

## 2019 HCPCS CODE ADDITIONS

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Effective February 1, 2019

### 2019 HCPCS CODE ADDITIONS

#### **Bolded Codes**

Bolded codes indicate notation of a special billing policy.

#### **Audiology**

**V5171, V5172, V5181, V5211 – V5215, V5221**

V5171, V5172, V5181, V5211 – V5215, V5221

A *Treatment Authorization Request* (TAR) is required for reimbursement. Modifier NU or RR is required.

Modifiers EP, U7 and 99 are allowed.

#### **Chemotherapy**

**A9513, C9038, J0185, J1454, J2797, J9044, J9057, J9173, J9311, J9312, Q2042**

#### A9513

Lutetium Lu 177 dotatate is indicated for the treatment of patients 18 years of age and older with somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors in adults.

An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary to treat progressive, advanced/inoperable or metastatic somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumor(s).
- Somatostatin receptors are present on the tumor based on diagnostic imaging such as a Gallium Ga-68 dotatate PET/CT scan or by somatostatin receptor scintigraphy (octreotide scan).
- The physician's legible, complete, and signed treatment plan/order for Lutetium Lu 177 dotatate.

Modifiers SA, UD, U7 and 99 are allowed.

#### C9038

Mogamulizumab-kpkc is indicated for the treatment of patients 18 years of age and older with relapsed or refractory mycosis fungoides or Sézary syndrome who have received at least one prior systemic therapy. An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary to treat relapsed or refractory mycosis fungoides or Sézary syndrome in patients who have received at least one prior systemic therapy.
- The physician's legible, complete, and signed treatment plan/order for mogamulizumab-kpkc.

One code from one of the following ICD-10-CM diagnosis codes is required for reimbursement: C84.00 – C84.09, C84.10 – C84.19.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### J0185

Aprepitant is indicated for the treatment of patients 18 years of age and older. It is used in combination with dexamethasone and a 5-HT<sub>3</sub> receptor antagonist to prevent nausea and vomiting symptoms associated with initial and repeat courses of highly-emetic cancer chemotherapy (HEC) or moderately-emetic cancer chemotherapy (MEC). No TAR is generally required for reimbursement unless the claim exceeds the recommended maximum dose or frequency.

ICD-10-CM diagnosis code Z51.11 is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

### J1454

Fosnetupitant-Palonosetron 235 mg/0.25 mg is indicated for the treatment of patients 18 years of age and older. It is used in combination with dexamethasone to prevent acute and delayed nausea and vomiting associated with initial and repeat courses of highly-emetogenic cancer chemotherapy.

ICD-10-CM diagnosis code Z51.11 is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

### J2797

Rolapitant is indicated for the treatment of patients 18 years of age and older. It is used in combination with dexamethasone and a 5-HT<sub>3</sub> receptor antagonist to prevent nausea and vomiting symptoms associated with initial and repeat courses of highly-emetic cancer chemotherapy (HEC) or moderately-emetic cancer chemotherapy (MEC).

ICD-10-CM diagnosis code Z51.11 is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

### J9057

Copanlisib is indicated for the treatment of patients 18 years of age or older with relapsed follicular lymphoma who have received at least two prior systemic therapies. A TAR is required for reimbursement. The TAR must include clinical documentation of the following:

- The service is medically necessary;
- The patient has follicular lymphoma in relapse despite having received at least 2 systemic chemotherapy treatment regimens;
- The physician's legible, complete, and signed treatment plan/order for copanlisib.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### J9173

Durvalumab is indicated for the treatment of patients 18 years of age and older for the following conditions:

- Urothelial Carcinoma
  - Locally advanced or metastatic disease that has progressed during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.
- Non-Small Cell Lung Cancer (NSCLC)
  - Unresectable Stage III NSCLC disease that has not progressed following concurrent platinum-based chemotherapy and radiation therapy.

A TAR is required for reimbursement. The TAR should include clinical documentation that demonstrates the following:

- The service is medically necessary.
- Alternative treatments have been tried or considered, have failed, or are contraindicated.
- The physician's legible, complete, and signed treatment plan/order for durvalumab.

Modifiers SA, UD, U7 and 99 are allowed.

### J9311

Rituximab and hyaluronidase human is indicated for the treatment of patients 18 years of age and older to treat oncologic diseases including the following conditions:

- Non-Hodgkin's Lymphoma (NHL)
- Chronic Lymphocytic Leukemia (CLL)

Rituximab and hyaluronidase human is not indicated for the treatment of non-oncologic conditions. Rituximab and hyaluronidase human is initiated only after patients have received at least one full dose of rituximab by intravenous (IV) infusion.

