Q4 HCPCS Level I and II Update (October 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.

Note: The effective date for code J0174 is July 6, 2023. The effective date for codes 90480 and 91318 thru 91322 is September 11, 2023.

Q4 Code Additions

Chemotherapy

The following Chemotherapy codes have special billing policies:

C9155, J9051, J9064, J9345

C9155

Epcoritamab-bysp (EPKINLY™)

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

Age must be 18 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

J9051

Bortezomib (MAIA)

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

Age must be 18 years or older.

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

Modifiers SA, UD, U7 and 99 are allowed.

J9064

Cabazitaxel (Sandoz)

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

Age is restricted to 18 years or older.

Required ICD-10-CM Diagnosis Code: C61.

One billing unit equals 1 mg.

Modifiers SA, UD, U7 and 99 are allowed.

J9345

Retifanlimab-dlwr (ZYNYZ™)

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 of age or older.
- Must be prescribed by or in consultation with an oncologist.
- Patient must have a diagnosis of Merkel cell carcinoma (MCC) with metastatic disease or recurrent, advanced locoregional disease not amenable to surgery or radiation.
- Patient has not received systemic therapy for MCC, including chemotherapy and prior PD-1 or PD-L1-directed therapy (for example, avelumab, pembrolizumab, atezolizumab, cemiplimab, dostarlimab, durvalumab, nivolumab, etc.
- Patient does not have clinically significant pulmonary, cardiac, gastrointestinal or autoimmune disorders.
- Patient does not have active bacterial, fungal, or viral infections, including hepatitis A, B, and C.
- Provider will evaluate liver enzymes, creatinine, and thyroid function at baseline and periodically during treatment.
- Patient is not pregnant or breastfeeding.

Initial authorization is for 6 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 disease progression or unacceptable toxicity such as immune-mediated adverse reactions, infusion-related reactions, complications of Allogeneic HSCT, etc.

Reauthorization is for 12 months.

Age must be 18 years or older.

Suggested ICD-10-CM Diagnosis Codes: C4A0, C4A4, C4A8, C4A9, C4A10, C4A20, C4A21, C4A22, C4A30, C4A31, C4A39, C4A51, C4A52, C4A59, C4A60, C4A61, C4A62, C4A70, C4A71, C4A72, C4A111, C4A112, C4A121, C4A122.

Frequency of billing equals 500 mg/500 units every four weeks.

Maximum billing units equals 500 mg/500 units.

Modifiers SA, UD, U7 and 99 are allowed.

Immunizations

The following Immunizations codes have special billing policies:

90480, 91318, 91319, 91320, 91321, 91322

90480

Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose

Modifiers SA, SB, UD, U7, U9 and 99 are allowed.

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

91318

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use

Age must be 4 years or younger.

Modifiers SA, SB, SL, UD, U7, U9 and 99 are allowed.

91319

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 10 mcg/0.2 mL dosage, tris-sucrose formulation, for intramuscular use

Age must be between 5 years to 11 years.

Modifiers SA, SB, SL, UD, U7, U9 and 99 are allowed.

91320

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use

Age must be 12 years or older.

Modifiers SA, SB, SL, UD, U7, U9 and 99 are allowed.

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

91321

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 25 mcg/0.25 mL dosage, for intramuscular use

Age must be 11 years or younger.

Modifiers SA, SB, SL, UD, U7, U9 and 99 are allowed.

91322

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 50 mcg/0.5 mL dosage, for intramuscular use

Age must be 12 years or older.

Modifiers SA, SB, SL, UD, U7, U9 and 99 are allowed.

