Q2 HCPCS Level I and II Update (April 1, 2023)

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.

Q2 Code Additions

Chemotherapy

C9146, C9147, C9148, J0208, J1449, J9196, J9294, J9294, J9296, J9297, Q5127, Q5129, Q5130

C9146

Mirvetuximab soravtansine-gynx (Elahere™)

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

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

Initial Approval Criteria:

- Must be used for FDA-approved indications and dosages
- Prescribed by or in consultation with an oncologist
- Patient must be 18 years of age or older
- Patient has tumors that are positive for FRα expression
- Patient has not responded to or is no longer responding to treatment with platinum-based chemotherapy
- Conduct an ophthalmic exam (visual acuity and slit lamp exam) prior to initiation of mirvetuximab soravtansine, every other cycle for the first 8 cycles, and as clinically indicated
- Administer prophylactic artificial tears and ophthalmic topical steroids.
- Patient has received one to three prior systemic treatment regimens, including at least one line of therapy containing bevacizumab
- Patient does not have moderate or severe hepatic impairment (total bilirubin greater than 1.5 ULN).

Initial approval is for 6 months

Continued therapy

- Patient continues to meet initial approval criteria
- Patient has experienced positive clinical response as evidenced by disease stabilization, decrease in tumor size, or lack of tumor spread
- Patient has unacceptable toxicity such as ocular toxicities, pneumonitis, severe peripheral neuropathy, pulmonary toxicity, etc.

Reauthorization is for 12 months

Age must be 18 years or older

Suggested ICD-10 Diagnosis Codes: C48.1, C48.2, C48.8, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.8.

Modifiers SA, UD, U7 and 99 are allowed.

C9147

Tremelimumab-actl (Imjudo®)

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

Age must be 18 years of age or older

Frequency of billing:

- HCC: 300 mg/300 units one time only
- NSCLC: 75 mg/75 units x 4 doses every 21 days, followed by 75 mg/75 units x 1 dose after 28 days (on day 112)

Modifiers SA, UD, U7 and 99 are allowed.

C9148

Teclistamab-cqyv (Tecvavli™)

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

Age must be 18 years of age or older.

Suggested ICD-10-CM Diagnosis Codes C90.00, C90.02

Modifiers SA, UD, U7 and 99 are allowed.

J0208

Sodium thiosulfate (Pedmark®)

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

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages
- Patient must be at least 1 month of age to 18 years of age
- It must be prescribed by or in consultation with an oncologist.
- Patient has a diagnosis of localized, non-metastatic solid tumors
- Drug is being used for prophylaxis of ototoxicity
- Patient will receive a chemotherapy treatment regimen that includes a cumulative cisplatin dose that is at least 200 mg/m² with individual cisplatin doses to be infused over less than 6 hours but at least 10 hours before the next cisplatin infusion
- Must document baseline serum sodium and potassium and as clinically indicated.
  - Baseline serum sodium must be less than 145 mmol/L

- Patient has no previous hypersensitivity to sodium thiosulfate or other thiol agents (e.g., amifostine trihydrate, N-acetylcysteine, MESNA, or captopril)

Initial authorization is for 6 months.

Continued Therapy

- Patient continues to meet initial approval criteria
- Documentation of positive clinical response
- Serum sodium is not greater than 145 mmol/L

Reauthorization is for 12 months.

Age must be at least 1 month to 18 years.

Modifiers SA, UD, U7 and 99 are allowed.

J1449

Eflapegrastim-xnst (Rolvedon™)

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

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

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Drug is being used for prophylaxis in patients with solid tumors or non-myeloid malignancy under one the following conditions:
  - Patient is receiving mylosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20 percent
  - Patient is undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 10 to 20 percent and at least one of the following risk factors for febrile neutropenia:
    - ❖ Age is over 65 years receiving full dose intensity chemotherapy
    - ❖ History of recurrent febrile neutropenia from chemotherapy
    - ❖ Extensive prior exposure to chemotherapy
    - ❖ Previous exposure of pelvis, or other areas of large amounts of bone marrow, to radiation
    - ❖ Persistent neutropenia (ANC less than or equal to1000/mm3)
    - ❖ Bone marrow involvement by tumor
    - ❖ Patient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS with low CD4 counts)
    - ❖ Recent surgery and/or open wounds
    - ❖ Poor performance status
    - ❖ Renal dysfunction (creatinine clearance less than 50 mL/min)
    - ❖ Liver dysfunction (elevated bilirubin more than 2.0 mg/dL)

- ❖ Chronic immunosuppression in the post-transplant setting, including organ transplant
- The patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome

Initial authorization is for 6 months.

Reauthorization is for 6 months for patients who continue to meet the above criteria.

