Q1 HCPCS Level I and II Update (January 1, 2023)

Note: Please note that the general code descriptions included are provided to assist with interpreting and navigating the content; providers are responsible for referencing the appropriate codebooks for up-to-date full descriptions when considering which code is appropriate to bill for the services rendered.

Q1 Code Additions

Evaluation and Management

The following code has special billing policies:

99418

99418

Prolonged inpatient or observation service.

Modifiers GC, SA, SB, U7, 24, 25, 57 and 99 are allowed

Injections

The following injections codes have special billing policies:

C9144, J0134, J0136, J0225, J0283, J0611, J0689, J0701, J0703, J0877, J0891, J0892, J0893, J0898, J0899, J1456, J1574, J1611, J1643, J2021, J2184, J2247, J2251, J2272, J2281, J2311, J2327, J2401, J2402, J3244, J3371, J3372, J9046, J9048, J9049, J9314, J9393, J9394, Q5126

C9144

Bupivacaine Solution (Posimir®)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years or older
- Patient is scheduled for elective outpatient procedure
- Patient is not undergoing a soft tissue procedure
- Patient is not undergoing obstetrical paracervical block anesthesia.
- Patient is not a pregnant or lactating female
- Patient is not on a long-term opioid or other analgesic therapy
- Patient does not have a known hypersensitivity to local anesthetic agents (e.g., lidocaine, bupivacaine, etc.).

Authorization is for three months.

Frequency of billing equals 660 mg/660 units as a single dose.

Maximum billing unit(s) equals 660 mg/660 units.

Modifiers SA, UD, U7 and 99 are allowed.

J0134, J0136

Acetaminophen

Patient must be two years of age or older (J0134). No age restriction (J0136).

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals4,000 mg/400 units.

Maximum billing unit(s) equals 4,000 mg/400 units per day.

Theses codes are reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) services.

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

J0225

Vustrisiran (AMVUTTREA™)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Must submit clinical documentation to substantiate the following:

- Must be for FDA-approved indications and dosing regimens.
- Must be 18 years of age or older.
- Must be prescribed by or in consultation with a neurologist, hematologist, cardiologist, geneticist, or a physician who specializes in the treatment of amyloidosis.
- Patient has a diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis with documented mutation in transthyretin (TTR) gene; or tissue biopsy results consistent with amyloid deposition.
- Patient has clinical signs and symptoms of the disease (for example, peripheral sensorimotor neuropathy, autonomic neuropathy, motor disability, etc.).
- Patient had one of the following test results at baseline:
  - Neuropathy Impairment Score of (five to 130)
  - Polyneuropathy disability (PND) score stage 3B or less (equal to or less than IIIb)
- Other causes of peripheral neuropathy have been ruled out.
- Patient has not had a liver transplant and is not planning to undergo one.
- Patient is receiving supplementation with vitamin A at the recommended daily allowance.
- Patient is not currently taking diflunisal, tafamidis, doxycycline, or inotersen.

Initial authorization is for 12 months

Continued therapy

- Patient continues to meet initial coverage criteria
- Patient has shown clinical improvement or lack of disease progression from baseline as evidenced by at least one of the following:
  - Improvement in neurologic impairment or motor function

– Improvement or stability in Neuropathy Impairment score, or Polyneuropathy disability (PND) score

Reauthorization is for 12 months.

Required ICD-10 Diagnosis Code: E85.1.

Frequency of billing equals 25 mg/ 25 units.

Maximum billing unit(s) equals 25 mg/25 units once every three months.

Modifiers SA, UD, U7 and 99 are allowed

J0283

Amiodarone (Nexerone)

Must be 18 years of age or older.

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

J0611

Calcium Gluconate

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

J0689

Cefazolin

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

J0701, J0703

Cefepime

Must be two months of age or older.

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals 1g/2 units-2g/4 units every 8 to12 hours.

Maximum billing unit(s) equals 2g/4 units.

Modifiers SA, UD, U7 and 99 are allowed.

J0877

Daptomycin

Must be 18 years of age or older.

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

J0891, J0892, J0898, J0899

Argatroban

No *Treatment Authorization Request* (TAR) is required for reimbursement.

To bill Argatroban for ESRD on dialysis use codes J0892 or J0899

Required ICD-10 Diagnosis Codes: N17.0 thru N17.9, N18.5, N18.6, N18.9 and N19

To bill Argatroban for non-ESRD use, use codes J0891 or J0898

Required ICD-10 Diagnosis Codes: D75.82

Modifiers SA, UD, U7 and 99 are allowed.

J0893

Decitabine

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

J1456

Fosaprepitant

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Patient must be 18 years and older.

