Q3 HCPCS Level I and II Update (July 1, 2024)

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. The Policy PDF has been updated after its initial publication on July 16, 2024, to reflect the removal of C9790 and updates to J3393 and J3394.

Q3 Code Additions

Chemotherapy

The following Chemotherapy codes have special billing policies:

J3263

J3263

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

Minimum age is 18 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

Injections

The following Injection codes have special billing policies:

J0687, J0872, J1597, J1598, J1748, J2183, J2246, J2267, J2373, J2468, J2470, J2471, J3247, J3393, J3394, J7171, Q5137, Q5138

J0687

Cefazolin

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

Minimum Age of 18 years and older (wg critical care only).

Modifiers SA, UD, U7 and 99 are allowed.

J0872

Daptomycin (Xella Pharmaceuticals)

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

The TAR must include clinical documentation that demonstrates all of the following:

- Used for all FDA-approved indications and dosages.
- Patient is at least 1 year of age or older.
- Prescribed by or in consultation with an infectious disease specialist.
- Patient has tried and failed or has contraindications to at least one other covered formulation of daptomycin or other formulation options must be unavailable or unsuitable based on susceptibility patterns or clinical guidelines.

Minimum age is 1 year of age or older.

Frequency of billing is equal to once every 24 hours.

Modifiers SA, UD, U7 and 99 are allowed.

J1597, J1598

Glycopyrrolate Injection

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

Modifiers SA, UD, U7 and 99 are allowed.

J1748

Infliximab-dyyb Injection (Zymfentra)

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

The TAR must include clinical documentation that demonstrates the following:

Universal Criteria:

- Used for all FDA approved indications and dosages; AND
- Patient is at least 18 years of age or older; AND
- Used in Crohn's disease or ulcerative colitis as maintenance treatment of moderately to severely active disease; AND
- Zymfentra is prescribed by or in consultation with a gastroenterologist; AND

Crohn's Disease

- Used as an Initial Therapy
  - Documentation of current use of an infliximab intravenous induction therapy for at least 10 weeks; AND
  - Patient meets one of the following:
    - ❖ Patient has tried or is currently taking systemic corticosteroids (for example, prednisone and methylprednisolone), or there is a contraindication to corticosteroids
    - ❖ Patient has tried one conventional systemic therapy for Crohn's disease (for example, azathioprine, 6-mercaptopurine or methotrexate)
      - *Exceptions to above*: Patient has tried at least one other biologic used for Crohn's disease (not including a biosimilar). Examples: Humira, etc.
    - ❖ Patient had ileocolonic resection
    - ❖ Patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas

Approval is for six months.

- Patient is currently on an Infliximab Product.
  - Patient has been established on therapy for at least six months; AND
  - Patient meets at least one of the following:

- ❖ Patient experienced a beneficial clinical response from baseline using at least one objective measure (for example, fecal markers, serum markers, imaging studies, etc.); OR
- ❖ Patient experienced an improvement in at least one symptom (fatigue, stool frequency, hematocrit, etc.) compared to baseline

Initial authorization is for 12 months.

Reauthorization:

This may be granted if:

- Patient continues to meet individual coverage criteria.
- Patient has shown a positive clinical response such as symptoms improvement or lack of disease progression.

Reauthorization will be for 12 months.

<u>Ulcerative Colitis</u>

- Used as Initial Therapy
  - Documentation of current use of an Infliximab intravenous induction therapy for at least 10 weeks; AND
  - Patient meets one of the following:
    - ❖ Patient had a trial of one systematic agent or was intolerant of these agents for ulcerative colitis (for example, 6-mercaptopurine, azathioprine, cyclosporine) or a corticosteroid (for example, prednisone or methylprednisolone); OR
    - ❖ Patient meets both of the following:
      - Patient has pouchitis; AND
      - Patient has tried therapy with an antibiotic (for example, metronidazole, ciprofloxacin, etc.), probiotic or corticosteroid enema

Approval is for six months.

- Patient is currently on Infliximab Product.
  - Patient has been established on therapy for at least six months; AND
  - Patient meets at least one of the following:
    - ❖ Patient experienced a beneficial clinical response from baseline using at least one objective measure (for example, fecal markers, serum markers, imaging studies, etc.); OR
    - ❖ Patient experienced an improvement in at least one symptom (fatigue, stool frequency, etc.) compared to baseline

Initial authorization is for 12 months.

