

Effective October 1, 2019

OCTOBER 2019 HCPCS CODE ADDITIONS

Bolded Codes

Bolded codes indicate notation of a special billing policy.

Chemotherapy

J9119, J9204, J9210, J9269, J9313, Q5116, Q5117, Q5118

J9119

Cemiplimab-rwlc is indicated for the treatment of patients 18 years of age and older.

The maximum allowed dose of 350mg/350units is reimbursable once every 21 days.

Modifiers SA, UD, U7 and 99 are allowed.

J9204

Mogamulizumab-kpkc is indicated for the treatment of patients 18 years of age and older.

The maximum allowed dose of 227 mg/227 units is reimbursable four times in the first 28-day cycle and twice in every 28-day cycle thereafter.

Modifiers SA, UD, U7 and 99 are allowed.

J9210

Emapalumab-lzsg is indicated for the treatment of patients 18 years of age and older.

An approved *Treatment Authorization Request (TAR)* is required for reimbursement. The TAR must document that the following criteria are met:

- The service is medically necessary for the treatment of an adult or pediatric patient with primary hemophagocytic lymphohistiocytosis (HLH)
- Treatment follows FDA-approved indications and dosages
- The patient exhibits refractory, recurrent or progressive disease or intolerance with conventional HLH therapy
- The patient has evidence of active disease as assessed by the treating physician; and
- The patient does not have active infection, including latent tuberculosis (TB)
- The patient will be receiving dexamethasone concurrently with empalumab-lzsg; and
- The patient has not undergone hematopoietic stem cell transplantation (HSCT)

The maximum billing unit of 2,273 mg/2,273 units is reimbursable two times per week.

ICD-10 CM diagnosis code D76.1 is suggested on the claim.

Modifiers SA, UD, U7 and 99 are allowed.

OCTOBER 2019 HCPCS CODE ADDITIONS

J9269

Tagraxofusp-erzs is indicated for patients 2 years of age and older.

The maximum allowed dose of 2730 mcg/273 units is reimbursable every 21 days and may be billed on days 1-5 of each 21-day cycle.

ICD-10-CM diagnosis code C86.4 is suggested.

Modifiers SA, UD, U7 and 99 are allowed.

J9313

Moxetumomab pasudotox-tdfk (Lumoxiti) is indicated for patients 18 years of age and older.

The maximum allowed dose of 9.1 mg/910 units may be billed on days 1, 3 and 5 of each 28-day cycle for six cycles.

Modifiers SA, UD, U7 and 99 are allowed.

Q5116, Q5117

CPT codes Q5116 [Trastuzumab-qyyp (Trazimera)] and Q5117 [Trastuzumab-anns (Kanjinti)] are both indicated for the treatment of patients 18 years of age and older.

For both codes, the maximum allowed dose of 1820 mg/182 units is reimbursable every three weeks.

Modifiers SA, UD, U7 and 99 are allowed.

Q5118

Bevacizumab-bvzr (Zirabev) is indicated for the treatment of patients 18 years of age and older.

The maximum allowed dose of 2280 mg/228 units is reimbursable every two weeks.

Modifiers SA, UD, U7 and 99 are allowed.

Injections

J0121, J0122, J0222, J0291, J0593, J0642, J1096, J1097, J1303, J1943, J1944, J2798, J3031, J3111, J7314, J7331, J7332, J7401

J0121

Omadacycline Tosylate (Nuzyra) is indicated for the treatment of patients 18 years of age and older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient is 18 years of age or older
- The case demonstrates the failure of two or more formulary antibiotics indicated for member's diagnosis and sufficiently effective against offending pathogen unless contraindicated or intolerable side effects

Approval quantity will be based on prescribing information and FDA-approved dosages. The maximum allowed dose of 1500 mg/1500 units may be reimbursed every 14 days.