Frequency of billing: 150 mg/150 units for one dose 30 minutes prior to chemotherapy.

Maximum billing units: 150 mg/150 units.

Modifiers SA, UD, U7 and 99 are allowed.

J1574

Ganciclovir

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Patient must be 18 years and older.

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Ganciclovir is being used for one of the following indications:
  - Patient is immunocompromised or has acquired immunodeficiency syndrome (AIDS) and ganciclovir is being used for the treatment of Cytomegalovirus (CMV) Retinitis.
- Patient is a transplant recipient at risk for CMV and ganciclovir is being used for the prevention of CMV disease.
- Patient has no history of hypersensitivity to acyclovir or ganciclovir.
- Oral antiviral products (for example, valganciclovir, ganciclovir, etc.) are not clinically appropriate.

Patient must meet A or B below:

A. Treatment of CMV Retinitis

- Patient is immunocompromised or has AIDS and has a diagnosis of CMV retinitis by ophthalmologic examination

B. Prevention of CMV Disease in Transplant Recipients

- Patient meets one of the following criteria:

- Patient is an organ transplant recipient and is at risk of CMV infection (CMV seropositive or a seronegative recipient of an organ from a CMV seropositive donor).
- Patient is a bone marrow recipient with asymptomatic CMV infection (CMV positive culture of urine, throat or blood)
- Patient is an allogeneic bone marrow transplant recipient at risk for CMV disease (Patients with histologic, immunologic or virologic evidence of CMV infection in the lung post-transplant)

Authorization is for six months

Modifiers SA, UD, U7 and 99 are allowed.

J1611

Glucagon

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

J1643

Heparin

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

J2021

Linezolid

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals1200 mg/ six units per 24 hours.

Maximum billing unit(s) equals 1200 mg/ six units.

Modifiers SA, UD, U7 and 99 are allowed.

J2184

Meropenem

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals 2 g/ 20 units every eight hours.

Maximum billing unit(s)equals 2 g/ 20 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2247

Micafungin

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals 150 mg/150 units daily.

Maximum billing unit(s) equals150 mg/150 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2251

Midazolam

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

J2272

Morphine

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Patient must be 18 years and older.

Modifiers SA, UD, U7 and 99 are allowed.

J2281

Moxifloxacin

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years of age or older.

Frequency of billing equals 400 mg/4 units every 24 hours.

Maximum billing unit(s) equals 400 mg/4 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2311

Naloxone (ZIMHI)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals 5 mg/five units times one. May repeat every two to three minutes until patient responsive or EMS arrives.

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

J2327

Risankizumab-rzaa

Patient must be 18 years of age or older

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Patient does not have active infection (including tuberculosis and hepatitis B virus [HBV]) or other serious active infection.
- Patient has baseline liver enzymes and bilirubin levels prior to treatment initiation.
- Patient does not have a known hypersensitivity to risankizumab.
- Must avoid use of live vaccines.

Patient must meet A, B or C below:

A. **Plaque Psoriasis (PsO)**

- Must be prescribed by or in consultation with a dermatologist.
- Patient must have a diagnosis of plaque psoriasis (with or without psoriatic arthritis) for at least six months before treatment initiation
- Patient has stable moderate to severe chronic plaque-type psoriasis with or without psoriatic arthritis and meets all of the following:
  – Static Physician Global Assessment (sPGA) score of at least three (moderate)
  – Psoriasis Area and Severity Index (PASI) 12 or more
  – Body Surface Area (BSA) of at least 10 percent
- Patient has a history of failure of one of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced. Corticosteroids (for example, betamethasone, clobetasol, desonide), Vitamin D analogs (for example, calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (for example, tacrolimus, pimecrolimus), Anthralin, coal tar or phototherapy.
- Patient must have tried and failed one of the preferred products (Remicade, Enbrel or Humira) unless intolerant, inadequate response or contraindication.

B. **Psoriatic Arthritis (PsA)**

- Must be prescribed by or in consultation with a dermatologist or rheumatologist
- Patient has a clinical diagnosis of PsA with symptom onset at least six months prior based on the Classification Criteria for PsA (CASPAR).
- Patient has active disease at baseline defined as five or more tender joints (based on 68 joint counts) and five or more swollen joints (based on 66 joint counts)
- Patient has a diagnosis of active plaque psoriasis with at least one psoriatic plaque of at least two cm diameter or nail changes consistent with psoriasis at baseline.
- Patient must have a history of failure of a three-month trial of at least one conventional Disease-Modifying Antirheumatic Drug (DMARD) such as methotrexate at maximally indicated doses within the last six months unless intolerant, contraindicated or clinically inappropriate.
- Patient must have tried and failed one of the preferred products (Remicade, Enbrel or Humira) unless intolerant, inadequate response or contraindication.
- Patient has not had a previous treatment with biologic agent.

