

Quarter 4 HCPCS Update

Effective October 1, 2020

Quarter 4 HCPCS Code Additions

Chemotherapy

The following chemotherapy codes have special billing policy:

C9062, C9064 thru C9066, J9227, J9304

C9062

HCPCS code C9062 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to weekly intervals of 1,800 mg/ 180 units.

Modifiers SA, UD, U7 and 99 are allowed.

C9064

HCPCS code C9064 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to weekly intervals of 60 mg/ 60 units for six weeks. For those with a complete response three months after initiation, a monthly dose may be administered for a maximum of 11 additional doses.

Modifiers SA, UD, U7 and 99 are allowed.

C9065

HCPCS code C9065 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to 14 mg/ m² on days 1, 8 and 15 of a 28-day cycle. Repeat cycles every 28 days.

Modifiers SA, UD, U7 and 99 are allowed.

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

- Must be used for FDA-approved indications and dosing regimens
- Patient must be 18 years of age or older
- Patient must have one of the following diagnoses:
 - Cutaneous T-cell lymphoma (CTCL)
 - Peripheral T-cell lymphoma (PTCL)
- Patient must have received at least one prior therapy with relapse or disease progression.

Quarter 4 HCPCS Code Additions

Initial authorization is for 6 months

Continued therapy:

- Patient continues to meet initial approval criteria
- Positive clinical response as evidenced by disease stabilization or lack of disease progression.

Reauthorization is for 12 months.

C9066

HCPCS code C9066 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to 10 mg/kg once weekly on days 1 and 8 of 21-day treatment cycles.

Modifiers SA, UD, U7 and 99 are allowed.

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

- Must be used for FDA-approved indications and dosing regimens
- Patient must be 18 years of age or older
- Patient must have a diagnosis of metastatic triple-negative breast cancer (mTNBC)
- Patient has received at least two prior therapies for metastatic disease.

Initial approval is for 12 months

Continued therapy:

- Patient continues to meet initial approval criteria
- Patient has shown positive clinical response as evidenced by disease stabilization or reduction of tumor size and spread.

Reauthorization is for 12 months.

J9227

HCPCS code J9227 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to 10 mg/kg every week for 4 weeks followed by every 2 weeks.

Modifiers SA, UD, U7 and 99 are allowed.

J9304

HCPCS code J9304 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to 500 mg/m² on day 1 of each 21-day cycle.

Modifiers SA, UD, U7 and 99 are allowed.

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

- Must be used for FDA labelled indications and dosing regimens
- Patient must be 18 years of age or older
- Patient has a diagnosis of malignant pleural mesothelioma; and
 - Used in combination with a cisplatin- or carboplatin-based regimen; or
 - Used as a single agent therapy; or
 - Used in combination with bevacizumab and either cisplatin or carboplatin followed by single-agent bevacizumab maintenance therapy

and

- Patient has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2; and
- Patient's disease presentation is unresectable; or
- Patient has a diagnosis of locally advanced or metastatic non-squamous, non-small cell lung cancer (NSCLC); and
 - Patient is using as a single agent after prior chemotherapy; or
 - Patient is using as a first-line therapy in combination with platinum-based chemotherapy with or without bevacizumab (or bevacizumab biosimilar); or
 - Patient is using as a single agent for maintenance therapy when disease has not progressed after four cycles of platinum-based, first-line therapy; or
 - Patient is using in combination with pembrolizumab and platinum chemotherapy for initial treatment in those confirmed with no EGFR or ALK genomic tumor aberrations; or
 - Patient is using as continuous maintenance therapy until disease progression, if given first-line as part of pembrolizumab/platinum chemotherapy/and pemetrexed regimen.
 - Pempfexy is not approvable for the treatment of patients with squamous cell non-small cell lung cancer.

Initial approval is for 6 months.

