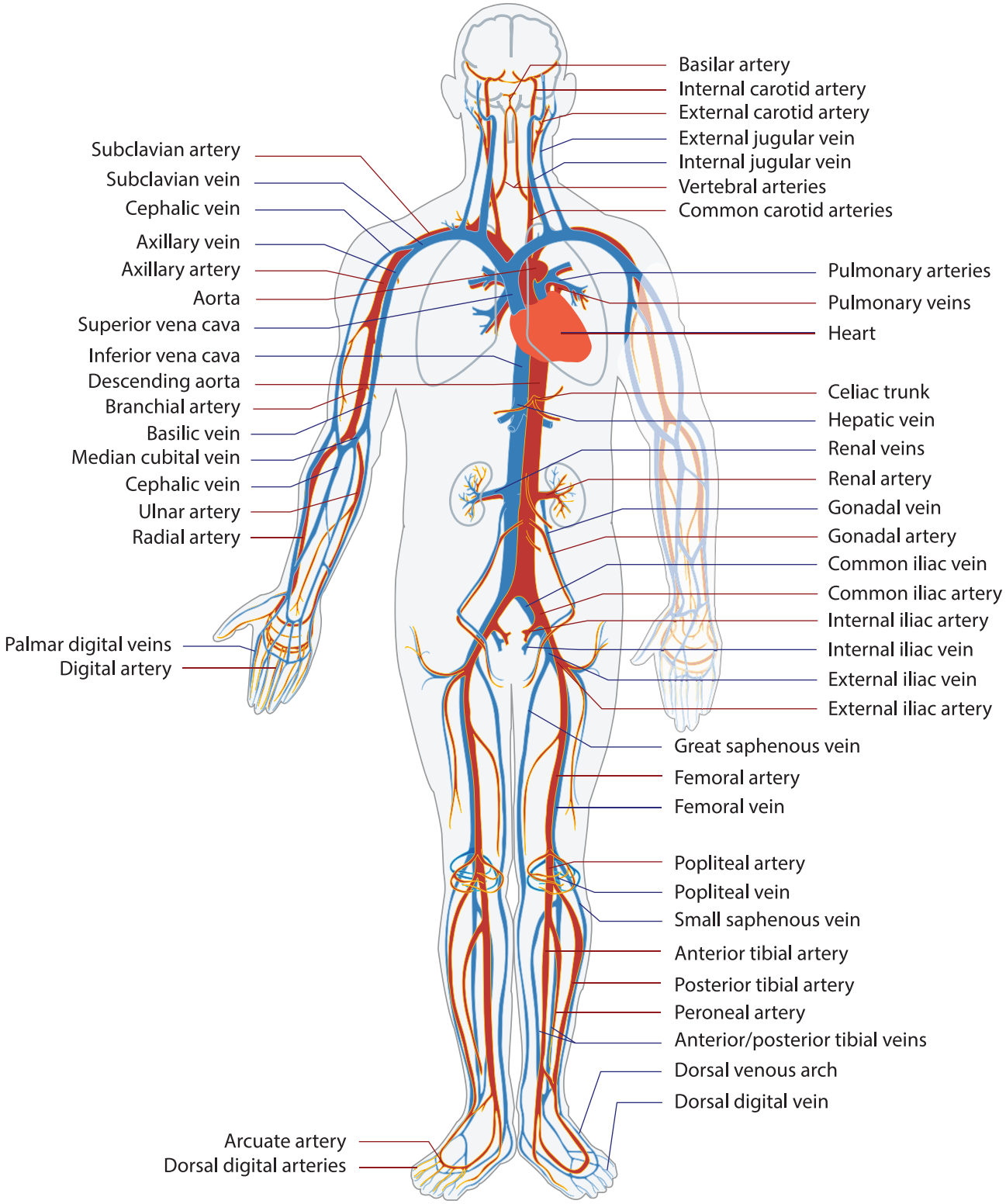
The HCPCS Level II coding system is a comprehensive, standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing. For each alpha-numeric HCPCS code, there is descriptive terminology that identifies a category of like items. These codes are used primarily for billing purposes. For example, suppliers use HCPCS Level II codes to identify items on claim forms that are being billed to a private or public health insurer. Currently, there are national HCPCS codes representing almost 8,000 separate categories of like items or services that encompass products from different manufacturers. When submitting claims, suppliers are required to use one of these codes to identify the items they are billing.

HCPCS is a system for identifying items and certain services. It is not a methodology or system for making coverage or payment determinations, and the existence of a code does not, of itself, determine coverage or non-coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or revision of HCPCS codes are made independent of the process for making determinations regarding coverage and payment.

