Annual HCPCS Level I and II Update (Effective January 1, 2022)

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.

Annual Code Additions

Anesthesia

The following anesthesia codes have special billing policies:

01937, 01938, 01939, 01940, 01941, 01942

01937, 01938, 01939, 01940, 01941, 01942

Percutaneous image-guided injection, drainage or aspiration codes 01937 and 01938, percutaneous image-guided destruction procedure by neurolytic agent codes 01939 and 01940, and percutaneous image-guided neuromodulation or intravertebral procedure codes 01941 and 01942 are indicated for the spine or spinal cord.

Modifiers AA, AG, ET, P1, P3, P4, P5, PA, PB, PC, QK, QS, QX, QY, QZ, U7, 22 and 99 are allowed.

Cardiology

The following cardiology codes have special billing policies:

93319, 93593, 93594, 93595, 93596, 93597, 93598

93319

3D echocardiographic imaging is indicated for the assessment of cardiac structure(s) and function.

Modifiers SA, U7 and 99 are allowed.

93593, 93594, 93595, 93596, 93597, 93598

Right and left heart catheterization codes 93593, 93594, 93595, 93596, 93597 and cardiac output measurement code 93598 are indicated for congenital heart defects.

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

Modifiers SA, U7, 53 and 99 are allowed.

Chemotherapy

The following chemotherapy codes have special billing policies:

C9087, J1952, J9021, J9061, J9272, Q2055

C9087

Cyclophosphamide is an alkylating agent indicated for the treatment of Malignant Diseases: malignant lymphomas, Hodgkin's disease, lymphocytic lymphoma, mixed-cell type lymphoma, histiocytic lymphoma, Burkitt's lymphoma; multiple myeloma, leukemias, mycosis fungoides, neuroblastoma, adenocarcinoma of ovary, retinoblastoma, breast carcinoma.

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 dosing regimens
- Patient has a diagnosis of one of the following malignant diseases:
  - Malignant lymphomas (Stages III and IV of the Ann Arbor staging system), Hodgkin's disease, lymphocytic lymphoma (nodular or diffuse), mixed-cell type lymphoma, histiocytic lymphoma, Burkitt's lymphoma
  - Multiple myeloma
  - Leukemias: chronic lymphocytic leukemia, chronic granulocytic leukemia (it is usually ineffective in acute blastic crisis), acute myelogenous and monocytic leukemia, acute lymphoblastic (stem-cell) leukemia (cyclophosphamide given during remission is effective in prolonging its duration)
  - Mycosis fungoides (advanced disease)
  - Neuroblastoma (disseminated disease)
  - Adenocarcinoma of the ovary
  - Retinoblastoma
  - Carcinoma of the breast
- Patient does not have hypersensitivity to cyclophosphamide
- Patient does not have urinary outflow obstruction

Approval is for 12 months.

Modifiers SA, UD, U7 and 99 are allowed.

J1952

Leuprolide is a gonadotropin-releasing hormone (GnRH) agonist indicated for the treatment of adult patients with advanced prostate cancer.

Frequency of billing is 42 mg/42 units every six months. Maximum billing unit(s) = 42 mg/42 units

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
- Patient must be 18 years of age or older
- Patient has a diagnosis of histologically confirmed advanced prostate cancer
- Patient is a candidate for androgen ablation therapy
- Patient has a baseline morning serum testosterone level greater than 150 ng/dL

- Patient has an Eastern Cooperative Oncology Group (ECOG) performance score less than or equal to two
- Patient does not have uncontrolled diabetes
- Patient must be treated with the less expensive but clinically appropriate Gonadotropin Releasing Hormone Agonist first (for example, Lupron Depot, Trelstar and Eligard), unless there is intolerance, treatment failure or contraindication

Initial approval is for 12 months.

Continued Therapy

Reauthorization is approvable if at least one of the following conditions apply:

- Patient continues to meet initial approval criteria
- Patient is responding to therapy as evidenced by achieving and maintaining serum testosterone suppression to less than or equal to 50 ng/dL by week four through week forty-eight of treatment
- Patient has significant reduction and continued suppression of PSA levels during treatment
- Patient does not show evidence of disease progression while on therapy.

Reauthorization is for 12 months.

