Organization of HCPCS
The Ingenix 2006 HCPCS Level II book contains mandated changes and new codes for use as of January 1, 2006. Deleted codes have also been indicated and cross-referenced to active codes when possible. New codes have been added to the appropriate sections, eliminating the time-consuming step of looking in two places for a code. However, keep in mind that the information in this book is a reproduction of the 2006 HCPCS; additional information on coverage issues may have been provided to Medicare contractors after publication. All contractors periodically update their systems and records throughout the year. If this book does not agree with your contractor, it is either because of a mid-year update or correction, or a specific local or regional coverage policy.

To make this year’s HCPCS book even more useful, we have included codes noted in addendum B of the November 2005 OPPS update as published in the Federal Register and from transmittals through 2005 that include codes not discussed in other CMS documents. The sources for these codes are often noted in blue beneath the description.

Index
Since HCPCS is organized by code number rather than by service or supply name, the index enables the coder to locate any code without looking through individual ranges of codes. Just look up the medical or surgical supply, service, orthotic, prosthetic, or generic or brand name drug in question to find the appropriate codes. This index also refers to many of the brand names by which these items are known.

Table of Drugs
The brand names listed are examples only and may not include all products available for that type of drug. Our table of drugs lists HCPCS codes from any available sections including A codes, C codes, J codes, S codes, and Q codes under brand and generic drug names with amount, route of administration, and code numbers. While we try to make the table comprehensive, it is not all-inclusive.

Color-coded Coverage Instructions
The Ingenix HCPCS Level II codebook provides colored symbols for each coverage and reimbursement instruction. A legend to these symbols is provided on the bottom of each two-page spread.

How to Use Ingenix HCPCS Level II Books

Blue Color Bar—Special Coverage Instructions
A blue bar for “special coverage instructions” over a code means that special coverage instructions apply to that code. These special instructions are also typically given in the form of Medicare Pub.100 reference numbers. The appendices provide the full text of the cited Medicare Pub.100 references.

Yellow Color Bar—Carrier Discretion
Issues that are left to “contractor discretion” are covered with a yellow bar. Contact the contractor for specific coverage information on those codes.
HCPCS LEVEL II EXPERT—INTRODUCTION

Red Color Bar—Not Covered by or Invalid for Medicare
Codes that are not covered by or are invalid for Medicare are covered by a red bar. The pertinent Medicare Internet-only manuals (pub. 100) reference numbers are also given explaining why a particular code is not covered. These numbers refer to the appendices, where we have listed the Medicare references.

The Ingenix HCPCS Level II codes follow the AMA CPT code book conventions to indicate new, revised, and deleted codes.
- A black circle (●) precedes a new code.
- A black triangle (▲) precedes a code with revised terminology or rules.
- A circle (○) precedes a reinstated code.
- Codes deleted from the 2005 active codes appear with a strike-out.

Quantity Alert
Many codes in HCPCS report quantities that may not coincide with quantities available in the marketplace. For instance, a HCPCS code for an ostomy pouch with skin barrier reports each pouch, but the product is generally sold in a package of 10. “10” must be indicated in the quantity box on the CMS claim form to ensure proper reimbursement. This symbol indicates that care should be taken to verify quantities in this code.

♀ Female Only
This icon identifies procedures that should only be reported for female patients.

♂ Male Only
This icon identifies procedures that should only be reported for male patients.

Age Edit
This icon denotes codes intended for use with a specific age group, such as neonate, newborn, pediatric, and adult. Carefully review the code description to assure the code you report most appropriately reflects the patient’s age.

Maternity
This icon identifies procedures that by definition should only be used for maternity patients generally between 12 and 55 years of age.
INTRODUCTION

1  ASC Groupings
Codes designated as being paid by ASC groupings that were effective at the time of printing are denoted by the group number.

2  Colorectal cancer screening; colonoscopy on individual at high risk

A4322 Irrigation syringe, bulb or piston, each

DMEPOS
Use this icon to identify when to consult the CMS DMEPOS for payment of this durable medical item.

A0999 Unlisted ambulance service

Skilled Nursing Facility (SNF)
Use this icon to identify certain items and services not covered under the Skilled Nursing Facility Prospective Payment System (SNFPPS).

J7191 Factor VIII (antihemophilic factor (porcine), per IU

Ingenix provides explanatory information in blue beneath many codes. These annotations help you better understand the code and its billing.

J7193 Factor IX (antihemophilic factor, purified, non-recombinant) per IU

Use this code for Hyate:C.

Medicare jurisdiction: local contractor.

J7502 Cyclosporine, oral, 100 mg

Use this code for Neoral, Sandimmune, Gengraf, Sangcya.

