CHAPTER 13
SECTION 23.1

PROVIDER CODING OF NON-INSTITUTIONAL SERVICES USING HCPCS

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I. ISSUE

What is TRICARE policy regarding provider reporting of non-institutional services by HCPCS?

II. BACKGROUND

The Health Care Financing Administration Common Procedure Coding System (HCPCS) includes three levels of codes as well as modifiers. Level I contains the AMA's numeric CPT codes. Level II contains alphanumeric codes for physician and other provider services not included in CPT, e.g., ambulance, DME, orthotics, prosthetics. Level II codes are maintained jointly by HCFA, Blue Cross and Blue Shield Association, the Health Insurance Association of America, and TMA. Level III codes are for services not covered by a Level I or Level II code. For TRICARE purposes, Level III codes are TRICARE established codes that cover a specific benefit that may not be coded by other organizations. TMA can request code assignment, where appropriate, as described in paragraph IV.D., below. For TRICARE, the hierarchy of the three levels is as follows: Level I, Level II, and Level III. Contractors are to use temporary codes only when permanent codes are not appropriate.

III. POLICY

All providers specialties and types of institutions except the following must report HCPCS codes on non-institutional claims (claims for which the contractors prepare a non-institutional HCSR):

Pharmacies - NDC codes

Residential Treatment Centers - Revenue codes

Skilled Nursing Centers - Revenue codes

Christian Science Sanatoria - Revenue codes

Dentists and Dental Services - ADA codes

IV. POLICY CONSIDERATIONS

A. PROVIDER REQUIREMENTS - The following special considerations apply to the following specific provider types:

1. DME and Other Equipment and Devices. All durable medical equipment (DME) and prosthetic and orthotic devices must be reported using Level II alphanumeric codes whether furnished by individual professional providers, medical equipment companies, or institutions such as hospitals. The only exception is DME that is included in an inpatient DRG or in an all-inclusive rate. HCPCS Level II codes beginning in E, K, and L describe DME and other equipment and devices. K codes are temporary codes established by Medicare carriers, but they may be used by contractors where they accurately describe the service. K codes may not be used if E or L codes describe the service.

2. Labs. Independent labs and labs based in facilities (e.g., hospitals) that provide outpatient services must report HCPCS. Most lab codes are found in Level I (80000-89999) of HCPCS. However, there are additional lab codes in Level II in the P and G series. The Level I codes are to be used prior to the Level II P series and the Level II P series are to be used prior to the Level II G series. Since the Level II G series are temporary codes, they should be used only when other Level I and Level II P series are not appropriate.

3. Drugs. HCPCS Level III codes are required for drugs, except for some hospital outpatient drugs. These are described in paragraph IV.A.6., below. Drug injections must be coded in HCPCS Level II codes in the J series.

4. Radiology and Other Diagnostic Services. HCPCS must be reported for radiology services whether provided by individual professional providers, medical equipment companies, or institutions such as hospitals. The only exception is where the service is included in an inpatient DRG payment or in an all-inclusive rate. Special provisions for hospital outpatient reporting are described in paragraph IV.A.6., below.

5. Ambulance Services. HCPCS are required for ambulance services and related supplies. Codes are in Level II in the A series.

6. Hospital Reporting of Outpatient Services on UB92. Hospitals should report the HCPCS code(s) that best describe the service(s) in column 44 of the UB92. HCPCS Level I and II codes are required for all services except supplies and most drugs. HCPCS Level II codes are required for drugs administered by injection or infusion, but not for other prescription drugs. There are situations where the best HCPCS code available does not describe hospital facility services, or includes professional and facility services. Improvements are gradually being made in HCPCS to include codes for appropriate hospital facility charges. Until such codes are available, hospitals should use the general facility charge code (HCPCS Level III Code 99088).

a. Units related to the HCPCS codes are reported in column 46. Related charges are shown in column 47.

b. Revenue codes are also required. Where the revenue code has no applicable HCPCS charge, the charges are shown for the revenue code in column 47. Otherwise, charges shown are for the HCPCS codes. There may be additional charges in the revenue center not

related to the HCPCS code. In these cases, the revenue code is repeated on the bill with the additional charges for the other services shown separately.

c. A description follows when HCPCS codes are required for hospital outpatient services and unique situations requiring special procedures.

