Optum

Desk Reference

Coders' Desk Reference for HCPCS Level II

Answers to your toughest HCPCS coding questions

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Contents

Introduction

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

Experienced coders are frustrated by limited definitions accompanying many HCPCS Level II codes. Beginning coders need guidelines on reporting HCPCS Level II codes as well as basic information about medical and reimbursement issues. Everyone requires up-to-date information about the anticipated changes to this 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, coders must first have an understanding of the coding systems involved.

Format

Since the first release of *Coders' Desk Reference for HCPCS*, coders' corrections, suggestions, and tips have been incorporated into every printing, making this book as informative and useful as possible. Changes reflecting the dynamic world of coding are ongoing, and Optum encourages input for inclusion in future editions of the book. Information in this product has been updated to reflect 2025 HCPCS codes.

Coders' Desk Reference for HCPCS is divided into convenient sections for easy use, with each section organized alphanumerically. Simply access the section by thumbing through the convenient tabbing system to find the specific item of interest.

Using HCPCS Codes

For the new coder, and even for the veteran, this chapter provides an overview of the HCPCS book—what it is and how best to use this coding system for identifying procedures.

Using HCPCS Modifiers

Modifiers augment HCPCS codes to the satisfaction of private and government payers. Optum coding experts interpret HCPCS modifiers and identify their advantage in reimbursement.

Social Determinants of Health (SDOH)

This chapter provides an overview of SDOH elements and codes for reporting.

Glossary and Reimbursement Terms

To get reimbursed in a timely manner, it is important to have a clear understanding of the terminology used by medical providers, major insurers, and the federal government. This section includes up-to-date terminology that will help coders have a better understanding of the complex reimbursement climate.

HCPCS Lay Descriptions

The lay descriptions contained in the *Coders' Desk Reference for HCPCS Level II* are written by Optum technical staff to provide a common or generally accepted method of accomplishing the service indicated by the HCPCS codes description. In cases where more than one procedure or method is reported by a single code, one example of those methods or procedures may be given in the lay description. No lay description in this product is intended to give an absolute, required method of performing the service described in the HCPCS code. Reflecting the full spectrum of variations in technology and of professional techniques would be impossible in a book this size. Each HCPCS code is followed by a detailed description of the supply, service, or procedure that code represents.

Coders' Desk Reference for HCPCS was developed to help providers comply with the emerging standards by which Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), medications, provider services, temporary Medicare codes, and other disparate items and services are coded, reported, and paid. Remember that *Coders' Desk Reference for HCPCS* is a post-treatment medical reference and, as such, it is inappropriate to use this manual to select medical treatment.

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

Using HCPCS 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 book.

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

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

Ambulance Modifiers

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

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

First-Listed Ambulance Modifiers

In addition, institutional-based providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM Ambulance service provided under arrangement by a provider of services

QN Ambulance service furnished directly by a provider of services

Ambulance Modifier Listing

D Diagnostic or therapeutic site other than "P" or "H" when reported as origin codes

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

G Hospital-based ESRD facility

H Hospital

I Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport

J Freestanding ESRD facility

N Skilled nursing facility

P Physician's office

R Residence

S Scene of accident or acute event

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

Additional Ambulance Modifiers

GM Multiple patients on one ambulance trip

GY Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit
Note: Append modifier GY when ambulance service is not medically necessary

QL Patient pronounced dead after ambulance called

TP Medical transport, unloaded vehicle

TQ Basic life support transport by a volunteer ambulance provider

HCPCS Level II Modifiers

Alphabetical Listing

A1 Dressing for one wound

A2 Dressing for two wounds

A3 Dressing for three wounds

A4 Dressing for four wounds

A5 Dressing for five wounds

A6 Dressing for six wounds

A7 Dressing for seven wounds

A8 Dressing for eight wounds

A9 Dressing for nine or more wounds

AA Anesthesia performed personally by anesthesiologist
- CPT codes approved for reporting with modifier AA are 00100–01999.
- If an anesthetist assists the physician in the care of a single patient, the service is considered personally performed by the physician. The anesthesiologist should report this service with modifier AA and the appropriate CPT code from series 00100–01999.
- Payment is not reduced when modifier AA is appended. Full payment is allowed when documentation supports that the service was personally performed by the physician.

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

AD Medical supervision by a physician; more than four concurrent anesthesia procedures
- Modifier AD is appended to physician claims when a physician supervised four or more concurrent procedures.

AE Registered dietitian

AF Specialty physician

AG Primary physician

AH Clinical psychologist

AI Principal physician of record

AJ Clinical social worker

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.
- Modifier AM is appended to indicate a team member visit was performed by the physician.
- Team member visits will be denied if only one person rendering services is billing for team services, as this is inappropriate billing practice.
- Modifier AM has no effect on payment.