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary.
- Alternative treatments have been tried or considered, have failed, or are contraindicated.
- The physician's legible, complete, and signed treatment plan/order for rituximab and hyaluronidase human.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### J9312

Rituximab is indicated for the treatment of patients 18 years or older. It is used to treat both oncologic and non-oncologic diseases including the following conditions:

- Non-Hodgkin's Lymphoma (NHL)
- Chronic Lymphocytic Leukemia (CLL)
- Rheumatoid Arthritis (RA)
- Granulomatosis with polyangiitis (GPA) (Wegener's Granulomatosis)
- Microscopic Polyangiitis (MPA)

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary.
- Alternative treatments have been tried or considered, have failed, or are contraindicated.
- The physician's legible, complete, and signed treatment plan/order for rituximab.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### Q2042

Tisagenlecleucel is used to treat oncologic disease including the following conditions:

- B-cell Acute Lymphocytic Leukemia (ALL) refractory to treatment or in second or later relapse in patients up to 25 years of age.
- Large B-cell Lymphoma, refractory or relapsed (r/r) after two or more lines of systemic therapy in adults including:
  - Diffuse Large B-cell Lymphoma (DLBCL), not otherwise specified.
  - High grade B-cell lymphoma and DLBCL arising from follicular lymphoma.

Tisagenlecleucel is not indicated for the treatment of patients with primary central nervous system lymphoma. The safety and efficacy of tisagenlecleucel in pediatric patients with relapsed or refractory DLBCL has not been established.

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates all of the following:

The service is medically necessary to treat: a pediatric or young adult patient with B-cell ALL, refractory or in second or later relapse, or to treat an adult with DLBCL, refractory or relapsed after two or more lines of systemic therapy.

- The service is medically necessary to treat:
  - A pediatric or young adult patient with B-cell ALL, refractory or in second or later relapse, or
  - An adult with DLBCL, refractory or relapsed after two or more lines of systemic therapy.
- The provider facility is certified by the Kymriah™ REMS (Risk Evaluation and Management Strategy) Program for tisagenlecleucel administration.
- The provider facility is accredited by the Foundation for the Accreditation of Cellular Therapy (FACT) for Immune Effector Cell Therapy (IECT).
- The physician's legible, complete, and signed treatment plan/order for tisagenlecleucel.

One code from one of the following ICD-10-CM diagnosis codes is required for reimbursement: C83.30 – C83.39, C91.00, C91.02.

Modifiers SA, UD, U7 and 99 are allowed.

**Injections**

**C9036, C9039, J0517, J0567, J0841, J1095, J1301, J1628, J1746, J3316, J3398, J3591, J7170, J9312, Q5109, Q5111**

C9036

Patisiran is indicated for the treatment of patients 18 years of age and older with symptomatic polyneuropathy caused by hereditary transthyretin-mediated amyloidosis (hATTR) in adults who have a documented TTR gene mutation.

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary to treat symptomatic polyneuropathy caused by hereditary transthyretin-mediated amyloidosis (hATTR).
- The patient has a documented TTR gene mutation.
- The physician's legible, complete, and signed treatment plan/order for patisiran.

ICD-10-CM diagnosis code E85.1 is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

C9039

Plazomicin is indicated for the treatment of patients 18 years of age and older.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### J0517

Benralizumab is indicated for the treatment of patients 12 years of age and older for the add-on maintenance treatment of severe asthma with an eosinophilic phenotype. Benralizumab is not indicated for the treatment of other eosinophilic conditions or for the relief of acute bronchospasm or status asthmaticus. Benralizumab is not indicated for use in combination with any of the following: mepolizumab, omalizumab, or reslizumab.

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the service is medically necessary to treat severe asthma with an eosinophilic type as add-on maintenance therapy:

- Severe asthma as defined by symptoms that are persistent and uncontrolled despite the use of high dose inhaled corticosteroids combined with a long-acting beta<sub>2</sub> agonist, leukotriene receptor agonist, or theophylline for  $\geq$  the previous one year or the use of systemic glucocorticoids for  $\geq$  50% of the previous year.
- Persistent uncontrolled asthma as defined by at least one of the following:
  - An ACQ score consistently  $>1.5$  (Asthma Control Questionnaire) or an ACT score  $<20$  (Asthma Control Test).
  - Two or more exacerbations in the previous year, each requiring 3 or more days of treatment with systemic glucocorticoids.
  - A history of hospitalization, intensive care unit stay, or mechanical ventilation in the previous year.
  - A FEV<sub>1</sub> (Forced Expiratory Volume in 1 second) at less than 80% of predicted after bronchodilator administration measured by pulmonary function testing or spirometry and documented by report and interpretation.
- Eosinophilia as defined by a blood eosinophil count of  $\geq 300$  cells/microliter at initiation of therapy and documented by laboratory report (in the absence of other causes of eosinophilia such as a documented or suspected parasitic infection, neoplastic disease, or hypereosinophilic syndromes, etc.).
- The physician's legible, complete, and signed treatment plan/order for benralizumab.