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

Injections

The following Injections codes have special billing policies:

C9152, C9153, C9157, C9158, J0174, J0349, J0801, J0802, J0874, J2359, J7519,

C9152

Aripiprazole (Abilify Asimtufii®)

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 of age or older.
- Must be prescribed by or in consultation with a psychiatrist.
- Patient has one of the following diagnoses:
  - Met the DSM criteria for diagnosis of schizophrenia.
  - Met the DSM criteria for a diagnosis of bipolar I disorder and is being used as maintenance monotherapy.
- Patient has established tolerability with oral aripiprazole in aripiprazole-naïve patients (may require up to a two-week trial of oral aripiprazole).
- Patient meets one of the following conditions:
  - Has a history of non-adherence, refuses to take oral medication, or oral medication is clinically inappropriate.
  - Treatment was initiated in inpatient during a recent hospitalization, within the last 60 days.
- Patient has no known hypersensitivity to aripiprazole or any of its excipients.

Initial authorization is for 6 months.

Continued Therapy

- Patient continues to meet initial approval criteria.
- Patient has experienced documented positive clinical response from baseline.

Reauthorization is for 12 months.

Age must be 18 years or older.

Suggested ICD-10-CM Diagnosis Codes: F20.0 thru F20.9, F25.0 thru F25.9 (Schizophrenia), F31.0 thru F31.31 (Bipolar Disorder)

Frequency of billing equals 960 mg/960 units every two months.

Maximum billing units equals 960 mg/960 units.

Modifiers SA, UD, U7 and 99 are allowed.

C9153

Amisulpride (Barhemsys®)

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 of age or older.
- Drug is being used under one of the following conditions:

  - Prevention of postoperative nausea and vomiting (PONV) and will be used alone or in combination with an antiemetic of a different class, OR
  - Treatment of PONV in patients who have received antiemetic prophylaxis with an agent of a different class or have not received prophylaxis.
- Patient has not received a preoperative dopamine-2 (D_2) antagonist (for example, metoclopramide).
- Prescriber will monitor electrocardiogram (ECG) for QTc prolongation, as clinically indicated.
- Must provide documentation justifying why other formulary alternatives for the prevention or treatment of PONV (for example, ondansetron, dexamethasone, etc.) are not an option.

Authorization is for one month.

Age must be 18 years or older.

Frequency of billing equals 10 mg/10 units for one dose.

Maximum billing units equals 10 mg/10 units.

Modifiers SA, UD, U7 and 99 are allowed.

C9157

Tofersen (QALSODY™)

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 of age or older.
- Must be prescribed by or in consultation with a neurologist with expertise in ALS.
- Patient has weakness attributable to ALS, and a confirmed diagnosis of ALS (definite or clinically probable) based on revised El Escorial World Federation of Neurology criteria, Awaji or Gold Coast criteria.
- Patient has a confirmed mutation in the superoxide dismutase 1 (SOD1) gene.
- Baseline documentation of functional ability prior to initiating treatment (e.g., muscle strength, respiratory strength, walking, climbing stairs, etc)
- Patient does not depend on invasive ventilation or tracheostomy.
- Patient was not previously treated for ALS with cellular therapies or gene therapies.

Initial authorization is for 6 months.

Continued therapy

- Patient continues to meet initial approval criteria.
- Positive clinical response as evidenced by documentation of less functional decline from baseline, reduction in decline in respiratory strength, or reduction in decline in muscle strength, etc.
- Patient does not depend on invasive ventilation or tracheostomy.

- Patient has an absence of unacceptable toxicity from the drug, for example, serious myelitis and/or radiculitis, papilledema, aseptic meningitis, etc.

Reauthorization is for 12 months.

Age must be 18 years or older.

Required ICD-10-CM Diagnosis Code: G12.21

Frequency of billing equals 100 mg/100 units every 14 days for three doses followed by 100 mg/100 units every 28 days.

Maximum billing units equals 100 mg/100 units.

Modifiers SA, UD, U7 and 99 are allowed.

