The HCPCS Coding System

The History of HCPCS

The American Medical Association (AMA) began developing a coding system called the Current Procedural Terminology, or CPT, in 1966. During the 1970s, the AMA updated the CPT several times to reflect the rapid changes in healthcare technology during that decade.

In 1983, the Centers for Medicare and Medicaid Services (CMS) adopted the CPT codes as part of providing a uniform system for healthcare providers to report services, procedures and supplies for Medicare and Medicaid reimbursement. The CPT codes constitute Level I of the Healthcare Common Procedural Coding System or HCPCS. There is a separate HCPCS manual of Level II codes for all the services, supplies and equipment that are not covered by CPT.

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). HIPAA made the Secretary of Health and Human Services responsible for adopting national uniform standards for the electronic transmission of financial and administrative health information. Rather than create a new coding system, the Secretary of Health and Human Services has continued to rely on the AMA to update the CPT codes and CMS to update the HCPCS Level II codes. Each year the codes have to cover new forms of treatment. Both coding systems are updated every year; you can buy the new manuals starting in November for use on January 1.
Level I and Level II Codes

The HCPCS Level II codes are a project of a committee called the Alpha-Numeric Workgroup that includes the CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association.

HCPCS is a collection of codes that represent procedures, supplies, products and services that may be provided to Medicare and Medicaid beneficiaries and to individuals with private health insurance. The CPT Codes constitute the Level I of HCPCS. HCPCS codes are only used in outpatient facilities and by healthcare providers. Inpatient health care facilities use diagnosis as the basis of payment for their services and assign ICD codes for inpatient procedures. In outpatient settings, the basis of payment is the treatment (as represented through HCPCS codes), not the diagnosis.

The codes in the CPT manual and the HCPCS Level II codes have a different appearance. The CPT codes are five digits. For example, the CPT code for a Brochoscopy with bronchial alveolar lavage is 31624. The Level II National Codes are alphanumeric, which only means that the first character of every five character code is a letter instead of a number. For example, the code for skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth is E2622.
The Importance of the HCPCS Codes

It is exciting that the US is moving towards having a single coding system. Since HIPAA, private insurers have followed CMS in using the national codes. Having a national code means moving toward a uniform system that may eventually help with data collection in a way that preserves patient privacy yet allows a better understanding of healthcare outcomes. In addition to being more efficient, the codes may eventually benefit public health.

For the medical coder, using the right code makes a difference. If the code is wrong, the insurer, whether it is a third-party payer or a government entity like Medicare, might refuse to pay or pay an amount too small to cover the provider's costs. If it causes an insurer to pay too much, inaccurate coding can even lead to the government penalizing a provider for submitting inappropriate claims. This is why it is critical for coders to have the most up-to-date version of the CPT.