

Introduction to the HCPCS Coding Report

In 2002, the Centers for Medicare and Medicaid Services (CMS) contracted with Jing Xing Technologies, Inc. (JXT) to review, analyze and recommend improvements in the process used by CMS to maintain the alphanumeric (A-N) portion of the Health Care Common Procedure Coding System (HCPCS). This report served as a catalyst for revising the HCPCS coding process which was announced in October of 2004. The press release announcing this change can be found on the HCPCS website at the following url: www.cms.hhs.gov/medicare/hcpcs/hcpcsreform.pdf

HCPCS Coding Report

Conducted by:

Jing Xing Technologies

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1 Executive Summary of Jing Xing Stakeholder Survey

1.1 Background

The Center for Medicare and Medicaid Services (CMS) contracted with Jing Xing Technologies, Inc. (JXT) to review, analyze and recommend improvements in the process used by CMS to maintain the alphanumeric (A-N) portion of the Health Care Common Procedure Coding System (HCPCS).¹

Note: On the HCPCS web site at the following location www.cms.hhs.gov/medicare/hcpcs, the press release of October 6th 2004 can be found that announces the new HCPCS Coding process.

In 2002, JXT conducted a comprehensive series of interviews with individuals who were involved in the process of assigning and maintaining the alphanumeric HCPCS codes, as well as users of the codes and representatives of the providers and producers of the items and services described by the codes. These individuals included CMS central office staff, Medicaid and VA staff that are part of CMS' coding workgroup, CMS claims processing contractors, and industry representatives from the manufacturing sector and patient service delivery sectors. The perspectives of these interested parties were collected under the assumption of no individual or organizational attribution. A series of general questions were used as a framework for the interviews, but all participants were urged to share any and all observations and suggestions, regardless of whether they fit the framework provided.

1.1.1 Overview of HCPCS

The HCPCS (Healthcare Common Procedure Coding System) was developed 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 and other health insurance programs to ensure that insurance claims are processed in an orderly and consistent manner. The HCPCS is divided into three principal subsystems, referred to as level I, level II, and level III.

Level I of the HCPCS is comprised of the CPT-4, a numeric coding system maintained by the American Medical Association (AMA). The CPT-4 is a uniform coding system used primarily to identify medical services and procedures furnished by physicians and other health care professionals. The AMA makes decisions regarding the addition,

¹ Information in this report reflects the process as it existed at the time the survey was conducted in 2002, under contract with Jing Xing Technologies. On the HCPCS web site at the following location www.cms.hhs.gov/medicare/hcpcs, the press release of October 6th 2004 can be found that announces the new process.

deletion, or modification of CPT-4 codes. The Editorial Panel for these decisions includes a representative from CMS. CPT-4 codes are 5 digit all numeric codes.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes, for example, ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT-4 codes, the level II HCPCS codes were established for submitting claims for these items. The development and use of level II of the HCPCS began in the 1980's. Level II codes are alphanumeric codes that consist of a single alphabetical letter followed by 4 numeric digits.

HCPCS level II permanent codes are maintained jointly by the Health Insurance Association of America, the Blue Cross and Blue Shield Association, and CMS.

Level III of HCPCS is the subsystem of codes that was developed by Medicaid State agencies, Medicare contractors, and private insurers for use in their specific programs or local areas of jurisdiction. Level III codes are also referred to as local codes. Local codes are established when an insurer prefers that suppliers use a local code to identify a service, for which there is no level I or level II code, rather than use a "miscellaneous or not otherwise classified code." This allows insurers to electronically process claims for new types of services for which a level I or level II code has not been established. Local codes/level III codes were also established for items or services not having the frequency of use, geographic distribution, or general applicability needed to justify the establishment of a level I or level II code. Level II codes are also alphanumeric codes that consist of a single alphabetical letter followed by 4 numeric digits.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates uniform national coding systems for transactions involving health care information. Consequently, the HCPCS level III local codes must be converted to level II national codes. A substantial effort has been undertaken by Medicaid State Agencies to identify duplicate codes and to request permanent codes where necessary. While HIPAA mandated an October 2002 deadline to eliminate local codes, the Benefits Improvement & Protection Act of 2000 (BIPA) extended that deadline until January 1, 2004. There is considerable concern that the local code conversion effort will not be completed on time.