ICD-10-CM diagnosis code J82 is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

### **J0567**

Cerliponase alfa is indicated for patients 3 years of age and older. It slows the loss of ambulation in symptomatic pediatric and adolescent patients with late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency. Neuronal ceroid lipofuscinosis (NCL) includes a group of lysosomal storage disorders that affect the nervous system. CLN2 is an inherited autosomal recessive disorder, caused by changes in the TPP1 gene. Symptoms of CLN2 generally develop between 2 and 4 years of life, but can present at an older age. Symptoms are progressive and may include intractable seizures, ataxia, myoclonus, vision loss, and developmental delays in speech, cognition, motor function, etc.

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary to treat symptomatic late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TTP1) deficiency.
- For the initial TAR the following supporting documentation must be submitted:
  - Subjective findings (complaints)
  - Objective findings (exams, lab results)
    - ❖ Enzyme levels or other laboratory testing
    - ❖ DNA mutation analysis
    - ❖ Medical history
    - ❖ Physical examination
  - Complications (for example, bony changes or kidney failure)
  - Quality of life issues (for example, severe, unremitting pain or extreme fatigue)
  - Identified licensed practitioner who will administer infusion therapy, coordinate care, and their
    - ❖ Plan: Include the treatment plan including the genetic evaluation and counseling information for the patient and family members.
    - ❖ Goal: Include specific information about the desired outcome; for example, to slow the progression of the disease, to allow regular attendance at work or school or to significantly improve the quality of life.
- The physician's legible, complete, and signed treatment plan/order for cerliponase alfa.

Initial TAR approval may be for up to six months and renewal TARs may be approved for up to one year. Renewal TARs must include follow-up information such as any significant changes in physical findings, laboratory parameters, symptoms and/or quality of life.

ICD-10-CM diagnosis code E75.4 is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.



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### J0841

Crotalidae immune F(ab')<sub>2</sub> (equine) is indicated for the management of adult and pediatric patients with North American rattlesnake envenomation.

One code from the following ICD-10-CM diagnosis code groups is required for reimbursement:  
T63.011A – T63.014S.

Modifiers SA, UD, U7 and 99 are allowed.

### J1095

Dexamethasone 9% Intraocular is used to manage post-operative inflammation of the eye in patients 18 years of age and older. Modifier LT or RT is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

### J1301

Edaravone is reimbursable for the treatment of patients 18 years of age and older with amyotrophic lateral sclerosis (ALS). The mechanism of therapeutic action is unknown; however, edaravone is a free-radical scavenger that may reduce oxidative stress of motor neurons, which has been implicated in the pathogenesis of ALS. In randomized controlled trials, edaravone has been found to slow functional deterioration in some ALS patients.

An approved TAR is required for reimbursement. The TAR should include clinical documentation that demonstrates the following:

- The service is medically necessary.
- The patient has been diagnosed with definite or probable ALS based on the El Escorial/Airlie House revised criteria or Awaji criteria.
- The physician's legible, complete, and signed treatment plan/order for edaravone.

For continued authorization, the TAR should include clinical documentation that edaravone use has slowed the progression of ALS, and the patient's overall function has improved or is superior relative to that projected for the natural course of ALS.

ICD-10-CM diagnosis code G12.21 is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

### J1628

Guselkumab injection is indicated for the treatment of patients 18 years of age and older with moderate-to-severe chronic plaque psoriasis (i.e. extensive and/or disabling disease) who are candidates for systemic therapy or phototherapy and when other systemic therapies are medically less appropriate.

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary.
- Alternative, conventional therapy has been tried or considered, has failed, or is contra-indicated.
- The physician's legible, complete, and signed treatment plan/order for guselkumab.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### J1746

Ibalizumab-uiyk, in combination with other antiretroviral agents, is used to treat human immunodeficiency virus type 1 (HIV-1) infection in heavily treatment-experienced patients 18 years of age and older, with multi-drug resistant HIV-1 infection failing their current antiretroviral regimen.

