**Effective February 1, 2018**

## 2018 CPT-4/HCPCS CODE ADDITIONS

**Bolded Codes**
Bolded codes indicate notation of a special billing policy.

### Anesthesia
00731, 00732, 00811 – 00813

### Audiology
**L8625**

L8625
HCPCS code L8625 must be billed with modifiers LT or RT. Modifiers U7 and 99 are allowed. HCPCS code L8625 is non-taxable and has a frequency limit of one per year for same or any provider. A *Treatment Authorization Request* (TAR) may be submitted to override the frequency limit.

### Blood and Blood Derivatives
**P9073, P9100**

P9073
Use HCPCS code P9073 to bill for platelets, pheresis, pathogen-reduced, each unit. Modifiers SA, U7, 22, 24, 25 and 99 are allowed.

P9100
HCPCS code P9100 has a frequency limit of 12 per day. Modifiers SA and U7 are allowed.

### Chemotherapy
**C9024, C9028, J9022, J9023, J9203, J9285, Q2040**

C9024
Daunorubicin-cytarabine is indicated for the treatment of patients 18 years of age and older with newly diagnosed therapy-related acute myeloid leukemia (t-AML) or AML with myelodysplasia-related changes (AML-MRC). HCPCS code C9024 is only reimbursable when billed in conjunction with ICD-10-CM diagnosis codes C92.00, C92.02, C92.40, C92.42, C92.50, C92.52, C95.60, C92.62, C92.A0 and C92.A2. Modifiers SA, SB, UD, U7 or 99 are allowed.

C9028
Inotuzumab ozogamicin is indicated for the treatment of patients 18 years of age and older with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL). HCPCS code C9028 is only reimbursable when billed in conjunction with ICD-10-CM diagnosis codes C91.01, C91.00 and C91.02. Modifiers SA, SB, UD, U7 or 99 are allowed.

J9022
Atezolizumab is indicated for the treatment of patients 18 years of age and older with:

- Locally advanced or metastatic urothelial carcinoma who:
  - Have disease progression during or following platinum-containing chemotherapy
  - Have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy
- Metastatic non-small cell lung cancer who have disease progression during or following platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving Atezolizumab.

An approved TAR is required for reimbursement. Documentation must indicate that the patient has either locally advanced or metastatic urothelial carcinoma, or metastatic non-small cell lung cancer.

Modifiers SA, SB, UD, U7 or 99 are allowed.

J9023
Avelumab is indicated for the treatment of:

- Patients 12 years of age and older with metastatic Merkel cell carcinoma.
- Patients with locally advanced or metastatic urothelial carcinoma (UC) who:
  - Have disease progression during or following platinum containing chemotherapy
  - Have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy

An approved TAR is required for reimbursement. Modifiers SA, SB, UD, U7 or 99 are allowed.

One of the following ICD-10-CM diagnosis codes is required on the claim:

| | | |
|---|---|---|
| C4A.0 | C4A.50 – C4A.52 | C67.7 |
| C4A.10 – C4A.12 | C4A.59 | C67.9 |
| C4A.20 – C4A-22 | C4A.8 | C68.0 |
| C4A.30 – C4A.31 | C4A.9 | C7B.1 |
| C4A.4 | C66.1 | Z85.821 |
| C4A.60 – C4A.62 | C66.2 | |
| C4A.7 – C4A.72 | C66.9 | |

J9203
Gemtuzumab ozogamicin is indicated for the treatment of:

- newly-diagnosed CD33-positive acute myeloid leukemia (AML) in patients 18 years and older.
- relapsed or refractory CD33-positive AML in patients 2 years of age and older.

HCPCS code J9203 is only reimbursable when billed in conjunction with one of the following ICD-10-CM diagnosis codes: C92.00, C92.01, C92.A1, C92.A0 and C92.02. Modifiers SA, SB, UD, U7 or 99 are allowed.