Modifiers SA, UD, U7 and 99 are allowed.

J9021

Asparaginase erwinia chrysanthemi (recombinant)-rywn is an asparagine specific enzyme indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of acute lymphoblastic leukemia (ALL) and lymphoblastic lymphoma (LBL) in adult and pediatric patients 1 month or older who have developed hypersensitivity to E. coli-derived asparaginase.

Modifiers SA, UD, U7 and 99 are allowed.

J9061

Amivantamab-vmjw is a bispecific Epidermal growth factor receptor (EGF) receptor-directed and mesenchymal-epithelial transition (MET) receptor-directed antibody indicated for the treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations, as detected by an FDA-approved test, whose disease has progressed on or after platinum-based chemotherapy.

Frequency of billing is 1400 mg/700 units weekly for four weeks, then every two weeks thereafter. Note that the initial dose is administered as a split infusion in week one on days one and two. Maximum billing unit(s) = 1400 mg/700.

Modifiers SA, UD, U7 and 99 are allowed.

J9272

Jemperli is a programmed death receptor-1 (PD-1)-blocking antibody indicated for the treatment of adult patients with mismatch repair deficient (dMMR) recurrent or advanced

endometrial cancer, as determined by an FDA-approved test, that has progressed on or following prior treatment with a platinum-containing regimen.

Frequency of billing equals 500 mg/50 units every three weeks for four doses, then three weeks after dose four, continue with 1000 mg/100 units every six weeks. Maximum billing unit(s) = 1000 mg/100 units.

Modifiers SA, UD, U7 and 99 are allowed.

Q2055

Abecma is a chimeric antigen receptor (CAR)-positive T-cell therapy targeting B-cell maturation antigen (BCMA) indicated for the treatment of adult patients with relapsed or refractory multiple myeloma after four or more prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody.

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
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with an oncologist or a hematologist
- Patient must have a diagnosis of relapsed and refractory multiple myeloma (RRMM)
- Patient has received four or more myeloma treatment regimens including a proteasome inhibitor (for example, bortezomib, carfilzomib, ixazomib), an immunomodulatory agent (for example, lenalidomide, pomalidomide, thalidomide) and an anti-CD38 antibody (for example, daratumumab, daratumumab/hyaluronidase,isatuximab)
- Eastern Cooperative Oncology Group (ECOG) performance status of less than or equal to 2
- Patient has no history of CNS disease (for example, seizure or cerebrovascular ischemia)
- Patient must have creatinine clearance greater than 30 mL/min
- Patient has left ventricular ejection fraction of 45 percent or greater
- Patient has no active infection or inflammatory disorders
- Patient must not have any of the following:
  - Aspartate aminotransferase (AST) and/or Alanine Aminotransferase (ALT) greater than 2.5 times the upper limit of normal (ULN)
  - Absolute neutrophil count (ANC) less than 1000cells/mm^3 and platelet count less than 50,000/mm^3
- Patient has not been previously treated with CAR-T therapy in RRMM
- Abecma will not be used concurrently with another CAR-T therapy
- Abecma must be administered at a healthcare facility certified by the manufacturer based on the Risk Evaluation and Mitigation Strategy (REMS) requirements defined by the FDA

- The provider facility is accredited by the Foundation for the Accreditation of Cellular Therapy (FACT) for Immune Effector Cell Therapy (IECT).
- Outpatient administration is restricted to Hospital Outpatient Services only.

Initial approval is for three months (one treatment only).

Reauthorization: Repeat treatment is not approvable.

Abecma REMS

Because of the risk of Cytokine Release Syndrome (CRS) and neurologic toxicities, Abecma is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Abecma REMS.

The required components of the Abecma REMS are:

- Healthcare facilities that dispense and administer Abecma must be enrolled and comply with the REMS requirements.
- Certified healthcare facilities must have on-site, immediate access to tocilizumab.
- Ensure that a minimum of two doses of tocilizumab are available for each patient for infusion within two hours after Abecma infusion, if needed for treatment of CRS.
- Certified healthcare facilities must ensure that healthcare providers who prescribe, dispense, or administer Abecma are trained in the management of CRS and neurologic toxicities.
- Further information is available at www.AbecmaREMS.com or contact Bristol-Myers Squibb at 1-888-423-5436.