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

J0122

Eravacycline (Xerava) is indicated for the treatment of patients 18 years of age and older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient is 18 years of age or older
- A diagnosis of complicated intra-abdominal infections (cIAIs) caused by one of the following susceptible microorganisms: Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii, Enterobacter cloacae, Klebsiella oxytoca, Enterococcus faecalis, Enterococcus faecium, Staphylococcus aureus, Streptococcus anginosus group, Clostridium perfringens, Bacteroides species and Parabacteroides distasonis, and
- Culture and sensitivity tests showing that the infection is not susceptible to the formulary alternatives or documentation of previous intolerance or contraindication to all formulary alternatives with shown susceptibility on the culture and sensitivity tests. The provider may also provide documentation showing that treatment was initiated during a recent hospitalization or other acute care treatment

Treatment may be authorized for a maximum of 14 days. The maximum allowed dose of 6364 mg/6364 units is reimbursable every 14 days.

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

J0222

Patisiran (Onpattro) is indicated for the treatment of patients 18 years of age and older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient is 18 years of age or older
- The patient has both of the following:
 - Biopsy verification of amyloidosis
 - Genetic testing results confirming a TTR gene mutation
- The patient is experiencing clinical signs and symptoms of the disease such as peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.
- The patient has tried or is currently receiving at least one systemic agent for symptoms of polyneuropathy from one of the following pharmacologic classes: a GABA analogue such as gabapentin, pregabalin or a tricyclic antidepressant such as nortriptyline, amitriptyline, etc.
- The patient is not to take patisiran concurrently with inotersen (Tegsedi), tafamidis meglumine (Vyndaqel), tafamidis (Vyndamex) or diflunisal

The maximum allowed dose of 30 mg /300 units is reimbursable every three weeks.

Modifiers SA, UD, U7 and 99 are allowed.

J0291

Plazomicin (Zemdri) is indicated for the treatment of patients 18 years of age and older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient must have a diagnosis of complicated urinary tract infection (cUTI) including pyelonephritis caused by Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis and Enterobacter cloacae
- The patient must be 18 years of age or older
- The patient must not be pregnant
- The provider must justify why patient cannot use formulary alternatives such as an aminoglycoside, carbapenems, fluoroquinolone or other therapeutic equivalent
- The provider must provide the patient's recent weight for dose determination

The maximum billing unit of 3400 mg/680 units is reimbursable every 24 hours for 4-7 days.

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

J0593

Lanadelumab-flyo (Takhzyro) is indicated for the treatment of patients 12 years of age and older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient must be 12 years of age or older
- Diagnosis of HAE must be confirmed by one of the following two options:
 - Low C4 level and low C1-INH antigenic or functional level
 - Normal C4 level and normal C1-INH level, and both of the following:
 - ❖ History of recurrent angioedema
 - ❖ Family history of angioedema
- The patient is using medication for prophylaxis against acute attacks of hereditary angioedema for one of the following two options:
 - Short-term prophylaxis prior to surgery, dental procedures or intubation
 - Long-term prophylaxis, and the individual has failed, or is intolerant to, or has a contraindication (such as pregnant or breastfeeding individuals) to 17 alpha-alkylated androgens (for example, danazol) or antifibrinolytic agents (for example, aminocaproic acid)
- The patient must not use Takhzyro with other FDA-approved products for long-term prophylaxis of HAE attaches such as Cinryze or Haegarda
- The dose must not exceed 300 mg every two weeks

Modifiers SA, UD, U7 and 99 are allowed.

J0642

Levoleucovorin (Khapzory) is indicated for the treatment of patients 6 years of age and older.

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

J1096

Dexamethasone ophthalmic insert (Dextenza) is indicated for the treatment of patients 18 years of age and older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient be 18 years of age or older
- The provider must verify that Dextenza will be placed by a provider immediately following ophthalmic surgery
- The provider must indicate the date of ophthalmic surgery
- The provider must provide clinical reasons why a corticosteroid ophthalmic solution or suspension is inadequate
- The provider must limit quantity to two inserts in a 30-day period

One of the following modifiers is required for reimbursement: LT (Left side) or RT (Right side). Modifiers SA, UD, U7 and 99 are allowed.

