



The National

Assistive Technology Advocacy Project

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HCPSC Codes: Frequently Asked Questions

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What is a HCPSC code?

HCPSC (often pronounced “hickpicks”) stands for the Healthcare Common Procedure Coding System. It was established in 1978 as a way to standardize identification of medical services, supplies and equipment.

There are two sets of codes. The first, or Level I, code set is a five-digit numeric code that contains the Physicians’ Current Procedural Terminology (CPT) maintained by the American Medical Association. The CPT is comprised of descriptive terms and identifying codes used primarily for billing for services provided by physicians and other healthcare professionals.

The second code set, or Level II, is a code set for medical services not included in Level I, such as durable medical equipment, prosthetics, orthotics and supplies. These codes are alpha-numeric in that they begin with a single letter, such as an “E” or “K” in the case of durable medical equipment, followed by four numbers.

What are some examples of HCPSC codes for durable medical equipment?

A HCPSC code can be fairly broad or very specific. For example, a bath/shower chair, with or without wheels, any size, has a HCPSC code of E0240. On the other hand, a lightweight manual wheelchair is coded K0003, a high strength lightweight manual wheelchair is coded K0004, and an ultra lightweight manual wheelchair is coded K0005. A skin-protection wheelchair seat cushion less than 22 inches in width but any depth is coded E2603, and a skin-protection seat cushion greater than 22 inches in width but any depth is coded E2604. However, if the wheelchair seat cushion is custom-fabricated, it has the HCPSC code of E2609 regardless of size.

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What is the purpose of HCPCS codes?

HCPCS codes were developed to simplify medical billing. According to the web site of the Center for Medicare and Medicaid Services (CMS), health care insurers process over 5 billion claims for payment in the United States each year. It was decided that standardized coding is necessary to ensure that claims processing proceeds in an orderly and uniform fashion.

Who uses HCPCS codes?

HCPCS codes are used by public and private health plans. At first, use of the HCPCS codes was voluntary. However in 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which required that CMS adopt standards for coding systems to be used for reporting and billing health care transactions.

On August 17, 2000, CMS published regulation 45 C.F.R. § 162.1002(a)(6), establishing the Healthcare Common Procedure Coding System as the coding system that entities covered by HIPAA are to use.

Are Medicare and Medicaid required to use HCPCS codes?

Yes. Under HIPAA, the HCPCS code sets are intended to be a uniform, fairly universal form of classifying similar durable medical equipment, prosthetics, and orthotics (DMEPOS), and pursuant to 45 C.F.R. § 160.103, HCPCS codes are to be used by all entities included in the definition of “health plans.” “Health plans” include the following:

- a group health plan, health insurance issuer or HMO, as defined in that section;
- Part A or Part B of the Medicare program;
- the Medicaid program;
- an issuer of a Medicare supplemental policy;
- an issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy;
- an employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers;
- the health care program for active military personnel;
- the veterans health care program;

- the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); the Indian Health Service program;
- the Indian Health Service program;
- the Federal Employees Health Benefits Program;
- an approved state child health plan;
- the Medicare+Choice program;
- a high risk pool that is a mechanism established under state law to provide health insurance coverage or comparable coverage to eligible individuals;
- any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care.

Who assigns the HCPCS codes?

CMS has the authority to assign HCPCS codes. According to the CMS website, HCPCS Level II codes are maintained by the CMS HCPCS Workgroup. The Workgroup includes representatives from private insurance companies, Medicaid, and the Pricing, Data Analysis and Coding Contractor (PDAC) and is responsible for all revisions, deletions and additions to the HCPCS codes.

Effective August 18, 2008, Noridian Administrative Services, LLC (NAS) is the PDAC. NAS will provide data analysis support; guide manufacturers and suppliers on the proper use of HCPCS for Medicare billing purposes; conduct national pricing functions; and assist CMS with fee schedules for durable medical equipment. According to the CME website, the PDAC is responsible for providing suppliers and manufacturers with assistance in determining which HCPCS code should be used to describe items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for the purpose of billing Medicare.

How is a HCPCS code used?

HCPCS coding is intended to be used to identify DMEPOS in a consistent fashion for billing purposes. However, health plans such as Medicare and Medicaid often use HCPCS codes as a method for formulating fee schedules for durable medical equipment. For example, NHIC, Corp., the CMS Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction A, has published a fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), that assigns a specific payment rate to items covered by a specific HCPCS code. That 2008 fee schedule can be found at www.medicarenhic.com/dme.

The fee schedule breaks the fee down by HCPCS code and by state. On page 40 of the fee schedule, the ultra lightweight manual wheelchair with the HCPCS code K0005 indicates a fee of \$1,848.76 for all states in Jurisdiction A (Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont).

The Medicaid agency in New York State also uses HCPCS codes in its fee schedule. In 2007, the reimbursement amount for the K0005 ultra lightweight manual wheelchair was \$1,779.08.

If an item has been assigned a HCPCS code, does this mean Medicare or Medicaid covers it?

No. There are a number of items with HCPCS codes that Medicare categorically does not cover. For example, the bath/shower chair, with or without wheels, any size, with a HCPCS code of E0240, is currently on the list of non-covered items for DME MAC Jurisdiction A.