With regard to the Medicare program, if specific Medicare coverage or payment indicators or values have not been established for any new HCPCS codes, this may be because a national Medicare coverage determination and/or fee schedule amounts have not yet been established for these items. This is neither an indicator of Medicare coverage or non-coverage. In these cases, until national Medicare coverage and payment guidelines have been established for these codes, the Medicare coverage and payment determinations for these items may be made based on the discretion of the Medicare contractors processing claims for these items.

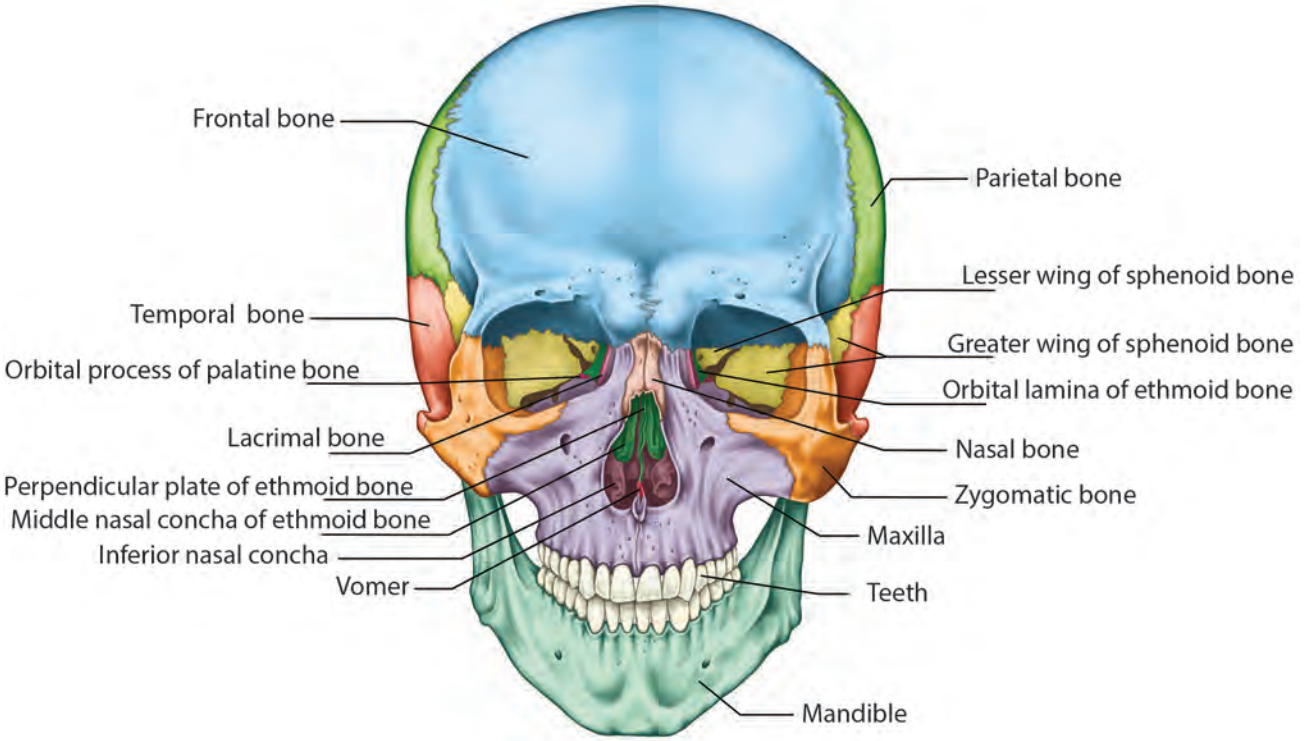
Anatomical Illustrations

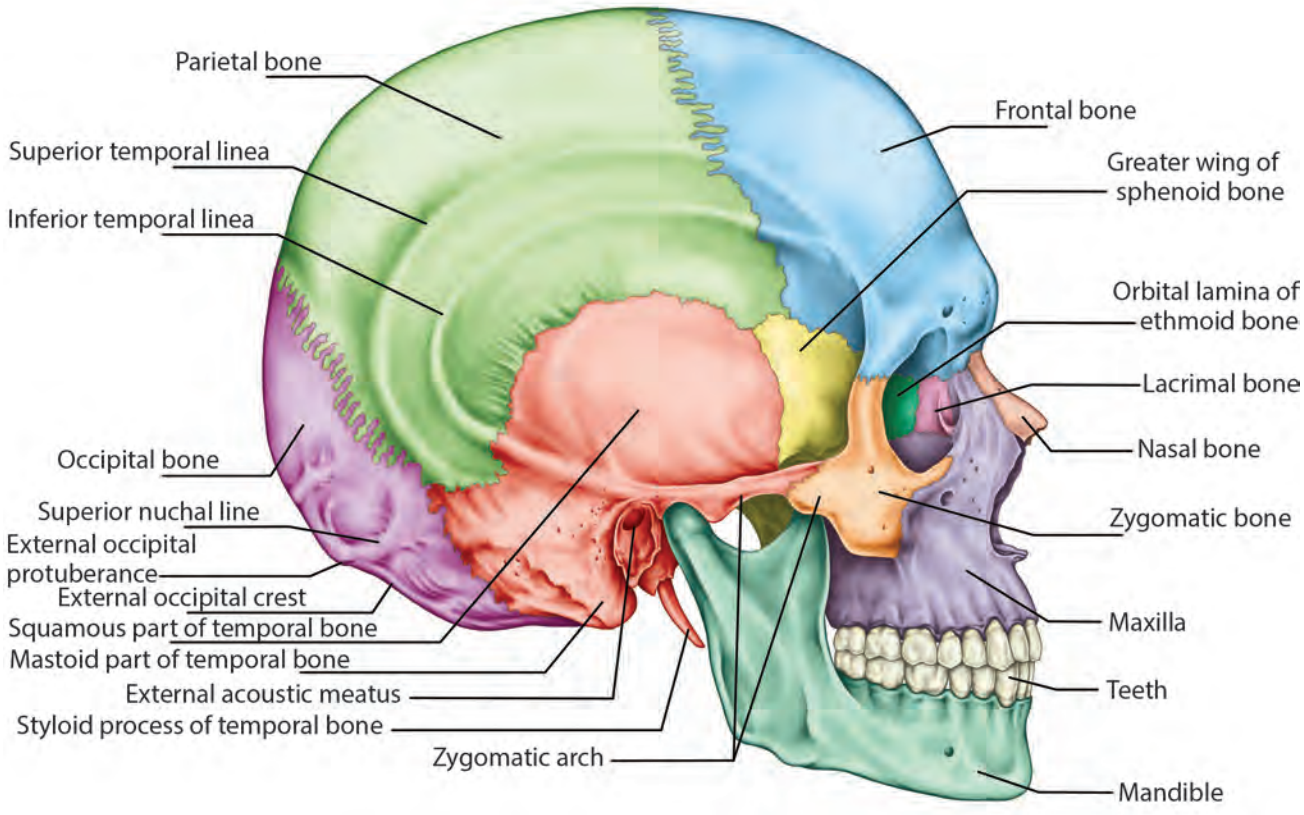
Circulatory System — Arteries and Veins



Title: Circulatory System Labels Biology Diagram, **License:** CC0 Creative Commons (Free for commercial use No attribution required), **URL link:** https://pixabay.com/en/circulatory-system-labels-biology-41523/

Skeletal System — Skull





Index to Services, Supplies, Equipment, Drugs

A

MEDICAL AND SURGICAL SUPPLIES (A4206-A8004)

INJECTION AND INFUSION SUPPLIES (A4206-A4232)

C **A4206** Syringe with needle, sterile, 1 cc or less, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4207** Syringe with needle, sterile 2 cc, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4208** Syringe with needle, sterile 3 cc, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4209** Syringe with needle, sterile 5 cc or greater, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **A4210** Needle-free injection device, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A4211** Supplies for self-administered injections N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4212** Non-coring needle or stylet with or without catheter N