Important Instructions for Billing

Due to systems limitations, providers are to take the following steps when submitting claims for Abecma:

1. Submit and receive back an approved *Treatment Authorization Request* (TAR)/Service Authorization Request (SAR)
2. Bill using Q2055 (idecabtagene vicleucel, up to 460 million autologous b-cell maturation antigen [bcma] directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose)
3. Completion of claim forms:
   - Claims are restricted to Hospital Outpatient Services. Note that claims from pharmacies and clinics will be denied
   - Outpatient claims may be billed by paper claim using *UB-04* or electronically using 837I.
   - Providers must submit one (1) service line on the TAR/SAR request and enter “5” in the Units box.
   - On the 837I or *UB-04* claim form, providers must submit one claim line to represent one (1) service.
     - ❖ Claims submitted with more than one claim line will be denied.
   - Providers must submit an invoice for reimbursement.

– This process will ensure that the total reimbursement paid for the quantity of five (5) is no more than the paid price on the provider submitted invoice.

– Abecma must be billed on its own with no other drug or biological.

4. For instructions regarding physician claim form completion, refer to the Forms page on the Medi-Cal Providers website, for completion of 837I and *UB-04* claim forms

Modifiers SA, UD, U7 and 99 are allowed

Evaluation and Management

The following evaluation and management codes have special billing policies:

99424, 99425, 99426, 99427, 99437

99424, 99425, 99426, 99427

Principal care management (PCM) services are provided when medical and/or psychological needs manifested by a single, complex chronic condition are expected to last at least three months.

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

99437

Chronic care management (CCM) service code 99437 must be billed in conjunction with change code 99491.

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

Gastroenterology

The following gastroenterology code has special billing policies:

91113

91113

Gastrointestinal imaging code 91113 is contraindicated in patients with known or suspected gastrointestinal obstruction, strictures or fistulae.

An approved *Treatment Authorization Request* (TAR) is required for reimbursement and is approved only for patients with incomplete colonoscopy.

Modifiers SA, U7 and 99 are allowed.

Injections

The following injection codes have special billing policies:

C9085, C9086, J0172, J2506

C9085

Avalglucosidase alfa-ngpt is a hydrolytic lysosomal glycogen-specific enzyme indicated for the treatment of patients 1 year of age and older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency).

Frequency of billing is:

- Greater than or equal to 30 kg, 20 mg/kg (of actual body weight) every two weeks
- Less than 30 kg, 40 mg/kg (of actual body weight) every two weeks

ICD-10-CM diagnosis code E74.02 is required on the claim.

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.
- Patient must be one year of age or older
- Must be prescribed by or in consultation with a neurologist, geneticist or other physician with specialty in treating Pompe disease
- Patient must have a diagnosis of late-onset Pompe disease confirmed by one or both of the following:
  - Llysosomal acid alpha-glucosidase (GAA) enzyme deficiency from any tissue source (for example skin fibroblast or muscle)
  - Genetic testing with two confirmed GAA gene variants
- Patient has documented baseline results of Forced Vital Capacity (FVC) and/or six Minute Walk Test (6MWT)
- Patient is not concurrently taking Alglucosidase Alfa (Lumizyme)

Initial authorization is for twelve months.

Continued therapy

Patient has shown clinical benefit as evidence by at least one of the following:

- Change in FVC (percent predicted) in the upright position from baseline.
- Change in total distance walked in six minutes (six Minute Walk Test, [6MWT]) from baseline.

Reauthorization is for twelve months.

Modifiers SA, UD, U7 and 99 are allowed.

C9086

Anifrolumab-fnia is a type I interferon (IFN) receptor antagonist indicated for the treatment of adult patients with moderate to severe systemic lupus erythematosus (SLE), who are receiving standard therapy.

Frequency of billing is 300 mg/300 units every twenty-eight days. Maximum billing units = 300 mg/300 units.