See also code: C9438

Drugs commonly reported with a code are listed underneath by brand or generic name.

A0999 Unlisted ambulance service

"See" references help you determine related or alternate codes for the supply or service.

CMS does not use consistent terminology when a code for a specific procedure is not listed. The code description may include any of the following terms: unlisted, not otherwise classified (NOC), unspecified, unclassified, other, and miscellaneous. If you are sure there is no code for the service or supply provided or used, be sure to provide adequate documentation to the payer. Check with the payer for more information.

MED: This notation precedes an instruction pertaining to this code in the Centers for Medicare and Medicaid Services’ (CMS) Publication 100 (Pub 100) electronic manual or in a National Coverage Determination (NCD). These CMS sources, formerly called the Medicare Carriers Manual (MCM) and Coverage Issues Manual (CIM), present the rules for submitting these services to the federal government or its contractors and are included in the appendix of this book.

A4300 Implantable access catheter, [e.g., venous, arterial, epidural subarachnoid, or peritoneal, etc.] external access

MED: 100-2, 15, 120
## APC Status Indicators

**A** - Indicates services that are paid under some other method such as the DMEPOS fee schedule or the physician fee schedule

**B** - Indicates codes not allowed or paid under OPPS

**C** - Indicates inpatient services that are not paid under the OPPS

**D** - Indicates services for which payment is not allowed under the OPPS. In some instances, the service is not covered by Medicare. In other instances, Medicare does not use the code in question but does use another code to describe the service.

**E** - Indicates corneal tissue acquisition costs, certain CRNA services and hepatitis B vaccines that are paid at reasonable cost

**F** - Indicates a current drug or biological for which payment is made under the transitional pass-through provisions

**G** - Indicates either a device paid under pass-through provisions; or brachytherapy sources and radiopharmaceuticals that are paid at reasonable cost

**H** - Indicates non-pass-through drugs and biologicals. Effective July 1, 2001, co-payments for these items and the service of the administration of the items are aggregated and may not exceed the inpatient hospital deductible.

### Examples

- **A4290** Sacral nerve stimulation test lead, each
- **A4321** Therapeutic agent for urinary catheter irrigation
- **A5505** Surgical trays
- **G0341** Percutaneous islet cell transplant, includes portal vein catheterization and infusion
- **A0021** Ambulance service, outside state per mile, transport (Medicaid only)
- **V2785** Processing, preserving and transporting corneal tissue
- **C9113** Injection, pantoprazole sodium, per vial
- **A9505** Thallium Tl-201 thallous chloride, diagnostic, per millicurie
- **A9535** Injection, methylene blue, 1 ml

*continued on next page*
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0008</td>
<td>Administration of influenza virus vaccine when no physician fee schedule service on the same day</td>
</tr>
<tr>
<td>G0333</td>
<td>Dispense fee initial 30 day</td>
</tr>
<tr>
<td>A4220</td>
<td>Refill kit for implantable infusion pump</td>
</tr>
<tr>
<td>G0177</td>
<td>Training and educational services related to the care and treatment of patient’s disabling mental health problems per session (45 minutes or more)</td>
</tr>
<tr>
<td>C1300</td>
<td>Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval</td>
</tr>
<tr>
<td>C9724</td>
<td>Endoscopic full-thickness plication in the gastric cardia using endoscopic plication system (EPS); includes endoscopy</td>
</tr>
<tr>
<td>G0101</td>
<td>Cervical or vaginal cancer screening; pelvic and clinical breast examination</td>
</tr>
<tr>
<td>C8952</td>
<td>Therapeutic, prophylactic or diagnostic injection; intravenous push</td>
</tr>
<tr>
<td>A4222</td>
<td>Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)</td>
</tr>
</tbody>
</table>

Indicates influenza or pneumococcal pneumonia vaccine paid as of reasonable cost with no deductible or coinsurance

Indicates that this code should not be reported by hospitals to their fiscal intermediary

Indicates services that are incidental, with payment packaged into another service or APC group

Indicates services paid only in partial hospitalization programs

Indicates significant procedures for which payment is allowed under the hospital OPPS but to which the multiple procedure reduction does not apply

Indicates surgical services for which payment is allowed under the hospital OPPS. Services with this payment indicator are the only ones to which the multiple procedure payment reduction applies.

Indicates visits for which payment is allowed under the hospital OPPS

Indicates ancillary services for which payment is allowed under the hospital OPPS

Indicates nonimplantable durable medical equipment (DME) that is billed by providers other than home health agencies to the DMERC

The "Q" icon is not included because there are no codes that have a "Q" status indicator in the 2006 HCPCS Level II code set.

Current as of 11/23/2005
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