AO Alternate payment method declined by provider of service

AP Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
- Modifier AP has no effect on payment.

AQ Physician providing a service in an unlisted health professional shortage area (HPSA)

AR Physician provider services in a physician scarcity area

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

AT Acute treatment (This modifier should be used when reporting services 98940, 98941, 98942)
- Modifier AT has no effect on payment for Medicare and many third-party carrier claims.

AU Item furnished in conjunction with a urological, ostomy, or tracheostomy supply

AV Item furnished in conjunction with a prosthetic device, prosthetic, or orthotic

AW Item furnished in conjunction with a surgical dressing

AX Item furnished in conjunction with dialysis services

AY Item or service furnished to an ESRD patient that is not for the treatment of ESRD

AZ Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment

Other Selected HCPCS Topics

Below is a list of selected HCPCS-related topics and the websites to visit for additional information. As policies and fee schedules change often, please confirm information to ensure claims are reported based on the most current information.

Ambulance Services

https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center

Appeals

Original Medicare (Fee-for-service)

https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals

Managed Care

https://www.cms.gov/medicare/appeals-grievances/managed-care

Demonstration Projects

https://www.cms.gov/medicare/demonstration-projects/demoprojectsevalrpts

Diabetic Supplies, Services, and Glucose Monitors

CMS generally defines diabetes mellitus as a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a two-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or a random glucose test greater than 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Medicare Insulin and Syringes

When insulin is furnished to inpatients in a covered hospital stay it is covered and payment is included in the reimbursement for the inpatient stay. For outpatient services, insulin is a self-administrable drug that is not covered unless administered in an emergency situation, such as to a patient in a diabetic coma.

Insulin syringes are covered only when they are furnished incident to a physician's professional services. To be covered under this provision an insulin syringe must have been used by the physician or under his or her direct personal supervision, and the insulin injection must have been given in an emergency situation (e.g., diabetic coma). Home use of an insulin syringe by a diabetic is not covered.

Blood Glucose Monitors and Related Supplies

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52464

Blood glucose monitors are meter devices that read color changes produced on specially treated reagent strips by glucose concentrations in the patient's blood. There are several types of blood glucose monitors. Medicare coverage of these devices varies depending on the type of device and the medical condition of the patient for whom the device is prescribed.

Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings are not covered as durable medical equipment for use in the home because the need for frequent professional re-calibration makes them unsuitable for home use.

Some types of blood glucose monitors that use a reflectance meter specifically designed for home use by diabetic patients may be covered as durable medical equipment, subject to the conditions and limitations described below.

Lancets, reagent strips, and other supplies necessary for the proper functioning of the device are also covered for patients for whom the device is indicated. Coverage of home blood glucose monitors and related supplies is limited to patients meeting the following conditions:

- The patient has diabetes (ICD-10-CM codes E08-E13) that is being treated by a physician.
- The patient's physician states that the patient is capable of being trained to use the device prescribed in an appropriate manner. In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to assure that the intended effect is achieved. This is permissible if the patient's physician properly documents it in the medical record.
- The glucose monitor and related accessories and supplies have been ordered by the physician who is treating the patient's diabetes and the treating physician maintains records reflecting the care provided including, but not limited to, evidence of medical necessity for the prescribed frequency of testing.
- The device is designed for home use rather than clinical.

There is a blood glucose monitoring system designed especially for use by those with visual impairments. The monitors used in such systems are identical in terms of reliability and sensitivity to the standard blood glucose monitors described above. They differ by having such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable the visually impaired to use the equipment without assistance. These blood glucose monitoring systems are covered under Medicare if the following conditions are met:

- The patient and device meet the conditions listed above for coverage of standard home blood glucose monitors.
- The patient's physician certifies that a visual impairment is severe enough to require use of this special monitoring system.

The additional features and equipment for use with these monitors justifies a higher reimbursement amount than allowed for standard blood glucose monitors.

Supplies used in home glucose monitoring are covered when the monitor is covered. The supplier must have an order that is signed and dated by the treating physician. The order for home blood glucose monitors and/or diabetic testing supplies must include all of the following elements:

- Item to be dispensed
- Quantity of items to be dispensed
- Specific frequency of testing
- Whether the patient has insulin-treated or non-insulin-treated diabetes
- Treating physician's signature
- Date of the treating physician's signature
- Start date of the order (only required if the start date is different from the signature date)

An order that states "as needed" will result in those items being denied as not medically necessary. The supplier is required to have a renewal order from the treating physician every 12 months. This renewal order must also contain the information specified above.