C. **Crohn’s Disease (CD)**

- Must be prescribed by or in consultation with a gastroenterologist.
- Patient has a diagnosis of CD for at least three months prior to baseline.
- Patient has a confirmed diagnosis of moderate to severe CD as assessed by stool frequency (SF), abdominal pain (AP) score, and Simple Endoscopic Score for Crohn's Disease (SES-CD).
- Crohn's disease activity index (CDAI) score 220 to 450 at baseline.
- Patient has inadequate response, intolerance or contraindication to at least one conventional therapy option such as corticosteroids (for example, prednisone,

methylprednisolone, budesonide), mercaptopurine (Purinethol), azathioprine (Imuran) or methotrexate (Rheumatrex, Trexall).

- Patient must have tried and failed one of the preferred products (Remicade or Humira, unless intolerant, inadequate response or contraindication.
- If female, participant must meet the contraception recommendations.
- Patient does not have a current diagnosis of ulcerative colitis or indeterminate colitis.
- Patient has not received Crohn's disease approved biologic agents (Remicade, Humira, Cimzia, Entyvio, Tysabri within eight weeks prior to Baseline or Stelara within 12 weeks prior to baseline).

Initial authorization is for 12 months

Continued therapy

- Patient continues to meet initial approval criteria.
- Patient has experienced positive clinical response as evidenced by disease improvement or stabilization compared to baseline.
- Liver enzymes and bilirubin levels are being monitored up to at least 12 weeks of treatment and thereafter as needed.

Reauthorization is for 12 months.

Frequency of billing equals 600 mg/600 units every four weeks.

Maximum billing unit(s) equals 600 mg/600 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2401

Chloroprocaine (Nesacaine, Nesacaine MPF)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, UD, U7 and 99 are allowed.

J2402

Chloroprocaine (Clorotekal®)

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years of age or older.

Frequency of billing equals 50 mg/50 units as a single dose.

Maximum billing unit(s) equals 50 mg/50 units.

Modifiers SA, UD, U7 and 99 are allowed.

J3244

Tigecycline

Safety warning:
All-cause mortality was higher in patients treated with tigecycline than comparators in a meta-analysis of clinical trials. Tigecycline should be reserved for use in situations when alternative treatments are not suitable.

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years of age or older.

Frequency of billing equals 100 mg100 units, followed by 50 mg /50 units every 12 hours.

Maximum billing unit(s) equals100 mg100 units.

Modifiers SA, UD, U7 and 99 are allowed.

J3371, J3372

Vancomycin

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Frequency of billing equals 2 g/4 units per 24 hours.

Maximum billing unit(s) equals 2 g/4 units.

Modifiers SA, UD, U7 and 99 are allowed.

J9046, J9048, J9049

Bortezomib

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years of age or older.

Required ICD-10 Diagnosis codes: C83.10 thru C83.19, C90.00 thru C90.02.

Modifiers SA, UD, U7 and 99 are allowed.

J9314

Pemetrexed

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Must be 18 years of age or older.

Frequency of billing equals 500 mg/m2 on day one of each 21-day cycle.

Suggested ICD-10 Diagnosis Codes: C34.00, C34.92.

Modifiers SA, UD, U7 and 99 are allowed.

J9393, J9394

Fulvestrant

No *Treatment Authorization Request* (TAR) is required for reimbursement.

Patient must be 18 years and older.

Modifiers SA, UD, U7 and 99 are allowed.

Q5126

Bevacizumab-maly (Alymsys®)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Patient must be 18 years of age or older.

Alymsys is considered medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosages.

- Alamsys will be used as a treatment for one the following:

Cervical cancer, persistent/recurrent/metastatic

- Treatment of persistent, recurrent, or metastatic cervical cancer (in combination with paclitaxel and either cisplatin or topotecan)
- Treatment of persistent, recurrent, or metastatic cervical carcinoma (in combination with pembrolizumab, paclitaxel [conventional], and either cisplatin or carboplatin) – (plus or minus individualized radiation therapy and/or palliative care)

Colorectal cancer, metastatic

- First- or second-line treatment of metastatic colorectal cancer (CRC) (in combination with fluorouracil-based chemotherapy)
- Second-line treatment of metastatic CRC (in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy) after progression on a first-line treatment containing bevacizumab
- Drug is not being used for the adjuvant treatment of colon cancer

Glioblastoma, recurrent

- Treatment of recurrent glioblastoma in adults

Non-small cell lung cancer, nonsquamous:

