OPTUM360®

DESK REFERENCE

Coders' Desk Reference for HCPCS Level II

Answers to your toughest HCPCS Level II coding questions

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Introduction to HCPCS

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

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

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

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

Coding Systems

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

Diagnosis Coding

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

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

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

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

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

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

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Using Modifiers

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

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

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

Ambulance Modifiers

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

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

Ambulance Modifier Listing

D Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes

E Residential, domiciliary, custodial facility (other than 1819 facility)

G Hospital-based ESRD facility

H Hospital

I Site of transfer (for example, airport or helicopter pad) between modes of ambulance transport

J Freestanding ESRD facility

N Skilled nursing facility

P Physician's office

R Residence

S Scene of accident or acute event

X Intermediate stop at physician's office on way to hospital (destination code only). Note: Modifier X can only be used as a designation code in the second position of a modifier

HCPCS Level II Modifiers

Alphabetical Listing

A1 Dressing for one wound

A2 Dressing for two wounds

A3 Dressing for three wounds

A4 Dressing for four wounds

A5 Dressing for five wounds

A6 Dressing for six wounds

A7 Dressing for seven wounds

A8 Dressing for eight wounds

A9 Dressing for nine or more wounds

AA Anesthesia performed personally by anesthesiologist

- CPT codes approved for use with modifier AA are 00100–01999.
- If an anesthetist assists the physician in the care of a single patient, the service is considered personally performed by the physician. The anesthesiologist should report this service with modifier AA and the appropriate CPT code from series 00100–01999.
- Modifier AA affects Medicare payment.

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

- Modifier AD affects Medicare payment as a distinct fee schedule amount exists.

AE Registered dietitian

AF Specialty physician

AG Primary physician

AH Clinical psychologist

AI Principal physician of record

AJ Clinical social worker

- Medicare limits allowable to 75 percent of the physician fee schedule.

AK Nonparticipating physician

AM Physician, team member service

- The physician member of a team is required to perform one out of every three visits made by a team member.

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Documentation Standards

Medical Records Documentation for Providers

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

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

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

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

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

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

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

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

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

General DME Documentation Standards

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

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

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

The DMEPOS Industry

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

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

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

Special Federal and Third-Party Payer Definitions

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

Defining DME

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

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

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Reimbursement Guidelines

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

DMEPOS Utilization and Authorization

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

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

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

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

These special reimbursement provisions clarify three basic facts:

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

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

PPS and Consolidated Billing

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

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

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HCPCS Lay Descriptions

A

A0021

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

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

A0080-A0210

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

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

A0100 Nonemergency transportation; taxi

A0110 Nonemergency transportation and bus, intra- or interstate carrier

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

A0130 Nonemergency transportation: wheelchair van

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

A0160 Nonemergency transportation: per mile - caseworker or social worker

A0170 Transportation ancillary: parking fees, tolls, other

A0180 Nonemergency transportation: ancillary: lodging-recipient

A0190 Nonemergency transportation: ancillary: meals, recipient

A0200 Nonemergency transportation: ancillary: lodging, escort

A0210 Nonemergency transportation: ancillary: meals, escort

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

A0225

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

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

A0380

A0380 BLS mileage (per mile)

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

A0382

A0382 BLS routine disposable supplies

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

A0384

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

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

A0390

A0390 ALS mileage (per mile)

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

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A6250

A6250 Skin sealants, protectants, moisturizers, ointments, any type, any size

Skin sealants and protectants are liquid barrier films made of polymers and solvents. The solvent evaporates after the sealant or protectant is applied to the skin, leaving behind a protective film. A moisturizer is a water and oil mixture. Ointments are oil in water emulsions. This code reports any type or size of skin sealant, protectant, moisturizer, or ointment when a more specific code is not available.

