HCPCS CODING AND REIMBURSEMENT FOR WOUND CARE TREATMENTS, EQUIPMENT AND PRODUCTS

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HCPCS (Health Care Common Procedure Coding System) coding is a standardized language used to describe services and medical equipment/products provided during the delivery of care. For health care professionals, it is a listing of descriptive terms for reporting medical services and procedures performed by physicians and other qualified providers. For reporting equipment and products, generic terminology identifies durable medical equipment, supplies used in conjunction with equipment and products, such as wound dressings. Drug and biologics codes are described by brand name.

The purpose of HCPCS coding is to ensure orderly and consistent claims processing by Medicare, Medicaid, and other health insurance programs. Prices and fees are NOT a part of coding. Selecting a code based on the fee schedule almost always results in an incorrect coding determination. HCPCS codes describe the *product*, not the *price.*

The entities that handle requests to add or revise the HCPCS believe that in most cases new products are adequately described in existing codes. If a product provides a function similar to that of those previously coded, a request for a new code is denied. In addition, there must be rigorous and scientifically reliable evidence that the treatment or product provides improved medical benefit over those currently used. Also, at least one insurance sector or public or private insurer must identify an operating need to identify the treatment or product separately, and there must be sufficient claims activity or volume to support adding a new code.

A common misconception is that the assignment of a code to a wound care treatment, equipment, or product guarantees reimbursement or a certain payment amount. In fact, the assignment of a code is not an approval, nor does it imply or guarantee claim reimbursement or coverage for the item or treatment. Each payer separately develops coverage criteria, coding guidelines, and amounts reimbursed for HCPCS codes. The connection of coding to coverage and payment is often found in a payer's coverage policy. For Medicare, it is the National or Local Coverage Determination and related Policy Articles. In addition, coding bulletins and other payer advisories often update coding instructions and provide more detail regarding the requirements for certain codes.

Accurate coding and reporting of services are critical aspects of proper billing. Both Medicare and Medicaid have implemented the National Correct Coding Initiative (NCCI) to promote correct coding and to control errors leading to inappropriate payment. All health care professionals, suppliers, and providers should use the NCCI website, tables, and manual to avoid coding and billing errors and subsequent payment denials.

HCPCS is divided into two subsystems, referred to as Level I and Level II. Level I CPT® (Current Procedural Terminology) is a set of codes, descriptions, and guidelines maintained by the American Medical Association (AMA). Level II is standardized coding used primarily to identify products, supplies, and services not included in the CPT®. It is maintained and distributed by the Centers for Medicare & Medicaid Services (CMS) and used by contract insurance companies that process and pay Part A and Part B claims. Other insurers use HCPCS as well to report services, supplies, or treatments. Some, however, may assign a code that would not be recognized by Medicare (known as "S" codes).

LEVEL I: CPT®

AMA CPT® codes are updated annually. Revisions occur via proposals for changes, additions, or deletions submitted by medical specialty and other professional societies. The CPT® Editorial Panel is ultimately responsible for reviewing proposals and voting on changes, which are then published annually.

An example of a Level I CPT® applicable to a wound care treatment/service, also called "active wound care management" (i.e., a procedure performed to remove devitalized and/or necrotic tissue and promote healing; the provider is required to have direct [one-on-one] patient contact) that was recently revised is:

97602: *Removal of devitalized tissue from wound(s), nonselective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.*

LEVEL II: HCPCS

These codes consist of a single alphabetical letter followed by four digits and a descriptor. Descriptors are generic whenever possible, but brand names are used to describe devices or drugs. This in no way implies that any health insurer covers or reimburses for a given product.