1.1.2 Detail of the HCPCS Level II Coding System and Process

At the following location on the HCPCS website, www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp titled "Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures" is a very comprehensive description of the HCPCS coding system and the associated coding modification process.²

² The information in the referenced website reflects the new title of the document with the revised coding procedures.

1.2 Overview of Interview Results

The following results of the interviews were from various personnel within and outside of CMS who were involved with the HCPCS coding process as well as users of the codes and representatives of the providers and producers of the items and services described by the codes.

The **interviewees expressed the following** primary concerns with the current coding process:

- The April to September coding workload is too time-compressed.
- When decisions must be deferred, it is often because information on the application form is not clear.
- Denied applicants want an appeal/reconsideration process.
- The HCPCS Coordinator needs more support.
- Claims processors and suppliers want individual codes rather than have to deal with the manual processing required when “miscellaneous” codes must be used.
- CMS staff needs to approach coding from more of a “national” coding system or HIPAA coding system mindset and less as a Medicare coding system.
- The process is not open, only payors make decisions.
- The process is slow.
- There is not enough feedback to applicants with respect to both where their applications are in the process and why applications are denied.
- There should be an appeals process for denied applications.
- Six months of marketing information before giving codes should be required.

1.3 Summary of Recommendations

JXT’s recommendations are organized by estimated time to implement and resources required as follows:

Near Term – Minimal Resource Investment

- Organize individual workgroup meeting agendas and overall application review agendas by subject areas in order to increase meeting time efficiency.
- Document decisions in detail in order to refine decision criteria and fully explain denials.
- Carefully analyze the cause of data errors that are reported by contractors to insure that future HCPCS tape information is as complete and accurate as possible.
- Give the SADMERC and VA application information as soon as it is received, so that they can maximize their review time for the workgroup.
- Permit applicants that have not quite met the six-month threshold for marketing information, to send in such information until the end of June.

Moderate Term – Moderate Resource Investment

- Institute an annual process improvement review. Once a year, devote the first workgroup meeting after the last National Panel³ meeting of a coding cycle to discussion of possible improvements in procedures, re-evaluation of decision criteria, application form revisions, improvements in applicant communication and information feedback, website enhancement, etc.
- Begin discussions within CMS regarding more formal review and input to the HCPCS workgroup from CMS Medical Officers
- Review the data request form. Consider tailoring versions of the form to different types of service. Consider versions for modifier requests, local code/temporary code conversion, and any other special circumstances.

Long term – Moderate Resource Investment

- Create a detailed tracking system for National Panel agenda items. Include receipt date, referral dates for sending “heads-up,” dates of meetings where the item was discussed and actions taken at meetings (deferral, preliminary recommendations, final actions, etc).
- Consider giving a preliminary decision to applicants for all items, as is now given for DME

Long term – Higher Resource Investment

- Move to semi-annual, and consider quarterly, issuance of permanent A-N HCPCS codes.
- Move to enhance the CMS HCPCS coding website to provide better status information to applicants by supplying information of interest from National Panel tracking system.

2 Current HCPCS Coding Process⁴

2.1 Organization and Staffing

Organizationally, the Alpha-Numeric HCPCS Coordinator position is located in the Division of Community Post Acute Care, in the Chronic Care Policy Group of the Center for Medicare Management. The Coordinator reports to the Deputy Director of the Chronic Care Policy Group.

³ Any reference to the “National Panel” in this document is part of the old HCPCS process. This panel no longer exists.

⁴ The research contracted with Jing Xing Technologies (2002) was conducted before the HCPCS coding process was refined. Please see the HCPCS coding website www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp for an updated HCPCS coding process titled “Healthcare Common Procedure System (HCPCS) Level II Coding Procedures”

The Coordinator, for many years, was the sole professional assigned full-time. Secretarial/administrative staff support was shared with other components.

2.2 Other Actors: Participants, Users and Interested Parties

In addition to the Coordinator's role, a number of other CMS central office staff members have a role in the coding process. A HCPCS Coding Workgroup is largely comprised of representative analysts from various CMS components that deal with the claims processing, payment policies and coverage policies of the items and services that are billed to the Medicare and Medicaid programs. Non-CMS members of the Workgroup include representatives from the SADMERC (Statistical Analysis Durable Medical Equipment Carrier), from the Veterans Administration and from the NASMD (National Association of State Medicaid Directors).