An order for supplies must also meet the following criteria:

- The patient has nearly exhausted the supply of test strips and lancets or useful life of one lens shield cartridge previously dispensed.
- When the treating physician has ordered a frequency of testing that exceeds utilization guidelines, there must be documentation in the patient's medical record stating the specific reason.
- The treating physician has seen the patient and has evaluated his or her diabetes control within six months prior to ordering strips and lancets or lens shield cartridges that exceed utilization guidelines.
- If refills of supplies that exceed utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) stating the patient is testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed utilization guidelines, new documentation must be present at least every six months.

Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physician that the atypical utilization is, in fact, warranted. Regardless of utilization, a supplier must not dispense more than a three-month quantity of glucose testing supplies at a time.

Social Determinants of Health

Introduction to Social Determinants of Health

Social determinants of health (SDOH) are the nonmedical factors and forces that influence a patient's daily life. SDOH are the conditions in the environments where patients are born, live, learn, work, play, and worship that affect how a patient functions, their health outcomes, and quality of life.

The five domains of SDOH are:

- Economic Stability
- Education Access and Quality
- Healthcare Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

These five domains can be further broken down into individual factors such as affordable housing, access to affordable health services, language and literacy, availability of affordable and nutritious foods, social support, transportation, workplace safety, etc. Each of these factors are interwoven, affect each other, and can have positive or negative connections to health outcomes, healthcare cost and utilization, and health equity. Health equity, where every person can achieve their highest level of health, can be attained when SDOH factors are addressed by reducing health disparities and maintaining healthy societies.

The Centers for Medicare and Medicaid Services (CMS) is designing and implementing policies and programs to support health for all beneficiaries in their programs. The goal is to eliminate avoidable differences in health outcomes in those who are disadvantaged or underserved. Per CMS, the five health equity priorities are:

- Priority 1: Expand the collection, reporting, and analysis of standardized data
- Priority 2: Assess causes of disparities within CMS programs and address inequities in polices and operations to close gaps
- Priority 3: Build capacity of healthcare organizations and the workforce to reduce health and healthcare disparities
- Priority 4: Advance language access, health literacy, and the provision of culturally tailored services
- Priority 5: Increase all forms of accessibility to healthcare services and coverage

Collecting, Use, and Reporting of SDOH Elements

While SDOH elements may have been documented throughout the patient's medical record, they have not always been captured and reported by medical coders. These data elements can be collected by any member of a patient's care team during any encounter. They are typically collected at intake through health risk assessments, screening tools, person to provider interview, and self-reporting by the patient. SDOH data may be documented in the reason for visit, diagnosis list, patient history, or provider notes. Coders may assign the appropriate SDOH codes based on data documented in the record, including self-reported data, which is signed off by the clinician or provider. If available, coding, billing, and electronic health records (EHR) may assist coders with assigning standardized codes.

Analysis of this data can help providers improve the quality of care, care coordination, and the patient's experience of their care. Patient's social risk factors and unmet needs can be identified, which in turn informs providers of needed services, follow-up, and discharge planning. Referrals may be triggers to social services that can meet patient's needs and referrals can be tracked between providers and social service organizations. SDOH data can be provided to executive leadership to inform development of value-based care opportunities. These findings can be shared with social service organizations, providers, health plans, and local patient advisory boards to help identify and provide for unmet needs.

Healthcare administrators should choose a SDOH screening tool, identify workflows that minimize staff burden, provide training to support data collection, invest in EHRs to facilitate data collection and coding, and decide what Z code data to use and monitor. A plan should be developed to utilize the data collected to enhance patient care, improve care coordination and referrals, support quality measurement, identify needs of the community/population, support the planning and implementation of social needs interventions, and monitor SDOH intervention effectiveness.

The healthcare team should follow best practices of collecting SDOH data in a sensitive and HIPAA-compliant manner. SDOH data should be consistently documented in the medical record/EHR, and patients referred to the appropriate social service organizations and other support services through local, state, and national resources. Coding professionals should follow the ICD-10-CM, CPT, and HCPCS coding guidelines, assigning all relevant codes to support quality improvement initiatives. Coding team managers should review codes for consistency and quality.

CPT, HCPCS, and ICD-10-CM Codes

CPT Codes

Per the American Medical Association (AMA), changes to the Evaluation and Management (E/M) coding guidelines help to facilitate the capture of SDOH data as it relates to the complexity or length of the visit. The E/M level of service is based on the level of medical decision making (MDM) or total time of the encounter.

