

## **PILOT MEDICAID HCPCS CODE MODIFICATION REQUEST GUIDELINES**

### **Instructions:**

1. Use the Pilot Medicaid HCPCS Code Modification Form to submit requests for new codes or modifications to existing codes. Only State Medicaid agencies may submit code requests using the Pilot Medicaid HCPCS code request process and application form.
2. Request one code, or a group of similar code requests, per submission packet.
3. In addition to providing the information requested, please include other descriptive and/or printed materials you think will be helpful in furthering the CMS HCPCS Workgroup's understanding of the nature of the service, product, or item, and the need for a new code.
4. Please do not label individual code requests with alphanumeric codes or suggest a specific alphanumeric code for your individual code request. If a decision is made to establish a new code, the CMS HCPCS Workgroup will assign a HCPCS code.
5. Sign and date each request. Be certain to provide the name, title, address, State and telephone number of the person to be contacted regarding this request.
6. All requested information must be supplied before the request for modification to the HCPCS coding system can be considered.
7. The complete request, including all supporting information, may not exceed 40 pages (front and back). Requests that exceed 40 pages will not be considered. Incomplete submittals will be returned for clarification.
8. Please include 38 copies of the completed request.
9. Submit coding requests to:

Medicaid HCPCS Coordinator  
Centers for Medicare & Medicaid Services  
Mail Stop S2-01-16  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**(DOWN LOAD PDF FILE)**  
**PILOT MEDICAID HCPCS CODE MODIFICATION REQUEST  
APPLICATION**

1. Name of service, product, or item\_\_\_\_\_.
2. Describe the service, product, or item in general terminology.
3. If this service, product, or item is required under Federal/State Law, please describe why and provide the "effective date."
4. Why are current codes and/or modifiers inadequate to describe the service, product, or item? Justification should be based on the effectiveness of the service, product, or item at issue. Include specifications regarding clinical indications for product/item use, clinical outcomes, product design and functionality, etc., as necessary, and compare these to currently available services, products, and items that have HCPCS codes. Also, include any peer-review clinical evidence that supports your comments.
5. Please identify the cost, and the differences in cost, compared to existing services, products, or items.
6. To the extent possible, provide information on which other States and payers already cover this service, product, or item, how long they have covered it, how many beneficiaries/patients receive it, how many claims have been paid, and what the total State expenditures have been for the service, product, or item.
7. Identify each State Medicaid program that supports this code request, and include the name and contact information for each State. A letter of support signed by the State Medicaid Director must be included for each State supporting the code request.
8. If this new code will promote administrative simplification and/or processing efficiency, please describe how.
9. When submitting a request for a code for an item/product, provide the date the item/product was approved for marketing by the Food and Drug Administration (FDA). If the product is exempt from FDA review and classification, please explain the basis for the exemption. Note: Documentation of FDA approval for drugs may be submitted after the coding application, but no later than March 31 of the current coding cycle.

Request submitted by:

Name: \_\_\_\_\_  
(Please print)

Title: \_\_\_\_\_

Name of State Agency: \_\_\_\_\_

Mailing Address:

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number and Extension: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

State Medicaid Director: \_\_\_\_\_

(Please print the full name)

Signature of State Medical Director: \_\_\_\_\_

Date: \_\_\_\_\_

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