A6251-A6256

A6251 Specialty absorptive dressing, wound cover, sterile, pad size 16 sq in or less, without adhesive border, each dressing

A6252 Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing

A6253 Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq in, without adhesive border, each dressing

A6254 Specialty absorptive dressing, wound cover, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing

A6255 Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, with any size adhesive border, each dressing

A6256 Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing

Specialty absorptive dressings are unitized multi-layer dressings that provide either a semi-adherent quality or nonadherent layer and highly absorptive layers of fibers, such as absorbent cellulose, cotton, or rayon. These may or may not have an adhesive border.

A6257-A6259

A6257 Transparent film, sterile, 16 sq in or less, each dressing

A6258 Transparent film, sterile, more than 16 sq in but less than or equal to 48 sq in, each dressing

A6259 Transparent film, sterile, more than 48 sq in, each dressing

Transparent film dressings are used on closed wounds or open partial thickness wounds with minimal exudate. Usual dressing change is up to three times per week.

A6260

A6260 Wound cleansers, any type, any size

This code reports wound cleansers of any type and any size that do not a have more specific code listed. Wound cleansers remove wound debris as the wound is cleansed and washed. Wound cleansers are often over-the-counter products that can be used as a rinse or can be sprayed on the wound.

A6261-A6262

A6261 Wound filler, gel/paste, per fl oz, not otherwise specified

A6262 Wound filler, dry form, per g, not otherwise specified

Wound fillers are dressing materials that are placed into open wounds to eliminate dead space and absorb exudate, or maintain a moist wound surface. Use these codes for wound fillers, gel/paste, or dry form not specifically listed elsewhere. Usual dressing change is up to once per day.

A6266

A6266 Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yd

Impregnated gauze dressings are woven or non-woven materials in which substances such as iodinated agents, petrolatum, zinc compounds, crystalline sodium chloride, chlorhexidine gluconate (CHG), bismuth tribromophenate (BTP), water, aqueous saline, or other agents have been incorporated into the dressing material by the manufacturer.

A6402-A6404

A6402 Gauze, nonimpregnated, sterile, pad size 16 sq in or less, without adhesive border, each dressing

A6403 Gauze, nonimpregnated, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing

A6404 Gauze, nonimpregnated, sterile, pad size more than 48 sq in, without adhesive border, each dressing

Usual non-impregnated gauze dressing change is up to three times per day for a dressing without a border and once per day for a dressing with a border. It is usually not necessary to stack more than two gauze pads on top of each other in any one area.

A6407

A6407 Packing strips, nonimpregnated, sterile, up to 2 in in width, per linear yd

Packing strips are placed in open wounds and are often used in wet-to-dry type of wound treatment. They are sterile supplies that are usually made of fine mesh cotton gauze. Some are impregnated with antiseptics, such as iodoform.

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C1818

C1818 Integrated keratoprosthesis

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

C1819

C1819 Surgical tissue localization and excision device (implantable)

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

C1820

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

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

C1821

C1821 Interspinous process distraction device (implantable)

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

C1822

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

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

C1823

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

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

C1824

C1824 Generator, cardiac contractility modulation (implantable)

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

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infusion to treat sever fungal infections and visceral leishmaniasis in patients refractory to or intolerant of conventional amphotericin B.

J0290

J0290 Injection, ampicillin sodium, 500 mg

Ampicillin is a form of penicillin used to treat respiratory or skin infections, urinary tract infections, bacterial meningitis, septicemia, and as a prophylaxis in dental procedures. It inhibits the formation of a cell wall during replication. It is effective against *E. coli, P. mirabilis*, enterococci, *Shigella, S. typhosa* and other Salmonella, non-penicillinase-producing *N. gonorrhoeae,* non-penicillinase-producing *H. influenzae* and staphylococci, and streptococci including *streptococcus pneumoniae, Shigella, S. typhosa* and other *Salmonella, E. coli, P. mirabilis*, and enterococci, and *O. Meningitides*. This drug may decrease the efficacy of oral contraceptives.

