Professional Coding System Overview

ACHIEVE REVENUE
MANAGEMENT

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Healthcare Common Procedure Coding System (HCPCS)

NATIONAL ASSOCIATION OF Community Health Centers®

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Healthcare Common Procedure Coding System (HCPCS)

WHAT?

WHY?

HOW?

WHAT
Is the HCPCS?

- Healthcare Common Procedure Coding System (HCPCS) is a standardized coding system describing services, drugs, items and supplies provided or rendered to a patient
- HCPCS is divided into two subsystems
  - Level I
    - Current Procedural Terminology (CPT®)
  - Level II
  - Alpha-numeric coding system
    - Identifies drugs, biologicals, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

WHAT
Is the CPT?

Current Procedural Terminology (CPT®)

- Coding system maintained by the American Medical Association (AMA)
- Divided into three categories
  - Category I
    - 5 numeric digit codes
    - Largest category of codes, primarily those commonly used by providers to report their services and procedures

WHAT
Is the CPT?

Category I code ranges arranged by related services:

• Evaluation and Management	99201-99499
• Anesthesiology	00100-01999, 99100-99140
• Surgery	10021-69990
• Radiology	70010-79999
• Pathology & Laboratory	80047-89398
• Medicine	90281-99199, 99500-99607

WHAT
Is the CPT?

Category II

- 5 digit codes ending with the letter “F”
- Supplemental codes to report and track performance measurements

Category III

- 5 digit codes ending with the letter “T”
- Temporary codes that represent new technologies, services and procedures

Healthcare Common Procedure Coding System (HCPCS)

WHAT?

WHY?

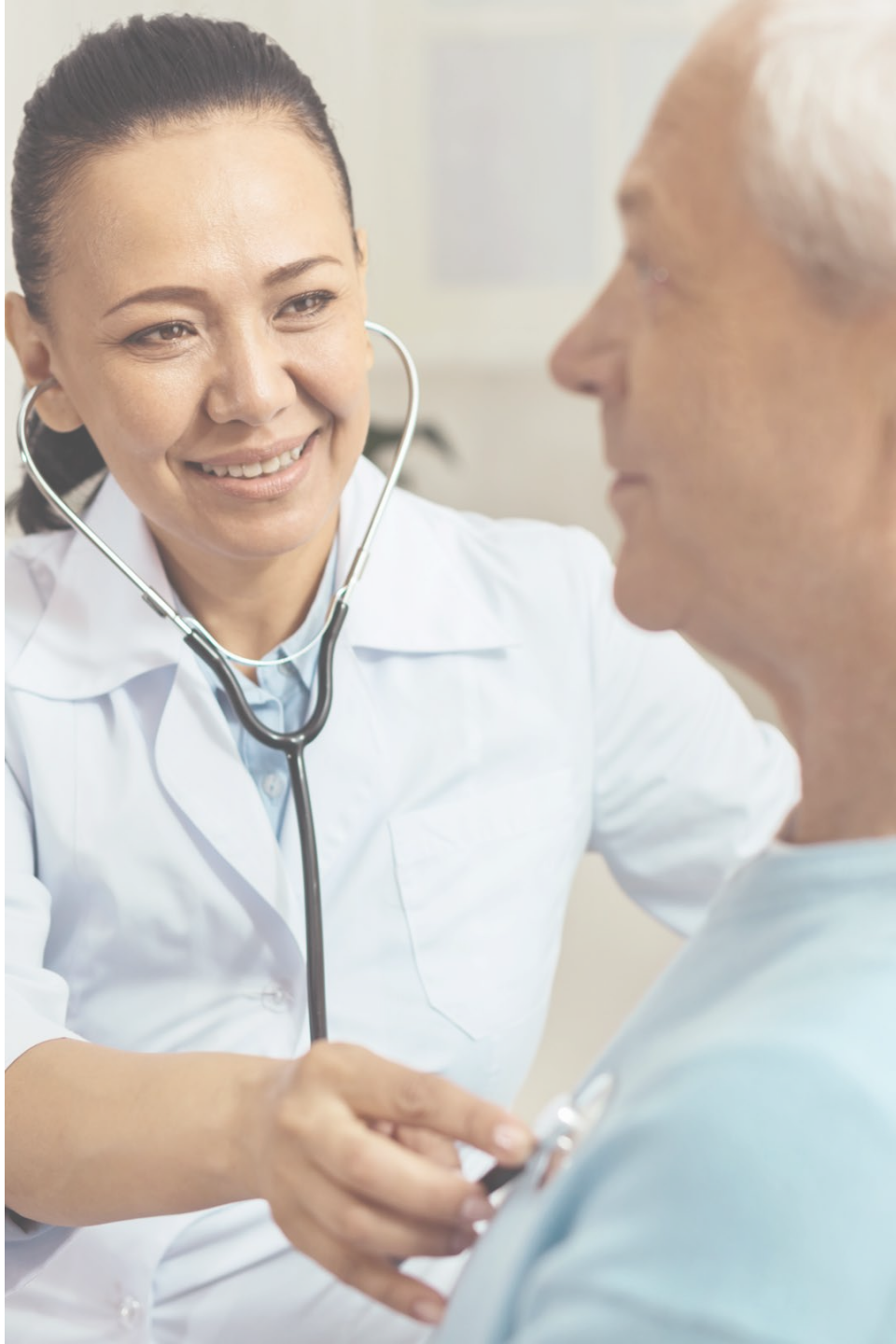
HOW?

