HCPCS Level II Coding Reference Guide

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HCPCS Level II Codes

The Healthcare Common Procedure Coding System (HCPCS) Level II is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT® codes such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office.

C-Codes

The C series of HCPCS ("C codes") reports drug, biological, and device codes that must be used by Outpatient Prospective Payment System (OPPS) hospitals for reporting facility (technical) services. Some of the items and services described by C codes are eligible for transitional pass-through payments for OPPS hospitals, have separate Ambulatory Payment Classification (APC) payments, or are items that are packaged. Hospitals are encouraged to report all applicable C codes regardless of payment status.

For device-intensive procedures performed in the hospital outpatient setting, Medicare requires the reporting of a device-related HCPCS Level II code on the claim. This is necessary to help ensure appropriate costs are captured for use in setting future hospital outpatient APC payment levels.

Report C1889 for a miscellaneous device that is implanted or inserted during a device-intensive OPPS procedure that is not described by a specific HCPCS Level II category C code. Report C1890 when a device is not implanted or inserted during a device-intensive OPPS procedure. Reporting these codes with a device intensive procedure satisfies the OPPS edit requiring a device code to be reported on a claim with a device-intensive procedure.

It is important to note that reporting HCPCS Level II codes does not necessarily result in additional reimbursement to the hospital.

Items without HCPCS II Codes

Many devices, supplies and other items used by hospitals and physicians do not have HCPCS Level II codes. This indicates that CMS and other payers do not have a need for these items to be individually identified on the claim, although the associated charges must still be reported.

When hospitals use a device or supply that does not have a HCPCS Level II code, they should report the charges in the revenue center code for the item, typically revenue center code 270 for Medical-Surgical Supplies or revenue center code 278 for Medical-Surgical Supplies/Implants. When hospitals or physicians use an item that does not have a HCPCS Level II code, they should build the cost for the item into their charge for the procedure or service.

Clarification of Device Kits

Some devices may be packaged within a device kit which contains both the device and a number of associated supplies used in a particular procedure. For the kit itself, no HCPCS code may have been established. However, if the kit contains individual items that separately qualify for transitional pass-through payments, these items should be separately reported with an applicable HCPCS codes. [Please note, the supplies contained in the kit would not be separately reported]. *AHA Coding Clinic® for HCPCS Volume 16, Number 3, Third Quarter 2016.*

Coding Examples

For plates, screws, bone void fillers, and DBM:
C1713 - Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. This may include orthopedic plates with accompanying washers and nuts. This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (i.e., bone substitute implanted into a bony defect created from trauma or surgery).

For joint replacement ie, ankle, knee, hip, shoulder etc:
C1776 - An artificial joint that is implanted in a patient. Typically, a joint device functions as a substitute to its natural counterpart.

For DeNovo, Chondrofix, Cellentra, PrimaGen (cell based technologies):
L8699 - Prosthetic implant, not otherwise specified

Common HCPCS Level II Codes for Zimmer Biomet Products

Note that HCPCS Level II codes are usually not product-specific and have very general descriptions.

Code	Description
A6260	Wound cleansers, any type, any size
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
C1763	Connective tissue, non-human (includes synthetic)
C1769	Guide wire
C1776	Joint device (implantable)
C1781	Mesh (implantable)
C1889	Implantable/insertable device for device intensive procedure, not otherwise classified
C1890	No implantable/insertable device used with device-intensive procedures
J3490	Unclassified drugs
J7321	Hyaluronan or derivative, Hyalgan, Supartz or VISCO-3, for intra-articular injection, per dose (effective for dates of service on or after April 1, 2021)
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose
L8699	Prosthetic implant, not otherwise specified
Q4100	Skin substitute, not otherwise specified
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter
Q4235	Amniorepair or altiply, per square centimeter (effective 7/1/2020)
S2325	Hip core decompression
S2900	Surgical techniques requiring use of robotic surgical system

For further assistance with reimbursement questions, contact the Zimmer Biomet Reimbursement Hotline at 866-946-0444 or reimbursement@zimmerbiomet.com, or visit our reimbursement web site at zimmerbiomet.com/reimbursement.

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