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
- Patient must be eighteen years of age or older
- Must be prescribed by or in consultation with a nephrologist or neurologist

- Patient has fulfilled at least four of the eleven American College of Rheumatology (ACR) classification criteria for SLE
- Patient has moderately to severely active SLE measured by both of the following:
  - A score on the Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) of six or higher and a score on the clinical SLEDAI-2K of four or higher.
  - At least one of the following
    - ❖ Severe disease activity in one or more organs (BILAG-2004 Index A)
    - ❖ Moderate activity in two or more organs (BILAG-2004 Index B)
- Patient was seropositive for antinuclear antibodies, anti–double-stranded DNA (anti-dsDNA) antibodies, or anti-Smith antibodies.
- Patient is receiving stable treatment with at least one of the following:
  - Glucocorticoids (for example, Prednisone, Methylprednisone, etc.)
  - An Antimalarial Agent (hydroxychloroquine or chloroquine)
  - Immunosuppresants (Azathioprine, Mycophenolate Mofetil, Mycophenolic Acid, Methotrexate, etc.).
- Patient does not have active severe lupus nephritis or neuropsychiatric SLE.

Initial approval is for twelve months.

Continued therapy

- Patient continues to meet initial approval criteria.
- Patient has shown positive clinical response as evidenced by one or more of the following:
  - Reduction in disease activity measured using the British Isles Lupus Assessment Group based Composite Lupus Assessment (BICLA)
  - Improvement in all organs with disease activity at baseline with no new flares.
  - Reduction in the dosages of oral corticosteroids from baseline.

Reauthorization is for twelve months.

Modifiers SA, UD, U7 and 99 are allowed.

J0172

Aducanumab-avwa is an amyloid beta-directed antibody indicated for the treatment of Alzheimer's disease.

Frequency of billing is every three weeks. ICD-10-CM codes: Primary diagnosis codes: G30.0, G30.1, G30.8, G30.9, G31.84; secondary diagnosis codes: F03.90 and F03.91 are required on the claim.

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
- Patient must be 50 to 85 years old.

  - Or patient is 50 years old or younger and has early onset Alzheimer's disease (AD) and meets eligibility criteria

- 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 and must have:
  - A global Clinical Dementia Rating (CDR) score of 0.5
  - A Mini-Mental State Examination (MMSE) score of 24 to 30
  - A positive amyloid Positron Emission Tomography (PET) scan or cerebrospinal fluid (CSF) testing for tau proteins.
  - An objective evidence of cognitive impairment at screening
- Patient must have an MRI at baseline and at seven and 12 months 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.
- If on drugs to treat symptoms related to AD, must be stable for at least 8 weeks prior to treatment initiation.
- Patient does not have any of the following:
  - A stroke or Transient Ischemic Attack (TIA) or unexplained loss of consciousness in the past one year
  - Relevant brain hemorrhage, bleeding disorder and cerebrovascular abnormalities
- All other causes of cognitive impairment have been excluded such as the following:
  - Vascular Dementia (for example, stroke, transient ischemic attack)
  - Lewy body dementia
  - Frontotemporal dementia
- Patient is not taking blood thinners (except for aspirin at a prophylactic dose or less)

Initial approval is for twelve months.

<u>Continued therapy</u>

- Patient has shown clinical benefit as evidenced by at least one of the following or 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.
- Patient does not have hypersensitivity reactions such as angioedema and urticaria.

Reauthorization is for twelve months.

Modifiers SA, UD, U7 and 99 are allowed.

J2506

Pegfilgrastim is a leukocyte growth factor indicated for the following:

- Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.
- Increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome).

Maximum billing unit(s) = six mg/12 units.

Modifiers SA, UD, U7 and 99 are allowed.

Non-Injection

The following non-injection code has special billing policies:

C9088

C9088

Zynrelef™ is a fixed-dose combination of bupivacaine and meloxicam is indicated in adults for soft tissue or periarticular instillation to produce postsurgical analgesia for up to 72 hours after bunionectomy, open inguinal herniorrhaphy and total knee arthroplasty.

Frequency is 400 mg/12 mg /400 units as a single dose. Maximum billing unit(s) = 400 mg/12 mg /400 units

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
- Patient must be 18 years of age or older
- Medication is being used to produce postsurgical analgesia and it has not been greater than 72 hours since surgery
- Patient had one of the following surgeries:
  - Bunionectomy
  - Open inguinal herniorrhaphy
  - Total knee arthroplasty
- Patient will not use local anesthetics within 96 hours of administration
- Patient does not have a known hypersensitivity (for example, anaphylactic reactions and serious skin reactions) to any amide local anesthetic
- Patient does not have a history of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs
- Patient is not undergoing obstetrical paracervical block anesthesia
- Patient is not undergoing coronary artery bypass graft (CABG) surgery

Authorization is for a single-dose administration

Modifiers UD and 99 are allowed.