WHY

Is the HCPCS Level I codes important to FQHCs?

Utilized for a variety or purposes including:

- Insurance claims submission and processing
- Tracking patient outcomes
- Identifying care gaps and improving quality of care
- Medical review
- Utilization comparison
- Establishing clinical protocols and outreach processes



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Healthcare Common Procedure Coding System (HCPCS)

WHAT?

WHY?

HOW?

HOW:
HCPCS codes are applied

- Criteria and instruction for code selection contained within:
  - Current Procedural Terminology (CPT®)
  - HCPCS Level II
  - American Medical Association (AMA)
  - Centers for Medicare & Medicaid Services
  - Payer guidelines and references

- Adherence is required and guidelines at the beginning of each section define items necessary to interpret and report on services in that section

HOW:
HCPCS codes are applied

- Patient specific documentation (health record) describes procedures, services or supplies rendered
- Code describing applicable item or service is selected
- Modifying factors & Place of Service are also noted, taken into consideration and reported through two digit “Modifiers” and “POS” codes outlined within the HCPCS mechanism

HOW:
HCPCS codes are applied

- When reporting CPT Category II codes to communicate supplemental information related to a patient/patient encounter selection, determine:
  - Numerator
  - Denominator
  - Exclusion(s)
  - Reporting instructions
- Alphabetic Measure Index found on the American Medical Association website
  - https://www.ama-assn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf

HOW:
CPT Category II codes are structured

Diabetes (DM)		
Brief Description of Performance Measure & Source and Reporting Instructions	**CPT Category II Code(s)**	**Code Descriptor(s)**
A1c Management [4] Whether or not patient received one or more A1c test(s) **Numerator:** Patients who received one or more A1c test(s) **Denominator:** Patients with diagnosed diabetes 18-75 years of age **Percentage** of patients with diagnosed diabetes aged 18-75 years with one or more A1c test(s). **Exclusion(s):** NONE **Reporting Instructions:** In order to meet this measure, the date of test, when it was performed, and the corresponding result are required. For this reason, report one of the three Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. The measure may also be met by reporting the Category I code, 83036 Hemoglobin; glycosylated (A1C), when performed. ►To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3051F, 3052F.◄	*3044F* ►3051F◄ ►3052F◄ *3046F*	*Most recent hemoglobin A1c (HbA1c) level < 7.0%* ►Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%◄ ►Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%◄ *Most recent hemoglobin A1c (HbA1c) level > 9.0%*

https://www.ama-assn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf