Optum

Desk Reference

Coders' Desk Reference for HCPCS Level II

Answers to your toughest HCPCS coding questions

2025

optumcoding.com

Contents

Introduction 1
Format 1
Using HCPCS Codes 1
Using HCPCS Modifiers 1
Glossary and Reimbursement Terms 1
HCPCS Lay Descriptions 1

Using HCPCS Codes 3
Keeping Current in Coding 3
The HCPCS Book Format 3

Using HCPCS Modifiers 7
Ambulance Modifiers 7
HCPCS Level II Modifiers 7

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) 21
The DMEPOS Industry 21
Special Federal and Third-Party Payer Definitions 21
Documentation Standards 23
DMEPOS Resources 27

Other Selected Topics for Medicare 29

Glossary and Reimbursement Terms 31

HCPCS Lay Descriptions 51

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 2024 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.

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.

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® 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 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.

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 (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 reported 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 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.
- Modifier AA affects Medicare payment.

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

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 air conditioner might yield certain medical benefits to a patient recuperating from a cardiac event. The air conditioner will lower the room temperature, which may in turn assist the

Other Selected Topics for Medicare

Below is a list of selected Medicare-related topics and the websites to visit. As policies and fee schedules can 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-and-grievances/mmcag

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

Electronic Billing and EDI Transactions
https://www.cms.gov/medicare/billing/electronicbillingeditrans

ESRD
https://www.cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center

Federally Qualified Health Centers (FQHC)
https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center

Fee Schedules
https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo

Fraud and Abuse
https://www.cms.gov/About-CMS/Components/CPI or the Office of Inspector General at https://oig.hhs.gov/fraud/

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

Home Health
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS

Home Infusion Therapy
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview

Medicare Coverage Topics Medicare Coverage Center
https://www.cms.gov/Center/Special-Topic/Medicare-Coverage-Center

Opioid Treatment Programs (OTP)
https://www.cms.gov/medicare/medicare-fee-for-service-payment/opioid-treatment-program

Pass-Through Payment Status
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS

Prior Authorization and Pre-Claim Review
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items

Preventive Services
https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo

Prospective Payment Systems
https://www.cms.gov/medicare/medicare-fee-for-service-payment/prospmedicarefeesvcpmtgen

Quality Payment Program (QPP)
https://qpp.cms.gov/

Rural Health Clinics
https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center

Skilled Nursing Facility (SNF)
https://www.cms.gov/Center/Provider-Type/Skilled-Nursing-Facility-Center

Glossary and Reimbursement Terms

An increasingly complex reimbursement climate means new terminology develops every year. The following glossary includes terms not only used when coding, it includes terms used by major insurers and the federal government.

AAPA. American Academy of Physician Assistants.

AAPC. American Academy of Professional Coders. National organization for coders and billers offering certification (CPC, CPC-H, and CPC-P) based upon physician-, outpatient facility-, or payer-specific guidelines.

AAPCC. Adjusted average per capita cost. Estimated average cost of Medicare benefits for an individual, based upon criteria including age, sex, institutional status, Medicaid, disability, and end-stage renal failure.

AAPPO. American Association of Preferred Provider Organizations.

abduction. Pulling away from a central reference line, such as moving away from the midline of the body.

abduction pillow. Device that immobilizes the hips and legs of hip surgery patients postoperatively.

ABN. Advance beneficiary notice.

abstractor. Person who selects and extracts specific data from the medical record and enters the information into computer files.

accrual. Amount of money set aside to cover a health care benefit plan's expenses based upon estimates using a combination of data, including the claims system and the plan's prior history. In facility accounting, accrual accounting records the expenses as they are incurred and the revenue as it is generated. This contrasts with cash accounting where expenses are recorded only when payment is made or revenues are recorded only when payment is received.

ACLS. Advanced cardiac life support. Certification for health care professionals who have achieved proficiency in providing emergent care of cardiac and respiratory systems and medication management.