J9285
Olaratumab is indicated for the treatment of patients 18 years of age and older with soft tissue sarcoma (STS). An approved TAR is required for reimbursement. The TAR must state that the patient has STS with a histologic subtype for which an anthracycline-containing regimen is appropriate and which is not amenable to curative treatment with radiotherapy or surgery. Modifiers SA, SB, UD, U7 or 99 are allowed.

Q2040
Tisagenlecleucel suspension is indicated for the treatment of patients 0 years to 25 years of age with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse. An approved TAR is required for reimbursement. The TAR must state that the patient has B-cell precursor ALL that is refractory or in second or later relapse. Providers must submit documentation that their program is accredited by the Foundation for the Accreditation of Cellular Therapy (FACT) for immune effector cell therapy. The provider and the facility must also submit documentation that their program has current Risk Evaluation and Mitigation Strategy (REMS) certification for the use of tisagenlecleucel. One of the following ICD-10-CM diagnosis codes are required on the claim: C91.00, C91.01, C91.02, C91.30, C91.31 and C95.01. Modifiers SA, SB, UD, U7 or 99 are allowed.

## DME

**E0953, E0954**

E0953
Wheelchair accessory, lateral thigh or knee support, any type, including fixing mounting hardware, each, must be billed with modifiers NU, NURB/RBNU or RR. Modifiers U7, J4 and 99 are allowed. HCPCS code E0953 is a non-taxable item and has a frequency limit of two every 12 months for any provider. A TAR may be submitted to override the frequency limit.

E0954
Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot, must be billed with modifiers NU, NURB/RBNU or RR. Modifiers U7, J4 and 99 are allowed. HCPCS code E0954 is a non-taxable item and has a frequency limit of two in five years for any provider. A TAR may be submitted to override the frequency limit.

## Evaluation and Management

**G0515**

G0515
Modifiers SA, U7, 24, 25 and 99 are allowed.

## Injections

**90756**

90756
CPT-4 code 90756 is reimbursable for Vaccines for Children and Presumptive Eligibility services.

Modifiers SA, SB, SK, SL, UD, U7 or 99 are allowed.

## Medicine

**93793, 94617, 94618, 96573**, **96574, J0604, J7345**

93793
Modifiers SA, SB, U7 or 99 are allowed.

94617 and 94618
Modifiers TC and 26 are required when billing separately for the technical and professional components. When billing for both the technical and professional component, no modifier is required. Modifier 99 must not be billed in conjunction with modifier 26 or TC. The claim will be denied.

Modifiers SA, SB, U7 or 99 are allowed.

96573, 96574
Modifiers SA, U7 or 99 are allowed.

J0604
Cinacalcet is indicated for the treatment of patients 18 years of age and older with secondary hyperparathyroidism (HPT) and chronic kidney disease (CKD), hypercalcemia with parathyroid carcinoma and severe hypercalcemia with primary hyperparathyroidism. An approved TAR is required for reimbursement with documentation of secondary HPT in patients with CKD on hemodialysis, hypercalcemia with parathyroid carcinoma and severe hypercalcemia with primary HPT. The following ICD-10-CM diagnosis codes are required on the claim: C75.0, E21.0 and N25.81, as well as any of the following ICD-10-CM diagnosis codes: E83.52, N18.1 – N18.6, N18.9 and D63.1. Modifiers SA, SB, UD, U7 or 99 are allowed.

J7345
Aminolevulinic acid 10% gel is indicated for the lesion-directed and field-directed treatment of actinic keratoses of mild-to-moderate severity on the face and scalp for patients 18 years of age and older. A TAR is required for reimbursement. ICD-10-CM diagnosis code L57.0 is required on the claim. Modifiers SA, SB, UD, U7 or 99 are allowed.

## Orthotics and Prosthetics

**L3761, L7700, Q0477**

L3761
Elbow orthosis with adjustable position locking joints, prefabricated, off-the-shelf must be billed with modifiers LT or RT. Modifiers U7 and 99 are allowed. This non-taxable item has a frequency limit of one every 12 months for any provider. A TAR may be submitted to override the frequency limit.