J1097

The maximum allowed dose of phenylephrine and ketorolac ophthalmic solution (Omidria) is four ml/four units.

Modifiers SA, UD, U7 and 99 are allowed.

J1303

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient is 18 years of age or older, and
- The patient has a documented diagnosis of PNH with granulocyte or monocyte clone size of more than 5 percent, and

For treatment naïve patients:

- Active hemolysis as measured by lactic acid dehydrogenase (LDH) level of 1.5 times the upper limit of normal (ULN) at screening and one of the following within three months of screening:
 - Fatigue, hemoglobinuria, abdominal pain, shortness of breath (dyspnea), anemia (hemoglobin <10 g/dl), history of major adverse vascular events (MAVE) (including thrombosis), dysphagia or erectile dysfunction; or history of pRBC transfusion due to PNH
- The patient must be vaccinated against meningococcal infections within three years prior to, or at the time of, initiating ravulizumab-cwvz. If ravulizumab-cwvz is initiated fewer than two weeks after vaccination, patients must receive prophylactic antibiotics until two weeks after vaccination.

For eculizumab conversion patients:

- Hemolysis as measured by LDH level less than 1.5 times the ULN at screening, and the patient has received treatment with eculizumab for at least six months
- The patient must be vaccinated against meningococcal infections within three years prior to, or at the time of, initiating therapy. If ravulizumab-cwvz is initiated fewer than two weeks after vaccination, patients must receive prophylactic antibiotics until two weeks after vaccination.

Continuation of therapy:

- Continuation of therapy in appropriate patients is considered medically necessary for the treatment of an individual with documented PNH who is currently receiving treatment with ravulizumab-cwvz and one of the following:
 - Hemolysis control measured by LDH level less than 1.5 times the ULN, or
 - Transfusion avoidance defined as elimination of transfusion requirements or reduced need for transfusions, or
 - Stabilization of hemoglobin levels, or
 - Improvement in FACIT-Fatigue scores

ICD-10 CM Diagnosis code D59.5 is suggested on the claim.

Modifiers SA, UD, U7 and 99 are allowed.

J1943

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient must be 18 to 65 years of age
- The patient must have established tolerability with oral aripiprazole if naïve to aripiprazole; may take up to two weeks
- The provider must show documentation of clinical rationale for avoiding 21-day oral aripiprazole loading dose due to history of patient non-compliance or hospitalization risk
- The provider must be initiating or re-initiating therapy with Aristada (aripiprazole lauroxil)
- Treatment must be used as a single dose and not for repeated dosing
- Treatment must use in conjunction with the first Aristada injection

Note: The first Aristada injection may be administered on the same day as Aristada Initio or up to 10 days thereafter

- Treatment must be used in conjunction with a single 30 mg dose of oral aripiprazole for the following regimens:
 - Patient is initiating therapy with Aristada, or
 - Patient is reinitiating therapy with Aristada after greater than seven weeks since last Aristada 441 mg dose injection or greater than 12 weeks after all other strengths of Aristada.

The maximum allowed dose of 675 mg/675 units is reimbursable after six weeks.

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

J1944

Aripiprazole lauroxil (Aristada) is indicated for the treatment of patients 18 to 65 years of age.

The maximum allowed dose of 882 mg/882 units is reimbursable every month.

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

J2798

Risperidone ER SQ Injection (Perseris) is indicated for the treatment of patients 18 to 65 years of age.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient must be 18 to 65 years of age
- The patient must have a documented history of poor adherence to oral risperidone
- The patient must be able to tolerate at least three mg of oral risperidone per day

Note: Neither a loading dose nor an overlap with oral risperidone is necessary

The maximum dose of 120mg/240 units is reimbursable every 4 weeks.

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

J3031

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- The patient is 18 years of age or older and is not pregnant
- The patient has had a trial of at least one drug from two oral classes used for migraine prophylaxis, including antiepileptic medications, beta-blockers or antidepressants
- The patient has a diagnosis of chronic migraine

The maximum dose of 225 mg/225 units is reimbursable every month.