If the SDOH factors are established by use of a standardized instrument, CPT code 96160 or 96161 may be assigned in addition to the E/M code. Per CPT, standardized instruments are validated tests administered and scored in a "standard" manner consistent with their validation. See Optum's *Current Procedural Coding Expert* for additional information regarding CPT codes for SDOH.

If the SDOH factors are established by use of a non-standardized instrument, 96160 or 96161 may not be reported. However, SDOH factors may raise the risk of complications or morbidity/mortality by limiting the capability to properly diagnose and treat patients, increasing the E/M level assigned. When SDOH significantly limits the diagnosis or treatment of a condition, this correlates to a moderate risk of morbidity in the E/M MDM table. See Optum's *Current Procedural Coding Expert*, appendix C, Evaluation and Management Extended Guidelines, for additional information.

HCPCS Codes

Beginning January 1, 2024, claims may be submitted for the SDOH Risk Assessment (G0136) as an additional element of the Annual Wellness Visit (AWV), G0438 or G0439.

G0136 Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes
G0438 Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439 Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit

The SDOH risk assessment is:

- Optional, at the discretion of the healthcare provider and patient
- Separately payable with no deductible or copay for the patient
- Standardized, evidence-based, and furnished in a manner appropriate for the patient's developmental, educational, and health literacy level
- Culturally and linguistically appropriate
- Subject to health professional eligibility and frequency limitations of the AWV

When furnished as an additional element of the AWV, the SDOH Risk Assessment should be reported with HCPCS code G0136 with modifier 33 appended along with the AWV HCPCS code G0438 (initial AWV) or G0439 (subsequent AWV) on the same claim with the same date of service. If reported without modifier 33, G0136 will be processed as if it were in conjunction with an Evaluation and Management or Behavioral Health service and deductible and copay will apply as appropriate for the patient.

Elements of the AWV may be initiated and furnished over a period of days. In this case, the date of service that should be reported is the date of service on which the entirety of the AWV is completed. The date of service reported is the date when the entirety of **both** the SDOH Risk Assessment and the AWV are completed. Medical record documentation should indicate the service began on one date and was completed on another date. Records from both dates of service

to be part of the global package for a primary surgical service and cannot be billed separately from the primary procedure.

MIS. Management information system. Hardware and software facilitating claims management.

mixed model. HMO that includes both an open panel and closed panel option.

ml. Milliliter.

MLP. Midlevel practitioners. Professionals such as nurse practitioners, nurse midwives, physical therapists, physician assistants, and others who provide medical care but do so with physician input.

MLT. Medical laboratory technician.

modality. ***1)*** Form of imaging (e.g., x-ray, fluoroscopy, ultrasound, nuclear medicine, duplex Doppler, CT, and MRI). ***2)*** Any physical agent applied to produce therapeutic changes to biologic tissue including, but not limited to, thermal, acoustic, light, mechanical, or electric energy.

modifier. Two characters that can be appended to a HCPCS code as a means of identifying circumstances that alter or enhance the description of a service or supply.

morbidity rate. In health care contracting, an actuarial term describing predicted medical expense rate.

MP. Metacarpal phalangeal.

MPH. Master of public health. Advanced degree.

MSA. Medical savings account.

MSN. Master of science in nursing.

MSW. Master's in social work.

MT. ***1)*** Medical technologist. ***2)*** Medical transcriptionist.

multiple birth. Two or more infants delivered at the same time.

multiple employer group. Group of employers who contract together to subscribe to a plan, broadening the risk pool and saving money. Different from a multiple employer trust.

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

NA. Nurse assistant.

NAHMOR. National Association of HMO Regulators.

NAIC. National Association of Insurance Commissioners. Organization of state insurance regulators.

national coverage determination. National policy statement regarding the circumstances under which a service, item, or test is considered reasonable and necessary or otherwise not covered for Medicare purposes.

National Supplier Clearinghouse. Entity that approves providers and medical equipment vendors as "suppliers" under the Medicare program, issuing an identification number to approved applicants.

national supplier identification number. Number with which providers or other health care professionals who disperse DMEPOS submit their claims. This number is obtained through an application to the National Supplier Clearinghouse, a centralized agency for DMEPOS suppliers.

NBICU. Newborn intensive care unit. Special care unit for premature and seriously ill infants.

NCD. National coverage determinations. National policy statements granting, eliminating, or excluding Medicare coverage for a service, item, or test and indicate CMS policy regarding the circumstances under which the service, item, or test is considered reasonable and necessary or otherwise not covered for Medicare purposes.

NCHS. National Center for Health Statistics. Division of the Centers for Disease Control and Prevention that compiles statistical information used to guide actions and policies to improve the public health of U.S. citizens. The NCHS maintains the ICD-10-CM coding system.

NCQA. National Committee for Quality Assurance. Organization that accredits managed care plans, or HMOs. In the future, the NCQA may play a role in certifying these organizations' compliance with the HIPAA A/S requirements.

ND. Doctor of naturopathy.

nebulization device. Device used to vaporize liquid medication for the airborne delivery of the medication to the patient. The medication is absorbed into the body via the respiratory tract. Medications can also be administered with a nebulizer to fragment and mobilize thick, excess mucous in the respiratory tract; these medications are broadly termed mucolytics.

NEC. Not elsewhere classifiable. Condition or diagnosis that is not provided with its own specified code in ICD-10-CM, but included in a more broadly defined code for other specified conditions.

neonatal period. Period of an infant's life from birth to the age of 27 days, 23 hours, and 59 minutes.

network model. Plan that contracts with multiple groups of providers, or networks, to provide care.

new patient. Patient who is receiving face-to-face care from a provider/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider based clinic or emergency department, within the past three years.

NOS. Not otherwise specified. Condition or diagnosis remains ill-defined and is unspecified without the necessary information for selecting a more specific code.

NP. ***1)*** Nurse practitioner. ***2)*** Neuropsychiatry.

NPI. National provider identifier. Standard eight-digit alphanumeric provider identifier implemented under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. The first seven digits identify the provider and the eighth position is a check digit. Providers are required to report their NPI number for electronic and paper billing.

O_2. Oxygen.

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

OIG. Office of Inspector General. Agency within the Department of Health and Human Services that is ultimately responsible for investigating instances of fraud and abuse in the Medicare and Medicaid and other government health care programs. OIG work plan Annual plan released by the Office of Inspector General (OIG) that details the areas of focus for fraud and abuse investigations.

open enrollment period. Time period during which subscribers in a health benefit program have the opportunity to re-enroll or select an alternative health plan being offered to them, usually without evidence of insurability or waiting periods.

open panel. Arrangement in which a managed care organization that contracts with providers on an exclusive basis is still seeking providers.

OPL. Other party liability. In coordination of benefits, the decision that the other plan is the primary plan.

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

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

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

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

OTR. Occupational therapist registered.

HCPCS Lay Descriptions

A

A0021

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

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

A0080-A0210

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

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

A0100 Nonemergency transportation; taxi

A0110 Nonemergency transportation and bus, intra- or interstate carrier

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

A0130 Nonemergency transportation: wheelchair van

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

A0160 Nonemergency transportation: per mile - caseworker or social worker

A0170 Transportation ancillary: parking fees, tolls, other

A0180 Nonemergency transportation: ancillary: lodging-recipient

A0190 Nonemergency transportation: ancillary: meals, recipient

A0200 Nonemergency transportation: ancillary: lodging, escort

A0210 Nonemergency transportation: ancillary: meals, escort

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

A0225

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

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

A0380

A0380 BLS mileage (per mile)

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

A0382

A0382 BLS routine disposable supplies

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

A0384

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

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

A0390

A0390 ALS mileage (per mile)

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

A0392

A0392 ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances)

Specialized disposable advanced life support (ALS) defibrillation supplies include such items as defibrillator electrodes (AED), pacing pads, combination pads, and gel pads.

A0394

A0394 ALS specialized service disposable supplies; IV drug therapy

Specialized disposable advanced life support (ALS) IV drug therapy supplies include items such as IV start kits, IV tubing, disposable armboard, catheter, pump sets, micro drip, and Y-site tubing. Report this code once for all IV drug therapy supplies used.

A0396

A0396 ALS specialized service disposable supplies; esophageal intubation

Specialized disposable advanced life support (ALS) esophageal intubation supplies, which are used for airway management, include such items as esophageal obturator, esophageal gastric tube, stylette, inflation syringe, endotracheal tube, laryngoscope blade, cricotracheotomy kits, and disposable bag valve mask.

A0398

A0398 ALS routine disposable supplies

Advanced life support (ALS) routine disposable supplies include such items as EKG electrodes, cervical collar, gauze, and dressings. Report a unit of one for all routine disposable supplies that are used.

A0420

A0420 Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments

This code reports ambulance waiting time for both BLS and ALS services. Time is reported in one-half hour increments. Do not report waiting time of less than one-half hour. Report one unit for each half-hour increment or portion thereof for waiting times of one-half hour or more.

A0422

A0422 Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation

This code reports the oxygen and oxygen supplies used in a life-sustaining situation during ambulance transportation (ALS or BLS). There are two levels of ambulance service, basic medical care or basic life support (BLS) and advanced emergency medical care or advanced life support (ALS).

A0424

A0424 Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)

This code reports charges for an additional ambulance attendant for both ground (BLS and ALS) and air (fixed wing and rotary transports). The need for an additional ambulance attendant must be substantiated by report.

