Q4 HCPCS Level I and II Update (October 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.

Note: CPT® code 90684 is effective for dates of service on or after June 27, 2024. HCPCS code J0175 is effective for dates of service on or after July 02, 2024.

Q4 Code Additions

Blood and Blood Derivatives

The following Blood and Blood Derivative code has special billing policies:

P9027

P9027

Red blood cells, leukocytes reduced, oxygen/carbon dioxide reduced.

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

Modifiers SA, UD, U7 and 99 are allowed.

Chemotherapy

The following Chemotherapy codes have special billing policies:

C9169, C9170, J9329

C9169

Nogapendekin alfa inbakicept-pmln (ANKTIVA).

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

The TAR must include clinical documentation that demonstrates the following:

- Must be prescribed by or in consultation with an oncologist or urologist.
- Must be for an FDA-approved indication and dosage.
- Patient must be 18 years of age or older.
- Patient has a diagnosis of Bacillus Calmette-Guérin (BCG)-negative non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors.
- Pregnancy testing and advice on contraception are provided to patient of reproductive potential prior to initiating treatment.
- Patient tried and was unresponsive to adequate BCG therapy, defined as administration of at least five of six doses of an initial induction course plus either of at least two of three doses of maintenance therapy or at least two of six doses of a second induction course.
- Must be used in combination with BCG.

Initial authorization is for six months.

Continued Therapy:

- Patient continues to meet initial approval criteria.
- Patient achieved complete response from the induction period, defined by negative results for cystoscopy (with TURBT/biopsies as applicable) and urine cytology.
- Patient has an absence of disease recurrence, disease progression and unacceptable toxicity.

Reauthorization is for 12 months. Maximum total treatment duration is 37 months.

Minimum age is 18 years old.

Maximum dosage is 400 mcg/400 units.

Modifiers SA, UD, U7 and 99 are allowed.

C9170

Tarlatamab-dlle (IMDELLTRA™)

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

Minimum age is 18 years old.

Maximum dosage is 10 mg/10 units.

Modifiers SA, UD, U7 and 99 are allowed.

J9329

Tislelizumab-jsgr (TEVIMBRA)

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

The TAR must include clinical documentation that demonstrates the following:

- Must be 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.
- Confirmed diagnosis of esophageal squamous cell carcinoma (ESCC).
- Tumor progress during or after prior systemic chemotherapy that did not include a PD-(L)1 inhibitor for advances unresectable/metastatic ESCC.
- Inadequate response, intolerance or contraindication to nivolumab or pembrolizumab.
- Patient is evaluated for baseline liver enzymes, creatinine and thyroid function.
- Pregnancy testing and advice on contraception are provided to patient of reproductive potential prior to initiating treatment.

Initial authorization is for 12 months.

Continued Therapy

- Patient continues to meet initial approval criteria.
- Patient has an absence of unacceptable toxicities or side effects, including immune-mediated adverse reactions or severe infusion reactions.

Reauthorization is for 12 months.

Age must be 18 years or older.

Frequency of billing is equal to 200 mg/200 units every three weeks.

Maximum billing unit(s) is equal to 200 mg/200 units.

Modifiers SA, UD, U7 and 99 are allowed.

Immunization

The following Immunization code has special billing policies:

90684

90684

Pneumococcal 21-Valent Conjugate (PCV21) (CAPVAXIVE™)

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

Age must be 19 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

Injection

The following Injection codes have special billing policies:

C9171, C9172, J0138, J0175, J1171, J1749, J2002, J2003, J2004, J2252, J2601, Q5135, Q5136

C9171

Pegulicianine (Lumisight)

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

Minimum age is 18 years old.

Modifiers SA, UD, U7 and 99 are allowed.