C9158

Risperidone (UZEDY™)

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

Must meet the following criteria for approval:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Prescribed by or in consultation with a psychiatrist.
- Patient must have a diagnosis of schizophrenia based on DSM-5 criteria for more than 1 year and has had 1 or more episodes of relapse in the last 24 months.
- Patient has an established stability and tolerability of oral risperidone.
  - Neither a loading dose nor overlap with oral risperidone is needed. Initiate Uzedy the day after the last dose of oral therapy.
- The patient must have a documented history of poor adherence to oral risperidone or has relapsed due to medication nonadherence or other reason why an oral formulation is clinically inappropriate.
- Must provide documentation justifying why formulary alternative injections such as Perseris or Risperdal Consta are not clinically appropriate.
- Patient has no history of hypersensitivity (eg, anaphylaxis, angioedema) to risperidone, paliperidone, or any component of the formulation.

Initial authorization is for 6 months.

Continued Therapy

- Patient continues to meet initial approval criteria.
- Patient has experienced documented positive clinical response from baseline.

Reauthorization is for 12 months.

Age must be 18 years or older.

Frequency of billing equals 50 mg per 50 units to 125 mg per 125 units once monthly **or** 100 mg per 100 units to 250 mg per 250 units every 2 months.

Maximum billing units equals 250 mg per 250 units.

Modifiers SA, UD, U7 and 99 are allowed.

J0174

Lecanemab-irmb (LEQEMBI®)

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

Must include clinical documentation that demonstrates all of the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 50 to 90 years old.
- Must be prescribed by or in consultation with a neurologist, geriatrician or psychiatrist.
- Patient must have a diagnosis of mild cognitive impairment (MCI) due to AD or mild AD dementia and must have all of the following:
  - A global Clinical Dementia Rating (CDR) score of 0.5 or 1.0.
  - Memory Box score of 0.5 or greater
  - Positive amyloid pathology by either visual read of PET or CSF assessment.
  - Mini-Mental State Examination (MMSE) score of 22 or more.
  - Objective evidence of cognitive impairment at screening.
- Patient does not have any of the following:
  - Any neurological condition (other than Alzheimer's disease) which may be contributing to cognitive impairment.
  - History of transient ischemic attacks, stroke, or seizures within the prior 12 months.
  - Evidence of clinically significant lesions that could indicate a dementia diagnosis other than Alzheimer's disease on brain MRI.
  - Bleeding disorder that is not under control.
- Patient does not have baseline Brain MRI (within the past year) that shows evidence of any of the following: more than 4 microhemorrhages (defined as 10 millimeter [mm] or less at the greatest diameter), a single macrohemorrhage greater than 10 mm at greatest diameter, an area of superficial siderosis, vasogenic edema, cerebral contusion, encephalomalacia, aneurysms, vascular malformations, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory, severe small vessel, or white matter disease or space occupying lesions or brain tumors
- Patient is not using anticoagulants or antiplatelets (except for aspirin at a prophylaxis dose or less).
- Patients receiving cholinesterase inhibitors or memantine or both must be on stable dose for at least 12 weeks.
- Leqembi will not be used in combination with any other amyloid beta-directed antibodies (for example, aducanumab [Aduhelm]).
- Patient must have an MRI at baseline and at 5th, 7th and 14th infusions to monitor for amyloid- related imaging abnormalities (ARIA).
  - Patients should be evaluated for brain hemorrhage, bleeding disorders, or cerebral abnormalities to assess potential risk for ARIA.

Initial approval is for 12 months.

Continued therapy

- Patient has shown clinical benefit as evidenced by at least one of the following or clinical benefit shown by other standard assessment scales:
  - A reduction in amyloid beta plaque from baseline in PET imaging of brain.
  - An improvement from baseline in Clinical Dementia Rating Scale-Sum of Boxes (CDR-SB) score.
  - An improvement from baseline in MMSE score.
  - Change from baseline in Alzheimer Disease Assessment Scale - Cognitive Subscale 14 (ADAS-cog14)
- Patient does not have unacceptable toxicity such as severe infusion-related reactions, amyloid related imaging abnormalities-edema (ARIA-E), amyloid related imaging abnormality hemorrhage (ARIA-H), angioedema (swelling) and anaphylaxis (allergic reaction) etc.

Reauthorization is for 12 months.