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates all of the following:

- The service is medically necessary for the treatment of multi-drug resistant HIV-1 infection in combination with other antiretroviral agent(s).
- The patient has a viral load  $\geq 1,000$  copies/mL.
- The patient has a history of receiving at least 6 months of antiretroviral treatment.
- The patient is receiving a failing antiretroviral treatment or has received a recently failed antiretroviral and is off therapy.
- Documentation of HIV-1 disease resistance to at least one antiretroviral medication from each of the following three classes of antiretroviral medications as measured by resistance testing:
  - 1) Nucleoside reverse transcriptase inhibitors, and
  - 2) Non-nucleoside reverse transcriptase inhibitors, and
  - 3) Protease inhibitors.
- The physician's legible, complete, and signed treatment plan/order for ibalizumab-uiyk.

ICD-10-CM diagnosis code B20 is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

### J3316

Triptorelin extended-release (XR) is indicated for the treatment of pediatric patients 2 to 12 years of age, with central precocious puberty. An approved TAR is required for reimbursement. The TAR should include clinical documentation that demonstrates all of the following:

- A diagnosis of central precocious puberty (idiopathic or neurogenic) as defined by the onset of secondary sexual characteristics before the age of 8 years in girls and age 9 years in boys.
- The clinical diagnosis is confirmed by a pubertal basal level of luteinizing hormone (LH) based on the laboratory reference ranges, a pubertal response to a GnRH stimulation test, and the child's bone age is advanced one year or more beyond the child's chronologic age.
- Alternate etiologies of precocious puberty have been considered, evaluated, and ruled-out by baseline evaluation and testing such as height, weight, and height velocity; a brain MRI; gonadal and adrenal ultrasound imaging; serum levels of estrogen or testosterone; and adrenal steroids and beta human chorionic gonadotropin levels.

ICD-10-CM diagnosis code E22.8 is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### J3398

Voretigene-neparvovec-ryzl is indicated for the treatment of patients 1 to 64 years of age with confirmed biallelic RPE65 mutation-associated retinal dystrophy. Patients must have viable retinal cells as determined by the treating physician(s).

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates all of the following:

- The service is medically necessary to treat retinal dystrophy due to confirmed RPE65 mutation(s) in both alleles by molecular pathology report;
- The patient has viable retinal cells in the eye indicated for treatment as determined by:
  1. An area of retina within the posterior pole of greater than 100 µm thickness measured by OCT (optical coherence tomography); or
  2. ≥3 disc areas of retina without atrophy or pigmentary degeneration within the posterior pole (a “disc area” is equivalent to the area of the optic disc); or
  3. A remaining visual field within 30 degrees of fixation as measured by a III43 isopter or equivalent.
- The physician’s legible, complete, and signed treatment plan/order for voretigene neparvovec-ryzl.

One of the following ICD-10-CM diagnosis codes is required for reimbursement: H35.50, H35.52 or H35.54.

Modifiers LT or RT are required. Modifiers SA, UD, U7 and 99 are allowed.

### J3591

Modifiers SA, UD, U7 and 99 are allowed.

### J7170

Emicizumab-kxwh is indicated for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients of all ages with hemophilia A (congenital factor VIII deficiency) with factor VIII inhibitors.

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary.
- The patient has a documented diagnosis of congenital factor VIII deficiency (hemophilia A).
- The patient has developed high-titer factor VIII inhibitors (≥5 Bethesda units (Bu)).
- The physician’s legible, complete, and signed treatment plan/order for emicizumab-kxwh as a routine prophylaxis to prevent bleeding episodes associated with hemophilia A with factor inhibitors.

One of the following ICD-10-CM diagnosis codes is required for reimbursement: D66 or D68.311.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### J9312

Rituximab is indicated for the treatment of patients 18 years of age and older. It used to treat both oncologic and non-oncologic diseases including the following conditions:

- Non-Hodgkin's Lymphoma (NHL)
- Chronic Lymphocytic Leukemia (CLL)
- Rheumatoid Arthritis (RA)
- Granulomatosis with polyangiitis (GPA) (Wegener's Granulomatosis)
- Microscopic Polyangiitis (MPA)

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary.
- Alternative treatments have been tried or considered, have failed, or are contraindicated.
- The physician's legible, complete, and signed treatment plan/order for rituximab.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### Q5109

Infliximab-qbtx injection is indicated for use in patients 18 years of age and older to treat the following conditions:

