Medicare Non-Covered Services HCPCS Codes

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This section contains five-character HCPCS Level II (national), interim codes, and three or four-character Health Insurance Portability and Accountability Act (HIPAA)-compliant revenue codes used for billing. This list is arranged in alphabetical order by service "description."

Although interim codes are not used to bill Medicare, they are included to assist providers in determining the "type of service" not covered by Medicare.

‹‹Billing Procedure for Medicare Non-Covered Services››

Codes	Description	When to Bill Medi-Cal Directly
G0156, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029	AIDS Waiver	Always
V5008, V5010, X4526, X4532, X4542	Audiology	Always
X4500 thru X4504, X4520, X4522, X4530, X4535, X4540, X4544	Audiology	If for hearing aid evaluation. Enter "hearing aid evaluation" in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form.
Z6200 thru Z6210, Z6300 thru Z6308, Z6400 thru Z6414, Z6500	Comprehensive Perinatal Services Program (CPSP)	Always
Z7500, Z7506, Z7508, Z7510, Z7512, Z7514, Z7610	Dental	Medicare denial not necessary. Explanation of Medicare benefits (EOMB) not necessary for ambulatory surgery centers for ICD-10-CM codes G50.0 thru G51.9 or K00.0 thru K08.99.
H0033	Directly Observed Therapy (DOT)	Always
A9273, A9274, A9279, A9281, E0240 thru E0248, E0273, E0625	DME	Always

Billing Procedure for Medicare Non-Covered Services (continued)

Codes	Description	When to Bill Medi-Cal Directly
‹‹E0970, E0979, E1091, K0740, K0872 thru K0876, K0881 thru K0883, K0887 thru K0889, K0892 thru K0898››	DME	On the UB-04, if the facility type code is other than 33 (Home Health – Outpatient) or 14, 24, 34, 44, 54, 64, 74, 75 or 89. On the CMS-1500, if the Place of Service code is other than 12 (Home) or 99 (Other).
E0970, E1012, E1085, E1086, E1089, E1090, E1250, E1260, E1285, E1290, K0065, K0898 **Note**: All codes falling within the listed ranges may not be Medi-Cal benefits. Refer to the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section for the covered code list.	DME	On the *CMS-1500*, if the Place of Service code is 31 (Nursing Facility Level B).
S9123, S9124, Z5814, Z5816, Z5820, Z5999	Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	If services are part of Medicare non-covered treatment.
J7999, J8499, S0257	End of Life Option Act (ELOA)	Medicare denial not required.
G9001, G9002, G9012, H0045, S5111, S5160, S5161, S9122, S9123, S9124, T1005, T1016, T1019, T2017, T2033, T2035, T2047	HCBS Waiver	Always

‹‹**Billing Procedure for Medicare Non-Covered Services (continued)**››

Codes	Description	When to Bill Medi-Cal Directly
V5014, V5021 thru V5080, V5120 thru V5159, V5171, V5172, V5181, V5190, V5211 thru V5215, V5221, V5230, V5264, V5265, V5267, V5298	Hearing Aids	Always
H0014	Heroin Detoxification (21-day only)	Always
0552, 0650, 0652, 0655, 0656/T2045, 0657, 0659	Hospice Care Services	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service.
0658	Hospice Room and Board	Always
A4335, A4554, A6250, T4521 thru T4537, T4540 thru T4544	Incontinence Medical Supplies	Always
A4232, A9274	Insulin Infusion Pump Supplies	Always
A0120, A0130, A0225, A0380, A0390, A0420, A0422, A0424, T2001, T2005 and T2007	Medical Transportation	Always

‹‹**Billing Procedure for Medicare Non-Covered Services (continued)**››

Codes	Description	When to Bill Medi-Cal Directly
A4206 thru A4209, A4212, A4213, A4215, A4223, A4244-A4248, A4461, A4657, A4927, A4930 thru A4932, A6010, A6021, A6022, A6154, A6196, A6197, A6199, A6203 thru A6224, A6228 thru A6248, A6251 thru A6259, A6261, A6262, A6266, A6402 thru A6404, A6407, A6410, A6411, A6442 thru A6447, A6453 thru A6455, A6457, T4537	Medical Supplies	If services are for Medicare non-covered treatment.
Z7506 thru Z7514	Operating/Recovery Room Services	If services are part of Medicare non-covered dental treatment.
E0439, E0440, E0443, E0444, E1391	Oxygen Delivery Systems and Supplies	On the CMS-1500, if the Place of Service code is 32 (Nursing Facility Level A) or 31 (Nursing Facility Level B). If the Place of Service code is 99 (Other), services are included in the per diem rate and are not separately reimbursable by Medicare or Medi-Cal.
X4300 thru X4312, X4320	Speech Therapy	Always
X9900 thru X9920	Subacute, Physician	Always
S0500, S0512, S0514, V2500, V2501, V2510, V2511, V2513, V2520, V2521, V2523	Vision Services – Contact lenses, per lens	If diagnosis is other than aphakia (ICD-10-CM codes H27.00 thru H27.03 or Q12.3), or pseudophakia (ICD-10-CM code Z96.1).

‹‹**Billing Procedure for Medicare Non-Covered Services (continued)**››

Codes	Description	When to Bill Medi-Cal Directly
S0516, V2020, V2025	Vision Services – Eyeglass frames	If diagnosis is other than aphakia (ICD-10-CM codes H27.00 thru H27.03 or Q12.3) or pseudophakia (ICD-10-CM code Z96.1).
V2599	Vision Services – Bandage contact lenses	If diagnosis is other than aphakia (ICD-10-CM codes H27.00 thru H27.03 or Q12.3) or pseudophakia (ICD-10-CM code Z96.1).
V2600, V2610, V2615	Vision Services – Low vision aids	Always
V2770	Vision Services – Occluder	Always

‹‹Legend››

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.