Guidance for Dually Eligible/Medi-Medi Enrollees:

Leqembi is covered under Medicare Part B. Medi-Cal is obligated to pay the coinsurance and/or deductibles. Medicare covers the drugs with traditional FDA approval in this class when a prescribing clinician or their staff decides the Medicare coverage criteria is met and also submits information to help answer treatment questions in a qualifying study. Providers can participate in the CMS National Patient Registry (or another CMS-approved study) to get Medicare payment for treating their patients with Leqembi. For additional details, see CMS's 2023 Coverage Criteria.

Age must be 50 to 90 years.

Required ICD-10-CM Diagnosis Codes:

Primary diagnosis: G30.0, G30.1, G30.8, G30.9, G31.84

Secondary diagnosis: F03.90, F03.91

Modifiers SA, UD, U7 and 99 are allowed.

J0349

Rezafungin (REZZAYO)

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

Must include clinical documentation that demonstrates the following:

- Must be used for an FDA-approved indication and dosage.
- Not used to treat endocarditis, osteomyelitis, and meningitis due to *Candida*.
- Be of age 18 years or older.
- Patient had a trial of at least caspofungin, micafungin, anidulafungin, fluconazole, amphotericin B, voriconazole.
- Must show documentation of culture or other laboratory data.

Duration of approval is for 4 weeks.

Age must be 18 years or older.

Frequency of billing equals 400 mg/400 units weekly.

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

Modifiers SA, UD, U7 and 99 are allowed.

J0801

Repository Corticotropin Injection (Acthar Gel)

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

Must include clinical documentation that demonstrates the following:

- Must be used for an FDA-approved indication and dosage.
- Not for use in patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, or sensitivity to proteins of porcine origin
- For infantile spasms:
  - Patient had inadequate response, intolerance, or contraindication to corticosteroid or vigabatrin.
  - Not suspected of congenital infections.
- For multiple sclerosis:
  - Documentation of concurrent multiple sclerosis agent.
  - Patient had inadequate response, intolerance, or contraindication to IV methylprednisolone or high dose oral prednisone.

Duration of approval is for 4 weeks.

Frequency of billing equals 120 USP units/3 units daily.

Maximum billing unit(s) equals 120 USP units/3 units.

Modifiers SA, UD, U7 and 99 are allowed.

J0802

Repository Corticotropin Injection (Purified Cortrophin Gel)

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

Must include clinical documentation that demonstrates the following:

- For FDA-approved indications and treatment regimens.
- TARs may be approved for any of the FDA-approved indications. In many instances, corticotropin is not considered first line therapy and may be used in special circumstances. The TAR must not only state the diagnoses but also must contain sufficient clinical information to establish medical necessity.
- Must document why other alternatives are not adequate, effective or have been deemed to be clinically contraindicated for the individual patient.

- **Rheumatic disorders:** As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis, and/or acute gouty arthritis.
- **Collagen diseases:** During an exacerbation or as maintenance therapy in selected cases of systemic lupus erythematosus or systemic dermatomyositis (polymyositis).
- **Dermatologic diseases:** Treatment of severe erythema multiforme (Stevens-Johnson syndrome) or severe psoriasis.
- **Allergic states:** Treatment of atopic dermatitis or serum sickness.
- **Ophthalmic diseases:** Treatment of severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as allergic conjunctivitis, keratitis, iritis, iridocyclitis, diffuse posterior uveitis, choroiditis, optic neuritis, chorioretinitis, and anterior segment inflammation.
- **Respiratory diseases: s**ymptomatic sarcoidosis.
- **Edematous states:** To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus.
- **Nervous system:** Acute exacerbations of multiple sclerosis

- Patient does not have scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, hypertension, or sensitivity to proteins derived from porcine sources.

Duration of approval is for 4 weeks.

Frequency of billing equals 120 USP units/3 units daily.

Maximum billing unit(s) equals 120 USP units/3 units.

Modifiers SA, UD, U7 and 99 are allowed.

