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CENTERS for MEDICARE & MEDICAID SERVICES

Public Affairs Office

MEDICARE NEWS

FOR IMMEDIATE RELEASE
October 6, 2004

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NEW CMS CODING CHANGES WILL HELP BENEFICIARIES
IMPROVEMENTS WILL SPEED USE OF TECHNOLOGY

Improvements unveiled today by Medicare for revising the process it uses to update the code sets that make it possible to pay for certain health care items and services will help get new technologies to patients more quickly, the Centers for Medicare & Medicaid Services (CMS) announced.

The codes developed through this process will be used not only by Medicare, but also by Medicaid, private insurers, providers and suppliers and others who engage in health care transactions. It will improve the development of codes for new technologies, and make it easier to make decisions on coverage and payment for these items, as well as provide a more open, transparent coding process. These changes will be phased in over an 18-month period beginning with the 2006 coding cycle.

The improvements announced today are among the first steps taken by CMS's new Council on Technology and Innovation (CTI), which was established under Section 942 of the Medicare Modernization Act (MMA) to coordinate the activities of coverage, coding, and payment processes affecting new technologies and procedures.

"We are delivering on our promise to our health care partners to create a more effective system for providing patients with faster access to the latest medical technologies" said CMS Administrator Mark B. McClellan, M.D., Ph.D. "By working with patient advocates, health care payers, and the suppliers and manufacturers of medical products, we have been able to identify many opportunities for improvements in the current coding process to keep coding issues from slowing the dissemination of new and improved treatments."

The Healthcare Common Procedure Coding System (HCPCS) was established in 1978 to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. Such coding is necessary for Medicare, Medicaid, and other health insurance programs to ensure that insurance claims are processed in an orderly and consistent manner. Initially, use of the codes was voluntary, but with the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) use of the HCPCS for transactions involving health care information became mandatory.

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The HCPCS is divided into two principal subsystems, referred to as Level I and Level II. Level I is comprised of the CPT-4, a numeric coding system maintained by the American Medical Association (AMA) to identify medical services and procedures furnished by physicians and other health care professionals.   The Level II HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes. It is maintained and distributed by CMS, in conjunction with private payer organizations.

The major new changes to the HCPCS coding process include:

- **Expansion of the Public Meetings** – The current public meetings related to durable medical equipment (DME) will be expanded to include all public requests for HCPCS products, supplies and services. Agenda items for the meetings will be published in advance, including descriptions of the coding requests, the requestor, and the name of the product or service. This change will provide more opportunities for the public to become aware of coding changes under consideration, as well as opportunities for public input into decision-making.

- **Appeals Process -** We expect to implement an appeals process in the 2007 coding cycle, whereby denied applicants will be allowed to appeal the decision and an opportunity to have their application reconsidered during the same coding cycle.

- **Public Notice of Decisions** – All preliminary decisions will be published on the CMS website prior to public meetings, to facilitate effective public discussion and comment. Final decisions based on public comments, as well as decisions resulting from appeals, will be similarly published.

- **Revision of the HCPCS Code Application Form** – The application format is being revised to be more streamlined, user-friendly, and to incorporate helpful suggestions received as a result of the stakeholder survey.

- **Elimination of Requirement for Marketing Data for Drugs** – The standard requirement for submission of 6 months of marketing data will be waived when the application pertains to a drug. FDA approval documentation will be accepted after the application deadline.

- **Reduction in Marketing Data for Non-drug items** – The marketing requirement for durable medical equipment, orthotics and supplies will be reduced from 6 months to 3.

- **Consideration of national Medicaid program operating needs –** CMS is working with State Medicaid Directors to establish a process to consider coding changes that may be needed based on national Medicaid program operating needs.

The number and complexity of coding applications submitted has increased dramatically over the past 10 years from 50 to nearly 300 applications per year. To accommodate these improvements, along

with the pending new changes in the HCPCS coding system, such as expanded opportunities for public input, the revised HCPCS coding process will be phased in over the next 18 months. *The first change in the process is an earlier application deadline of January 3, 2005.* This change will permit expanded opportunities for public comment on preliminary coding decisions compared to the current coding update schedule.

Herb Kuhn, Director, Center for Medicare Management and Chair of the CTI stated, "We intend to use the changes we are announcing today to improve the quality of the decisions that are made and lead to greater acceptance and transparency of our process." He indicated that the Agency expects to hold an "Open Door" forum later this month to brief interested parties on the revised process and respond to questions. The CMS Special Revising HCPCS Coding Process Open Door will be held Wednesday, October 27th from 2-4 p.m. More information will be available soon at www.cms.hhs.gov/opendoor.

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