C9172

Fidanacogene elaparvovec-dzkt (BEQVEZ™)

A *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 or in consultation with a hematologist.
- Patient is under the care of hematology/oncology or Hemophilia Treatment Center (HTC).
- Patient is 18 to 64 years of age with a confirmed diagnosis of moderate to severe Hemophilia B (less than or equal to 2 IU/dL or less than or equal two percent endogenous factor IX) meeting all of the following:
  - Currently uses factor IX prophylaxis therapy (minimum of 50 exposure days to factor IX replacement therapy), or

  - Has current or historical life-threatening hemorrhage, or
  - Has repeated, serious spontaneous bleeding episodes, and
  - Does not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approved test.
- Patient does not have any of the following:
  - Prior treatment with any gene therapy for Hemophilia B
  - History of chronic infection including active hepatitis B, hepatitis C or HIV
    - Positive hepatitis B surface antigen, hepatitis B virus deoxyribonucleic acid positivity, or hepatitis C virus ribonucleic acid
    - Currently on antiviral therapy for hepatitis B or C
    - Serological evidence of HIV-1 or HIV-2 with CD4 counts less than or equal to 200/mm^3 and/or a viral load greater than 20 copies/mL
  - Signs of liver disease:
    - Ascites
    - Encephalopathy
    - Coagulopathy
    - Hypoalbuminemia (levels less than the normal limits)
    - Gastrointestinal varices
    - Jaundice
    - Cirrhosis
    - Portal hypertension
    - Splenomegaly
    - Liver fibrosis-FibroScan score greater than 8 kPa units
    - FibroTest/FibroSure greater than 0.48
    - Aspartate aminotransferase (AST)-to-Platelet ratio greater than 1
    - Alanine aminotransferase (ALT), AST or alkaline phosphatase greater than two times the upper limit of normal (ULN)
    - Bilirubin greater than one and a half times the ULN
  - Renal impairment
  - Any conditions associated with increased thromboembolic risk
  - Neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid titer greater than or equal to 1:1 as detected by an FDA-approved test. More information can be found on the List of Cleared or Approved Companion Diagnostic Devices (In Vitro and Imaging Tools) on the FDA website
  - History of or current inhibitor to factor IX (greater than or equal to 0.6 Bethesda units)
  - Participated in a gene transfer trial or in a clinical trial with an investigational

drug

- Required lab:
  - Liver function tests (ALT, AST, alkaline phosphatase, bilirubin)
  - Elastography and/or ultrasound and other laboratory assessments for liver fibrosis such as Liver fibrosis-FibroScan score, FibroTest/FibroSure or AST-to-Platelet ratio if signs of liver disease are present
  - Anti-AAVRh74var neutralizing antibodies (nAb) titer
  - Inhibitor to factor IX
  - Hepatitis B and C, and HIV screening tests
- Patient is utilizing contraception method until three consecutive samples are negative for vector shedding or six months after receiving Beqvez.
- Plan of post Beqvez administration hepatic function (ALT and AST) and factor IX activity monitoring once or twice weekly for at least four months and as indicated per package insert.
- Monitor patients with risk factors for hepatocellular carcinoma following Beqvez administration with regular liver ultrasound and Alpha-fetoprotein testing for five years.

Authorization equals three months (one treatment in a lifetime).

Reauthorization is never.

Required age is 18 to 64 years old.

Suggested ICD-10 code: D67

Frequency of billing is one treatment in a lifetime.

Modifiers UD and 99 are allowed.

J0138

Acetaminophen and Ibuprofen (Combogesic IV)

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

Age must be 18 years or older.

Frequency of billing is equal to every six hours for up to five days.

Maximum dosage is 4000 mg per 1200 mg acetaminophen per 1200 mg ibuprofen (equivalent to 400/400 units per 24 hours).

Modifiers SA, UD, U7 and 99 are allowed.

J0175

Donanemab-azbt (Kisunla)

A *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.
- Must be prescribed by or in consultation with a neurologist, geriatrician or psychiatrist.
- Patient is diagnosed with mild cognitive impairment or mild dementia stage of disease.

- Confirmed presence of amyloid beta pathology through PET imaging.
- Patient is offered to be tested for ApoE ε4 and informed of the risk of amyloid related imaging abnormalities (ARIA).
- Patient has a recent baseline brain MRI prior to initiating treatment and will obtain an MRI prior to the second, third, fourth and seventh infusions to monitor for ARIA.

Initial authorization is for six months.