ACR. ***1)*** American College of Radiology. ***2)*** Adjusted community rate, calculation of what premium the plan charges to provide Medicare-covered benefits for greater frequency of use by participants.

activities of daily living. Self-care activities often used to determine a patient's level of function such as bathing, dressing, using a toilet, transferring in and out of bed or a chair, continence, eating, and walking.

actuarial assumptions. Characteristics used in calculating the risks and costs of a plan, including age, sex, and occupation of enrollees; location; utilization rates; and service costs.

adduction. Pulling toward a central reference line, such as toward the midline of the body.

adjudication. Processing and review of a submitted claim resulting in payment, partial payment, or denial. In relationship to judicial hearings, it is the process of hearing and settling a case through an objective, judicial procedure.

admission. Formal acceptance of a patient by a health care facility.

ADS. Alternative delivery system. Any health care delivery system other than traditional fee-for-service.

advance beneficiary notice. Written communication with a Medicare beneficiary given before Part B services are rendered, informing the patient that the provider (including independent laboratories, physicians, practitioners, and/or suppliers) believes Medicare will not pay for some or all of the services to be rendered. Form CMS-R-131 (revised 03/2011) may be used for all situations where Medicare payment is expected to be denied.

adverse selection. In health care contracting, the risk of enrolling members who are sicker than assumed and who will utilize expensive services more frequently.

age restriction. In health care contracting, limitation of benefits when a patient reaches a certain age.

age/sex rating. In health care contracting, structuring capitation payments based on members' ages and genders.

aggregate amount. Contracted maximum for which a member is insured for any single event in a health plan.

AHA. American Hospital Association. Health care industry association that represents the concerns of institutional providers. The AHA hosts the National

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.

that connects to a vein. The port contains a subcutaneous septum that allows blood to be withdrawn and drugs to be injected. The device consists of a reservoir (or portal) composed of a self-sealing silicone bubble and a catheter. The catheter runs from the port to a major vein (e.g., jugular, subclavian). Ideally it terminates in the superior vena cava near the right atrium. This position allows injected drugs to spread quickly and efficiently throughout the body.

C1789

C1789 Prosthesis, breast (implantable)

A breast implant is a prosthesis used to modify the size, form, and feel of a woman's breast in a post-mastectomy reconstruction; improve chest wall congenital deformities; augment the breast; or perform gender transition (male to female). Breast implants are surgically placed in anatomical relation to the pectoralis major muscle.

C1813

C1813 Prosthesis, penile, inflatable

The inflatable penile prosthesis is a medical device used for men with organic or psychogenic impotence who suffer from erectile dysfunction. This prosthesis is also used in the final stages of plastic surgery phalloplasty in gender reassignment surgery, as well as in total phalloplasty in males that need genital modification. The inflatable penile prosthesis is made of three components: cylinders, pump, and reservoir. It can be inflated and deflated upon demand.

C1814

C1814 Retinal tamponade device, silicone oil

Silicone oil is a silicon analogue of carbon based organic compounds that can form long and complex molecules based on silicon rather than carbon. This HCPCS Level II code represents silicone oil used as a permanent or prolonged retinal tamponade for the treatment of complex retinal detachments. The vitreous is a clear collagen gel that fills the eye and helps the retina lie smoothly and firmly against the back wall of the eyeball. Silicone oil is injected to help return the retina to its normal position or to replace vitreous fluid removed during other retina repair procedures. The silicone oil eventually dissipates and may be replaced with body fluids.

C1815

C1815 Prosthesis, urinary sphincter (implantable)

An artificial urinary sphincter (AUS) is a medical device that closely simulates the function of a biological urinary sphincter. A donut-shaped sac that circles the urethra, an AUS offers a competent bladder outlet during urinary storage and an open, unobstructed outlet to allow voiding. When the sac is filled with fluid, it squeezes the urethra closed. When a valve implanted under the skin is pressed, the fluid is released allowing the urethra to open and urine to flow.