Age must be 18 years of age or older

Frequency of billing is 13.2 mg/132 units

Maximum billing unit(s) is 13.2 mg/132 units once per chemotherapy cycle

Modifiers SA, UD, U7 and 99 are allowed.

J9196

Gemcitabine

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

Gemcitabine is reimbursable when billed in conjunction with CPT® code 96413 (chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug).

Modifiers SA, UD, U7 and 99 are allowed.

J9294, J9296

Pemetrexed (Alimta®, Teva, Accord and Hospira)

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

Age must be 18 years of age or older.

Maximum dose is 500 mg/m^2

Frequency is every 21 days

Providers may bill for an entire vial of pemetrexed when it is necessary to discard the unused portion of the vial because only a partial dose was required to treat the patient.

Suggested ICD-10-CM Diagnosis Codes: C34.00 thru C34.92.

Modifiers SA, UD, U7 and 99 are allowed.

J9297

Pemetrexed (Pemfexy™, Sandoz)

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

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

- Must be used for FDA labelled indications and dosing regimens
- Patient must be 18 years of age or older
- Patient has a diagnosis of malignant pleural mesothelioma; and
  - Used in combination with a cisplatin- or carboplatin-based regimen; or
  - Used as a single agent therapy; or

- Used in combination with bevacizumab and either cisplatin or carboplatin followed by single-agent bevacizumab maintenance therapy

  and

- Patient has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2; and
- Patient's disease presentation is unresectable; or

- Patient has a diagnosis of locally advanced or metastatic non-squamous, non-small cell lung cancer (NSCLC); and
  - Patient is using as a single agent after prior chemotherapy; or
  - Patient is using as a first-line therapy in combination with platinum-based chemotherapy with or without bevacizumab (or bevacizumab biosimilar); or
  - Patient is using as a single agent for maintenance therapy when disease has not progressed after four cycles of platinum-based, first-line therapy; or
  - Patient is using in combination with pembrolizumab and platinum chemotherapy for initial treatment in those confirmed with no EGFR or ALK genomic tumor aberrations; or
  - Patient is using as continuous maintenance therapy until disease progression, if given first-line as part of pembrolizumab/platinum chemotherapy/and pemetrexed regimen.
  - Pemetrexed is not approvable for the treatment of patients with squamous cell non-small cell lung cancer.

Initial approval is for 6 months.

Continuation of therapy:

- Patient continues to meet initial coverage criteria
- Patient shows positive clinical response as evidenced by disease stabilization or lack of disease progression

Reauthorization is for 12 months.

Suggested ICD-10-CM Diagnosis Codes: C34.00 thru C34.92.

Frequency of billing equals 500 mg/m^2 on day 1 of each 21-day cycle.

Modifiers SA, UD, U7 and 99 are allowed.

Q5127, Q5130

Pegfilgrastim-fpgk (Stimufend®), Pegfilgrastim-pbbk (Fylnetra)

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

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

- Must be used for FDA-approved indications and dosages
- Drug is being used for prophylaxis in patients with solid tumors or non-myeloid malignancy under one the following conditions:

- Patient is receiving mylosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20 percent
- Patient is undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 10 to 20 percent and at least one of the following risk factors for febrile neutropenia:
  - ❖ Age is over 65 years, receiving full dose intensity chemotherapy
  - ❖ History of recurrent febrile neutropenia from chemotherapy
  - ❖ Extensive prior exposure to chemotherapy
  - ❖ Previous exposure of pelvis, or other areas of large amounts of bone marrow, to radiation
  - ❖ Persistent neutropenia (ANC less than or equal to 1000/mm3)
  - ❖ Bone marrow involvement by tumor
  - ❖ Patient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS with low CD4 counts)
  - ❖ Recent surgery and/or open wounds
  - ❖ Poor performance status
  - ❖ Renal dysfunction (creatinine clearance less than 50 mL/min)
  - ❖ Liver dysfunction (elevated bilirubin more than 2.0 mg/dL)
  - ❖ Chronic immunosuppression in the post-transplant setting, including organ transplant
- The patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome

Initial authorization is for 6 months.

Reauthorization is for 6 months for patients who continue to meet the above criteria.

Frequency of billing is 6 mg/12 units once per chemotherapy cycle

Maximum billing unit(s) is 6 mg/12 units

Modifiers SA, UD, U7 and 99 are allowed.

