Effective January 1, 2020

2020 HCPCS CODE ADDITIONS

Bolded Codes
Bolded codes indicate notation of a special billing policy.

Chemotherapy
J9199, J9309

J9199
HCPCS code J9199 is indicated for the treatment of patients of any age and billing frequency is limited to weekly intervals

Modifiers SA, UD, U7 and 99 are allowed.

J9309
HCPCS code J9309 is indicated for the treatment of patients 18 years of age or older and billing frequency is limited to once every 21 days for 6 cycles, any provider.

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

- FDA-approved indications and dosages, and
- There is a diagnosis of diffuse large B-cell lymphoma (DLBCL), and
- The patient has relapsed or refractory disease, and
- Polatuzumab vedotin is administered in combination with bendamustine and a rituximab product, and
- The patient received at least two prior systemic chemotherapies, and
- The patient is not a candidate for autologous hematopoietic stem cell transplantation (HSCT), and
- The patient has not previously undergone allogeneic HSCT, and
- The patient does not have active central nervous system lymphoma or histologically transformed lymphoma, and
- Initial approval is for twelve months.

ICD-10 CM diagnosis codes C83.30–C83.39 are suggested on the claim.

Modifiers SA, UD, U7 and 99 are allowed.

Durable Medical Equipment
A4226, E0787, E2398, K1005

A4226
HCPCS code A4226 is reimbursable for Presumptive Eligibility for Pregnant Women services, is non-taxable and billing frequency is limited to once per week, any provider.

Modifier NU is required.

E0787
HCPCS code E0787 is reimbursable for Presumptive Eligibility for Pregnant Women services, is taxable and billing frequency is limited to once in five years, any provider.

An approved TAR is required for reimbursement.

Modifier NU is required.

E2398
HCPCS code E2398 is non-taxable and billing frequency is limited to once in five years, any provider.

Modifier NU, NU/RB or RB/NU is required, and modifier J4 is allowed. This is not a rental item.

K1005
HCPCS code K1005 is for female patients only ranging from 12 to 60 years of age. The code is taxable and billing frequency is limited to thirty one units per month, any provider.

Modifier NU is required.

Immunizations
90619

90619
HCPCS code 90619 is reimbursable for Presumptive Eligibility for Pregnant Women services.

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

Injections
C9054, C9055, J0179

C9054
HCPCS code C9054 is indicated for the treatment of patients 18 years of age or older and is reimbursable once every 12 hours for five to seven days.

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

- FDA-approved indications and dosages, and
- Patient is 18 years of age or older, and
- A negative pregnancy status in females of child-bearing age must be verified, and
- There is an establishment of diagnosis; microbiologic Gram stain and culture of sputum for Community-acquired Pneumonia (CAP), and
- Justification for failure to use formulary alternatives such as macrolides, fluoroquinolones, or beta-lactam antibiotics, such as allergy or intolerance is shown or

Documentation of recent hospitalization and parenteral antibiotics and/or locally validated risk factors for MRSA may also satisfy TAR requirements.

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

C9055
HCPCS code C9055 is indicated for the treatment of patients ranging from 18 to 65 years of age and billing frequency limited to once per pregnancy.

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

- FDA-approved indications and treatment regimens, and
- The patient is 18 years of age or older, and
- The patient is less than or equal to six months postpartum, and
- The onset of symptoms was in the third trimester or within four weeks of delivery, and
- Moderate to severe postpartum depression was confirmed by a Hamilton Rating Scale for Depression (HAM-D) of more than or equal to twenty, or other comparable standardized rating scale, and
- An adequate trial of at least two anti-depressants from two separate drug classes at an adequate dose and treatment duration of a minimum of four weeks plus or minus psychotherapy, and
- The patient does not have active psychosis, and
- Initial approval is for 30 days (one time use per pregnancy).

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

J0179
HCPCS code J0179 is indicated for the treatment of patients 18 years of age or older. The maximum allowed dose of 6 mg (per eye) is reimbursable every 25 to 31 days for the first 3 doses, then every 8 to 12 weeks, any provider.

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

- FDA-approved indications and treatment regimens, and
- The patient must be 18 years of age or older, and
- The patient has a diagnosis of Neovascular (wet) Age-Related Macular Degeneration (AMD), and
- Patient has tried and failed or is intolerant to treatment with an intravitreal vascular endothelial growth factor (VEGF) inhibitor (for example. Bevacizumab or ranibizumab), and
- The patient does not have ocular or periocular infections, and
- The patient does not have an active intraocular inflammation, and
- Initial approval is for twelve months.

Reauthorization: Must continue to meet the medical necessity criteria for continuation of therapy.

Modifier LT or RT is required and modifiers SA, UD, U7 and 99 are allowed.

Modifier SA is allowed.

Orthotics and Prosthetics

L2006, L8033

L2006, L8033
HCPCS Codes L2006 and L8003 are non-taxable and billing frequency is limited to once every twelve months, any provider.

An approved TAR is required for reimbursement.

Modifier LT or RT is required.

Radiology

A9590

A9590
HCPCS code A9590 is indicated for the treatment of patients 12 years of age or older and billing frequency is limited to once every ninety days..

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

- FDA-approved indications and dosages, and
- The patient is 12 years of age or older, and
- The patient has a documented diagnosis of iobenguane scan positive, unresectable, locally advanced or metastatic pheochromocytoma or paraganglioma, and
- Iobenguane I-131 is used as a primary treatment if prior positive MIBG scan, and
- The patient is not a candidate for chemotherapy or other curative therapies, and
- A negative pregnancy status in females of child-bearing age must be verified, and
- The patient's platelet count must not be less than 80,000/mcL or absolute neutrophil count is not less than 1,200/ mcL.

Coverage is provided at the FDA-approved dosage for one dosimetric and up to two therapeutic doses to be administered within six months of approval.

ICD-10-CM diagnosis codes C74.10, C74.11, C74.12, C75.5, C7A.1, C7A.8, D35.00, D35.01, D35.02, D35.6, D44.7 or Z51.0 are suggested on the claim.

Modifiers SA, SD, U7 and 99 are allowed.

Surgery

C1734, C1824, C1839, C1982, C2596, C9757

2020 HCPCS DELETED CODES

Non-Injectable Drugs

Deleted Code
C9407

Psychological Services

Deleted Code
G0515

Radiology

Deleted Code
C9408