C1816

C1816 Receiver and/or transmitter, neurostimulator (implantable)

A neurostimulator, also called an implanted pulse generator, is a battery powered medical device that delivers electrical impulses through a lead to electrodes implanted near the spinal cord or an affected peripheral nerve. The device is used to stimulate the spinal cord or peripheral nerve and block the transmission of pain to the brain. The neurostimulator system includes an integrated circuit, a radio-wave transceiver, a battery, and a connector block. There are two types of neurostimulation systems based on the location of the battery: a fully implanted system has an internal power source or one with an external power source.

C1817

C1817 Septal defect implant system, intracardiac

An intracardiac septal defect implant system is an implant placed within the heart for closure of a variety of defects that may occur in the dividing wall that separates the left and right sides of the heart. The septal defect implant system represented by this code includes a delivery catheter.

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

H2011

H2011 Crisis intervention service, per 15 minutes

Mental health crisis intervention provides immediate support for an individual in personal crisis with outpatient status. The aim of this service is to stabilize the individual during a psychiatric emergency and is billed in 15-minute increments.

H2012

H2012 Behavioral health day treatment, per hour

Day treatment for behavior health focuses on maintaining and improving functional abilities for the individual. Clients may participate in activities in a therapeutic and social environment several times per week for several hours per day to improve personal skills. This code is reported per hour of daytime behavioral health treatment.

H2013

H2013 Psychiatric health facility service, per diem

A psychiatric health facility is specifically licensed as such and is differentiated from a hospital with an inpatient psychiatric ward, psychiatric hospital, or crisis residential services. This facility provides services in an acute non-hospital inpatient setting, and includes appropriate care in psychiatry, clinical psychology, social work, rehabilitation, drug administration, and other basic needs, per diem.

H2014

H2014 Skills training and development, per 15 minutes

Skills training and development provides the patient with necessary abilities that will enable the individual to live independently and manage his/her illness and treatment. Training focuses on skills for daily living and community integration for patients with functional limitations due to psychiatric disorders, per 15 minutes.

H2015-H2016

H2015 Comprehensive community support services, per 15 minutes

H2016 Comprehensive community support services, per diem

Comprehensive community support services consist of mental health and substance abuse services. These services assist individuals in achieving their recovery and rehabilitation goals. The program aims to reduce psychiatric and addiction symptoms and to assist in developing community living skills. The services may include coordination of services, support during a crisis, development of system monitoring and management skills, monitoring medications, and help in developing independent living skills. Report H2015 for comprehensive community support services per each 15 minutes or H2016 for per diem.

H2017-H2018

H2017 Psychosocial rehabilitation services, per 15 minutes

H2018 Psychosocial rehabilitation services, per diem

Psychosocial rehabilitation services are intended to help individuals to compensate for or to eliminate functional deficits and environmental and interpersonal barriers associated with mental illness. The goal of the program is to help individuals achieve the fullest possible integration as an active and productive member of their family and community with the least possible ongoing professional intervention. Activities are done to achieve the goals for the individual. This is a face-to-face intervention and the services may be provided in a group or an individual setting. Report these codes for psychosocial rehabilitation services in 15-minute increments or a per diem charge.

H2019-H2020

H2019 Therapeutic behavioral services, per 15 minutes

H2020 Therapeutic behavioral services, per diem

Therapeutic behavioral services are treatments that attempt to change unhealthy, potentially dangerous, or self-destructive behaviors. It focuses on helping an individual understand how the behavior affects life and emotions. Behavioral therapy is usually action-based, using techniques of classical conditioning and operant conditioning. The behavior itself is the problem and the goal is to minimize or eliminate the problem. Each payer, agency, or organization has their own definition and categorization of therapeutic behavioral services. Consult the appropriate party for additional information.

H2021-H2022

H2021 Community-based wrap-around services, per 15 minutes

H2022 Community-based wrap-around services, per diem

Wrap-around community services are provided for a short period of time for seriously emotionally disabled youth. These services are provided for children/adolescents with a rate classification level (RCL) placement higher than 12. These codes include support and training for family members as an integral part of services provided.

H2023-H2024

H2023 Supported employment, per 15 minutes

H2024 Supported employment, per diem

Supported employment services are available to individuals with serious mental illness. Employment specialists assist in obtaining and maintaining employment in the community and in continuing treatment for the client to ensure rehabilitation and productive employment.