- 1) Crohn's Disease
  - Moderate-to-severely active disease refractory to conventional therapy.
  - Enterocutaneous or rectovaginal fistulizing active disease.
- 2) Ulcerative Colitis
  - Moderate-to-severely active disease refractory to conventional therapy.
- 3) Rheumatoid Arthritis
  - Moderate-to-severely active disease, when used in combination with methotrexate, refractory to methotrexate alone and/or to other conventional therapy.
- 4) Ankylosing Spondylitis
  - Active disease refractory to conventional therapy.
- 5) Psoriatic Arthritis
  - Active disease refractory to conventional therapy.
- 6) Plaque Psoriasis
  - Chronic severe (i.e. extensive and/or disabling) disease in adults who are candidates for systemic therapy and when other systemic therapies are medically less appropriate.

Infliximab-qbtx injection is indicated for use in children 6 years of age and older to treat the following condition:

- 7) Pediatric Crohn's Disease
  - Moderate-to-severely active disease that is refractory to conventional therapy.

An approved TAR is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- The service is medically necessary.
- Alternative, conventional therapy has been tried or considered, has failed, or is contraindicated.
- The physician's legible, complete, and signed treatment plan/order for infliximab.

Modifiers SA, UD, U7 and 99 are allowed.

### Q5111

Pegfilgrastim-cbqv is indicated in patients of all ages to reduce the incidence of neutropenia-related infection in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.

One of the following ICD-10-CM diagnosis codes is required on the claim: D70.1 or Z51.11

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS CODE ADDITIONS

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### Medicine

#### J2062

##### J2062

Treatment with HCPCS code J2062 is restricted to patients 18 years of age and older. Modifiers SA, UD, U7 and 99 are allowed.

### Radiology

#### A9589

##### A9589

Modifiers SA, UD, U7 and 99 are allowed.

### Skin Substitutes

#### Q4183 – Q4198, Q4200 – Q4204

##### Q4183 – Q4198, Q4200 – Q4204

Modifiers U7 and 99 are allowed.

### Surgery

#### C1823, C9751 – C9755, L8608

##### C1823

Providers must submit a copy of the invoice for reimbursement. Modifiers U7 and 99 are allowed.

##### C9751 – C9755

Assistant surgeon services are not reimbursable. Modifiers U7 and 99 are allowed.

##### L8608

HCPCS code L8608 is limited to two in a lifetime, one per eye, for any provider. A TAR may be used to override the frequency limit.

One of the following modifiers is required for reimbursement: LT (Left side) or RT (Right side).

Modifiers U7 and 99 are allowed.

### Telemedicine

#### G0071, G2010, G2012

##### G0071, G2010, G2012

HCPCS codes G0071, G2010 and G2012 are reimbursable when performed according to telemedicine guidelines and when billed with modifiers GT or 95.

Modifiers U7 and 99 are allowed.

**2019 HCPCS CHANGE CODES**

**Bolded Codes**

Bolded codes indicate notation of special billing policy.

**Injections**

**Q5101**

Q5101

Filgrastim-sndz is used to enhance neutrophil production for the following indications in patients of all ages:

- Non-myeloid malignancies in patients receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.
- Acute myeloid leukemia (AML) in patients receiving induction or consolidation chemotherapy.
- Non-myeloid malignancies in patients receiving myeloablative chemotherapy prior to a bone marrow transplant.
- Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis in patients receiving cell therapy.
- Severe chronic neutropenia in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

One of the following ICD-10-CM diagnosis codes is required for reimbursement: D70.0, D70.1, D70.4, D70.8, D70.9 or Z51.11.

Modifiers SA, UD, U7 and 99 are allowed.

## 2019 HCPCS DELETED CODES

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### 2019 HCPCS DELETED CODES

#### Audiology

##### Deleted Code

V5170  
V5180  
V5210  
V5220

#### Chemotherapy

##### Deleted Code

C9024  
C9028  
C9030  
C9031  
C9033  
C9463  
C9464  
C9492  
J9310  
Q2040

#### Injections

##### Deleted Code

C9014 – C9016  
C9029  
C9032  
C9034  
C9465 – C9469  
C9493  
J0833  
Q5102  
Q9993  
Q9995

#### Medicine

##### Deleted Code

C9275  
C9497  
C9741  
G9686



## 2019 HCPCS DELETED CODES

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### Podiatrist

#### Deleted Code

K0903  
Q4131  
Q4172

### Radiology

#### Deleted Code

C8904  
C8907  
C9744  
G9534 – G9536  
G9538

### Surgery

#### Deleted Code

C9748  
C9750