Whether an item with a HCPCS code is covered under a particular state Medicaid program depends on whether the item meets the state's definition of durable medical equipment, prosthetics, orthotics, or any other service covered in that state.

Are the assigned HCPCS codes product-specific?

No. While the codes contain a descriptive term as well as an alpha numeric identifying code, the descriptive term will not refer to a specific product. However, in certain instances, product manufacturers submitted information about specific models of equipment to the CMS HCPCS Workgroup, who then assigned an appropriate HCPCS code to each model. For example, manufacturers of wheelchair seat and back cushions submitted information about each model to the group working on HCPCS coding of seat and back cushions, and each model was assigned the appropriate HCPCS code based on the information provided.

In 2006, the number of codes for power wheelchairs greatly expanded, and power wheelchair models were likewise individually reviewed and assigned the appropriate HCPCS code based on information provided by the manufacturer. Power wheelchairs also fall within a Group, numbered 1 through 4, with Group 4 (HCPCS codes K0868-K0886) being models with the most advanced speed and range performance. Currently, the DME MAC for Jurisdiction A states it does not cover Group 4 power wheelchairs because it does not consider them necessary for use in the home. However, if criteria is met for a Group 2 or Group 3 power wheelchair, it will reimburse at that amount as the least costly alternative. (See www.medicarenhic.com/dme. Click on LCDs on the left, then scroll down to Power Mobility Devices.)

Does HIPAA require that state Medicaid agencies use HCPCS codes for pricing?

No. HIPAA only requires that state Medicaid agencies use HCPCS codes in billing for *classification* purposes. In fact, insurers such as Medicaid should not use coding as a means for eliminating coverage of more expensive items of DME.

What is an example of an insurer using coding as a means for eliminating coverage of more expensive items of DME?

The New York State DME Medicaid fee schedule has only one HCPCS code for lifts: E0630. Until recently, the descriptive term for E0630 was “patient lift, hydraulic with seat”¹ with a reimbursement amount of \$1,035.36. The New York fee schedule does not contain any power lift HCPCS codes and therefore, vendors must submit prior approval requests for power and electric lifts under a miscellaneous code. For several years, the Medicaid agency often returned prior approval requests for power lifts to the vendor, claiming that the request had to be re-submitted using the E0630 code. Since most power and electric lifts cost vendors more than \$1,035.36, this would have eliminated the availability of power and electric lifts to Medicaid recipients in New York.

Why should I care about HCPCS codes?

In many instances, coding will be undisputed. Instead, issues may turn on whether the item is medically necessary or the least costly alternative.

In some instances, however, as noted above, coding decisions may result in insufficient reimbursement rates, making the item unavailable to the recipient because equipment vendors will not supply the item at the reimbursement cost for the code selected by the insurer.

As funding options tighten, insurers may be tempted to include accessories under the HCPCS code for the main item. For example, instead of paying for a wheelchair base under one code and paying separately for the accessories either under their own code or under a miscellaneous code, insurers may insist that the reimbursement fee for the wheelchair base includes those accessories at no additional reimbursement.

Have coding disputes ever been resolved in the recipient’s favor?

Yes. In New York, a lawsuit entitled *Haines v. Novello* involved a coding dispute. In fact, the lawsuit involved a power lift that the Medicaid agency insisted should have been coded as E0630. The lawsuit was resolved by stipulation when the Medicaid agency agreed to disseminate a statewide policy for handling prior approval requests when the agency thought the vendor had submitted a prior approval request using the wrong HCPCS code. The policy requires that the agency provide the vendor with an

¹The descriptive term for E0630 recently changed to “patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s).”

opportunity to demonstrate that the item fits within the code selected by the vendor. If the agency still believes its coding is correct, it must send a notice to the vendor and the recipient, advising the recipient of his or her right to a fair hearing to challenge the agency's coding determination. The stipulation, which includes a copy of this policy, was signed by a federal court judge, giving it the force of a court order.

Arguably, when the HCPCS code for a particular type of equipment is broad and the reimbursement fee for that code is so low that it excludes certain items, an exclusionary list is created, in violation of the guidance of CMS set forth in a policy letter dated September 4, 1998. A copy of the letter can be found on the CME website, <http://www.cms.hhs.gov/smdl/downloads/SMD090498.pdf>.

What other issues may arise over HCPCS codes?

The insurer or payer may decide not to follow the codes for a given product. For example, in New York, the state Medicaid agency has refused to follow the HCPCS code for wheelchair seat cushions classified as custom fabricated with HCPCS codes of E2609, claiming that the product did not fit within the state definition of "custom fabricated." This issue has been successfully challenged at administrative fair hearings.

Where can I find HCPCS codes?

HCPCS codes can be found (although not easily) on the CMS website, <http://www.cms.hhs.gov/home/medicare.asp>. Under coding, click on "HCPCS Release and Code Sets." Then click on "Alpha-Numeric HCPCS" on the left. Click on the "2008 Alpha-Numeric HCPCS File" and download the ZIP file. The "08anweb.xls" file contains a spread-sheet of all the HCPCS codes.

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