An example of a Level II alpha-numeric generic descriptor for a wound dressing is:

A6209: *Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing. More information on this code is found in the DME MAC Local Coverage Determination and Policy Article: Made of open cell, medical grade expanded polymer; with non-adherent property over wound site. Foam dressings are covered items when used on full thickness wounds (e.g., stage III or IV ulcers) with moderate to heavy exudates. Usual dressing change for a foam wound cover when used as primary dressing is up to three times per week.*

HCPCS Level II also includes temporary codes assigned for procedures, professional services, or devices ("G," "K," "Q," and "S" codes). "G" codes are assigned to procedures/professional services that do not have CPT® codes. "K" codes are established for the exclusive use of the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for processing Medicare Part B claims for DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies). "Q" codes are assigned to a number of categories and are unique in that they identify a product by brand name. Private insurers maintain "S" codes. Items with these codes are not payable by Medicare.

In addition to the alpha-numeric codes, HCPCS contains modifiers, two-position codes and descriptors used to indicate that a service provided or a procedure performed has been altered but has not changed in its definition or code. For example, when a Part B Medicare supplier provides surgical dressings, the claim form must include the appropriate modifier regarding the number of wounds. For example:

- **A1 to A9 modifiers are used to designate the number of wounds.**
- **A1 (dressing for one wound);**
- **A2 (dressing for two wounds); up to A9 (dressing for nine or more wounds).**

The CMS Alpha-Numeric Editorial Panel maintains and publishes these codes and accepts requests to modify existing codes or to establish new codes. Anyone can submit such a request. Information is available online at www.cms.gov in the HCPCS General Information section.

Verification and assignment of an existing Level II HCPCS to a wound care product or treatment are the functions of the Medicare Pricing, Data Analysis, and Coding Contractor (PDAC). The current contractor is Noridian Healthcare Solutions, LLC. Information on coding verification, fee schedules, and the Product Classification List is located at www.dmepdac.com.

Submitting a Coding Verification Request is a preliminary step for recommending a modification to the Level II HCPCS. Once a manufacturer, distributor, or supplier submits appropriate documentation, the PDAC performs a Coding Verification Review and then notifies the applicant regarding which code to use. However, this in no way guarantees coverage or payment for the item. The manufacturer or distributor must report any changes regarding products for which the PDAC has issued a written coding determination.

A product listed on the Product Classification List (PCL) will require a new coding verification application to be sent to the PDAC when:

The product currently listed has changed from the initial coding verification review conducted by the PDAC (or former SADMERC). For example, the product is made out of a different material or is a different size, or the manufacturing of the product was changed.

There is the addition of a new product name to the PCL for an existing model number.

Surgical dressings have changed sizes.

There is an addition of model numbers for lumbar sacral orthoses, thoracic lumbar sacral orthoses, and power mobility devices, including power operated vehicles and power wheelchairs.

There is a request to reinstate a product on the PCL that is currently listed with an effective end date.

There is a request to change any information currently listed on the PCL from what was submitted on the original coding verification application due to a manufacturer change, such as a change in labeling, product name change, or model number change.

The following situations describe circumstances that would require only the submission of the appropriate signed and dated attestation form(s) on company letterhead, identifying all affected products listed on the PCL and stating that none has changed.

A manufacturer/distributor name change has occurred as a result of a corporate merger or purchase: submit a copy of the "Attestation regarding manufacturer name change resulting from corporate merger or purchase" and legal documentation confirming this corporate change.

The addition of a new manufacturer/distributor name as a result of a private label agreement: submit a copy of the "Attestation regarding addition of a new manufacturer/distributor name resulting from a private label agreement" (manufacturer attestation) and the "Attestation regarding addition of a new manufacturer/distributor name resulting from a private label agreement" (distributor attestation).

NOTE: If the appropriate attestation form is not completed or the required legal documentation is not supplied, a new coding verification application must be submitted.

The following situations describe circumstances when the PDAC will update the PCL without requiring the submission of a new coding verification application or an attestation form:

Information on the PCL is incorrect as a result of an error regarding what was submitted on the original application. Examples include a wrong or misspelled manufacturer/distributor name, wrong or misspelled product name, incorrect model number, incorrect HCPCS code, incorrect effective beginning date, or incorrect classification category.