Continued therapy

- Patient continues to meet initial approval criteria.
- Patient has shown clinical benefit as evidenced by at least one of the following or 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
  - An improvement from baseline in Alzheimer's Disease Assessment Scale-Cognitive Subscale (ADAS-Cog) score
  - An improvement from baseline in Alzheimer's Disease Cooperative Study-Instrumental Activities of Daily Living (ADCS-iADL) score
- Patient has an absence of unacceptable toxicities, side effects, hypersensitivity reactions and infusion-related reactions.
- Continue stopping dosing with donanemab-azbt based on reduction of amyloid plaques to minimal levels on amyloid PET imaging if applicable.

Reauthorization is for 12 months.

Age must be 18 years or older.

Frequency of billing is equal to 1400 mg/700 units every four weeks.

Maximum dosage is equal to 1400 mg/700 units.

Modifiers SA, UD, U7 and 99 are allowed.

J1171

Hydromorphone (Dilaudid)

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

Modifiers SA, UD, U7 and 99 are allowed.

J2002

Lidocaine Hydrochloride and 5 percent Dextrose

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

Modifiers SA, UD, U7 and 99 are allowed.

J2003

Lidocaine HCl

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

Maximum dosage is equal to 300mg/300 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2004

Lidocaine HCI with epinephrine

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

Maximum dosage is equal to 500mg/500 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2252

Midazolam (VERSED, NAYZILAM®)

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

Modifiers SA, UD, U7 and 99 are allowed.

J2601

Vasopressin

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

Age must be 18 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

Q5135

Tocilizumab-aazg (TYENNE®)

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

Tyenne will be considered medically necessary when the following criteria is met:

Universal Criteria:

- Must be used for FDA-approved indications and dosages.
- Must be prescribed by or in consultation with a specialist (rheumatologist).
- Test and monitor patients for latent and active TB initially and during treatment.
- Routine monitoring of patients for the development of signs and symptoms of infection during and after treatment.
- Tyenne is not used in combination with biological DMARDs such as TNF antagonists, IL-1R antagonists, anti-CD20 monoclonal antibodies and selective co-stimulation modulators or other biosimilars.
- The absolute neutrophil count (ANC) is above 2000 per mm^3, platelet count is above 100,000 per mm^3.
- ALT or AST is not more than one and a half times the upper limit of normal (ULN).
- Live vaccines must not be administered during therapy.

Initial Authorization Criteria:

Rheumatoid Arthritis (RA):

- Patient is 18 years of age or older.
- Diagnosis of moderately to severely active rheumatoid arthritis.
- Unless contraindicated, patient has tried and failed one or more nonbiologic Disease-Modifying Anti-Rheumatic Drugs (DMARDs) (for example, methotrexate, leflunomide, hydroxychloroquine, etc.) or
- Unless contraindicated, patient has tried and failed at least one tumor necrosis factor (TNF alpha) (for example. Enbrel, Humira).

Polyarticular Juvenile Idiopathic Arthritis (PJIA):

- Patient is 2 years of age or older.
- Diagnosis of active polyarticular juvenile idiopathic arthritis.
- Unless contraindicated, patient has tried and failed at least one oral nonbiologic Disease-Modifying Anti-Rheumatic Drugs (DMARDs) (for example, methotrexate, leflunomide, hydroxychloroquine, etc.) or
- Unless contraindicated, patient has tried and failed at least one tumor necrosis factor (TNF alpha) (for example, Enbrel, Humira).

Giant Cell Arteritis (GCA):

- Patient is 18 years of age or older.
- Diagnosis of giant cell arthritis.
- Unless contraindicated, patient has tried and failed treatment with high dose glucocorticoids (for example, prednisone).

Systemic Juvenile Idiopathic Arthritis (SJIA):

- Patient is 2 years of age or older.
- Diagnosis of active systemic juvenile idiopathic arthritis.
- Unless contraindicated, patient has tried and failed NSAIDs or corticosteroids or
- Unless contraindicated, patient has tried and failed at least one oral nonbiologic Disease-Modifying Anti-Rheumatic Drugs (DMARDs) (for example, methotrexate, leflunomide, hydroxychloroquine, etc.).

Initial authorization is for 12 months.