J0874

Daptomycin

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

Age must be 1 year or older.

Modifiers SA, UD, U7 and 99 are allowed.

J2359

Olanzapine

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

Age must be 13 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

J7519

Mycophenolate Mofetil

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

Age must be 3 months or older.

Suggested ICD-10-CM Diagnosis Codes: T86, Z94

Modifiers SA, UD, U7 and 99 are allowed.

Non-Injectable Drugs

The following non-injectable drugs codes have special billing policies:

J0889

J0889

Daprodustat (JESDUVROQ)

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

Must include clinical documentation that demonstrates the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient has been receiving dialysis for at least 4 months.
- Patient is iron replete.
- Documented assessment of serum alanine aminotransferase (ALT), aspartate aminotransferase (AST), alkaline phosphatase, and total bilirubin prior to initiation of JESDUVROQ.
- Patient does not have severe hepatic impairment (Child-Pugh Class C).
- Patient does not have a history of myocardial infarction, cerebrovascular event, or acute coronary syndrome within the past 3 months.
- Patient does not have a NYHA Class IV chronic heart failure.
- Patient does not have uncontrolled hypertension.
- Patient is not taking a strong cytochrome P450 2C8 (CYP2C8) inhibitors such as gemfibrozil.
- Patient does/did not gastrointestinal bleeding or erosion within the past 4 weeks.
- Patient does not have an active malignancy.
- Patient has had an inadequate treatment response, intolerance or contraindication to epoetin alfa, epoetina alfa-epbx, or darbepoetin alfa.

Initial approval is for 6 months.

Treatment continuation

- Patient continues to meet initial approval criteria.
- Patient has experience positive clinical response as evidenced by an improvement in hemoglobin levels.

Reauthorization is for 12 months.

Age must be 18 years or older.

Required ICD-10-CM Diagnosis Codes: D63.1, N18.4, N18.5, N18.9

Frequency of billing equals 24 mg/24 units daily.

Maximum billing unit(s) equals 24 mg/24 units.

Modifiers SA, UD, U7 and 99 are allowed.

Ophthalmology

The following Ophthalmology code has special billing policies:

J2781

J2781

Pegcetacoplan (SYFOVRE)

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

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

- Must be used for FDA approved indication and dosages.
- Patient must be 60 years of age or older.
- Must be prescribed by or in consultation with an ophthalmologist.
- Patient has a diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).
- Diagnosis has been confirmed by geographic atrophy secondary to age-related macular degeneration sensitive tests (e.g., optical coherence tomography [OCT], fundus autofluorescence [FAF] imaging).
- The GA is not secondary to any conditions other than AMD (e.g., Stargardt disease, cone rod dystrophy, toxic maculopathies).
- Patient does not have ocular or periocular infections; active intraocular inflammation.

Initial authorization is for 6 months.

Continuation of therapy

- Patient continues to meet initial coverage criteria.
- Patient has experienced positive response to therapy (e.g., disease stabilization or slowing of the rate of disease progression compared to pre-treatment baseline or reduction in total area of GA lesions.

Reauthorization is for 12 months.

Age must be 60 years or older.

Suggested ICD-10-CM Diagnosis Codes: H35.3113, H35.3114, H35.3123, H35.3124, H35.3133, H35.3134, H35.3193, H35.3194

Frequency of billing equals 15 mg/15 units every 25 to 60 days.

Maximum billing unit(s) equals 15 mg/15 units.

Modifiers RT or LT are required.

Modifiers UD and 99 are allowed.

Orthotics and Prosthetics

The following orthotics and prosthetic code has special billing policies:

L5991

L5991

Age must be 22 years of age to 64 years of age.

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

Modifiers LT and RT are required.

Frequency is once every 5 years.

Contraindications

Risk/Potential Benefit Information

The OPRA™ Implant System is not recommended for patients if any of the following is applicable:

- The patient's bone growth is not complete based on X-ray examination.
- The patient has bone anatomy that is not typical and may affect treatment with OPRA™.