Reauthorization:

This may be granted if:

- Patient continues to meet initial coverage criteria.

- Patient has shown a positive clinical response such as symptoms improvement or lack of disease progression.

Reauthorization will be for 12 months.

Minimum age is 18 years or older.

Frequency of billing is equal to 120 mg / 12 units every two weeks.

Maximum dosage is equal to 120 mg / 12 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2183

Meropenem

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

Minimum age is a pediatric patient older than three months (wg critical care only).

Maximum age is 17 years old or younger.

Frequency of billing is equal to six g / 60 units every 24 hours.

Maximum dosage is equal to six g / 60 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2246

Micafungin

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

Frequency of billing equals 150 mg/150 units daily.

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

J2267

Mirikizumab (OMVOH)

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

The TAR must include clinical documentation that demonstrates the following:

- Must be for an FDA-approved indication and dosage.
- Patient must be 18 years old.
- Must be prescribed by or in consultation with a gastroenterologist.
- Patient has been evaluated and, if applicable, treated for active or latent Tuberculosis infection prior to initiating treatment with mirikizumab-mrkz.
- Patient has a baseline liver enzymes and bilirubin levels prior to treatment initiation.
- Patient's age-appropriate immunizations are current.
- Inadequate response, intolerance, or contraindication to at least one of the following: infliximab, adalimumab, golimumab, vedolizumab, tofacitinib or ustekinumab.

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 for at least 24 weeks of treatment and routinely thereafter as needed.

Reauthorization is for 12 months.

Minimum age is 18 years of age or older.

Frequency of billing equals 300 mg / 300 units every four weeks.

Maximum billing unit(s) equals 300 mg / 300 units.

J2373

Phenylephrine Hydrochloride (immphentiv)

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

Frequency of billing units is equal to 250 mcg / 13 units.

Maximum Billing unit(s) is equal to 250 mcg / 13 units once.

Modifiers SA, UD, U7 and 99 are allowed.

J2468

Palonosetron (avyxa)

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

Minimum age is 18 years or older.

Frequency of billing is equal to 250 mcg / 10 units once.

Maximum billing unit(s) is equal to 250 mcg / 10 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2470, J2471

Pantoprazole (PROTONIX)

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

Minimum age is 18 years or older.

Maximum billing unit(s) is equal to 80 mg / two units.

Modifiers SA, UD, U7 and 99 are allowed.

J3247

Secukinumab (COSENTYX)

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

The TAR must include clinical documentation that demonstrates the following:

- Must be used for an FDA-approved indication and dosage.
- Must be administered intravenously.
- Must be 18 years of age or older.

- Patient has been evaluated and, if applicable, treated for active or latent Tuberculosis infection prior to initiating treatment with seckukinumab.
- Patient's age-appropriate immunizations are current.
- Psoriatic arthritis:
  - Inadequate response, intolerance, or contraindication to at least one of the following: etanercept, infliximab, adalimumab, certolizumab
- Ankylosing spondylitis or non-radiographic axial spondyloarthritis:
  - Inadequate response, intolerance, or contraindication to at least one of the following: infliximab, etanercept, adalimumab, certolizumab, golimumab and their biosimilars

Initial authorization is for 12 months.

Continued Therapy

- Patient continues to meet initial approval criteria.
- Patient has shown positive clinical response as evidenced by disease improvement or disease stabilization compared to baseline.

Reauthorization is for 12 months.

Minimum age is 18 years or older.

Frequency of billing equals every four weeks.

Modifiers SA, UD, U7 and 99 are allowed.

J3393

Betibeglogene autotemcel (ZYNTEGLO)

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

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

- Must be prescribed for FDA-approved indications and dosages.
- Patient must be four to 50 years of age.
  - Patients less than 5 years of age must weigh at least six kg (13.2 lbs) and be able to provide the minimum number of cells required for the manufacturing process
- Must be prescribed by, or in consultation with, a hematologist or other specialist with expertise in the diagnosis and treatment of β-thalassemia.
- Patient has a clinically documented diagnosis of transfusion-dependent beta thalassemia (TDT) based on one of the following:
  - History of transfusions of at least 100 milliliter per kilogram per year (mL/kg/year) of packed red blood cells (pRBCs) in the prior two years
  - History of eight or more transfusions of pRBCs per year in the prior two years
- Patient has non-β0/β0 genotype (includes ß0/ß+,ß0/ßE, ß+/ß+ and ß+/ßE) , β0/β0 genotype and others such as β0/IVS-I-110 or IVS-I-110/IVS-I-110.
- Patient is clinically stable and eligible to undergo hematopoietic stem cell transplant (HSCT).