Universal Reauthorization:

- Patient continues to meet the initial criteria.
- Normal lab results as documented by routine laboratory monitoring (neutrophils, platelets, lipids and liver function tests).
- Lack of unacceptable toxicities (serious infections, hepatotoxicity, GI perforation, etc.) and documentation of positive clinical outcome (percent improvement in JIA ACR core set, physical global assessment, functional ability, etc.).

Reauthorization is for 12 months.

Must be 2 years of age or older for PJIA and SJIA.

Must be 18 years of age or older for RA and GCA.

Modifiers SA, UD, U7 and 99 are allowed.

Q5136

Denosumab-bbdz (Prolia®, Jubbonti®, Xgeva®, Wyost®)

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

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

Prolia & Jubbonti

For the treatment of postmenopausal women with osteoporosis at high risk for fracture, and for the treatment to increase bone mass in men with osteoporosis at high risk for fracture:

Initial Criteria:

- Prescribed for FDA-approved indications and dosages.
- Must be at least 18 years of age or skeletally mature adolescents as defined by at least one mature long bone (for example, closed epiphyseal growth plate of the humerus) and a body weight greater than or equal to 45 kg.
- Diagnosis of osteoporosis.
- Documentation that the patient is at high risk for fracture (for example, multiple risk factors for fracture, history of fracture, or Bone mineral density (BMD) T-Score at hip or spine less than or equal to -3.0).

Documented history of failure, intolerance or contraindication to other available osteoporosis therapies (for example, alendronate, zoledronic acid, etc.).

For the treatment of glucocorticoid-induced osteoporosis in men and women at high risk for fracture:

Initial Criteria:

- Prescribed for FDA-approved indications and dosages.
  - Must be at least 18 years of age or skeletally mature adolescents as defined by at least one mature long bone (for example, closed epiphyseal growth plate of the humerus) and a body weight greater than or equal to 45 kg
- Diagnosis of osteoporosis induced by glucocorticoid therapy.
  - Patient is either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and expected to remain on glucocorticoids for at least six months
- Documentation that the patient is at high risk for fracture (for example, multiple risk factors for fracture, history of fracture, or Bone mineral density (BMD) T-Score at hip or spine less than or equal to -3.0).
- Documented history of failure, intolerance or contraindication to other available osteoporosis therapies (for example, alendronate, zoledronic acid, etc.).

For the treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer:

Initial Criteria:

- Prescribed for FDA-approved indications and dosages.
  - Prescribed by or in consultation with an oncologist
  - Must be at least 18 years of age or skeletally mature adolescents defined by at least one mature long bone (for example, closed epiphyseal growth plate of the humerus) and a body weight greater than or equal to 45 kg
  - Diagnosis of nonmetastatic prostate cancer
  - Patient is receiving androgen deprivation therapy (for example, leuprolide, bicalutamide, etc.)
  - Documented history of failure, intolerance, or contraindication to oral bisphosphonate or IV bisphosphonate therapies (for example, alendronate, zoledronic acid, etc.)

For the treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer:

Initial Criteria:

- Prescribed for FDA-approved indications and dosages.
- Diagnosis of breast cancer.
  - Prescribed by or in consultation with an oncologist.
  - Must be at least 18 years of age or skeletally mature adolescents as defined by at least one mature long bone (for example, closed epiphyseal growth plate of the humerus) and a body weight greater than or equal to 45 kg
  - Patient is receiving aromatase inhibitor therapy (for example, anastrozole, exemestane, etc.)
  - Documented history of failure, intolerance, or contraindication to oral bisphosphonate or IV bisphosphonate therapies (for example, alendronate, zoledronic acid, etc.)