The manufacturer/distributor has discontinued production of a product. The effective end date needs to be included with this request.

The manufacturer/distributor requests additional model numbers be added to an existing product line currently listed on the PCL. Examples include:
  • New color added to the product line
  • New size added to the product line that is within the current size range of the assigned HCPCS coding

NOTE: A statement attesting that the product has not changed from the previously coded product currently listed on the PCL must be included with the request, along with product literature and the effective beginning date for the new product.

Although coding is one component of reimbursement, there are multiple pieces of information needed to determine whether a certain treatment, piece of equipment, or wound care product is eligible for reimbursement, including:

• **Clinical setting of use/provider type:** acute care hospital, long-term care or rehabilitation hospital, skilled nursing facility, home health agency, physician's office, outpatient clinic, hospice, assisted living residence, nursing home, or patient's home.

• **Payer specifics:** Medicare, Medicaid, managed care organization, health maintenance organization (HMO), supplemental insurer, private insurer, Veterans Affairs, workers' compensation; other specific patient insurer information such as verification of coverage benefits, copayment amounts, deductibles.

• **Payer coverage policy:** for the specific treatment, equipment, or wound care product

• **Payer medical necessity requirements:** specific diagnoses (International Classification of Diseases-tenth revision [ICD-10]) or other clinical conditions that must be present, including documentation of prior treatments tried and failed for the treatment, equipment, or product to be covered and reimbursed.

• **Codes:** verified by the AMA for the procedure/treatment (CPT®), submitted to and assigned by CMS, or verified by the PDAC contractor, reviewed or verified by Medicare contractor or other insurer for treatment included in a local coverage determination

• **Payment:** fee schedule, assigned payment amount, or procedure for determining the amount reimbursed.

• **Utilization parameters:** limits on frequency of treatment, number of supplies allowed per a period of time, or restrictions on a specific treatment modality.

About the Author

Glenda Motta, RN, BSN, MPH, WOCN, a reimbursement consultant and wound care expert, is President/CEO of GM Associates, Inc. (Loveland, Colorado). She is a past President of the Wound, Ostomy and Continence Nurses Society (WOCN) and has published more than 125 articles. She was the founding clinical editor of *WoundSource™: The Kestrel Wound Product Sourcebook.*

Disclaimer: Reimbursement information changes frequently. Providers should always verify coverage policy, medical necessity requirements and coding instructions, and should review bulletins issued by the specific payer.

Sources

American Medical Association. Current Procedural Terminology (CPT®). Chicago, IL: American Medical Association, 2017.

Centers for Medicare & Medicaid Services. HCPCS—General Information. www.cms.gov/Medicare/Coding/MedH-CPCSGenInfo/index.html

Centers for Medicare & Medicaid Services. How to Use the National Correct Coding Initiative (NCCI) Tools. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools-.pdf

Centers for Medicare & Medicaid Services. National Correct Coding Initiative Edits. www.cms.gov/NationalCorrectCodInitEd

Noridian Healthcare Solutions, LLC. DME Coding System (DMECS) Info. www.dmepdac.com/dmecs/index.html

Wound Care Reimbursement Resources

The following websites are operated by government and/or contracted agencies independent of Kestrel Health Information, Inc. The links provided in this document are subject to change without notice.

Correct Coding – HCPCS Coding Recommendations from Non-Medicare Sources. DME MAC joint publication
https://www.dmepdac.com/resources/articles/2016/08_03_16b.html

American Medical Association. Current Procedural Terminology – CPT®
https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology

Centers for Medicare & Medicaid Services: https://www.cms.gov
Durable Medical Equipment (DME) Center: https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html
Medicare Coverage Database (MCD): https://www.cms.gov/medicare-coverage-database/

Noridian Health Care Solutions, LLC - Pricing, Data Analysis and Coding (PDAC) Contractor
https://www.dmepdac.com/

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