(1) Radiology and Other Diagnostic Procedures

(a) General Requirements -- Hospitals report HCPCS codes for all radiology services and other diagnostic procedures. Most related HCPCS codes are in Level I, but some are in Level II in the M (Cardiology) and R (Radiology) series.

(b) Aborted Procedure -- When a procedure is not completed, hospitals bill an unlisted code showing the actual charges for radiology services and for other diagnostic procedures. See paragraph IV.A.6.c.(1)(g), below, for an explanation of unlisted codes.

(c) Combined Procedures (Radiology) -- There are no separate codes covering certain combined procedures, (e.g., a hand and forearm included in a single X-ray). In this case, the hospital may use the code for the more expensive procedure. Charges must be for the combined procedure, not two procedures.

(d) Radiation Treatment Delivery -- The hospital should not bill weekly treatment management services (codes 77419 - 77499). Instead, they should bill for radiation treatment deliver (codes 77401 - 77404, 77406 - 77409, 77411 - 77414, and 77416). The hospital should enter the number of services in the units field.

(e) High Osmolar Contrast Material (HOCM) (Radiology) -- When a hospital provides a radiology procedure with HOCM, the HCPCS code that indicates “with” contrast material is billed. If HCPCS does not have codes that distinguish between “with” and “without” contrast material, the hospital uses the closest available code to the service. In such cases, the hospital may bill HOCM separately in addition to the radiology procedure, or it may include the HOCM as part of the amount for the radiology procedure. If billed separately, revenue code 255 is used.

(f) Low osmolar Contrast Material (LOCM) Radiology -- The applicable Level I HCPCS codes for intrathecal injections are:

70010, 70015, 72240, 72255, 72265, 72270, 72285, 72295

Level II codes for contrast material are:

A4644 - Supply of low osmolar contrast material (100-199 mgs of iodine);

A4645 - Supply of low osmolar contrast material (200-299 mgs of iodine); or

A4646 - Supply of low osmolar contrast material (300-399 mgs of iodine).

(g) Radiology or Other Diagnostic Unlisted Service or Procedure -- Hospitals may find radiology and other diagnostic services for which a corresponding code in HCPCS may not be found. This is because these are typically services that are rarely provided, unusual, or new. The hospital should assign the appropriate "unlisted procedure" code found in the CPT.

(2) Other Diagnostic and Medical Services. The following instructions apply to reporting medical and additional diagnostic services other than lab, radiology or other diagnostic tests. These reporting requirements apply to hospital services provided in clinics, emergency departments, and other outpatient departments.

(a) Level I codes do not always reflect the technical component of a service furnished by the hospital. Therefore, the hospital should ignore any wording that indicates that the service must be performed by a physician. In cases where there are separate codes for the technical component, professional component and/or complete procedure, the hospital should use the code that represents the technical component. If there is no technical component code for the service, the hospital should use the code that represents the complete procedure.

(b) Codes used to report clinic and emergency room visits are designed primarily for professional services, but are to be used by a hospital to report facility charges because of the absence of specific facility charges. Related charges reported are for the facility charge only. Separate billing is appropriate on the HCFA form 1500 for professional services.

(c) Chemotherapy - The hospital should use Level I codes for chemotherapy administration, and show the number of visits for units. The hospital should code the drugs administered during chemotherapy using Level II HCPCS codes in the J series; and Q series where temporary codes are applicable. Other outpatient hospital drugs are not coded in HCPCS but may be billed under appropriate revenue codes without HCPCS.

(3) Non-Reportable HCPCS Codes -- Hospitals do not use the following list of HCPCS codes to report diagnostic and medical services. These codes are for professional services and should be billed on a HCFA form 1500, but may be billed separately from the institutional services by the hospital on a UB-92 when sufficient information is submitted to process the claim as professional services.

99341 - 99350	Home Services
99221 - 99233	Hospital Inpatient Services
99499	Unlisted Evaluation and Management Services

(4) Outpatient Surgery -- A hospital should use Level I codes to report significant outpatient surgical procedures.