A0425

A0425 Ground mileage, per statute mile

This code reports ground mileage. Mileage and reimbursement rates are generally defined by and under the jurisdiction of state statutes.

vivax, Plasmodium malariae, P. ovale, and susceptible strains of *Plasmodium falciparum* (but not the gametocytes of *P. falciparum*). It is not effective against exoerythrocytic forms of the parasite. Chloroquine is administered orally. The injectable form has been discontinued.

J0391

J0391 Injection, artesunate, 1 mg

Artesunate is an antimalarial indicated for the initial treatment of children and adults with severe malaria. Treatment with artesunate should be followed by a complete course of treatment with an oral antimalarial regimen. It is supplied in a single dose vial of 110 mg powder that requires constitution with the supplied diluent. The recommended dosage is 2.4 mg/kg body weight administered via slow intravenous (IV) infusion over one to two minutes at 0 hours, 12 hours, 24 hours, then once daily until the patient can tolerate oral antimalarial therapy. Artesunate should not be administered by continuous IV infusion. See full prescribing information for complete administration instructions.

J0395

J0395 Injection, arbutamine HCl, 1 mg

Per the FDA, this drug is no longer available in the United States.

J0400

J0400 Injection, aripiprazole, intramuscular, 0.25 mg

Aripiprazole (trade name Abilify) is an antipsychotic medication indicated for the treatment of adults, ages 18 years and older, with agitation associated with schizophrenia or bipolar mania. The precise mechanism of action of aripiprazole is not known. The drug has a strong attraction to dopamine and serotonin receptor sites and acts as an agonist to various dopamine and serotonin subtypes. It is supplied in single dose vials of 9.75 mg/1.3 ml for administration via intramuscular (IM) injection. The recommended dosage is 9.75 mg up to a maximum dose of 30 mg/day, injected by a health care professional. At least two hours must pass between doses. Care should be taken to not substitute this formulation with the aripiprazole (trade name Abilify Maintena) used for the treatment of other disorders. See full prescribing information for complete administration instructions.

J0401

J0401 Injection, aripiprazole (Abilify Maintena), 1 mg

Aripiprazole (trade name Abilify Maintena) is a long-acting, atypical antipsychotic formulation indicated for the treatment of schizophrenia and for the maintenance monotherapy treatment of bipolar I disorder in adults, ages 18 years and older. The precise mechanism of action of aripiprazole is not known. The drug has a strong attraction to dopamine and serotonin receptor sites and acts as an agonist to various dopamine and serotonin subtypes. It is available in kits of single dose vials or single dose prefilled syringes of 300 mg and 400 mg strength lyophilized powder, both requiring reconstitution with sterile water. Once reconstituted, it should be administered via deep intramuscular (IM) deltoid or gluteal injection once monthly by a health care professional. Dosage adjustments can only be made using the 300 mg or 400 mg vials. Tolerability must first be established with the oral formulation. Following the first aripiprazole injection, oral aripiprazole should be administered for 14 consecutive days to achieve therapeutic concentration. Care should be taken to not substitute this formulation with the short-acting aripiprazole injection (9.75 mg per vial) used for the treatment of agitation in patients with schizophrenia or mania. See full prescribing information for complete administration and dosage instructions.

J0402

J0402 Injection, aripiprazole (Abilify Asimtufii), 1 mg

Aripiprazole (trade name Abilify Asimtufii) is an antipsychotic medication indicated for the treatment of schizophrenia in adults, ages 18 years and older, and for maintenance monotherapy for patients with bipolar I disorder. The precise mechanism of action of aripiprazole is not known. The drug has a strong attraction to dopamine and serotonin receptor sites and acts as an agonist to various dopamine and serotonin subtypes. It is an extended-release suspension supplied as 720 mg/2.4 ml and 960 mg/3.2 ml prefilled syringes and is administered via intramuscular (IM) injection into the gluteal muscle. The recommended dosage is 960 mg administered once every two months as a single IM injection. Dosage can be reduced to 720 mg for patients with adverse reactions or for patients that are poor CYP2D6 metabolizers. Patients who have never taken aripiprazole must have tolerability established with oral aripiprazole prior to initiation of IM treatment. See full prescribing information for complete administration instructions.