J7665

J7665 Mannitol, administered through an inhaler, 5 mg

Mannitol inhalation substance is used in bronchial challenge tests to help diagnose patients with symptoms of asthma. It is a sugar alcohol substance that constricts the bronchial constriction. Respiratory measurements are taken prior to and after the administration of the mannitol inhaler. The mannitol is administered to the patient in graduated doses until the patient has a positive response or 635 mg of mannitol has been administered.

J7667-J7670

J7667 Metaproterenol sulfate, inhalation solution, compounded product, concentrated form, per 10 mg

J7668 Metaproterenol sulfate, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per 10 mg

J7669 Metaproterenol sulfate, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per 10 mg

J7670 Metaproterenol sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per 10 mg

Metaproterenol sulfate is a bronchodilator used to treat asthma, bronchitis, and emphysema. It acts on the beta receptors in the bronchial smooth muscles to relax bronchospasms that cause difficulty breathing. The medication comes in powder form and in a solution that is used with a nebulizer and in a hand-held aerosol.

J7674

J7674 Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg

Methacholine chloride is a synthetic choline ester that acts to induce bronchoconstriction. This medication is used in a bronchospasm provocation test to diagnose asthma. This is often done when spirometry alone does not provide a definitive diagnosis. Two different dilution schedules are used in North America to perform the test. Both use 100 mg of methacholine. One is based on a two minute tidal breathing dosing protocol and the other is a five breath dosimeter protocol. Both methods utilize a nebulizer to administer the medication.

J7676

J7676 Pentamidine isethionate, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg

Pentamidine isethionate is an aromatic diamidine that is an anti-protozoal. Its mechanism of action is not completely known. It is thought the drug interferes with the synthesis of DNA, RNA, and protein, causing cell death. Pentamidine isethionate is indicated as a treatment for *Pneumocystis jirovecii*, trypanosomiasis, and leishmaniasis. The drug may be administered by intramuscular injection, inhalation, or intravenous infusion over one hour. The inhalation solution is inhaled through a special breathing unit that ensures the drug reaches deep into the lungs. The recommended dosage for the inhalation solution is 300 mg once a month, administered via a nebulizer. Treatment usually takes 30 to 45 minutes.

J7677

J7677 Revefenacin inhalation solution, FDA-approved final product, noncompounded, administered through DME, 1 mcg

Revefenacin inhalation solution is an anticholinergic used for the treatment of chronic obstructive pulmonary disease (COPD) in adult patients, ages 18 years and older. Anticholinergics inhibit the cholinergic/acetylcholine M3 receptor of smooth muscle, allowing the muscles around the airway of the lungs to remain relaxed, and preventing common symptoms of COPD, such as chest tightness, cough, shortness of breath, and wheezing. It is a clear, colorless, aqueous solution supplied in 175 mcg unit-dose vials, wrapped in a foil pouch, and administered once daily through a standard nebulizer connected to an air compressor. The vial should not be removed from the foil pouch until immediately prior to use and any remaining solution should be discarded.

J7680-J7681

J7680 Terbutaline sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per mg

J7681 Terbutaline sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per mg

Terbutaline sulfate is a beta$_2$-adrenergic agonist that functions as a bronchodilator. It works, in part, by stimulating the conversion of adenosine triphosphate (ATP) to cyclic 3',5'-adenosine monophosphate, which relaxes bronchial muscles. Terbutaline sulfate is indicated for the prevention and reversal of bronchospasm in asthma, bronchitis, and emphysema.