Xgeva & Wyost

For the prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors:

Initial Criteria:

- Must be used for FDA-approved indications and dosages.
- Must be at least 18 years of age or skeletally mature adolescents as defined by at least one mature long bone (for example, closed epiphyseal growth plate of the humerus) and a body weight greater than or equal to 45 kg.
- Prescribed by or in consultation with an oncologist.
- Diagnosis of multiple myeloma or bone metastases from solid tumors.
- Patient does not have pre-existing hypocalcemia**.**

For the treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity:

Initial Criteria:

- Must be used for FDA-approved indications and dosages.
- Prescribed by or in consultation with an oncologist.
- Must be at least 18 years of age or skeletally mature adolescents defined by at least one mature long bone (for example, closed epiphyseal growth plate of the humerus) and a body weight greater than or equal to 45 kg.
- Patient does not have pre-existing hypocalcemia.
- Diagnosis of giant cell tumor of bone and tumor is either unresectable or surgical resection is likely to result in severe morbidity**.**

For the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy:

Initial Criteria:

- Must be used for FDA-approved indication and dosages.
- Prescribed by or in consultation with an oncologist.
- Must be at least 18 years of age or skeletally mature adolescents as defined by at least one mature long bone (for example, closed epiphyseal growth plate of the humerus) and a body weight greater than or equal to 45 kg.
- Diagnosis of hypercalcemia of malignancy.
- Albumin-corrected calcium of greater than 12.5 mg/dL (3.1 mmol/L).
- Inadequate response, intolerance, or contraindication to intravenous bisphosphonate therapy seven to 30 days prior to initiation of therapy.

Initial authorization is for 12 months.

Continued Therapy Criteria for All Approved Indications

- Patient meets the initial TAR criteria for each indication.
- Documentation of positive clinical response to therapy.

Re-authorization is for 12 Months.

Modifiers SA, UD, U7 and 99 are allowed.

Non-Injection

The following non-injection code has special billing policies:

J8541

J8541

Dexamethasone Tablets (Hemady)

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

Age must be 18 years or older.

Required ICD-10-CM Diagnosis Codes: C90.0, C90.01, C90.02, C90.00

Modifiers SA, UD, U7 and 99 are allowed.

Proprietary Laboratory Analyses (PLA)

The following PLA codes have special billing policies:

0488U, 0494U

0488U

A *Treatment Authorization Request* (TAR) requires documentation of the following criteria:

For fetal RhD status

- The patient is currently pregnant, and
- The pregnant patient is RhD negative, and
- The pregnant patient has not been tested with another cell-free DNA test for fetal RhD status during the same pregnancy.

For fetal status of non-RhD red blood cell (RBC) antigens

- The patient is currently pregnant, and
- The pregnant patient has alloantibodies to one or more non-RhD RBC antigens, and
- The paternal non-RhD RBC antigen status is either heterozygous or unknown, and
- The pregnant patient has not been tested with another cell-free DNA test to determine fetal status of non-RhD RBC antigens during the same pregnancy.

Reimbursement will be limited to once per pregnancy, unless there is documentation of medical necessity.

Modifiers 33, 90 and 99 are allowable.

0494U

A *Treatment Authorization Request* (TAR) requires documentation of the following criteria:

For fetal RhD status

- The patient is currently pregnant, and
- The pregnant patient is RhD negative, and
- The pregnant patient has not been tested with another cell-free DNA test to determine fetal RhD status during the same pregnancy.

Reimbursement will be limited to once per pregnancy, unless there is documentation of medical necessity.

Modifiers 33, 90 and 99 are allowable.

Radiology

The following Radiology code has special billing policies:

A9610

A9610

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

Modifiers SA, U7 and 99 are allowable.

Skin Substitutes

The following Skin Substitutes codes have special billing policies:

A2027, A2028, A2029, Q4334, Q4335, Q4336, Q4337, Q4338, Q4339, Q4340, Q4341, Q4342, Q4343, Q4344, Q4345

A2027, A2028, A2029, Q4334, Q4335, Q4336, Q4337, Q4338, Q4339, Q4340, Q4341, Q4342, Q4343, Q4344, Q4345

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

Modifiers SA, U7 and 99 are allowed.

Q4 Code Deletions

Table of HCPCS Q4 Code Deletions

Effective October 1, 2024

Subject	Deleted Code
Injection	J1170 (replaced with J1171), J2001 (replaced with J2003), J9258
Non-Injection	J8520 (replaced with J8522), J8521 (replaced with J8522)
Proprietary Lab Analyses (PLA)	0078U, 0167U, 0396U
Radiology	C9150 (replaced with A9610)