The other direct participants in the coding process are the three National HCPCS Coding Panel members. In addition to one CMS member, there is one member representing the national Blue Cross and Blue Shield Association (BC/BS) and one member representing the Health Insurance Association of America (HIAA).

2.3 Workflow and Workload

The HCPCS Coordinator's office is the focal point for A-N coding activities. Applications are initially received, reviewed for completeness and given an agenda item number. Monthly workgroup meetings are scheduled, space is arranged for meetings, meeting agendas and copies of application documents are prepared for and sent to each workgroup member. The monthly workgroup meetings are conducted and decisions are recorded. The Coordinator schedules, arranges and assists in conducting the public meetings, moderated by staff from the CMS Office of Professional Relations, as required for DME coding changes. In addition to the scheduled public meetings for DME, the Coordinator handles all the arrangements for a number of private meetings at CMS held with code applicants. The Coordinator follows up on pended items, prepares decision recommendation documents to send to the National HCPCS Coding Panel and again, performs all the administrative work associated with panel meetings. The Coordinator notifies the appropriate CMS staff of final decisions and prepares decision notification letters to code applicants.

At their monthly meetings, the HCPCS Coding workgroup reviews, in detail, each of the coding requests. They usually have at least two weeks to read the application documents, research any questions or issues they encounter, and, if necessary, consult with other members of their particular component. The associated members of the workgroup from the SADMERC, VA and the NASMD, review the application documents and gather input from their organizations, as they determine is necessary. For example, the SADMERC shares the requests with the HCPCS coordinators and Medical Directors at each DMERC. The SADMERC teleconferences with the DMERCs prior to the workgroup meeting and presents the consensus of the conferees at the workgroup meeting.

The National Panel members also review the application documents and gather input from their organizations, in a manner they choose, and as they determine is necessary.

Permanent alphanumeric HCPCS code modifications are implemented once each year, on January 1. Coding requests are received throughout the year, however the vast majority of requests are received during the last weeks of March. April 1 is the deadline date for making requests that can be processed in time to be included as permanent code modifications effective the following January 1.

For the coding cycle implemented January 1, 2003, there were 264 coding agenda items. Approximately 60 of the agenda items were requests for multiple coding changes. The agenda indicated as many as 37 separate requested changes in a single agenda item. JXT believes 500 total coding requests is a reasonable approximation of the workload for the January 2003 coding cycle. As noted, the vast majority of these requests were received in late March and thus, the bulk of the actual review process only began in April. By the end of August, the reviews were completed, meetings held and decisions were made, in CMS's estimation, for 99% of the requests. During the five months of intense decision-making, there were four National Panel meetings. The average decision-making pattern during this period works out to five weeks of workgroup review and recommendations and then a National Panel meeting to finalize decisions on those recommendations. DME public meetings were held two to three weeks before three of the Panel meetings. This allowed the workgroup to consider information gained there in its review and recommendation process for the next Panel meeting.

3 Analysis of Current Process and Views of Interested Parties

3.1 Problem: Only one permanent code update per year.

The current alphanumeric (A-N) HCPCS coding process to issue permanent A-N codes is essentially an annual process that begins in late March, takes from two to five months for decision-making, and takes four to seven months to implement those decisions. An item that is among the first received during the deadline rush could be reviewed by the workgroup in April, forwarded to the National Panel and approved in May. The last item may not be approved until August. Since all approved codes are implemented in January of the following year, the finalized approval for the first item (occurring in May) takes effect seven months later. The finalized approval for the last item (occurring in August) takes effect four months later. The time-compressed nature of this process appears to be the root cause of many of the concerns expressed to JXT in the interviews.

Some interviewees believe the single annual update causes their review work to be too rushed and causes stress on the HCPCS Coordinator's office. Associated workgroup members and participants would also like more review time. If a miscellaneous code is the only way to bill an item, claims processors would like to avoid manual processing and get permanent codes as soon as possible, as would suppliers and manufacturers. Manual

processing is more costly for claims processors and for suppliers if the claims processor must ask for more detailed information (i.e., more phone time, paper documentation, increased payment delays, etc.). Manufacturers feel their requests are hurried through the decision process and yet the overall process to get an approval for requests is long and slow.