BETOS: D1A Medical/surgical supplies
Other carrier priced

C **A4213** Syringe, sterile, 20 cc or greater, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4215** Needle, sterile, any size, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A4216** Sterile water, saline and/or dextrose, diluent/flush, 10 ml DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4217** Sterile water/saline, 500 ml DME N
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: AU

D **A4218** Sterile saline or water, metered dose dispenser, 10 ml N
BETOS: O1E Other drugs

D **A4220** Refill kit for implantable infusion pump N
BETOS: D1A Medical/surgical supplies
Other carrier priced

C **A4221** Supplies for maintenance of non-insulin drug infusion catheter, per week (list drugs separately) DME N
BETOS: D1E Other DME

C **A4222** Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately) DME N
BETOS: D1E Other DME

C **A4223** Infusion supplies not used with external infusion pump, per cassette or bag (list drugs separately) N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4224** Supplies for maintenance of insulin infusion catheter, per week DME N
BETOS: D1E Other DME

D **A4225** Supplies for external insulin infusion pump, syringe type cartridge, sterile, each DME N
BETOS: D1E Other DME

I **A4226** Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing, per week E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

D **A4230** Infusion set for external insulin pump, non needle cannula type N
BETOS: D1E Other DME

Insulin pump

D **A4231** Infusion set for external insulin pump, needle type N
BETOS: D1E Other DME