L7700
Gasket or seal, for use with prosthetic sock insert, any type, each, must be billed with modifiers LT or RT. Modifiers U7 and 99 are allowed. This non-taxable item has a frequency limit of one every 12 months for any provider. A TAR may be submitted to override the frequency limit.

Q0477
Power module patient cable for use with electric or electric/pneumatic ventricular assist device, replacement, is a non-taxable item with a frequency limit of one every year for any provider. A TAR may be submitted to override the frequency limit. Modifiers U7, 99, RB and NU are allowed.

## Pathology

**81105 – 81112**, **81120**, **81121**, **81175**, **81176**, **81238**, **81258**, **81259**, **81269**, **81283**, **81334**, **81361 – 81364**, **81448**, **81520**, **81521**, **86008**, **86794**, **87634**, **87662**

81105 – 81112
One of the following ICD-10-CM diagnosis codes is required on the claim: D69.51 and P61.0.

81120, 81121
CPT-4 codes 81120 and 81121 are limited to once in a lifetime for any provider. CPT-4 codes 81120 and 81121 are only reimbursable when billed in conjunction with one of the following ICD-10-CM diagnosis codes (except with valid *Treatment Authorization Request* [TAR]): C71.0 – C71.9.

81175, 81176
CPT-4 codes 81175 and 81176 are limited to once in a lifetime for any provider. CPT-4 codes 81175 and 81176 are only reimbursable when billed in conjunction with one of the following ICD-10-CM diagnosis codes (except with valid TAR): C93.10-C93.12, D46.0 – D46.C and D47.1.

81238
CPT-4 code 81238 is limited to once in a lifetime for any provider. CPT-4 code 81238 is only reimbursable when billed in conjunction with ICD-10-CM diagnosis code D67 (except with valid TAR).

81258, 81259, 81269, 81361 – 81364
CPT-4 codes 81258, 81259, 81269 and 81361 – 81364 are limited to once in a lifetime for any provider.

81283
CPT-4 code 81283 is limited to once in a lifetime for any provider and is only reimbursable when billed in conjunction with ICD-10-CM diagnosis code B18.2.

81334
CPT-4 code 81334 is limited to once in a lifetime for any provider. It is only reimbursable when billed in conjunction with one of the following ICD-10-CM diagnosis codes: C92.00 – C92.02 and C92.40 – C92.A2.

81448
CPT-4 code 81448 is limited to once in a lifetime for any provider. It is only reimbursable when billed in conjunction with one of the following ICD-10-CM diagnosis codes (except with valid TAR): G11.4 and G60.0.

81520
CPT-4 code 81520 is limited to once in a lifetime for any provider and requires a TAR with documentation of the following criteria:

- The recipient is estrogen and progesterone receptor (ER/PgR)-positive.
- The recipient is HER2-receptor negative.
- The recipient is lymph node negative.
- The recipient has stage I or stage II breast cancer.
- The recipient is a candidate for chemotherapy.
- The assay is used within six months of diagnosis.
- The recipient is under consideration for adjuvant systemic therapy.

81521
CPT-4 code 81521 is limited to once in a lifetime for any provider and requires a TAR with documentation of the following criteria:

- The recipient has high clinical risk per MINDACT categorization.
- The recipient is estrogen and progesterone receptor (ER/PgR)-positive.
- The recipient is HER2-receptor negative.
- The recipient is lymph node negative or lymph node positive.
- The recipient is a candidate for chemotherapy.
- The assay is used within six months of diagnosis.
- The recipient is under consideration for adjuvant systemic therapy.