Possible solution:

During the single coding cycle in 2002, there were four National Panel meetings. Application reviews and coding decisions were made between April and August. The average decision-making pattern during this period works out to five weeks of workgroup review and recommendations and then a National Panel meeting to finalize decisions on those recommendations. DME public meetings were held two to three weeks before three of the Panel meetings. This allowed the workgroup to consider information gained there in its review and recommendation process for the next Panel meeting. The four months between September 1 and December 31 were necessary for implementation of the coding changes by January 2003.

Alternatively, two eight-month cycles, one beginning October 1 and one beginning May 1, would permit two permanent code issuances per year (January and July). This scenario would twice allow four months for decision-making and four months for implementation. The average decision-making pattern during these periods works out to eight weeks of workgroup review and recommendations and then a National Panel meeting to finalize decisions on those recommendations. The DME public meetings could continue to be held two to three weeks before Panel meetings. The implementation time allowance would remain the same.

The total number of coding change requests should be the same in a given year. So the review workload also would be the same except for the added scrutiny that the longer review time would permit. The decision making workload per cycle could be cut in half, although it is certainly possible that some factor will cause one cycle typically to be somewhat more busy than the other (e.g., coding changes caused by legislation may usually be implemented in January.)

In fact, there may be an advantage to CMS, particularly in the first expanded cycle, to insure a lighter load of applications. For example, if CMS decided to test their capacity to run two cycles in the fall of 2003, CMS might limit the number of applications for the cycle to the first 150 individual code requests received (this would be somewhat less than one third of our estimated 500 annual code requests). This might ease the transition, and since there would be an incentive to be among the first in, applications would probably be submitted earlier than the typical last week rush.

There would be increased administrative costs in planning, particularly in setting up multiple DME public meetings. There would be increased costs on the implementation end from multiple HCPCS tape releases transmittals. But in this case, savings may be

offset from less re-work of tape errors that are not made because the implementation process has become more routine and familiar.

Manufacturers would welcome the shorter turnaround on their applications, especially the proverbial application that just missed the deadline and now will take a total of 21 months to get a code. Under a twice-yearly process, that application would be processed in 15 months.

3.2 Problem: Communication with applicants needs improvement.

Under the current HCPCS procedures, all applicants are notified of the outcome of their requests in October. They made their requests six or more months ago and the decision on their requests was essentially finalized one to four months ago. In the case of DME, CMS provides a preliminary finding on whether the final decision appears favorable or unfavorable. This information is shared because there is an opportunity for a public meeting on DME requests. Those who have a preliminary, favorable finding do not gain any benefit by making a public presentation. Those that have a preliminary, unfavorable finding may be able to provide additional information to the workgroup that would strengthen their request. Other than the DME preliminary finding, there is no information routinely shared with applicants.

Applicants express frustration that when they receive the final decision letter in October, the reasons for denials are not explained and that even for approved codes sometimes the crosswalk from the application requests to the approved codes is unclear and they are the last to know that they have been approved. JXT believes that the lack of detail in denial explanations leads, in significant part, to the industry calls for an appeal/reconsideration process.

A number of survey comments expressed the notion that most applicants do not know the details of the coding process or that they can request a meeting with CMS. However, substantial information on the process and the opportunity to meet is available on the CMS website (see Attachment 1).⁵ Although linked on the HCPCS coding page, the information is located in a Medicare payment area of the CMS website concerned with clinical laboratory services and DMEPOS.

Possible Solutions

CMS could use its HCPCS website to better advantage. Although there is a listing of current National Panel agenda items, the descriptions of the requests are not particularly detailed, especially when the agenda item covers more than one coding request. The agenda is a comprehensive list of pending items, but there is no way to tell if the item has

⁵ “Attachment 1” no longer exists. See the following url for an updated version of the new HCPCS coding process titled “Healthcare Common Procedure System (HCPCS) Level II Coding Procedures” www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp

been on an actual workgroup meeting agenda or on a National Panel meeting agenda. If CMS could enhance and expand the information on its website, it would make the timing of coding process more clear, and would let the individual requestor know where their application was in the process. The workgroup agendas could be posted to the website and the National Panel agenda items under review for that meeting could be listed. A similar posting could be made for the National Panel meetings. The National Panel agenda items descriptions could have more detail in order that any reader would be able to know the same details on all the code requests.