Examples of bone anatomy that is not typical:

- Bone measurements outside defined interval.
- Unexpected development
- Conditions which are not favorable for device to be installed such as deformities, fracture, infection.
  - The patient would have less than 2 mm of remaining cortex bone available around the implant, if implanted.
  - The patient has osteoporosis (weak bones).
  - The patient is older than 65 years or younger than 22 years.
  - The patient's body weight is higher than 220 lbs including the prosthesis.
  - The patient suffers from other diseases that might affect treatment with OPRA™. Examples of other diseases are:
    - Severe peripheral vascular (blood vessels outside the brain and heart) disease.
    - Diabetic mellitus (diabetes) with complications.
    - Skin disorders involving the stump.
    - Neuropathy or neuropathic disease (damage or disease to nerves) and severe phantom pain.
    - Active infection or dormant (currently not active) bacteria.
    - Metabolic bone disease and/or metastatic lesions in the residual femur.
  - The patient is pregnant.
  - The patient is not expected to be able to follow the treatment and follow up rules.

Proprietary Laboratory Analyses (PLA)

The following PLA codes have special billing policies:

0408U, 0409U, 0416U

0408U, 0416U

Modifiers 33, 90, and 99 are allowed.

These codes are reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) program.

0409U

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

Modifiers 33, 90 and 99 are allowed.

Frequency is limited to once in a lifetime.

TAR requires documentation of the following criteria:

- The patient has a diagnosis of non-small cell lung cancer, and
- The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible, and
- Management is contingent on the test results

Radiology

The following radiology codes have special billing policies:

A9573, A9603, A9697, C9156, C9788, C9789, C9790, C9791

A9573

Age must be 2 years or older.

Modifiers SA, U7 and 99 are allowed.

A9603, A9697

Age must be 18 years or older.

Modifiers SA, U7 and 99 are allowed.

C9156

Age must be 18 years or older.

Modifiers SA, U7 and 99 are allowed.

Required ICD-10-CM Diagnosis Codes: C61.0-C61.9, C79.82, R97.2

C9788

Age must be 18 years or older.

Modifiers SA, U7, 99, LT and RT are allowed.

C9789

Age must be 18 years or older.

Modifiers SA, U7 and 99 are allowed.

Required ICD-10-CM Diagnosis Codes: C64.9, C65.1, C65.2, C65.9, C79.00, C79.10, C79.11, C79.19

C9790

Age must be 18 years or older.

Modifiers SA, U7, 99, LT and RT are allowed.

Required ICD-10-CM Diagnosis Codes: Z85.528, Z85.5, Z85.2

C9791

Modifiers SA, SB, U7 and 99 are allowed.

Skin Substitutes

The following skin substitute codes have special billing policies:

A2022, A2023, A2024, A2025, Q4285, Q4286

A2022, A2023, A2024, A2025, Q4285, Q4286

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

Modifiers SA, U7 and 99 are allowed.

Q4 Code Changes

Effective April 18, 2023, codes 0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0051A, 0052A, 0053A, 0054A, 0064A, 0071A, 0072A, 0073A, 0074A, 0081A, 0082A, 0083A, 0091A, 0092A, 0093A, 0094A, 0111A, 0112A, 0113A, 91300, 91301, 91305, 91306, 91307, 91308, 91309 and 91311 are no longer benefits.

Effective June 1, 2023, codes 0031A, 0034A and 91303 are no longer benefits.

Effective September 12, 2023, codes 0121A, 0124A, 0134A, 0141A, 0142A, 0144A, 0151A, 0154A, 0164A, 0171A, 0172A, 0173A, 0174A, 91312, 91313, 91314, 91315, 91316 and 91317 are no longer benefits.

Q4 Code Deletions

Table of HCPCS Q4 Code Deletions

Effective October 1, 2023

Subject	Deleted Code
Chemotherapy	J0800
Injections	C9151
Proprietary Laboratory Analyses	0066U, 0357U, 0386U, 0397U