Ophthalmology

The following ophthalmology codes have special billing policies:

66989, 66991

66989, 66991

Cataract extraction surgery codes require an approved *Treatment Authorization Request* (TAR) with assistant surgeon services not payable.

Modifiers AG, ET, PA, PB, PC, SC, UA, UB, U7, 22, 47, 51, 52, 53, 54, 55, 62, 66, 76, 77, 78, 79 and 99 are allowed.

Pathology

The following pathology codes have special billing policies:

0286U, 0287U, 0301U, 0302U, 80220, 80503, 80504, 80505, 80506, 81349, 81523, 81560, 82653, 83521, 83529, 86015, 86036, 86037, 86051, 86052, 86053, 86231, 86258, 86362, 86363, 86364, 86381, 86596, 87154

0286U

CEP72, NUDT15 and TPMT15 gene analysis common variants code requires an approved *Treatment Authorization Request* (TAR) for reimbursement. The TAR must include clinical documentation that demonstrates all of the following:

- The patient is undergoing thiopurine therapy, and
- The patient has severe or prolonged myelosuppression

Modifiers 33, 90 and 99 are allowed.

0287U

Thyroid oncology code 0286U requires an approved *Treatment Authorization Request* (TAR) for reimbursement. The TAR must include clinical documentation that demonstrates all of the following:

1. The patient is under evaluation for thyroid nodule(s), and
2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following:
   – Follicular lesion of undetermined significance (FLUS), Bethesda III, or
   – Atypia of undetermined significance (AUS), Bethesda III, or
   – Follicular neoplasm, Bethesda IV.
3. The diagnostic or treatment strategy will be contingent on test results

Modifiers 33, 90 and 99 are allowed.

0301U, 0302U, 80220, 80503, 80504, 80505, 80506, 81349, 81560, 82653, 83529, 86231, 86362, 86596

Modifiers 33, 90 and 99 are allowed.

81523

Breast oncology code 81523 requires an approved *Treatment Authorization Request* (TAR) for reimbursement. The TAR must include clinical documentation that demonstrates all of the following:

- The recipient has high clinical risk per MINDACT categorization.
- The recipient is estrogen and progesterone receptor (ER/PgR)-positive.
- The recipient is HER2-receptor negative.
- The recipient is lymph node negative or lymph node positive.
- The recipient is a candidate for chemotherapy.
- The assay is used within six months of diagnosis.
- The recipient is under consideration for adjuvant systemic therapy.

Use CPT code 81523 when billing for MammaPrint. As noted in the 2017 ASCO guideline, the Adjuvant! Online website was not functional. As an alternative, clinicians can determine a patient's clinical risk status by using the printed version of the Adjuvant! Online clinical risk criteria found in the Data Supplement of the MINDACT publication.

Modifiers 33, 90 and 99 are allowed.

83521

Immunoglobulin light chains code 83521 has a frequency of nine per day.

Modifiers 33, 90 and 99 are allowed.

86015

Actin (smooth muscle) antibody code 86015 has a frequency of three per day.

Modifiers 33, 90 and 99 are allowed.

86036

Antineutrophil cytoplasmic antibody screen code 86036 has a frequency of three per day.

Modifiers 33, 90 and 99 are allowed.

86037

Antineutrophil cytoplasmic antibody titer code 86037 has a frequency of three per day.

Modifiers 33, 90 and 99 are allowed.

86051

Aquaporin-4 (neuromyelitis optica) antibody enzyme-linked immunosorbent immunoassay code 86051 has a frequency of three per day.

Modifiers 33, 90 and 99 are allowed.

86052

Aquaporin-4 (neuromyelitis optica) antibody cell-based immunofluorescence assay code 86052 has a frequency of four per day.

Modifiers 33, 90 and 99 are allowed.