CMS could follow the same process used for DME of making a preliminary, favorable or unfavorable finding. This would create a more uniform coding process for all items and maximize applicant feedback. It would require additional resources to handle the inevitable meeting requests on preliminarily unfavorable decisions and it might make sense to offer a public presentation opportunity after the DME meetings. This could reduce any need for a formal appeal process.

CMS could give more detail in its denial letters and more precision to its approvals. If CMS believes a requested item should be coded under an existing code, then CMS could give the specific code to use. If a request presented evidence why the item should be considered unique, CMS could explain why the evidence was not acceptable (e.g., there was no independent, demonstrated clinical study that supported the evidence, research (with cite) found conflicting evidence, etc.) CMS could begin to keep a comprehensive list of detailed reasons for denials and approvals in order to better describe and maintain uniformity in its coding criteria and decisions. CMS could make an effort to detail in its meeting minutes the precise reasons for approval or denial in order to give more detail in denial letters. More documentation requirements again imply more administrative resource needs.

CMS could undertake a review of the current website coding application and background materials (forms, instructions and explanatory information) with an eye to de-emphasizing Medicare references, in order to reinforce the recognition of the increased CMS responsibilities for maintaining codes to serve all insurers. The detailed information on coding shown in Attachment 1⁶ should be separated from the Medicare payment information and relocated to the coding page. Alternatively, the information could be duplicated and co-located on the coding page.

The HCPCS coding request form could also be revised to eliminate as much of the completion instructions as possible from the form itself and move them to the introductory material preceding the form. Each element on the form could then be more fully explained to applicants and if problems or confusion about an element arise, the instructions can be modified without revising the form itself. Enhanced explanations, would lead to more complete and detailed original applications, easier decision-making and less need for reconsideration.

⁶ “Attachment 1” no longer exists. See the following url for an updated version of the new HCPCS coding process titled “Healthcare Common Procedure System (HCPCS) Level II Coding Procedures” www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp

3.3 Problem: Participation in the coding process may need expansion

Although HCPCS coding decisions have effects on all segments of the health care system, those decisions are in the hands of the healthcare insurers. Most of the interviewed industry representatives believe they should have a formal role in coding decisions. They point to the national coverage decision process as a more inclusive or participatory process. JXT believes direct participation by industry representatives would raise a number of concerns that would have to be addressed by CMS. Selecting appropriate representatives from multiple organizations, complying with Federal Advisory Committee requirements, re-structuring the process as well as the funding and staffing requirements of a more involved and formalized process are all problematic.

Possible Solutions

CMS could fully examine the feasibility of formally including industry representatives in the decision making process for HCPCS coding. If CMS finds it to be infeasible, it would be worthwhile to make the feasibility document public.

4 Recommendations

The overarching impression JXT has from this project is one of common concern and honest interest of all parties for improving the alphanumeric HCPCS coding process. The following recommendations have separated into sub-groupings based on their complexity and resource costs which, ultimately, JXT believes must drive the timing and feasibility of their implementation. Near term recommendations are those that could be implemented immediately. Moderate term recommendations are those that, in JXT's view would probably have to wait at least until after the current annual coding cycle.

Finally, with respect the strong industry call for a formal appeal or reconsideration process, it is the opinion of JXT that if the various recommended improvements made below are adopted by CMS, the need for such a process will be diminished. There will be a substantial correction of the conditions that give rise to these calls (confusion over reasons for denials, criteria for giving codes, lack of information on meeting or re-submission opportunities, etc.). Additional layers of formal review would seem more likely to slow and confound the existing process.

Near Term – Minimal Resource Investment

- Consider organizing individual workgroup meeting agendas by topic areas. Arrange old business and new business by subject area, rather than all old business first and then new business.
 - Relieves those who attend only for specific subject matter areas from waiting around for fragmented agenda items.