J0456

J0456 Injection, azithromycin, 500 mg

Azithromycin is an antibiotic used in treating a wide range of bacterial infections including community acquired pneumonia, urethritis, and tonsillitis. It binds to the ribosomal subunit and disrupts microbial protein synthesis. It is effective against *Staphylococcus aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis*, *Neisseria gonorrhoeae*, *Chlamydia pneumoniae*, *Chlamydia trachomatis*, *Legionella pneumophila*, *Mycoplasma hominis*, *Mycoplasma pneumoniae*, *Streptococcus agalactiae*, *Streptococcus pyogenes*, and *Haemophilus ducreyi*. Azithromycin is administered orally or via intravenous (IV) infusion over one to three hours. The recommended dosage is 500 mg once daily for one or two days, followed by an oral regimen.

J0457

J0457 Injection, aztreonam, 100 mg

Aztreonam is a synthetic beta-lactam antibiotic that prohibits the creation of bacterial cell walls, causing cellular death. It is indicated for the treatment of children and adults, ages 9 months and older, with gynecologic infections, intra-abdominal infections, lower respiratory tract infections, septicemia, skin and skin structure infections, and urinary tract infections caused by a wide range of susceptible gram-negative microorganisms. It is also indicated as adjunctive therapy for surgical infections including abscesses, cutaneous infections, infections that complicate hollow viscus perforations, and serous surface infections. It is supplied in single dose vials of 20 ml/1 gm and 30 ml/2 gm requiring reconstitution and is administered via intramuscular (IM) into deep muscle mass or via intravenous (IV) injection. The dosage, frequency, and route of administration vary depending on patient age and the condition treated. Dosage adjustments may be required for patients with renal impairment. See full prescribing information for complete administration instructions.

J0461

J0461 Injection, atropine sulfate, 0.01 mg

Atropine is an extract of an alkaloid from the plants belladonna, hyoscyamus, or stramonium. It is also made synthetically. Atropine sulfate is a highly toxic compound of atropine and sulfuric acid that has the same uses and effects as atropine. It blocks the neurotransmitter acetylcholine in muscarinic receptors of the parasympathetic system. Muscarinic receptors occur throughout the nervous system, including in the heart, smooth muscles of the blood vessels, lungs, salivary glands, gastrointestinal tract, and eye. Atropine sulfate in clinical doses counteracts the peripheral vessel dilatation and abrupt decrease in blood pressure produced by other drugs or biologicals. Systemic doses slightly raise systolic and lower diastolic pressures, slightly increase cardiac output, and decrease central venous pressure. Atropine is used as an antispasmodic to relax smooth muscles, to reduce secretions in the respiratory tract, and to temporarily increase heart rate or decrease AV-block until definitive treatment can take place, and as an antidote for cholinergic drugs toxins, poisoning from organophosphorus insecticides or certain toxic mushrooms. Since it counteracts the side effects of neuromuscular blockers and gases used in anesthesia, it may also be administered as a preanesthesia medication.

J0470

J0470 Injection, dimercaprol, per 100 mg

Dimercaprol, also known as BAL in oil, is a chemical compound dispersed in peanut oil used as a chelating agent. Certain heavy metals, especially arsenic, gold, lead, and mercury, bind with some of the pyruvate-oxidase enzymes and inhibit their normal functioning. Dimercaprol has a stronger attraction to the metal than the protein. It binds to the metal in a stable complex and carries it out of the body. It is indicated as a treatment for arsenic, gold, and mercury (soluble inorganic compounds) poisoning following ingestion, inhalation, or absorption through the skin of these metals or their salts, or following overdose of therapeutic agents containing these metals. Dimercaprol, in conjunction with edetate calcium disodium (calcium EDTA), is also used as a treatment for lead poisoning. Treatment should begin immediately after exposure. It is administered by intramuscular injection only and the drug needs to be administered repeatedly for several days. Dosages vary from 2.5 to 5 mg/kg of body weight every four to six hours depending on the metal that caused the poisoning. Pediatric dosages for lead poisoning vary from 50 to 75 mg per square meter of body surface area every four hours followed by calcium EDTA.

J0475-J0476

J0475 Injection, baclofen, 10 mg

J0476 Injection, baclofen, 50 mcg for intrathecal trial

Baclofen is a chemical analogue of y-aminobutyric acid, an amino acid also known as GABA that is used as a muscle relaxant and antispastic. GABA is the

K0051

K0051 Cam release assembly, footrest or legrest, replacement only, each

A cam release assembly device allows quick and easy release and removal of the legrest or footrest of a wheelchair. The legrest or footrest can be removed for access to the patient and transporting the wheelchair.

K0052

K0052 Swingaway, detachable footrests, replacement only, each

Swing away footrests form a platform on which the foot is supported. The hinged connection enables the footrest to rotate out of the way when the patient is transferred into or out of the wheelchair. Use this code to report removable swing away footrests.