86053

Aquaporin-4 (neuromyelitis optica) antibody flow cytometry code 86053 has a frequency of two per day.

Modifiers 33, 90 and 99 are allowed.

86258

Gliadin (deamidated) antibody each immunoglobulin class code 86258 has a frequency of four per day.

Modifiers 33, 90 and 99 are allowed.

86363

Myelin oligodendrocyte glycoprotein antibody flow cytometry code 86363 has a frequency of two per day.

Modifiers 33, 90 and 99 are allowed.

86364

Tissue transglutaminase each immunoglobulin code 86364 has a frequency of four per day.

Modifiers 33, 90 and 99 are allowed.

86381

Mitochondrial antibody code 86381 has a frequency of three per day.

Modifiers 33, 90 and 99 are allowed.

87154

Culture, typing; identification of blood pathogen and resistance typing, when performed, by nucleic acid (DNA or RNA) probe, multiplexed amplified probe technique including multiplex reverse transcription, when performed, per culture or isolate, 6 or more targets. HCPCS code 87154 is reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) services.

Modifiers 33, 90 and 99 are allowed.

Pulmonology

The following pulmonology codes have special billing policies:

94625, 94626

94625, 94626

Physician or other qualified health care professional services for outpatient pulmonary rehabilitation includes therapeutic services and all related monitoring services to improve respiratory function. Patients with post-COVID-19 pulmonary sequelae are eligible for pulmonary rehabilitation.

Frequency of billing is 36 sessions. ICD-10-CM diagnosis codes J41.0 thru J41.8, J43.0 thru J43.9, J44.9, U07.01, Z76.82 or Z94.2 are required on the claim.

Modifiers SA, U7, 99 and GP are allowed.

Radiology

The following radiology codes have special billing policies:

77089, 77090, 77091, 77092, A9595, M1072, M1073, M1074, M1075, M1076, M1077, M1078, M1079, M1080, M1081, M1082, M1083, M1084, M1085, M1086, M1087, M1088, M1089, M1094, M1095, M1096, M1097, M1098, M1099, M1100, M1101, M1102, M1103, M1104, M1105

77089, 77090, 77091, 77092

Trabecular bone score (TBS), structural condition of the bone microarchitecture codes are imaging tests for patients.

Modifiers U7 and 99 are allowed.

A9595

Piflufolastat F 18 (Pylarify®) is a radioactive diagnostic agent indicated for positron emission tomography (PET) of prostate-specific membrane antigen (PSMA) positive lesions in men with prostate cancer ages 18 years of age or older.

Maximum billing unit(s) = 370 MBq (10 mCi)/10 units.

A9595 and is separately billable and not split billable. Providers must complete CMS-1500 form including the medically justified ICD-10-CM diagnosis code(s). Providers must include an invoice showing the acquisition cost of the product for the claim. The invoice must have a date prior to the date of service or the claim will be denied.

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
- Patient must be 18 years of age or older
- Patient has a diagnosis of biopsy-proven prostate cancer with subsequent definitive therapy
- Patient has a suspected recurrence of prostate cancer based on rising PSA after definitive therapy on the basis of:
- Post-radical prostatectomy: detectable or rising PSA that is equal to or greater than 0.2 ng/mL with a confirmatory PSA greater than or equal to 0.2 ng/mL, or
- Patient had post-radiation therapy, cryotherapy, or brachytherapy with increase in PSA level that is elevated by at least two ng/mL above the nadir
- Patient has a negative or equivocal standard-of-care imaging (with CT scan or MRI) within 60 days prior to the PET scan with Pylarify
- Patient does not have ongoing treatment with any systemic therapy (for example, androgen deprivation therapy [ADT], antiandrogen, gonadotropin-releasing hormone [GnRH], luteinizing hormone-releasing hormone [LHRH] agonist or antagonist) for prostate cancer

Approval is for three months.

Modifiers UD, U7 and 99 are allowed.