Continuation of therapy:

- Patient continues to meet initial coverage criteria
- Patient shows positive clinical response as evidenced by disease stabilization or lack of disease progression

Reauthorization is for 12 months.

Home and Community Based Services

The following code has special billing policy:

T2047

T2047

HCPCS code T2047 is reimbursable for Presumptive Eligibility for Pregnant Women services and is a Medicare non-covered service.

Modifiers SA, SB, U7 and 99 are allowed.

Injections

The following injection codes have special billing policy:

J1632, J1738, J3032, J7351

J1632

HCPCS code J1632 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to one time per pregnancy.

Modifiers SA, UD, U7 and 99 are allowed.

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

- For FDA-approved indications and treatment regimens
- Must be 18 years of age or older
- Must be ≤ 6 months postpartum
- Onset of symptoms was in the third trimester or within 4 weeks of delivery
- Must be diagnosed with moderate to severe postpartum depression confirmed by Hamilton Rating Scale for Depression (HAM-D) ≥ 20, or other comparable standardized rating scale
- An adequate trial of at least two anti-depressants from two separate drug classes at an adequate dose and treatment duration was shown to be ineffective or produced untoward effects when used by the patient; or
- Must document why other alternatives are not adequate, effective or have been deemed to be clinically contraindicated for the individual patient.
 - Alternatives indicated for PPD include selective serotonin reuptake inhibitor (SSRI), serotonin-norepinephrine reuptake inhibitor (SNRI), tricyclic antidepressant (TCA), bupropion, or mirtazapine
- Must not have active psychosis

REMS Program

Zulresso is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Zulresso REMS because excessive sedation or sudden loss of consciousness can result in serious harm.

Requirements of the Zulresso REMS include the following:

- Healthcare facilities must enroll in the program and ensure that Zulresso is only administered to patients who are enrolled in the Zulresso REMS.
- Pharmacies must be certified with the program and must only dispense Zulresso to healthcare facilities who are certified in the Zulresso REMS.
- Patients must be enrolled in the Zulresso REMS prior to administration of Zulresso.
- Wholesalers and distributors must be registered with the program and must only distribute to certified healthcare facilities and pharmacies.

Further information, including a list of certified healthcare facilities, is available at the [Zulresso REMS website](#) or 1-844-472-4379.

J1738

HCPCS code J1738 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to daily intervals of 30 mg/ 30 units.

Modifiers SA, UD, U7 and 99 are allowed.

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

- Must be prescribed for FDA-approved indications and dosages
- Patient must be 18years of age or older
- Must be used for the management of moderate-to-severe pain, alone or in combination with non-NSAID analgesics
- Must not be intended for long-term use
- Must not be used in the setting of coronary artery bypass graft (CABG) surgery

J3032

HCPCS code J3032 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to 300 mg/ 300 units every three months.

Modifiers SA, UD, U7 and 99 are allowed.

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

- Must be prescribed for FDA-approved indications and dosing regimens
- Patient must be 18 years of age or older
- Patient must have a diagnosis of one of the following:
 - Episodic migraine defined as 4 to 14 headache days per month, at least four of which were migraine days during the previous three-month period; or
 - Chronic migraine defined as 15 to 26 headache days per month, at least eight of which were migraine days for over three months
- Patient must have tried and failed or is intolerant to or has contraindication to at least one drug from two oral classes used for migraine prophylaxis, including antiepileptic medications, beta-blockers, calcium channel blockers or antidepressants
- Must not be taken in combination with any other monoclonal antibody targeting the CGRP pathway, such as Ajovy (fremanezumab), Emgality (galcanezumab), Aimovig (erenumab), Nurtec ODT (rimegepant) and Ubrovelvy (ubrogepant).

Initial authorization is for six months.

Continued therapy:

- Patient continues to meet initial approval criteria
- Patient has experienced a positive clinical response to therapy as demonstrated by a reduction in headache frequency and/or severity

Reauthorization is for twelve months

J7351

HCPCS code J7351 is indicated for the treatment of patients 18 years of age and older and billing frequency is limited to one implant (10 mcg)/10 units per eye, per lifetime.