I **A4232** Syringe with needle for external insulin pump, sterile, 3 cc E1
BETOS: D1E Other DME
Service not separately priced by Part B

REPLACEMENT BATTERIES (A4233-A4236)

C **A4233** Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each DME E1
BETOS: D1E Other DME
DME Modifier: NU

♂ Male only ♀ Female only A Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

D **A4394** Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4395** Ostomy deodorant for use in ostomy pouch, solid, per tablet DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4396** Ostomy belt with peristomal hernia support DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4397** Irrigation supply; sleeve, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4398** Ostomy irrigation supply; bag, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4399** Ostomy irrigation supply; cone/catheter, with or without brush DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4400** Ostomy irrigation set DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4402** Lubricant, per ounce DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4404** Ostomy ring, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4405** Ostomy skin barrier, non-pectin based, paste, per ounce DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4406** Ostomy skin barrier, pectin-based, paste, per ounce DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4407** Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4408** Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4409** Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4410** Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4411** Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, with built-in convexity, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4412** Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4413** Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4414** Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4415** Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 inches, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4416** Ostomy pouch, closed, with barrier attached, with filter (1 piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4417** Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4418** Ostomy pouch, closed; without barrier attached, with filter (1 piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4419** Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4420** Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4421** Ostomy supply; miscellaneous N
BETOS: D1F Prosthetic/Orthotic devices

D **A4422** Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4423** Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4424** Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4425** Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4426** Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each DME N
BETOS: D1F Prosthetic/Orthotic devices

ADMINISTRATIVE, MISCELLANEOUS AND INVESTIGATIONAL (A9150-A9999)

MISCELLANEOUS SUPPLIES AND EQUIPMENT (A9150-A9300)

D **A9150** Non-prescription drugs B
BETOS: O1E Other drugs
Other carrier priced

I **A9152** Single vitamin/mineral/trace element, oral, per dose, not otherwise specified E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **A9153** Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A9155** Artificial saliva, 30 ml B
BETOS: Z2 Undefined codes
Other carrier priced

I **A9180** Pediculosis (lice infestation) treatment, topical, for administration by patient/caretaker E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

M **A9270** Non-covered item or service E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-11, 100.1

S **A9272** Wound suction, disposable, includes dressing, all accessories and components, any type, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B
Statute: 1861(n)

M **A9273** Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S **A9274** External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B
Statute: 1861(n)

M **A9275** Home glucose disposable monitor, includes test strips E1
BETOS: T1E Lab tests - glucose
Service not separately priced by Part B

S **A9276** Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1861(n)

S **A9277** Transmitter; external, for use with interstitial continuous glucose monitoring system E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1861(n)

S **A9278** Receiver (monitor); external, for use with interstitial continuous glucose monitoring system E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1861(n)

S **A9279** Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified E1
BETOS: T2D Other tests - other
Service not separately priced by Part B
Statute: 1861(n)

S **A9280** Alert or alarm device, not otherwise classified E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861

S **A9281** Reaching/grabbing device, any type, any length, each E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1862 SSA

S **A9282** Wig, any type, each E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861SSA

S **A9283** Foot pressure off loading/supportive device, any type, each E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1862a(i)13

D **A9284** Spirometer, non-electronic, includes all accessories N
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **A9285** Inversion/eversion correction device A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S **A9286** Hygienic item or device, disposable or non-disposable, any type, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B
Statute: 1834

M **A9300** Exercise equipment E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A9550** Technetium Tc-99m sodium gluceptate, diagnostic, per study dose, up to 25 millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9551** Technetium Tc-99m succimer, diagnostic, per study dose, up to 10 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9552** Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4; 2008, Q3
Pub: 100-4, Chapter-13, 60.16

C **A9553** Chromium Cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9554** Iodine I-125 sodium iothalamate, diagnostic, per study dose, up to 10 microcuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9555** Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Value not established
Coding Clinic: 2005, Q4

C **A9556** Gallium Ga-67 citrate, diagnostic, per millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9557** Technetium Tc-99m bicisate, diagnostic, per study dose, up to 25 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9558** Xenon Xe-133 gas, diagnostic, per 10 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9559** Cobalt Co-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9560** Technetium Tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4; 2008, Q3

C **A9561** Technetium Tc-99m oxidronate, diagnostic, per study dose, up to 30 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9562** Technetium Tc-99m mertiatide, diagnostic, per study dose, up to 15 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9563** Sodium phosphate P-32, therapeutic, per millicurie K
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9564** Chromic phosphate P-32 suspension, therapeutic, per millicurie E1
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9566** Technetium Tc-99m fanolesomab, diagnostic, per study dose, up to 25 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9567** Technetium Tc-99m pentetate, diagnostic, aerosol, per study dose, up to 75 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9568** Technetium Tc-99m arcitumomab, diagnostic, per study dose, up to 45 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine

PROCEDURES / PROFESSIONAL SERVICES (G0008-G9987)

VACCINE ADMINISTRATION (G0008-G0010)

C **G0008** Administration of influenza virus vaccine S

CPT® Crosswalk: 90460, 90461, 90471, 90472, 90473, 90474, 90630, 90644, 90647, 90648, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90664, 90666, 90667, 90668, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90689, 90697, 90749, 90756

BETOS: O1G Immunizations/Vaccinations

Coding Clinic: 2003, Q2; 2006, Q2; 2009, Q2; 2016, Q4; 2018, Q3

Pub: 100-4, Chapter-18, 10.4.3; 100-4, Chapter-18, 10.4.1; 100-4, Chapter-18, 10.3.1.1; 100-4, Chapter-18, 10.2.5.2; 100-4, Chapter-18, 10.2.1; 100-2, Chapter-12, 40.11

C **G0009** Administration of pneumococcal vaccine S

CPT® Crosswalk: 90460, 90461, 90471, 90472, 90473, 90474, 90670, 90732, 90749

BETOS: O1G Immunizations/Vaccinations

Coding Clinic: 2003, Q2; 2009, Q2; 2016, Q4; 2018, Q3

Pub: 100-4, Chapter-18, 10.4.3; 100-4, Chapter-18, 10.4.1; 100-4, Chapter-18, 10.3.1.1; 100-4, Chapter-18, 10.2.5.2; 100-4, Chapter-18, 10.2.1; 100-2, Chapter-12, 40.11

C **G0010** Administration of Hepatitis B vaccine S

CPT® Crosswalk: 90460, 90461, 90471, 90472, 90636, 90697, 90723, 90739, 90740, 90743, 90744, 90746, 90747, 90748, 90749

BETOS: O1G Immunizations/Vaccinations

Coding Clinic: 2016, Q4; 2018, Q3

Pub: 100-4, Chapter-18, 10.3.1.1; 100-4, Chapter-18, 10.2.5.2; 100-4, Chapter-18, 10.2.1; 100-2, Chapter-12, 40.11

ANALYSIS OF SEMEN SPECIMEN (G0027)

C **G0027** Semen analysis; presence and/or motility of sperm excluding huhner ♂ N

BETOS: T1H Lab tests - other (non-Medicare fee schedule)

Price subject to national limitation amount

PROFESSIONAL SERVICES FOR DRUG INFUSION (G0068-G0070)

▲ D **G0068** Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes A

BETOS: M4A Home visit

Price established using national RVUs

▲ D **G0069** Professional services for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes A

BETOS: M4A Home visit

Price established using national RVUs

▲ D **G0070** Professional services for the administration of intravenous chemotherapy or other intravenous highly complex drug or biological infusion for each infusion drug administration calendar day in the individual's home, each 15 minutes A

BETOS: M4A Home visit

Price established using national RVUs

TELEMED SERVICES (G0071)

C **G0071** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only A

BETOS: M5D Specialist - other

Price established by carriers

HOME CARE MANAGEMENT SERVICES (G0076-G0087)

C **G0076** Brief (20 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B

BETOS: M4A Home visit

Price established by carriers

C **G0077** Limited (30 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B

BETOS: M4A Home visit

Price established by carriers

C **G0078** Moderate (45 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B

BETOS: M4A Home visit

Price established by carriers

D **G0124** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician ♀ B
BETOS: T1H Lab tests - other (non-Medicare fee schedule)
Price established using national RVUs

MISCELLANEOUS DIAGNOSTIC AND THERAPEUTIC SERVICES (G0127-G0372)

D **G0127** Trimming of dystrophic nails, any number N
BETOS: P5A Ambulatory procedures - skin
Price established using national RVUs

D **G0128** Direct (face-to-face with patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes B
BETOS: Y2 Other - non-Medicare fee schedule
Value not established
Statute: 1833(a)
Pub: 100-2, Chapter-12, 30.1; 100-2, Chapter-12, 40.8; 100-4, Chapter-5, 20.4

C **G0129** Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more) P
BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B
Coding Clinic: 2012, Q4

D **G0130** Single energy X-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel) Z3 ASC S
BETOS: I4B Imaging/procedure - other
Price established using national RVUs

C **G0141** Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician ♀ B
BETOS: T1H Lab tests - other (non-Medicare fee schedule)
Price established using national RVUs

C **G0143** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision ♀ A
BETOS: T1H Lab tests - other (non-Medicare fee schedule)
Price subject to national limitation amount

C **G0144** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision ♀ A
BETOS: T1H Lab tests - other (non-Medicare fee schedule)
Price subject to national limitation amount