- Consider organizing the overall annual application review agendas by topic area and by general complexity of topic area. The workgroup or HCPCS coordinator should have a sense of which topic areas usually require less or more detailed research. Those areas that typically require less research should be scheduled for early workgroup meetings, allowing more time for the more complex reviews.
 - Would reinforce the efficiency of the previous recommendation.
 - Would give the SADMERC and Veterans Administration additional lead-time for their internal review processes.
- Consider more detailed minutes of workgroup meetings, public meetings and National Panel meetings. Take time at the meetings, after each agenda item, to recap the specific points that were important in making decisions. Become more willing to specify exactly which codes meeting members believe should be used if an application is denied.
 - Will permit better explanations of denials to applicants.
 - Will enhance the ability to refine and specify necessary decision criteria.
- Carefully monitor each reported data error that occurs with the issuance of the HCPCS tape. Determine the point in the data tape process that the error occurred and see if some modification of the process can eliminate similar future errors.
 - Should help eliminate HCPCS tape errors and omissions and tape/CWF conflicts.
- Provide the SADMERC and Veterans Administration workgroup members with “heads-up” copies of DMEPOS coding requests immediately upon receipt (even if the request does not get an agenda number, e.g., an application is pended because there some missing information). Do not wait until agenda packages are ready for the entire workgroup.
 - This will maximize the ability of CMS partners to complete a thorough review of items in their respective areas of subject matter competencies.
- In return for the “heads-up” courtesy, CMS should ask that the SADMEC and VA (and any other workgroup entity or member willing to pre-screen particular subject areas) provide feedback, as soon as possible, when their review appears particularly complex.
 - This will allow the HCPCS coordinator to put items that need longer review time on a subsequent agenda rather than the next agenda. This could avoid wasting discussion time on items that will ultimately be deferred in any case.
- Permit applicants to continue to send in marketing information (say until June 30) if needed to meet the six-month threshold and for future coding cycles consider whether a shorter period of data would suffice.
 - This will somewhat reduce one of the technical criticisms by industry and will have little impact on the review workload.

Moderate Term – Moderate Investment

- Institute an annual process improvement review. Once a year, devote the first workgroup meeting after the last National Panel meeting of a coding cycle to discussion of possible improvements in procedures, re-evaluation of decision criteria, application form revisions, improvements in applicant communication and

information feedback, website enhancement, etc. Schedule a two-day meeting if there is actual coding work to be done, but devote the first day strictly to process improvement. Again, the following month, schedule a two-day meeting if there is actual coding work to be done, but devote the first day strictly to finalizing the implementation of agreed upon process improvements.

- o For this year, consider a two-day process improvement meeting to consider the moderate and long term recommendations of this report.
- Begin discussions within CMS on more formal review and input to workgroup from CMS Medical Officers. Establish consistent input documentation (e.g., short memo requirements or review sign-off form).
 - o This will improve consistency and confidence of the workgroup's decision making.
- Review data request form. Consider tailoring versions of the form to different types of service. Consider versions for modifier requests, local code/temporary code conversion, and any other special circumstances. Remove specific Medicare references.

Long term – Moderate Resource Investment

- Create an agenda item tracking system. Include receipt date, referral dates for sending “heads-up,” dates of meetings where item was discussed and actions taken at meetings (deferral, preliminary recommendations, final actions, etc.). Look to CMS National Coverage Decisions web site for ideas.
 - o Will help inform applicants of the progress of their requests.
 - o If the website is enhanced, could be posted there

Long term – Higher Resource Investment

- Move to enhance the CMS HCPCS coding website. Look to CMS National Coverage Decisions web site for ideas.
 - o Could provide better status information to applicants.
 - o Could provide better calendar of meetings information.
- Consider giving a preliminary decision on items in addition to those given for DME.
 - o Will create a more uniform coding process for all items and maximize applicant feedback.
 - o Will require additional resources to handle meeting requests on denials or to conduct public presentation opportunity.
- Move to semi-annual issuance of permanent A-N HCPCS codes.

- Any disincentive felt by suppliers or claims processors with respect to increased systems modification is outweighed by their common dislike for the use of “miscellaneous” NOC (not otherwise classified codes).
- The more frequent issuance of permanent codes will reduce requests for and concomitant problems with temporary codes.
- More frequent issuance of permanent codes may actually permit more time for decision-making and more time to prepare for issuance.