86008

CPT-4 code 86008 is limited to 50 units annually for any provider (except with valid TAR override). When billing for CPT-4 code 86008, providers must include documentation in the recipient's medical record with one of the following criteria:

- The recipient has asthma or rhinitis, and the test is needed to determine the potential sensitivity to inhalant allergens, which may be clinically relevant.
- The recipient is undergoing testing to identify a specific cause of anaphylaxis, which includes at least one of the following:
  - Venom testing for insect sting reactions as a complementary test for skin testing (that is, for recipients with an anaphylactic reaction to a sting but a negative skin test)
  - Medication
  - Food
  - Latex
- The recipient is undergoing an evaluation for allergic bronchopulmonary aspergillosis (ABPA) or allergic fungal rhinosinusitis (AFRS).
- The recipient is undergoing an evaluation for food allergy.
- The recipient is undergoing an evaluation for atopic dermatitis or acute urticaria.
- The recipient is undergoing an environmental assessment for exposure to dust mites, cockroaches, molds, cats, dogs or rodents.
- As a complementary test for skin testing in any one of the following clinical scenarios:
  - A recipient is undergoing evaluation for stinging insect hypersensitivity.
  - When confirmation of skin test results are required.
  - When skin test extracts are not available.
- For a recipient who cannot undergo skin testing due to one of the following conditions:
  - Widespread skin disease (such as dermatographism, ichthyosis or generalized atopic dermatitis).
  - Recipient is receiving skin test suppressive therapy.
  - Uncooperative recipients.
  - When the history suggests an unusually greater risk of anaphylaxis from skin testing.

86794, 87634, 87662

CPT-4 codes 86794, 87634 and 87662 are reimbursable for Presumptive Eligibility services.

## Physician Administered Drugs (PAD)

**C9014, C9015, C9016, C9029, J0565, J0606, J1428, J1555, J1627, J1726, J1729, J2326, J2350, J3358, J7296**

C9014
Cerliponase alfa is indicated to slow the loss of ambulation in symptomatic patients 3 years of age and older with late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase-1 (TPP1) deficiency. An approved TAR is required for reimbursement. The TAR must state that the patient is at risk for preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. ICD-10-CM diagnosis code E75.4 is required on the claim. Modifiers SA, SB, UD, U7 or 99 are allowed.

C9015
C-1 esterase inhibitor (Haegarda) is indicated for routine prophylaxis to prevent hereditary angioedema (HAE) attacks in patients 12 years of age and older. Modifiers SA, SB, UD, U7 or 99 are allowed.

C9016
Triptorelin (Triptodur) is indicated for the treatment of patients 2 years and older with central precocious puberty. HCPCS code C9016 is only reimbursable when billed in conjunction with one of the following ICD-10-CM diagnosis codes: E22.8 and E30.1. Modifiers SA, SB, UD, U7 or 99 are allowed.

C9029
Guselkumab is indicated for the treatment of patients 18 years of age and older with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy. HCPCS code C9029 is only reimbursable when billed in conjunction with one of the following ICD-10-CM diagnosis codes: L40.0, L40.4, L40.8, L40.9, L41.3, L41.4, J92.9 and K05.00. Modifiers SA, SB, UD, U7 or 99 are allowed.

J0565
Bezlotoxumab is indicated to reduce recurrence of Clostridium difficile infection (CDI) in patients 18 years of age or older who are receiving antibacterial drug treatment of CDI and are at a high risk for CDI recurrence. HCPCS code J0565 is only reimbursable when billed in conjunction with ICD-10-CM diagnosis code A04.7. Modifiers SA, SB, UD, U7 or 99 are allowed.

J0606
Etelcalcetide is indicated for the treatment of secondary hyperparathyroidism (HPT) in patients 18 years of age and older with chronic kidney disease (CKD) on hemodialysis. An approved TAR is required for reimbursement. The TAR must document secondary HPT in patients with CKD on hemodialysis. ICD-10-CM diagnosis code N25.81 is required on the claim, as well as any of the following ICD-10-CM codes: N18.1 – N18.6, N18.9 and D63.1. Modifiers SA, SB, UD, U7 or 99 are allowed.

J1428
Eteplirsen is indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 18 years of age and older who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping. This indication is approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in some patients treated with Exondys 51. HCPCS code J1428 is only reimbursable when billed in conjunction with ICD-10-CM diagnosis code G71.0. Modifiers SA, SB, UD, U7 or 99 are allowed.