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

J3111

Romosozumab-aqqg (Evenity) is indicated for the treatment of patients 18 years of age or older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- Treatment is indicated for osteoporosis in postmenopausal women at high risk of fracture
- The patient must document a bone mineral density (BMD) T-score of ≤ -2.5 or FRAX Score indicating major fracture risk greater than 20 percent or HIP Fracture greater than 3 percent, or non-traumatic fracture.
- The patient has tried and failed, or is intolerant, or has a contraindication to bisphosphonate therapy.
- The patient has tried and failed, or is intolerant, or has a contraindication to injectable osteoporosis treatment drugs such as teriparatide, denosumab and abaloparatide.
- The patient must correct pre-existing hypocalcemia prior to initiation of therapy
- The patient had no myocardial infarction or stroke within one year of starting Evenity.
- The patient is taking a minimum 500 mg calcium and 600 IU vitamin D daily or contraindication
- The patient is not using Evenity in combination with denosumab, bisphosphonates, calcitonin, raloxifene, zolendronic acid, teriparatide or abaloparatide.
- Treatment duration must be limited to 12 months only

The maximum dose of 210 mg/210 units is reimbursable every month.

Modifiers SA, UD, U7 and 99 are allowed.

J7314

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient has a diagnosis of chronic (duration of one year or more) non-infectious uveitis affecting the posterior segment of the eye
- The patient is 18 years of age or older
- At least one of the following two options has been met for the affected eye(s):
 - The patient has experienced a treatment failure or intolerance of at least two administrations of intra- or peri-ocular injections of corticosteroids,
- The patient has experienced a treatment failure or intolerance ex or one conventional therapy, for example:
 - Systemic or topical corticosteroids such as prednisone or prednisolone acetate respectively
 - Immunosuppressive agents (for example, azathioprine, cyclosporine, methotrexate or mycophenolate)
 - Tumor Necrosis Factor (TNF) inhibitors (for example Humira)
- Individual has experienced at least two separate recurrences of uveitis requiring treatment with systemic corticosteroids or ocular injections of corticosteroids.

The maximum allowed dose of 0.18mg/18 units per eye is reimbursable every 36 months.

One of the following modifiers is required for reimbursement: LT (Left side) or RT (Right side). Modifiers SA, UD, U7 and 99 are allowed.

J7331, J7332

Hyaluronan or derivatives (Triluron or Synojoynt) are injected directly into a patient's knee for relief of pain associated with osteoarthritis. Triluron is indicated for the treatment of patients 18 years of age and older. Synojoynt is indicated for the treatment of patients 21 years of age and older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient must be 18 years of age or older (Triluron) or 21 years of age or older (Synojoynt)
- The patient has documented clinical diagnosis of osteoarthritis of the knee
- The patient has documented failure, inadequate response, or intolerance to at least two of the following pharmacologic therapies
 - Two oral or topical [e.g., oral non-steroidal anti-inflammatory drugs (NSAIDs), COX-2 inhibitors, or topical NSAIDS (e.g. diclofenac 1 percent gel)]
 - Acetaminophen (and or topical capsaicin cream)
 - One or more trials in the last 12 months of intra-articular steroid injections unless intolerant or contraindicated
- The patient has completed at least one course of physical therapy for knee osteoarthritis
- There are no contraindications to the injections (active joint infection, bleeding disorder)
- The patient must be treated with the less expensive but clinically appropriate hyaluronan derivatives first

OR

For treatment continuation, the following criteria must be met:

- The patient has successfully used hyaluronic acid derivatives in the same knee (there must be at least a six-month interval before approval of a repeat course)

The maximum allowed dose is 20mg/20 units per knee 60 mg/60 units may be reimbursed every six months.

One of the following modifiers is required for reimbursement: LT (Left side) or RT (Right side). Modifiers SA, SB, UD, U7 and 99 are allowed.