- Patient is not pregnant or breastfeeding.
- Patient must not have clinically significant and active bacterial, viral, fungal or parasitic active infection.
  - Patient must not have active infection with human immunodeficiency virus type 1 or 2 (HIV-1 and HIV-2), hepatitis B virus (HBV) or hepatitis C (HCV)
- Patient does not have a known and available Human leukocyte antigen (HLA) matched family donor.
- Patient does not have prior hematopoietic stem cell transplantation (HSCT) or gene therapy.
- Patient does not have any evidence of iron overload.
- Patient does not have cardiac T2 less than 10 msec by MRI, liver iron concentration greater than or equal to 15 mg/g, or advanced liver disease confirmed by MRI.
- Discontinue anti-retroviral medications and/or hydroxyurea one month prior to the planned start of mobilization and conditioning.
- Discontinue iron chelators seven days prior to initiation of myeloablative conditioning.
- Hemoglobin (Hb) greater than or equal to 11 g/dL maintained for at least 30 days prior to mobilization and myeloablative conditioning.
- Patient will undergo pretreatment hematopoietic stem cell mobilization, apheresis, full myeloablative conditioning with busulfan followed by washout period of at least 48 hours prior to treatment with Zynteglo.

Authorization is for 12 months (treatment is for once in a lifetime).

Reauthorization is not approvable.

Must be between four and 50 years of age.

Frequency of billing equals once in a lifetime.

ICD-10-CM diagnosis code D56.1 is required.

Maximum dose equals three units.

Modifiers UD and 99 are allowed.

J3394

Lovotibeglogene autotemcel (LYFGENIA™)

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

The TAR must include clinical documentation that demonstrates the following:

- Must be used for FDA-approved indications and dosages.
- Must be prescribed by or in consultation with a hematologist who is an expert in treating sickle cell disease (SCD).
- Patient must have a diagnosis of SCD (diagnosis with either βS/βS, βS/β0 or βS/β+ genotype).
- Patient must be 12 years of age or older with Sickle Cell Disease (SCD) and a history of vaso-occlusive events (VOEs):

  - At least four severe VOEs in the 24 months requiring greater than or equal to 24-hour hospital or emergency room (ER) observation unit visit or at least two visits to a day unit or ER over 72 hours with both visits requiring intravenous treatment defined as having any of the following:
    - ❖ An episode of acute pain with no medically determined cause other than a VOE lasting more than two hours
    - ❖ Acute chest syndrome (ACS)
    - ❖ Acute hepatic sequestration
    - ❖ Acute splenic sequestration
    - ❖ Acute priapism
- Patient must be in good health and be able to receive autologous hematopoietic stem cell (HSC) transplantation.
- Karnofsky or performance status of greater than or equal to 60 (16 years of age or older) or a Lansky performance status of greater than or equal to 60 (younger than 16 years of age).
- No severe cerebral vasculopathy, defined by any history of:
  - Overt ischemic or hemorrhagic stroke
  - Abnormal transcranial doppler (TCD) greater than 200 cm/sec requiring chronic transfusion
  - Occlusion or stenosis in the circle of Willis
  - Presence of Moyamoya disease
- Baseline left ventricular ejection fraction (LVEF) greater than 45 percent measured by cardiac echography.
- No advanced Liver Disease defined as any of the following:
  - Persistent aspartate transaminase (AST), alanine transaminase (ALT) or direct bilirubin value greater than three times the upper limit of normal (ULN).
  - Baseline prothrombin time or partial thromboplastin time greater than one and a half times ULN, suspected of arising from liver disease
  - Magnetic Resonance Imaging (MRI) of the liver demonstrating clear evidence of cirrhosis
  - MRI findings suggestive of active hepatitis, significant fibrosis, inconclusive evidence of cirrhosis
  - Liver iron concentration greater than or equal to 15 mg/g require liver biopsy for older than 18 years of age
- For patients with a history of iron overload or serum ferritin levels greater than 1000 ng/mL, a cardiac MRI is required. Cardiac T2* must be greater than 10 ms.
- **Required Lab/Test:**
  - Genetic test:
    - ❖ No more than two α-globin gene deletions