J1555
Immune globulin subcutaneous, 20% solution (Cuvitru) is indicated for the treatment of patients as replacement therapy for primary humoral immunodeficiency (PI) in patients 2 years of age and older. An approved TAR is required for reimbursement. Modifiers SA, SB, UD, U7 or 99 are allowed.

J1627
Granisetron extended release injection is indicated for the prevention of nausea and/or vomiting associated with the initial and repeat courses of emetogenic cancer therapy, postoperative, anesthesia. An approved TAR is required for reimbursement. The TAR must state that the treatment is for a patient with nausea and/or vomiting associated with cancer treatment. The following ICD-10-CM diagnosis codes are required on the claim: K91.0, R11.0, R11.2, Z51.11 and Z98.890. Modifiers SA, SB, UD, U7 or 99 are allowed.

J1726
HCPCS code J1726 is reimbursable for female recipients only.

Modifiers SA and UD are allowed.

J1729
HCPCS code J1729 is reimbursable for female recipients only.

Modifiers SA and UD are allowed.

J2326
Nusinersen is indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients. An approved TAR is required for reimbursement. The TAR must document that the patient has the diagnosis of spinal muscular atrophy confirmed by genetic testing. For patients under age 21, please refer to California Children's Service (CCS) Numbered Letter 06-0317 Service Authorization Requests (SAR) details. The following ICD-10-CM diagnosis codes are required on the claim: G12.0, G12.1, G12.20 – G12.25, G12.29, G12.8 and G12.9 Modifiers SA, SB, UD, U7 or 99 are allowed.

J2350
Ocrelizumab is indicated for the treatment of patients 18 years of age and older with relapsing or primary progressive forms of multiple sclerosis. HCPCS code J2350 is only reimbursable when billed in conjunction with ICD-10-CM diagnosis code G35. Modifiers SA, SB, UD, U7 or 99 are allowed.

J3358
Ustekinumab indicated for the treatment of patients 18 years of age and older with:

- Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.
- Active psoriatic arthritis, alone or in combination with methotrexate.
- Moderately to severely active Crohn's disease (CD) who have failed or were intolerant to to:
  - treatment with immunomodulators or corticosteroids, but never failed a tumor necrosis factor (TNF) blocker or
  - treatment with one or more TNF blockers

An approved TAR is required for reimbursement. The TAR must document that the patient has moderate to severe plaque psoriasis or active psoriatic arthritis. Modifiers SA, SB, UD, U7 or 99 are allowed.

J7296
HCPCS code J7296 is reimbursable for female recipients only.

Modifiers SA, SB, U7 or UD are allowed.

## Radiology

**71045 – 71048, 74018, 74019, 74021, C9738**

71045 – 71048, 74018, 74019, 74021
Modifiers TC and 26 are required when billing separately for the technical and professional components. When billing for both the technical and professional component, no modifier is required. Modifier 99 must not be billed in conjunction with modifier 26 or TC, otherwise the claim will be denied.

C9738
HCPCS code C9738 is only reimbursable when billed in conjunction with ICD-10-CM diagnosis code C67.9.

## Skin Substitutes

Q4176 – Q4182

## Surgery

15730, 15733, **19294**, **20939**, 31241, 31253, 31257, 31259, 31298, 32994, 34701 – 34708, **34709**, 34710, **34711**, 34712, **34713 – 34716**, 36465, 36466, 36482, **36483**, 38222, 38573, 43286 – 43288, **55874**, **58575**, 64912, **64913, C9748**

19294, 20939, 34709, 34711, 34713 – 34716, 36483, 64913
CPT-4 codes 19294, 20939, 34709, 34711, 34713 – 34716 and 64913 are exempt from the modifier 51 reimbursement cutback.

55874
CPT-4 code 55874 is restricted to male recipients only.

58575
CPT-4 code 58575 has a frequency limitation of once in a lifetime and is restricted to female recipients only. When billing for primary surgeons, the claim requires an approved TAR for reimbursement.