M1072

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1072 requires one of the following ICD-10-CM diagnosis codes on the claim: C21.0, C21.1, C21.8, C43.51, C44.500, C44.510, C44.520, C44.590, C4A.51, D01.3, D03.51 or Z85.048.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1073

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1073 requires one of the following ICD-10-CM diagnosis codes on the claim: C21.0, C21.1, C21.8, C43.51, C44.500, C44.510, C44.520, C44.590, C4A.51, D01.3, D03.51 or Z85.048.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1074

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1074 requires one of the following ICD-10-CM diagnosis codes on the claim: C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.8, C67.9, C79.11 or D09.0.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1075

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1075 requires one of the following ICD-10-CM diagnosis codes on the claim: C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.8, C67.9, C79.11 or D09.0.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1076

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1076 requires on of the following ICD-10-CM diagnosis codes on the claim: C73, C78.8, C79.51, C79.52, Z85.830 or Z85.9.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1077

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1077 requires one of the following ICD-10-CM diagnosis codes on the claim: C73, C78.8, C79.51, C79.52, Z85.830 or Z85.9.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1078

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1078 requires on of the following ICD-10-CM diagnosis codes on the claim: C19, C79.31, C79.32, Z85.841 or Z85.9.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1079

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1079 requires one of the following ICD-10-CM diagnosis codes on the claim: C19, C79.31, C79.32, Z85.841 or Z85.9.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1080

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1080 requires on of the following ICD-10-CM diagnosis codes on the claim: C79.81, D05.00, D05.01, D05.02, D05.11, D05.12, D05.81, D05.82, D05.90, C50.011, C50.012, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511, C50.511, C50.512, C50.521, C50.522, C50.611, C50.612, C50.811, C50.119, C50.121, C50.122, C50.621, C50.622, C50.812, C50.821, C50.822, C50.911, C50.912, C50.921, C50.922, C50.929, D05.01, D05.02, D05.11, D05.12, D05.81, D05.82, D05.90 or Z85.3.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1081

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1081 requires one of the following ICD-10-CM diagnosis codes on the claim: C79.81, D05.00, D05.01, D05.02, D05.11, D05.12, D05.81, D05.82, D05.90, C50.011, C50.012, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511, C50.511, C50.512, C50.521, C50.522, C50.611, C50.612, C50.811, C50.119, C50.121, C50.122, C50.621, C50.622, C50.812, C50.821, C50.822, C50.911, C50.912, C50.921, C50.922, C50.929, D05.01, D05.02, D05.11, D05.12, D05.81, D05.82, D05.90 or Z85.3.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1082

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1082 requires on of the following ICD-10-CM diagnosis codes on the claim: C72.9, C47.9, D33.7, D33.9, D43.9, D49.7 or Z85.848.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1083

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1083 requires one of the following ICD-10-CM diagnosis codes on the claim: C72.9, C47.9, D33.7, D33.9, D43.9, D49.7 or Z85.848.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1084

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1084 requires on of the following ICD-10-CM diagnosis codes on the claim: C53.0, C53.1, C53.8, C53.9 or D06.9.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1085

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1085 requires one of the following ICD-10-CM diagnosis codes on the claim: C53.0, C53.1, C53.8, C53.9 or D06.9.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1086

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1086 requires on of the following ICD-10-CM diagnosis codes on the claim: C18.7, C19 or C20.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1087

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1087 requires one of the following ICD-10-CM diagnosis codes on the claim: C18.7, C19 or C20.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1088

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1088 requires on of the following ICD-10-CM diagnosis codes on the claim: C76.0, C47.0, C49.0, C77.0, C83.71, C81.91 or C83.51.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1089

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1089 requires one of the following ICD-10-CM diagnosis codes on the claim: C76.0, C47.0, C49.0, C77.0, C83.71, C81.91 or C83.51.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1094

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1094 requires on of the following ICD-10-CM diagnosis codes on the claim: C46.50, D02.20, C78.00, C34.91, C34.92, C78.01, C78.02, C34.90, C34.80, C34.81, C34.82, C34.12, C34.11, C34.2, C34.31 or C34.32.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1095

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1095 requires one of the following ICD-10-CM diagnosis codes on the claim: C46.50, D02.20, C78.00, C34.91, C34.92, C78.01, C78.02, C34.90, C34.80, C34.81, C34.82, C34.12, C34.11, C34.2, C34.31 or C34.32.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1096