- Absolute neutrophil count of greater than or equal to 1000/µL (greater than or equal to 500/µL if on Hydroxyurea treatment) or a platelet count greater than or equal to 100,000/µL
- Liver function test:
  - ❖ Patient must not have advanced liver disease defined by any of the following:
    - Persistent AST, ALT or direct bilirubin three times the upper limit of normal (ULN)
    - Baseline prothrombin time or partial thromboplastin time greater than one and a half times ULN
    - Active hepatitis
    - Significant fibrosis
    - Cirrhosis
    - Liver iron concentration greater than or equal to 15 mg/g (require follow-up liver biopsy in subjects older than 18 years of age)
- Prothrombin time or partial thromboplastin time

- No active infection including, but not limited to:
  - Human immunodeficiency virus 1 and 2 (HIV-1/HIV-2)
    - ❖ A negative serology test for HIV is required
  - Hepatitis B virus (HBV) or hepatitis C (HCV)
    - ❖ Negative HBV DNA is required
    - ❖ Undetectable HCV viral load is required
- No prior or current malignancy or immunodeficiency disorder, except previously treated, non-life threatening, cured tumors.
- No immediate family member with a known or suspected Familial Cancer Syndrome.
- No matched related hematopoietic stem cell donor.
- No prior allogeneic or autologous HSC transplant or gene therapy.
- No allergy or contraindications to dimethyl sulfoxide (DMSO), plerixafor or busulfan.
- Patient is not pregnant.
- Discontinue anti-retroviral medications and/or disease modifying therapies (for example, hydroxyurea) one month prior to the planned start of mobilization and conditioning.
- Discontinue iron chelators seven days prior to initiation of myeloablative conditioning.
- Patient’s current weight must be provided.

Authorization is for 12 months (one dose per lifetime).

Reauthorization is not approvable.

Minimum age must be 12 years of age or older.

Frequency of billing equals once in a lifetime.

Minimum recommended dose is three times 10^6 CD34 plus cells/kg of body weight.

Maximum dose equals four units.

ICD-10-CM diagnosis codes D57.00 through D57.819 are required (except D57.3 which is not reimbursable).

Modifiers UD and 99 are allowed.

J7171

ADAMTS13, recombinant-krhn (ADZYNMA®)

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

Must be two years of age or older.

Modifiers SA, UD, U7 and 99 are allowed.

Q5137, Q5138

Ustekinumab-auub (WEZLANA™)

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

The TAR must include clinical documentation that demonstrates the following:

Universal Criteria:

- 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.
- Must avoid use of live vaccines.
- Patient must meet A, B, C or D below.

A. Moderate to Severe Plaque Psoriasis (Ps):

- Must be prescribed by or in consultation with a dermatologist.
- Patient must be six years of age or older.
- 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) greater than or equal to 12
  - Body Surface Area (BSA) greater than or equal to 10 percent
- Patient is a candidate for systemic therapy or phototherapy.
- Patient must have a history of inadequate response to at least one of the following systemic therapies up to maximally indicates doses, unless intolerant, contraindicated or clinically inappropriate:
  - Methotrexate

- Cyclosporine
- Acitretin

B. Active Psoriatic Arthritis (PsA):

- Must be prescribed by or in consultation with a dermatologist or rheumatologist.
- Patient must be six years of age or older.
- 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 greater than or equal to five tender joints (based on 68 joint counts) and greater than or equal to five swollen joints (based on 66 joint counts).
- 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.

C. Moderately to severely active Crohn's disease (CD):

- Patient must be 18 years of age or older.
- 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 - 450 at Baseline.
- 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).

D. Ulcerative Colitis, Moderate-to-Severe:

- Patient has a documented diagnosis of moderately to severely active ulcerative colitis. for at least three months prior to Baseline.
- Must be prescribed by or in consultation with a gastroenterologist.
- Patient must be 18 years of age or older.
- Patient must have a history of inadequate response, intolerance, or contraindication to one or more of the following conventional therapies: Oral 5-aminosalicylates (for example, sulfasalazine, mesalamine), glucocorticoids (for example, prednisone, budesonide) and/or immunomodulators (for example, azathioprine, 6-mercaptopurine, methotrexate), unless clinically inappropriate.

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.

Reauthorization is for 12 months.

Must be six years of age or older (Q5137).