K0053

K0053 Elevating footrests, articulating (telescoping), each

Elevating footrests can be raised up to elevate and support the patient's legs. The telescopic feature allows the legrest to be lengthened as a support for patients with longer limbs. Use this code to report each elevating, articulating footrest.

K0056

K0056 Seat height less than 17 in or equal to or greater than 21 in for a high-strength, lightweight, or ultralightweight wheelchair

A standard wheelchair has a nonadjustable back height of 16 to 21 inches. The standard wheelchair weighs more than 36 pounds. This code reports a seat height less than 17 inches or equal to or greater than 21 inches that is designed for use in a high-strength, lightweight, or ultra lightweight wheelchair.

K0065

K0065 Spoke protectors, each

Wheelchair spoke protectors, or spoke guards, are lightweight discs designed to cover the back wheels of wheelchairs. These protectors prevent fingers from going into the spokes of the wheelchairs.

K0069-K0070

K0069 Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only, each

K0070 Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only, each

The rear wheels are the large wheels on the back of a wheelchair often used for propulsion. The wheel assembly is comprised of the rear wheel, spokes, and hub. The wheels may come with solid or pneumatic tires. Use these codes to report the rear wheel assembly (based on type of tire).

K0071-K0077

K0071 Front caster assembly, complete, with pneumatic tire, replacement only, each

K0072 Front caster assembly, complete, with semipneumatic tire, replacement only, each

K0073 Caster pin lock, each

K0077 Front caster assembly, complete, with solid tire, replacement only, each

Casters are the front wheels of a wheelchair and are designed to pivot and allow the patient to steer the chair. The caster assembly is composed of the front wheel and the castor fork assembly. Casters may come with pneumatic, semi pneumatic, or solid tires. Use these codes to report the complete front caster assembly (based on type of tire) or to report the pin that locks the caster in place.

K0098

K0098 Drive belt for power wheelchair, replacement only

A drive belt is used with the belt-drive power wheelchair to connect the motor to the drive wheels.

K0105

K0105 IV hanger, each

The IV hanger is a pole that attaches to a wheelchair to allow the patient to receive an infusion.

K0108

K0108 Wheelchair component or accessory, not otherwise specified

A wheelchair component or accessory is an addition or a part of a wheelchair. Report this code for a wheelchair component or accessory that is not identified by a more specific HCPCS Level II code.

K0195

K0195 Elevating legrests, pair (for use with capped rental wheelchair base)

An elevating legrest is a wheelchair accessory required by patients who have musculoskeletal conditions, casts, or braces that prevent 90-degree flexion at the knee. It may also be required for patients with significant edema of the lower extremities requiring elevation of the legs and for patients who require a reclining back on the wheelchair. This code reports a single elevating legrest and all hardware required for complete assembly. Report this code twice for patients who require elevating legrests for both legs.

K0455

K0455 Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)

Epoprostenol (Flolan) is a medication used primarily to treat pulmonary hypertension. Its brief half-life typically requires continuous parenteral infusion. The infusion pump is usually delivered through the subclavian or jugular veins, sometimes through a tunneled catheter that exits in an area maintainable by the patient. The pump is typically portable, worn on a harness or belt, and powered by 9-volt or AA alkaline batteries. Often a second unit is worn, or immediately available, and alternated every 24 hours to ensure uninterrupted delivery.

K0462

K0462 Temporary replacement for patient-owned equipment being repaired, any type

This code reports temporary replacement of patient equipment that is being repaired.

K0552

K0552 Supplies for external noninsulin drug infusion pump, syringe type cartridge, sterile, each

This code reports the sterile supplies required for the syringe type cartridge external drug infusion pump. The pump runs on electrical current.

K0601-K0605

K0601 Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each

K0602 Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each

K0603 Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each

K0604 Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each

K0605 Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each

The external infusion pump (EIP) is a small portable device that provides a continuous infusion therapy over an extended time period. The EIP requires batteries for operation. Use these codes to report the batteries required by an EIP that is owned by the patient.

K0606-K0609

K0606 Automatic external defibrillator, with integrated electrocardiogram analysis, garment type

K0607 Replacement battery for automated external defibrillator, garment type only, each

K0608 Replacement garment for use with automated external defibrillator, each

K0609 Replacement electrodes for use with automated external defibrillator, garment type only, each

Automatic external defibrillators are compact and portable devices that deliver an electrical shock to a person who has a sudden cardiac arrest. Automatic external defibrillator units use a microprocessor inside of a portable defibrillator to interpret a person's heart rhythm through electrodes. The computer recognizes ventricular fibrillation or ventricular tachycardia. Once recognized, the computer advises the operator/user that electrical defibrillation is needed or it will automatically deliver a countershock. The patient wears the external defibrillator in a vest.