J0291

J0291 Injection, plazomicin, 5 mg

Plazomicin is an aminoglycoside antibiotic indicated for the treatment of adults,18 years of age and older, with complicated urinary tract infections (cUTI), including pyelonephritis, caused by the following organisms: *Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis,* and *Enterobacter cloacae.* It is supplied in a single-dose vial of 500 mg/10 mL and is administered by intravenous infusion over 30 minutes every 24 hours for four to seven days. The recommended dosage is 15 mg/kg of body weight. Patients must have a creatinine clearance greater than or equal to 90 mL/min prior to start and daily during treatment. The dosage may need to be adjusted for patients with renal impairment and may need to be adjusted due to changes in renal function or results of daily creatinine clearance.

J0295

J0295 Injection, ampicillin sodium/sulbactam sodium, per 1.5 g

Ampicillin sodium and sulbactam sodium are used to treat gynecologic, intra-abdominal, and skin infections. Ampicillin inhibits the formation of a cell wall during replication and sulbactam inactivates the enzyme produced by the bacteria to make them resistant to the ampicillin. It is effective against *Staphylococcus aureus, Staphylococcus epidermidis, Staphylococcus saprophyticus, Streptococcus faecalis, Streptococcus pneumoniae, Streptococcus pyogenes, Streptococcus viridans, Haemophilus influenzae, Moraxella (Branhamella) catarrhalis, Escherichia coli, Klebsiella* species, *Proteus mirabilis, Proteus vulgaris, Providencia rettgeri, Providencia stuartii, Morganella morganii, Neisseria gonorrhoeae, Clostridium* species, *Peptococcus* species, *Peptostreptococcus* species, and *Bacteroides* species, including *B. fragilis*. Ampicillin sodium and sulbactam sodium are administered via intramuscular injection, which is given only to adults, and intravenous injection, which is given by slow infusion over 10 to 15 minutes.

J0300

J0300 Injection, amobarbital, up to 125 mg

Amobarbital is a barbiturate derivative that activates one of the major inhibitory neurotransmitters in the body, which reduces input resistance, depresses the electrical discharge along the cell and increases the conduction at the chloride channels, and increases the amplitude and decay time of inhibitory postsynaptic currents. Amobarbital, also known as truth serum, is indicated as a treatment for convulsions, anxiety, epilepsy, and as a short-term treatment of insomnia. The drug is also used for preoperative sedation. It is a schedule II drug with the suppository being a schedule III drug. This medication is administered orally, rectally, via intramuscular injection, and via intravenous push injection.

J0330

J0330 Injection, succinylcholine chloride, up to 20 mg

Succinylcholine chloride is skeletal muscle relaxant. It is used in combination with anesthesia to relax skeletal muscles for surgery, intubation, seizure control, and orthopedic manipulations. It reacts with cholinergic receptors of the motor end plates to create depolarization. Flaccid paralysis begins within one minute after administration and lasts approximately four to six minutes.

J0348

J0348 Injection, anidulafungin, 1 mg

Anidulafungin is a semisynthetic lipopeptide derived from the fungus *Aspergillus nidulans*. It is used as an antifungal drug. Anidulafungin disrupts the synthesis of a component of the fungal cell membrane. This component is not present in mammalian cells. Anidulafungin is indicated for the treatment of candidemia, intra-abdominal, peritoneal, and esophageal *Candida* infections. The drug may cause allergic reactions. Anidulafungin must be administered by intravenous infusion. Recommended dosage for esophageal candidiasis is an initial dose of 100 mg followed by 50 mg daily. The duration of treatment depends upon the patient's response, but should be for a minimum of 14 days or for at least seven days following resolution of symptoms. Recommended dosage for candidemia, intra-abdominal and peritoneal *Candida* infections is an initial dose of 200 mg followed by 100 mg daily. The duration of treatment depends upon the patient's response, but should continue for at least 14 days after the last positive culture.

J0350

J0350 Injection, anistreplase, per 30 units

Anistreplase is a complex composed of streptokinase and lys-plasminogen. It is also known as anisoylated

SAMPLE

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