J7401

Mometasone Furoate Sinus Implant (Sinuva) is indicated for the treatment of patients 18 to 65 years of age.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Patient has undergone ethmoid sinus surgery
- Patient has a diagnosis of recurrent nasal polyps and chronic sinusitis
- Patient must have tried and failed inhaled nasal corticosteroids for at least three months at the maximum recommended dosage
- Patient does not have a known hypersensitivity to mometasone furoate or any ingredient of the Sinuva sinus implant
- Must not be for a repeat implantation

Modifiers SA, UD, U7 and 99 are allowed.

Skin Substitutes

Q4205, Q4206, Q4208, Q4209, Q4210, Q4211, Q4212, Q4213, Q4214, Q4215, Q4216, Q4217, Q4218, Q4219, Q4220, Q4221, Q4222, Q4226

Q4205, Q4206, Q4208 - Q4222, Q4226

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

These codes must be billed "By Report with an invoice attached. All skin substitute codes are reimbursable only when billed in conjunction with a CPT procedure in the range of 15271 – 15278. Providers may consult the Surgery: Integumentary System (surg integ) portion of the Medi-Cal Provider Manual for information on specific procedures.

Modifiers SA, U7 and 99 are allowed.

OCTOBER 2019 HCPCS CHANGE CODES

Bolded Codes

Bolded codes indicate notation of a special billing policy.

Chemotherapy

J0641

J0641

Levoleucovorin is approved for the treatment of patients 6 years of age or older.

Modifiers SA, UD, U7 and 99 are allowed.

Injections

J2794, J7311, J7313

J2794

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient must be 18 years of age or older
- The patient must be able to tolerate at least two mg of oral risperidone per day and must have a documented history of poor adherence to oral risperidone
- Oral risperidone or other antipsychotics administered with Risperdal Consta should be tapered off after three (3) weeks

The maximum allowed dosage of 50mg/100 units is reimbursable every 14 days.

Modifiers SA, UD, U7 and 99 are allowed.

J7311

Fluocinolone acetonide intravitreal implant (Retisert), 0.59 mg, is indicated for the treatment of patients 12 years of age and older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient must have a diagnosis of chronic non-infectious uveitis affecting the posterior segment of the eye for one year or more
- The patient must be 12 years of age or older
- Previous treatment regimens must have failed (i.e., recurrent uveitis despite use of traditional therapy) or the patient was intolerant to traditional treatment including intravitreal steroid injections, systemic corticosteroids and/or immunosuppressive agents (i.e., cyclosporine, azathioprine, methotrexate), or
- The patient must be experiencing adverse events associated with high dose systemic steroid or immunosuppressive therapy.

The maximum allowed dosage is 0.59 mg/59 units per eye is reimbursable every 30 months.

One of the following modifiers is required for reimbursement: LT (Left side) or RT (Right side). Modifiers SA, UD, U7 and 99 are allowed.

J7313

Fluocinolone Acetonide Intravitreal Implant (Iluvien) is indicated for the treatment of patients 18 years of age and older.

An approved TAR is required for reimbursement. The TAR must document that the following criteria are met:

- Treatment follows FDA-approved indications and dosages
- The patient must:
 - Be 18 years of age or older
 - Not have active an ocular or periocular infection
 - Not have glaucoma
 - Have a diagnosis of macular edema
 - Have previously received a treatment course with corticosteroids and did not have a clinically significant rise in intraocular pressure

The maximum dosage of 0.19 mg/19 units per eye is reimbursable every 36 months

Skin Substitutes
Q4122, Q4165, Q4184

Q4122, Q4165, Q4184

These codes must be billed "By Report" with an invoice attached. All skin substitute codes are reimbursable only when billed in conjunction with a CPT procedure in the range of 15271 – 15278.

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

Modifier SA is allowed.

OCTOBER 2019 HCPCS DELETED CODES

Chemotherapy

Deleted Codes

C9038
C9044
C9045

Injections

Deleted Codes

C9035
C9036
C9037
C9039
C9040
C9043
C9048
C9049
C9050
C9051
C9052
C9447
J1942
S1090