Modifier RT or LT is required on the claim. Modifiers UD and 99 are allowed.

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

- Must be used for FDA-labelled indications and dosages
- Patient must be 18 years of age or older
- Patient must have a diagnosis of Open Angle Glaucoma or Ocular Hypertension
- Must be prescribed by or in consultation with an ophthalmologist
- The affected eye has not received prior treatment with Durysta
- Patient has had a trial of at least one prostaglandin analog (as monotherapy or combination therapy) with insufficient response, intolerance or adverse effects (for example, bimatoprost, latanoprost, travoprost, or tafluprost).
- Patient has had a trial of least two ophthalmic products with different mechanisms of action, such as a prostaglandin analog, beta blocker (e.g. Timolol, Betaxolol, levobunolon), alpha agonist (e.g. Brimonidine, Apraclonidine), carbonic anhydrase inhibitor (e.g. Dorzolamide, Brinzolamide), etc., and had insufficient response, intolerance or adverse effects.
- Patient does not have any of the following contraindications:
 - Ocular or periocular infections
 - Corneal endothelial cell dystrophy
 - Prior corneal transplantation
 - Absent or ruptured posterior lens capsule

Approval duration: one implant, per eye, per lifetime.

Continued therapy: Reauthorization is not allowed.

Medicine

The following medicine codes have special billing policy:

G1020 thru G1023, Q9001 thru Q9003

G1020 thru G1023

HCPCS codes G1020 thru G1023 are reimbursable for Presumptive Eligibility for Pregnant Women services.

Modifiers SA, SB, U7 and 99 are allowed.

Q9001 thru Q9003

HCPCS codes Q9001 thru Q9003 are reimbursable for Presumptive Eligibility for Pregnant Women services.

Modifiers SA, SB, U7 and 99 are allowed.

Radiology

The following radiology codes have special billing policy:

C9060, C9067

C9060

HCPCS code C9060 is a radioactive diagnostic agent indicated for use with positron emission tomography (PET) imaging for the detection of ER-positive lesions as an adjunct to biopsy in patients 18 years of age and older with recurrent or metastatic breast cancer. Prescribing restrictions are limited to 6 mCi/6 units.

Code C9060 is separately billable and is not split-billable. Providers must complete a *CMS-1500* form, including the medically justified ICD-10-CM diagnosis code(s). Providers must include an invoice showing the acquisition cost of the product for the claim. The invoice must have a date prior to the date of service or the claim will be denied.

Modifiers SA, UD, U7 and 99 are allowed.

Recommended dose is 222 MBq (6 mCi), with a range of 111 MBq to 222 MBq (3 mCi to 6 mCi), administered as an intravenous injection over 1 to 2 minutes.

Recommended imaging start time is 80 minutes (range 20 minutes to 80 minutes) after drug administration.

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

- Must be used for FDA approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient must have an approval for a PET scan and the PET scan code must be billed on the same date of service.
- Patient has first recurrence of breast cancer or stage IV disease as defined by the American Joint Committee on Cancer staging system for breast cancer.
- Patient had documented histologically confirmed invasive breast carcinoma.
- Patient is scheduled to undergo core needle biopsy or surgery for histological confirmation and determination of estrogen receptor (ER) status of recurrent or distant metastatic cancer within 15 days after Fluoroestradiol F-18 (FES) scan; or
 - Patient had core needle biopsy of recurrent or distant metastatic cancer within 30 days before FES scan and biopsy specimens are available for determination of ER status.
- Patient discontinued selective ER modulators or fulvestrant for at least 60 days prior to FES scan.
- Patient has Eastern Cooperative Oncology Group performance status of ≤ 2 .