Must be 18 years of age or older (Q5138).

Modifiers SA, UD, U7 and 99 are allowed.

Medicine

The following Medicine code has special billing policies:

G9037

G9037

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

Modifiers SA, U7, 99 and GQ are allowed.

Non-injection

The following Non-injection codes have special billing policies:

J8611, J8612

J8611

Methotrexate (JYLAMVO)

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

Must be 18 years of age or older.

Modifiers SA, UD, U7 and 99 are allowed.

J8612

Methotrexate (XATMEP)

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

Must be younger than 18 years of age.

Modifiers SA, UD, U7 are 99 are allowed.

Ophthalmology

The following Ophthalmology code has special billing policies:

J7355

J7355

Travoprost (iDose® TR)

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

Travopost is considered medically necessary when the following criteria are met:

- Must be used for FDA-labelled indication 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 or iDose TR.
- 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 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 equals one implant per eye per lifetime.

Continued Therapy

Reauthorization is not allowed.

Frequency of billing equals one implant (75 mcg) / 75 units per eye per lifetime.

Maximum billing unit(s) equals one implant (75 mcg) / 75 units per eye.

Proprietary Laboratory Analyses (PLA)

The following PLA codes have special billing policies:

0471U, 0473U, 0475U

0471U

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

A TAR requires documentation of the following criteria:

- The patient has been diagnosed with colorectal cancer, and
- Management is contingent on the test results.

Frequency is limited to once in a lifetime.

Modifiers 33, 90 and 99 are allowed.

0473U

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

A TAR requires documentation of the following criteria:

For Somatic Testing:

- The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and
- The patient either has not been previously tested using the same next-generation sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and

- The decision for additional cancer treatment is contingent on the test results.

Independent of the above criteria, somatic testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.

Frequency is limited to once in a lifetime.

Modifiers 33, 90 and 99 are allowed.

0475U

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

A TAR requires documentation of the following criteria:

For Germline Testing:

- The patient has prostate cancer, and
- The patient has a clinical indication for germline (inherited) testing for hereditary cancer (e.g., NCCN Guidelines for Prostate Cancer), and
- The patient has a risk factor for germline (inherited) cancer (e.g., NCCN Guidelines for Prostate Cancer), and
- The patient has not been previously tested with the same germline genetic content.

Frequency is limited to once in a lifetime.

Modifiers 33, 90 and 99 are allowed.

Radiology

The following Radiology codes have special billing policies:

0877T, 0878T, 0879T, 0880T, 0888T, 0889T, 0890T, 0891T, 0892T, 0898T, 0899T, 0900T, A9506

0877T, 0878T, 0879T, 0880T, 0888T

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

Modifiers SA, U7 and 99 are allowed.

0889T, 0890T, 0891T, 0892T

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

ICD-10-CM codes I63.19 or I69.320 are required.

Must be 18 years of age or older.

Modifiers SA, U7 and 99 are allowed.

0898T

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

ICD-10-CM code C61 is required.

Must be 18 years of age or older.

Modifiers SA, U7 and 99 are allowed.

0899T, 0900T

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

Must be 18 years of age or older.

Modifiers SA, U7 and 99 are allowed.

A9506

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

Must be 6 years of age or older.

Modifiers SA, U7 and 99 are allowed.

Skin Substitutes

The following Skin Substitutes codes have special billing policies:

Q4311, Q4312, Q4313, Q4314, Q4315, Q4316, Q4317, Q4318, Q4319, Q4320, Q4321, Q4323, Q4324, Q4325, Q4326, Q4327, Q4328, Q4329, Q4330, Q4331, Q4332, Q4333

Q4311, Q4312, Q4313, Q4314, Q4315, Q4316, Q4317, Q4318, Q4319, Q4320, Q4321, Q4323, Q4324, Q4325, Q4326, Q4327, Q4328, Q4329, Q4330, Q4331, Q4332, Q4333

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

Modifiers SA, U7 and 99 are allowed.

Q3 Code Deletions

Table of HCPCS Q3 Code Deletions

Effective July 1, 2024

Subject	Deleted Code
Chemotherapy	J9371
Injection	C9166 (replaced by J3247), C9167 (replaced by J7171), C9168 (replaced by J2267), J2780, S0164 (replaced by J2470, J2471)
Proprietary Laboratory Analyses	0204U, 0353U
Radiology	C9790
Surgery	Q4210, Q4277