- First-line treatment of unresectable, locally advanced, recurrent or metastatic nonsquamous non-small cell lung cancer (in combination with carboplatin and paclitaxel)

Ovarian (epithelial), fallopian tube, or primary peritoneal cancer:

- Stage III or IV disease, following initial surgical resection: Treatment of stage III or IV epithelial ovarian, fallopian tube, or primary peritoneal cancer following initial surgical resection (in combination with carboplatin and paclitaxel, followed by single-agent bevacizumab)
- Platinum-resistant recurrent: Treatment of platinum-resistant recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (in combination with paclitaxel, doxorubicin [liposomal], or topotecan) in patients who received no more than two prior chemotherapy regimens
- Platinum-sensitive recurrent: Treatment of platinum-sensitive recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (in combination with carboplatin and paclitaxel or with carboplatin and gemcitabine and then followed by single-agent bevacizumab)

Renal cell carcinoma, metastatic:

- Treatment of metastatic renal cell carcinoma (in combination with interferon alfa)

Initial authorization is for six months.

Continued therapy:

- Patient continues to meet initial approval criteria
- Patient has experienced positive clinical response such as stabilization of disease or decrease in tumor size or spread.

- Patient has absence of unacceptable toxicity such as gastrointestinal perforations and fistula, severe arterial thromboembolic events (ATE) grade four venous thromboembolic events (VTE), hypertensive crisis or hypertensive encephalopathy, posterior reversible encephalopathy syndrome (PRES), nephrotic syndrome (less than 2g of proteins in urine), severe infusion-related reactions, congestive heart failure (CHF), etc.

Reauthorization is for 12 months.

Modifiers SA, UD, U7 and 99 are allowed.

Non-Injectable Drugs

The following non-injectable code has special billing policies:

C9143

Cocaine HCL Nasal

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

- Must be used for FDA- approved indications and dosages
- Patient mut be 18 years or older
- Patient requires a diagnostic or surgical procedure on or through accessible mucous membranes of the nasal cavities.
- Patient does not have any of the following:
  - Coronary artery disease,
  - Congestive heart failure,
  - Irregular heart rhythm, abnormal screening ECG
  - Uncontrolled hypertension (defined as systolic blood pressure (BP) equal to or greater than140 mm Hg or diastolic BP equal to or greater than 90mm Hg)
  - Recent or active history of myocardial infarction
  - Thyrotoxicosis.
  - Epilepsy.
  - Hereditary pseudocholinesterase deficiency.
- Patient is not on any of the following:
  - Cholinesterase inhibitors.
  - α-modifying drugs
  - Tricyclic antidepressants.

Authorization is for three months.

Frequency of billing equals 160 mg /160 units in both nasal cavities for one dose.

Maximum billing unit(s) equals160 mg /160 units.

Modifiers SA, UD, U7 and 99 are allowed.

Psychological Services

The following psychological service code has special billing policies:

G0323

G0323

This code is reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) services.

Modifiers SA, U7 and 99 are allowed.

Radiology

The following radiology codes have special billing policies:

0716T, 0721T, 0722T, 0723T, 0724T, 3100F

0716T

Minimum age is 18.

Modifier TC, 26, 99 are allowed.

Required ICD-10 Diagnosis Codes: I25.10, P29.4, I5A, I24.8, I21.A1, I25.89, I25.2, I21.4, I25.5, I25.6, I20.0, I20.1, I20.2, I20.8, I20.9, I25.110, I25.111. I25.112. I25.118. I25.119, I25.700, I25.701, I25.702, I25.708, I25.709, I25.720, I25.721, I25.722, I25.728, I25.729, I25.790, I25.791, I25.792, I25.798, I25.799.

0723T, 0724T

Modifier TC, 26, 99 are allowed.

Required ICD-10 Diagnosis Codes: 001, 009, 035, 074, 080, 088, 090, 091, 099, 111.

0721T, 0722T, 3100F

Modifier 26, 99 are allowed.

Required ICD-10 Diagnosis Code: 001, 009, 035, 074, 080, 088, 090, 091, 099, 111.

Skin Substitutes

The following skin substitute codes have special billing policies:

Q4236, Q4262, Q4263, Q4264

Q4236, Q4262, Q4263, Q4264

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifiers SA, U7 and 99 are allowed.

Q1 Code Deletions

Table of HCPCS Q1 Code Deletions

Subject	Deleted Code
Injection	C9142 (replaced by Q5126), J2400, J9044
Medicine	G9904, G9907, G9909
Surgery	C1849, G0308, G0309, G2170, G2171