C **G0145** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision ♀ A
CPT® Crosswalk: 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88155, 88160, 88161, 88162, 88164, 88165, 88166, 88167, 88172, 88173, 88174, 88175, 88177, 88199
BETOS: T1H Lab tests - other (non-Medicare fee schedule)
Price subject to national limitation amount

C **G0147** Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision ♀ A
BETOS: T1H Lab tests - other (non-Medicare fee schedule)
Price subject to national limitation amount

C **G0148** Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening ♀ A
BETOS: T1H Lab tests - other (non-Medicare fee schedule)
Price subject to national limitation amount

C **G0151** Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes B
BETOS: Y2 Other - non-Medicare fee schedule
Service not separately priced by Part B
Pub: 100-4, Chapter-10, 40.2; 100-4, Chapter-11, 30.3

C **G0152** Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes B
BETOS: Y2 Other - non-Medicare fee schedule
Service not separately priced by Part B
Pub: 100-4, Chapter-11, 30.3; 100-4, Chapter-10, 40.2

C **G0153** Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes B
BETOS: Y2 Other - non-Medicare fee schedule
Service not separately priced by Part B
Pub: 100-4, Chapter-10, 40.2; 100-4, Chapter-11, 30.3

Appendix A
Table of Drugs and Biologicals

Generic and brand-name drugs found throughout the Table of Drugs and Biologicals are a representative sample of drugs and biologicals commonly associated with HCPCS Level II codes. Please check the CMS and FDA websites for the most up-to-date information on coverage, active brand names, and validity of drugs.

Caution: Never code directly from the Table of Drugs and Biologicals. Always cross-reference the code to the Tabular List before final code assignment. Questions regarding coding and billing guidance should be submitted to the insurer in whose jurisdiction a claim would be filed. For private sector health insurance systems, please contact the individual private insurance entity. For Medicaid systems, please contact the Medicaid Agency in the state in which the claim is being filed. For Medicare, contact the Medicare contractor.

Abbreviations used in the Table of Drugs and Biologicals

IA - Intra-arterial administration
IV - Intravenous administration
IM - Intramuscular administration
IT - Intrathecal
SC - Subcutaneous administration
INH - Administration by inhaled solution
VAR - Various routes of administration
OTH - Other routes of administration
ORAL - Administered orally

Intravenous administration includes all methods, such as gravity infusion, injections, and timed pushes into blood vessels, usually veins. IM refers to injections into muscles; IT to injections into the spinal column; and SC to injections into tissues (not muscle) under the skin. VAR 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. OTH indicates other administration methods, such as intraocular injections, suppositories, or catheter injections.

Drug Name	Unit Per	Route	Code
ABATACEPT	10 mg	IV	J0129
ABCIXIMAB	10 mg	IV	J0130
ABELCET®	10 mg	IV	J0287
ABILIFY MAINTENA®	1 mg	IM	J0401
ABILIFY®	0.25 mg	IM	J0400
ABOBOTULINUM TOXIN A	5 IU	IM	J0586
ACCUNEB®	1 mg	INH	J7613
ACCUNEB® CONCENTRATED FORM	1 mg	INH	J7611
ACETADOTE®	100 mg	IV	J0132
ACETAMINOPHEN	10 mg	IV	J0131
ACETAZOLAMIDE SODIUM	up to 500 mg	IV, IM	J1120
ACETYLCYSTEINE	100 mg	IV	J0132
ACETYLCYSTEINE, UNIT DOSE, COMPOUNDED	1 gram	INH	J7604
ACETYLCYSTEINE, UNIT DOSE, NON-COMPOUNDED	1 gram	INH	J7608
ACLASTA®	1 mg	IV	J3489
ACOVA®	1 mg	IV	J0883
ACOVA®	1 mg	IV	J0884
ACTEMRA®	1 mg	IV	J3262
ACTHAR GEL, H.P.®	up to 40 IU	IV, IM, SC	J0800
ACTHREL®	1 mcg	IV, IM	J0795
ACTIMMUNE®	3 million IU	SC	J9216
ACTIVASE®	1 mg	IV	J2997
ACYCLOVIR	5 mg	IV	J0133
ADAGEN®	25 IU	IM	J2504
ADALIMUMAB	20 mg	SC	J0135
ADCETRIS®	1 mg	IV	J9042
ADENOCARD®	1 mg	IV	J0153
ADENOSINE	1 mg	IV	J0153
ADO-TRASTUZUMAB EMTANSINE	1 mg	IV	J9354
ADRENACLICK®	0.1 mg	SC, IM	J0171
ADRENALIN, EPINEPHRINE	0.1 mg	SC, IM	J0171