Approval is for 3 months

C9067

HCPCS code C9067 is a radioactive diagnostic agent indicated for use with positron emission tomography (PET) for localization of somatostatin receptor positive neuroendocrine tumors (NETs) in adult and pediatric patients. Prescribing restrictions are limited to 5 mCi/500 units.

C9067 is separately billable and not split-billable. Providers must complete *CMS 1500* form including the medically justified ICD-10-CM diagnosis code(s). Providers must include an invoice showing the acquisition cost of the product for the claim. The invoice must have a date prior to the date of service or the claim will be denied.

Modifiers SA, UD, U7 and 99 are allowed.

In adults, the recommended amount of radioactivity to be administered for PET imaging is 4 mCi (148 MBq) with a range of 3 mCi to 5 mCi (111 MBq to 185 MBq) administered as an intravenous injection with an injection rate of approximately 10 seconds per mL.

In pediatric patients, the recommended amount of radioactivity to be administered for PET imaging is 0.043 mCi/kg of body weight (1.59 MBq/kg) with a range of 0.3 mCi (11.1 MBq) to 3 mCi (111 MBq) as an intravenous injection with an injection rate of approximately 10 seconds per mL.

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

- Must be used for FDA-approved indications and dosages
- Must be used with PET for localization of somatostatin receptor positive neuroendocrine tumors (NETs)
- Patient must have an approval for a PET scan and the PET scan code must be billed on the same date of service

Approval is for 3 months.

Surgery

The following surgery codes have special billing policy:

C9761, C9768, C9769, Q4249, Q4250, Q4254, Q4255

C9761

HCPCS code C9761 is reimbursable for the primary surgeon only. Assistant surgeon services are not reimbursable.

Modifiers AG, ET, PA, PB, PC, SC, UA, UB, U7, 22, 47, 51, 53, 54, 55, 62, 66, 76 thru 80 and 99 are allowed.

C9768

HCPCS code C9768 is reimbursable for the primary surgeon only. Assistant surgeon services are not reimbursable.

Modifiers AG, ET, PA, PB, PC, SC, UA, UB, U7, 22, 47, 51, 53, 54, 55, 62, 66, 76 thru 80 and 99 are allowed.

Code C9768 is exempt from the modifier 51 cutback.

C9769

HCPCS code C9769 is reimbursable for the primary surgeon only. Assistant surgeon services are not reimbursable. Code C9769 is reimbursable for male patients only.

Modifiers AG, ET, PA, PB, PC, SC, UA, UB, U7, 22, 47, 51, 53, 54, 55, 62, 66, 76 thru 80 and 99 are allowed.

Quarter 4 HCPCS Code Additions

Q4249, Q4250, Q4254, Q4255

HCPCS codes Q4249, Q4250, Q4254 and Q4255 require a *Treatment Authorization Request* (TAR) and must be billed by report with an invoice attached.

Modifiers U7 and 99 are allowed.

Modifiers

The following modifiers have no special billing policy:

J5, V4

Quarter 4 HCPCS Code Changes

Chemotherapy

J9305

HCPCS code J9305 no longer requires ICD-10-CM diagnosis codes on the claim for reimbursement.

Allied Health and Other Programs

G0396, G0397, G2011

HCPCS codes G0396, G0397 and G2011 are reimbursable for Presumptive Eligibility for Pregnant Women services.

Modifiers SA, SB, U7 and 99, U7 are allowed.

One of the following ICD-10-CM diagnosis codes is required on the claim: F10.14, F10.920, F10.921, F17.200 thru F17.203, F17.220, F17.290, F17.291, F17.293, F17.298, F17.299, F17.220, F19.10 thru F19.19, F19.120 thru F19.122, F19.129, F19.2, F19.90, F19.150 thru F19.159, F19.180 thru F19.182, F19.188, Z72.0 or Z87.891.

Quarter 4 HCPCS Deleted Codes

Injections

Deleted Codes

C9055

C9059

C9061

C9063