J7682

J7682 Tobramycin, inhalation solution, FDA-approved final product, noncompounded, unit dose form, administered through DME, per 300 mg

Tobramycin is an aminoglycoside antibiotic, which is derived from various species of *Streptomyces* bacteria or produced synthetically. Aminoglycosides inhibit bacterial protein synthesis by binding with the 30S ribosomal subunit and are bactericidal. Streptomycin is derived from *Streptomyces tenebrarius* and inhibits protein synthesis, causing cell death. Susceptibility studies should be performed prior to the

L5974-L5975

L5974 All lower extremity prostheses, foot, single axis ankle/foot

L5975 All lower extremity prostheses, combination single axis ankle and flexible keel foot

These codes report the supply of specific types of prosthetic feet. A single axis ankle is capable of dorsiflexion and plantarflexion only (the movement of the foot up and down). This is among the more fundamental designs of prosthetic feet. The keel is the component of a prosthetic foot that generally runs from heel to toe near the footplate. A flexible keel may be made of carbon reinforced fibers, metal, or resilient materials. The flexible keel absorbs impact and transfers energy as weight rolls from heel strike to "toe-off," the moment when weight is released from the forefoot. Flexible keels are integral components of many energy storing prosthetic feet.

L5976

L5976 All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)

This code refers to the supply of a specific level of energy-storing prosthetic foot, whereby some type of material deforms with weight pressure but then resumes its original shape as pressure is removed with a consequent release of energy. The keel is the component of a prosthetic foot that generally runs from heel to toe near the footplate. A flexible keel, which may be made of carbon-reinforced fibers, metal, or resilient materials, absorbs impact and transfers energy as weight rolls from heel strike to "toe-off" the moment when weight is released from the forefoot. Flexible keels are integral components of many energy-storing prosthetic feet.

L5978-L5979

L5978 All lower extremity prostheses, foot, multiaxial ankle/foot

L5979 All lower extremity prostheses, multiaxial ankle, dynamic response foot, one-piece system

These codes report the supply of a specific type of foot prosthesis. A multi-axial ankle is capable of dorsiflexion and plantarflexion (the movement of the foot up and down), as well as limited twisting motion, medial and lateral movement, and internal and external rotation. This offers stability and allows the user to better negotiate uneven terrain. The dynamic response foot is a type of energy storing prosthetic foot. It falls well within the range of active use, but somewhat short of the high-end athletic prostheses. The keel in this type of foot is energy absorbing with good transfer upon "toe-off." Sure-Flex, Genesis II, and Seattle Lite are considered in this category.

L5980-L5981

L5980 All lower extremity prostheses, flex-foot system

L5981 All lower extremity prostheses, flex-walk system or equal

These codes report the supply of a specific type of foot prosthesis. The original flex-foot system was a unique design to accommodate active users. The foot was developed in the early 1980s using a single L-shaped strip of carbon fiber, which at the time was a material new to prosthesis fabrication. The lower horizontal portion was fitted to sole material, and the upper vertical part was attached to the pylon. A separate strip was attached to the rear of the footplate like a leaf spring to act as the heel. The design provides springlike compression action, as well as some torque and flexibility properties. The foot is known for high flexibility and good energy-storing capabilities and remains in widespread use. The flex-walk system is a second generation of the flex-foot design and addresses the needs of amputees with longer residual limbs with moderate activity levels, as well as pediatric applications. Both versions adapt well to both endoskeletal and exoskeletal shank designs.

L5982-L5984

L5982 All exoskeletal lower extremity prostheses, axial rotation unit

L5984 All endoskeletal lower extremity prostheses, axial rotation unit, with or without adjustability

When the prosthesis incorporates an axial rotation device, this net torque acting about the long axis of the socket is able to rotate the socket externally, the only resistance to such rotation being the relatively weak return spring in the axial rotation device. The axial rotation tends to relieve the contact pressures that caused the torque and thus reduces pressures in the critical anteromedial region of the brim. With an axial rotation device, the socket is free to respond to the demands of the stump and relieve the pressures and torque caused by cyclic action of the musculature.

L5985

L5985 All endoskeletal lower extremity prostheses, dynamic prosthetic pylon

This code reports the supply of a dynamic pylon for a lower-extremity prosthesis system. A pylon is a post-like structure fitted to the residual limb socket on one end and the prosthetic foot component on the other. The pylon may be a tube made of aluminum, titanium, steel, or carbon fiber-reinforced plastic. A dynamic pylon has energy-storing properties, typically provided by an internal spring or series of springs. Some models, such as the Endolite telescopic torsion pylon, also allow for some twisting movement. The energy-return feature absorbs shock and in some users provides gait efficiency with less energy outlay.