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1096 requires on of the following ICD-10-CM diagnosis codes on the claim: C82.0 thru C82.9, C81.3, C82.90, C83.1, C85.9, C83.57, C83.77, C82.97, C83.70, C83.5, C81.4, C84.4, C83.10, C81.1, C81.2, C81.70, C83.50, C85.97, C83.0, C85.10, C83.72 or Z85.71.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1097

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1097 requires one of the following ICD-10-CM diagnosis codes on the claim: C82, C81.3, C82.90, C83.1, C85.9, C83.57, C83.77, C82.97, C83.70, C83.5, C81.4, C84.4, C83.10, C81.1, C81.2, C81.70, C83.50, C85.97, C83.0, C85.10, C83.72 or Z85.71.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1098

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1098 requires ICD-10-CM diagnosis code C25.3 on the claim.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1099

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1099 requires ICD-10-CM diagnosis codes C25.3 on the claim.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1100

Radiation therapy for prostate cancer under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1100 is restricted to males.

One of the following ICD-10-CM diagnosis codes is required on the claim: C61, C63.7, Z85.46 or D07.5.

Modifier 26 is required. Modifiers SA, U7 and 99 are allowed.

M1101

Radiation therapy for prostate cancer under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1101 is restricted to males.

One of the following ICD-10-CM diagnosis codes is required on the claim: C61, C63.7, Z85.46 or D07.5.

Modifier TC is required. Modifiers U7 and 99 are allowed.

M1102

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1102 requires one of the following ICD-10-CM diagnosis codes on the claim: C15.3, D01.40, C26.0, C17.9, C78.4, C17.8, Z85.068 or C7A.019.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1103

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1103 requires one of the following ICD-10-CM diagnosis codes on the claim: C15.3, D01.40, C26.0, C17.9, C78.4, C17.8, Z85.068 or C7A.019.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

M1104

Radiation therapy under the Radiation Oncology model, 90-day episode, professional component HCPCS code M1104 requires ICD-10-CM diagnosis code C55 on the claim.

Modifier 26 is required on the claim. Modifiers SA, U7 and 99 are allowed.

M1105

Radiation therapy under the Radiation Oncology model, 90-day episode, technical component HCPCS code M1105 requires ICD-10-CM diagnosis codes C55 on the claim.

Modifier TC is required on the claim. Modifiers U7 and 99 are allowed.

Skin Substitutes

The following skin substitute codes have special billing policies:

A2001, A2002, A2003, A2004, A2005, A2006, A2007, A2008, A2009, A2010, Q4199

An approved *Treatment Authorization Request* (TAR) is required for reimbursement for the above listed skin substitutes. Modifiers U7 and 99 are allowed for all skin substitute codes.

Annual Code Changes

Evaluation and Management

The following evaluation and management codes have special billing policies:

99439, 99490, 99491

99439

Chronic care management code 99439 has a frequency limit of two per month by any provider.

99490, 99491

Chronic care management codes 99490 and 99491 are reimbursable in the same calendar month by any provider. Frequency of billing is once per month.

Annual Code Deletions

Table of HCPCS Annual Code Deletions

Subject	Deleted Code
Chemotherapy	C9081 C9082 C9083
Injection	J2505
Otolaryngology	G9348 G9349 G9350
Pulmonology	G0424 G8925 G8926
Surgery	C9752 C9753

Table of CPT Annual Code Deletions

Subject	Deleted Code
Anesthesiology	01935 01936
Audiology	69715 69718 92559 92560 92561
Cardiology	33722 93530 93531 93532 93533 93561 93562 95943
Dental	D4320 D4321 D8050 D8060 D8690
Gastroenterology	43850 43855
Orthopedics	63194 63195 63196 63198 63199
Otolaryngology	21310

Table of CPT Annual Code Deletions (continued)

Subject	Deleted Code
Obstetrics	59135
Pathology	80500 80502
Oncology	0208U
Pulmonology	33470
Radiology	72275 76101 76102 92564

Table of Specialty Program Code Deletions

Program	Deleted Code
California Children's Services	01935 (SCG 01) 01936 (SCG 01) 59135 (SCG 51) 72275 (SCG 01) 76102 (SCG 01) 92559 (SCG 04, 05) 93530 (SCG 02) 93533 (SCG 02) 93561 (SCG 02) J2505 (SCG 01)