Drug Name	Unit Per	Route	Code
ADRENALIN®	0.1 mg	SC, IM	J0171
ADRIAMYCIN RDF®	10 mg	IV	J9000
ADRIAMYCIN®	10 mg	IV	J9000
ADVATE®	1 IU	IV	J7192
ADYNOVATE®	1 IU	IV	J7207
AFAMELANOTIDE IMPLANT	1 mg	OTH	J7352
AFLIBERCEPT	1 mg	OTH	J0178
AFSTYLA®	1 IU	IV	J7210
AGALSIDASE BETA	1 mg	IV	J0180
AGGRASTAT®	0.25 mg	IM, IV	J3246
AJOVY®	1 mg	SC	J3031
AKYNZEO®	300 mg and 0.5 mg	ORAL	J8655
ALA-TET®	up to 250 mg	IM, IV	J0120
ALATROFLOXACIN MESYLATE	100 mg	IV	J0200
ALBUTEROL AND IPRATROPIUM BROMIDE, NON-COMPOUNDED	up to 2.5 mg/ up to 0.5 mg	INH	J7620
ALBUTEROL, CONCENTRATED FORM, COMPOUNDED	1 mg	INH	J7610
ALBUTEROL, CONCENTRATED FORM, NON-COMPOUNDED	1 mg	INH	J7611
ALBUTEROL, UNIT DOSE, COMPOUNDED	1 mg	INH	J7609
ALBUTEROL, UNIT DOSE, NON-COMPOUNDED	1 mg	INH	J7613
ALDESLEUKIN	single use vial	IV	J9015
ALDURAZYME®	0.1 mg	IV	J1931
ALEFACEPT	0.5 mg	IM, IV	J0215
ALEMTUZUMAB	1 mg	IV	J0202
ALFERON N®	250,000 IU	OTH	J9215
ALGLUCERASE	10 IU	IV	J0205
ALGLUCOSIDASE ALFA	10 mg	IV	J0220
ALIMTA®	10 mg	IV	J9305
ALIQOPA®	1 mg	IV	J9057
ALKERAN®	2 mg	ORAL	J8600

Mod	Modifier Description, Definition, Explanation, and Tips
AH	**Clinical psychologist** **Definition:** Append this modifier to indicate the services of a clinical psychologist. **Explanation:** This modifier indicates the services the provider is reporting are for a qualified clinical psychologist for the psychiatric therapeutic procedures that he performs for a patient in a facility. The modifier indicates that a clinical psychologist, who qualifies as per Medicare guidelines to provide these services, is performing the service the facility is reporting under the CPT® code for the procedure. **Tips:** When the facility uses this modifier with any CPT® code, it lets the payer know that a qualified clinical psychologist handled the services and reimbursement can be made as per Medicare payment guidelines. If you fail to append the right modifier to the CPT® code, it may lead to incorrect payments and fraudulent claims.
AI	**Principal physician of record** **Definition:** Append this modifier to the initial hospital and nursing home visit codes to show that the provider is responsible for the overall care of the patient. **Explanation:** This modifier indicates the service by the admitting or attending provider who oversees the patient's care, as distinct from other providers who may furnish specialty care. The principal provider of record shall append modifier AI to the initial visit code. The primary purpose of this modifier is to identify the principal provider of record on the initial hospital and nursing home visit codes. **Tips:** Remember that modifier AI is for inpatient use only, not for outpatient evaluation and management, or E/M, codes. Modifier AI is informational only and does not impact the payment.
AJ	**Clinical social worker** **Definition:** Append this modifier to indicate the services of a clinical social worker. **Explanation:** This modifier indicates the services of a qualified clinical social worker for therapeutic procedures that he performs in the facility. The modifier indicates that a clinical social worker, who qualifies as per Medicare guidelines to provide these services, is performing the service the facility is reporting under the CPT® code for the procedure. **Tips:** When the facility uses this modifier with any CPT® code, it lets the payer know that a qualified clinical social worker handled the services and reimbursement can be made as per CMS payment guidelines. If you fail to append the right modifier to the CPT® code, it may lead to incorrect payments and fraudulent claims.
AK	**Non participating physician** **Definition:** Append this modifier to indicate the services of a non participating physician. **Explanation:** This modifier indicates the services of a non participating provider who chooses not to participate in the Medicare fee schedule reimbursement, meaning he does not accept the Medicare approved amount as full payment for covered service. Medicare does not reimburse non participating physicians directly. Instead Medicare reimburses the patient for the allowable costs. The provider has to arrange for payment directly from the patient. **Tips:** Use this modifier to represent the services of a non participating physician in a critical access hospital.
AM	**Physician, team member service** **Definition:** Append this modifier to indicate the services of a member of a provider's team, usually a physician assistant who is part of the provider's team. **Explanation:** Append modifier AM if a physician assistant or other team member of the provider's team renders service. Usually, the supervising provider bills these services and the provider uses this modifier to indicate that his team member performs the service. **Tips:** This modifier is informational only and should not impact reimbursement. It just identifies that during the procedure the provider is not rendering the actual service but he is supervising the service.
AO	**Alternate payment method declined by provider of service** **Definition:** Append this modifier to each line of service on a claim if the provider prefers to decline participation in an alternate payment method by the payer. **Explanation:** Modifier AO indicates that the provider declines an alternate payment methodology and wants to continue with the original method of reimbursement. Use this modifier if you do not prefer to participate in bundled payment program for example for a care improvement initiative under the Affordable care act and you would continue to receive the reimbursement according to regular fee for service payment rules. **Tips:** If the provider does not report the AO modifier on each line of service on the claim then the provider receives the claim back as unprocessable with instruction to rebill the services on separate claims.