A hysterectomy informed consent form is required for claims submitted for hysterectomy services.

C9748
HCPCS code C9748 is reimbursable for male recipients only. A TAR is required when billing for assistant surgeon services. Modifiers AG, U7 and 99 are allowed.

HCPCS code C9748 is not reimbursable for Presumptive Eligibility services.

## 2018 CPT-4/HCPCS CHANGE CODES

**Bolded Codes**
Bolded codes indicate notation of special billing policy.

### Medicine

**96567**

96567
CPT-4 code 96567 may be billed with modifier SA.

### Pathology

**81257**, **81400**, **81401**, **81403**, **81405**, **81406**

81257
CPT-4 code 81257 is limited to once in a lifetime for any provider.

81400
A TAR for CPT-4 code 81400 will no longer be approved with documentation of the following criteria:

- Human Platelet Antigen genotyping:
  - The patient has clinical features suspicious for, or requires the service as a confirmatory test for neonatal alloimmune thrombocytopenia, or,
  - The patient has clinical features suspicious for, or requires services as a confirmatory test for post transfusion purpura
- IL28B
  - The patient has genotype 1 hepatitis C virus infection, and,
  - Treatment will be contingent on the test results.

81401
A TAR for CPT-4 code 81401 may now be billed with documentation of one of the following criteria:

- LINC00518 (long intergenic non-protein coding RNA 518):
  - The patient has diagnosis of melanoma, and
  - The treatment strategy will be contingent on test results
- PRAME (preferentially expressed antigen in melanoma):
  - The patient has diagnosis of melanoma, and
  - The treatment strategy will be contingent on the test results

81403
A TAR for CPT-4 code 81403 will no longer be approved with documentation of the following criteria:

- IDH1 – Patient with diagnosis of grade II, III or IV glioma
- IDH2 – Patient with diagnosis of grade II, III or IV glioma

81405
A TAR for CPT-4 code 81405 may now be billed with documentation of one of the following criteria:

- CPOX (coproporphyrinogen oxidase), full gene sequence:
  - The patient has elevated urinary and fecal coproporphyrin III, and
  - The patient requires the service as a confirmatory test for hereditary coproporphyria
- PKLR (pyruvate kinase, liver and RBC), full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for pyruvate kinase deficiency

81406
A TAR for CPT-4 code 81406 can now be billed with documentation of one of the following criteria:

- HMBS (hydroxymethylbilane synthase), full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for acute intermittent porphyria
- PPOX (protoporphyrinogen oxidase), full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for acute variegate porphyria

## Physician Administered Drugs (PAD)

**C9488**

C9488
ICD-10-CM diagnosis codes E87.1, E87.70 and E87.79 are no longer required on the claim form when billing. Patients must be 18 years of age or older to receive treatment.

## 2018 CPT-4/HCPCS DELETED CODES

### Anesthesia

**Deleted Code**
00740
00810
01180
01190
01682

### Evaluation and Management

**Deleted Code**
G9381
G9496

### Injections

**Deleted Code**
C9483
C9484
C9485
C9486
C9487
C8489
C9490
C9491
C9494
J1725
J9300
Q9984
Q9985
Q9986
Q9989

## Medicine

**Deleted Code**
93982
94620
97532
97762
99363
99364
G0502
G0503
G0504
G0505
G0507
G8696
G8697
G8698
G8879
G8947
G8971
G8972

## Pathology

**Deleted Code**
83499
84061
86185
86243
86378
86729
86822
87277
87470
87477
87515
88154
P9072
Q9987

## Radiology

**Deleted Code**
71010
71015
71020 – 71023
71030
71034
71035
74000
74010
74020
75658
75952 – 75954
77422
78190
A9599
G0202
G0204
G0206

## Surgery

**Deleted Code**
15732
29582
29583
31320
34800
34802 – 34806
34825
34826
34900
36120
36515
55450
64565
69820
69840
G0364