(a) Definition of Surgery -- surgery is defined as incision, excision, amputation, introduction, repair, destruction, endoscopy, suture or manipulation. The codes for surgery are in the Level I portion of HCPCS beginning with 10000 and ending at 69979.

The claim includes the hospital's charges for the surgery as well as all other services provided on the day the procedure was performed. Usually only one surgical procedure is entered on a claim. However, upon occasion, more than one outpatient surgical procedure might be furnished at the same session. In such cases, all significant surgical procedures are reported.

(b) Unlisted Service or Procedure -- There may be surgical procedures performed that are not found in any level of HCPCS. These are typically services that are rarely provided, unusual, variable, or unlisted procedures. When an unlisted procedure code is used, the contractor may have to develop for the operative report. Pertinent information includes a definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. If it is determined that an adequately descriptive code is contained in HCPCS, the contractor will advise the hospital of the correct code and process the claim. If after review the determination is that no existing code sufficiently describes the procedure, the contractor will process the claim using the unlisted code for that specialty and follow the procedures below, paragraph IV.C., for requesting assignment of a TRICARE code.

NOTE: If the claim was submitted via EMC or identified after the bill has been processed, an operative report, the provider number, revenue codes, and charges are sufficient information. It is not necessary to recreate the claim.

(c) Aborted Surgical Procedures -- An aborted surgical procedure is recorded by entering the appropriate ICD-9-CM diagnosis code (i.e., V64.1, V64.2, or V64.3) on the bill.

(5) Durable Medical Equipment (DME) and Orthotic/Prosthetic Devices -- A hospital must use HCPCS Level II codes to report durable medical equipment, oxygen, and prosthetic and orthotic devices. If DME is rented, the modifier for rental DME for HCPCS Level II Codes, is required.

B. Annual Update.

HCFA updates the alphanumeric (Level II) portion of HCPCS annually and incorporates the updated AMA material to create the HCPCS file. The contractors should obtain and update their HCPCS file at the same time the AMA CPT codes are updated normally at the beginning of the calendar year.

C. Requesting Assignment of TRICARE Codes. TRICARE codes (Level III) are for services not covered by any Level I or Level II code. The contractor may request assignment of a TRICARE code through TMA, Medical Benefits and Reimbursement Systems (MB&RS). If approved, MB&RS will notify the TMA Data Quality and Functional Proponency (DQ&FP) so that the code can be added to the HCPCS database. Before requesting a TRICARE code the contractor should assure there is no Level I or Level II code that describes the services or procedure. The contractor should follow the procedures below when requesting a TRICARE code.

1. Determine whether a TRICARE code is necessary. If TMA analysis determines that the TRICARE code is not necessary or appropriate, the contractor will be notified which existing national HCPCS code to use;

2. Determine whether the code has national applicability. If a national code is subsequently established, contractors will convert the TRICARE code to the specified national (Level I or II) code;

3. Propose an appropriate code or modifier;

4. Provide the descriptor or terminology used, and any additional information such as individual consideration (IC), appropriate sex, age, etc.;

5. Describe the reason the code assignment is being requested, e.g., local practice, new technology. This provides background that helps TMA and HCFA in deciding whether or not a national code may be required;

6. Describe any coverage, utilization, or reimbursement limits placed upon the service;

7. Provide any additional information which would be useful to TMA and HCFA, such as the number of services being provided, whether only a few or a large number of providers/suppliers are performing the service, whether limited geographically or widespread;

8. Provide the closest existing HCPCS code(s).

D. Reimbursement.

Pricing of Level II HCPCS Codes will continue under the allowable charge methodology per Chapter 13, Section 1.3, Allowable Charges/Application of the Maximum Allowable Prevailing Charge. Once sufficient data is collected, the contractors, as part of the CMAC annual update, will be provided pricing information for Levels I, II, and III.

V. EFFECTIVE DATE

September 1, 1997, beginning with the Health Care Financing Administration Common Procedure Coding System National Level II Medicare Codes 1997 Edition.

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