T2007

T2007 Transportation waiting time, air ambulance and nonemergency vehicle, one-half (1/2) hour increments

This code represents the idle or unloaded waiting time that a transport, air ambulance, or nonemergency vehicle spends waiting for a particular patient.

T2010-T2011

T2010 Preadmission screening and resident review (PASRR) Level I identification screening, per screen

T2011 Preadmission screening and resident review (PASRR) Level II evaluation, per evaluation

Preadmission screening and resident review (PASRR) is a protection for patients with serious mental illness or intellectual disabilities. PASRR is intended to prevent patients from being inappropriately admitted to nursing facilities that cannot provide the specialized care they require. Federal law requires all patients, regardless of payer source, be given a level I identification screening to identify mental illnesses or intellectual disabilities. Level I screens are generally forms completed by hospital discharge planners, community health nurses, or other practitioners defined by state law. Patients who do or may have a mental illness or intellectual disabilities are then referred for a level II evaluation. The level II evaluation is provided to all patients identified in level I and any resident who has experienced a significant change in condition. This level II evaluation is the resident review that is conducted according to federal delineated criteria. Once it is determined that a patient has a mental illness or intellectual disabilities, it must be determined what specialized services are needed and whether the nursing home can provide those services. Types of specialized services and their definition may vary by state.

T2012-T2021

T2012 Habilitation, educational; waiver, per diem

T2013 Habilitation, educational, waiver; per hour

T2014 Habilitation, prevocational, waiver; per diem

T2015 Habilitation, prevocational, waiver; per hour

T2016 Habilitation, residential, waiver; per diem

T2017 Habilitation, residential, waiver; 15 minutes

T2018 Habilitation, supported employment, waiver; per diem

T2019 Habilitation, supported employment, waiver; per 15 minutes

T2020 Day habilitation, waiver; per diem

T2021 Day habilitation, waiver; per 15 minutes

Habilitation is the act of making an individual capable of fitting into and/or functioning in society. The codes indicated here generally refer to people who have disabilities that initially prevent them from functioning independently in society. Habilitation provides the assistance that these people need to attain their goals, wants, and/or needs. Paraprofessionals and professionals usually provide support, training, and any required therapy. Day habilitation may be a full day of directed services or may be an alternate day where recreational activities are the main body of the day.

T2022-T2023

T2022 Case management, per month

T2023 Targeted case management; per month

Case management is an effort to improve care and to contain costs by having one party manage or coordinate all care delivered to patients who have certain complex illnesses or injuries, including mental and behavioral health issues. Case management may include, but is not limited to, the evaluation of a condition, the development and implementation of a plan of care, the coordination of medical resources, and the appropriate communication to all parties. Targeted case management targets a specific population subgroup.

T2024-T2025

T2024 Service assessment/plan of care development, waiver

T2025 Waiver services; not otherwise specified (NOS)

Medicaid may choose to wave certain requirements in conjunction with specialized programs. In these cases, waivers usually refer to permission from the federal government to waive or change certain requirements.

T2026-T2027

T2026 Specialized childcare, waiver; per diem

T2027 Specialized childcare, waiver; per 15 minutes

Specialized childcare usually refers to childcare provided to an individual who has special physical or developmental needs. It may also refer to childcare needed during nonstandard hours, such as overnight, or care for a mildly ill child who cannot attend school or regular daycare. Most states require providers of specialized childcare to be certified, licensed, or otherwise deemed qualified to care for the child. The waiver refers to permission from the federal government to state Medicaid plans to finance services that are not in compliance with federal regulations.

T2028-T2029

T2028 Specialized supply, not otherwise specified, waiver

T2029 Specialized medical equipment, not otherwise specified, waiver

These codes represent specialized supplies or durable medical equipment that is not otherwise identified by other HCPCS Level II codes. The waiver refers to permission from the federal government to state