Appendix I Publication 100 References

Disclaimer: This appendix includes relevant sections of the CMS Medicare and Medicaid Publication 100 information but is not an all-inclusive document. CMS updates policies and procedures frequently. The information contained here was the most up-to-date information on the CMS website at the time of printing. For more recent updates, visit the CMS website.

100-1, Chapter-1, 10.1

Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and Skilled Nursing Facility (SNF) Services - A Brief Description

Hospital insurance is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers post hospital extended care in SNFs and post hospital care furnished by a home health agency in the patient's home. Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, are also a Part A benefit for beneficiaries in a covered Part A stay. The purpose of these additional benefits is to provide continued treatment after hospitalization and to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payments for services rendered to beneficiaries by providers (i.e., hospitals, SNFs, and home health agencies) are generally made to the provider. In each benefit period, payment may be made for up to 90 inpatient hospital days, and 100 days of post hospital extended care services.

Hospices also provide Part A hospital insurance services such as short-term inpatient care. In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

The Part A benefit categories of inpatient hospital services and SNF services are each subject to separate and mutually exclusive day limits, so that the use of benefit days under one of these benefits does not affect the number of benefit days that remain available under the other. Accordingly, the 90 days of inpatient hospital benefits (plus 60 nonrenewable lifetime reserve days — see Pub. 100-02, Medicare Benefit Policy Manual, chapter 5) that are available to a beneficiary in a hospital do not count against the 100 days of posthospital extended care benefits that are available in a SNF, and vice-versa.

100-1, Chapter-3, 20.5

Blood Deductibles (Part A and Part B)

Program payment may not be made for the first 3 pints of whole blood or equivalent units of packed red cells received under Part A and Part B combined in a calendar year. However, blood processing (e.g., administration, storage) is not subject to the deductible.

The blood deductibles are in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible.

The deductible applies only to the first 3 pints of blood furnished in a calendar year, even if more than one provider furnished blood.

100-1, Chapter-3, 20.5.2

Part B Blood Deductible

Blood is furnished on an outpatient basis or is subject to the Part B blood deductible and is counted toward the combined limit. It should be noted that payment for blood may be made to the hospital under Part B only for blood furnished in an outpatient setting. Blood is not covered for inpatient Part B services.

100-1, Chapter-3, 20.5.3

Items Subject to Blood Deductibles

The blood deductibles apply only to whole blood and packed red cells. The term whole blood means human blood from which none of the liquid or cellular components have been removed. Where packed red cells are furnished, a unit of packed red cells is considered equivalent to a pint of whole blood. Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the blood deductible. However, these components of blood are covered as biological.

Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §231 regarding billing for blood and blood products under the Hospital Outpatient Prospective Payment System (OPPS).

100-1, Chapter-3, 30

Outpatient Mental Health Treatment Limitation

Regardless of the actual expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. The limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program and it will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:

- January 1, 2010 –December 31, 2011, the limitation percentage is 68.75%.
  (Medicare pays 55% and the patient pays 45%).
- January 1, 2012 –December 31, 2012, the limitation percentage is 75%
  (Medicare pays 60% and the patient pays 40%).
- January 1, 2013 –December 31, 2013, the limitation percentage is 81.25%.
  (Medicare pays 65% and the patient pays 35%).
- January 1, 2014 –onward, the limitation percentage is 100%
  (Medicare pays 65% and the patient pays 35%).
- January 1, 2014 –onward, the limitation percentage is 100%
  (Medicare pays 80% and the patient pays 20%).

For additional details concerning the outpatient mental health treatment limitation, please see the Medicare Claims Processing Manual, Publication 100-04, chapter 9, section 60 and chapter 12, section 210.

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