Q5129

Bevacizumab-adcd (Vegzelma)

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

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

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Vegzelma will be used as a treatment for one of the following conditions:
  - **A. Cervical cancer, persistent/recurrent/metastatic**
    - ❖ Treatment of persistent, recurrent, or metastatic cervical cancer (in combination with paclitaxel and either cisplatin or topotecan)

- ❖ Treatment of persistent, recurrent, or metastatic cervical carcinoma (in combination with pembrolizumab, paclitaxel [conventional], and either cisplatin or carboplatin) – (plus or minus individualized radiation therapy and/or palliative care)

- **B. Colorectal cancer, metastatic**
  - ❖ First- or second-line treatment of metastatic colorectal cancer (CRC) (in combination with fluorouracil-based chemotherapy)
  - ❖ Second-line treatment of metastatic CRC (in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy) after progression on a first-line treatment containing bevacizumab
  - ❖ Drug is not being used for the adjuvant treatment of colon cancer
- **C. Glioblastoma, recurrent:**
  - ❖ Treatment of recurrent glioblastoma in adults
- **D. Non-small cell lung cancer, nonsquamous:**
  - ❖ First-line treatment of unresectable, locally advanced, recurrent or metastatic nonsquamous non-small cell lung cancer (in combination with carboplatin and paclitaxel)
- **E. Ovarian (epithelial), fallopian tube, or primary peritoneal cancer:**
  - ❖ Stage III or IV disease, following initial surgical resection: Treatment of stage III or IV epithelial ovarian, fallopian tube, or primary peritoneal cancer following initial surgical resection (in combination with carboplatin and paclitaxel, followed by single-agent bevacizumab)
  - ❖ Platinum-resistant recurrent: Treatment of platinum-resistant recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (in combination with paclitaxel, doxorubicin [liposomal], or topotecan) in patients who received no more than two prior chemotherapy regimens
  - ❖ Platinum-sensitive recurrent: Treatment of platinum-sensitive recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (in combination with carboplatin and paclitaxel or with carboplatin and gemcitabine and then followed by single-agent bevacizumab)
- **F. Renal cell carcinoma, metastatic:**
  - ❖ Treatment of metastatic renal cell carcinoma (in combination with interferon alfa)

Initial authorization is for 6 months.

<u>Continued Therapy</u>

- Patient continues to meet initial approval criteria.
- Patient has experienced positive clinical response such as stabilization of disease or decrease in tumor size or spread.
- Patient has absence of unacceptable toxicity such as gastrointestinal perforations and fistula, severe arterial thromboembolic events (ATE), grade four venous thromboembolic events (VTE), hypertensive crisis or hypertensive encephalopathy, posterior reversible encephalopathy syndrome (PRES), nephrotic syndrome (less than

2g of proteins in urine), severe infusion-related reactions, congestive heart failure (CHF), etc.

Reauthorization is for 12 months.

Age must be 18 years of age or older.

Modifiers SA, UD, U7 and 99 are allowed.

Durable Medical Equipment (DME) Supply

The following DME Supply code has special billing policies:

A7049

A7049

Modifier NU is required.

Frequency is once in 3 years.

This code is taxable.

Injections

The following Injections codes have special billing policies:

C9145, C9149, J0218, J0612, J0613, J1411, J1747

C9145

Aprepitant (Aponvie™)

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

Aponvie is considered medically necessary when all of the following criteria are met.

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Aponvie is being used for the prevention of postoperative nausea and vomiting (PONV)
- Patient must not be a pregnant female
- Patient will not be taking this with Pimozide

Authorization: one month (one treatment course)

Age must be 18 years of age or older

Frequency of billing = 32 mg/32 units prior to induction of anesthesia.

Maximum billing unit(s) = 32 mg/32 units

Modifiers SA, UD, U7 and 99 are allowed.

C9149

Teplizumab-mzwv (Tzield™)

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

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

- Must be used for FDA-approved indications and dosages

- Patient must be 8 years of age or older
- Must be prescribed by or in consultation with an endocrinologist
- Patient has a diagnosis of Stage 2 type 1 diabetes (TID) confirmed by at least two of the following pancreatic islet cell autoantibodies:
  - Glutamic acid decarboxylase 65 (GAD) autoantibodies
  - Insulin autoantibodies (IAA)
  - Insulinoma-associated antigen 2 autoantibodies (IA-2A)
  - Zinc transporter 8 autoantibodies (ZnT8A)
  - Islet-cell autoantibodies (ICA)
- Patient has dysglycemia (abnormal blood glucose) without overt hyperglycemia using an oral glucose tolerance test (OGTT) OR if an OGTT is not available, an alternative method for diagnosing dysglycemia without overt hyperglycemia may be used.
  - According to the American Diabetes Association (ADA) 2022 Standards of Medical Care in Diabetes, dysglycemia may be diagnosed based on any of the following:
    - ❖ 2-hour plasma glucose (PG) level of 140 to 199 mg/dL (7.8 to 11.0 mmol/L) during OGTT
    - ❖ A fasting plasma glucose (FPG) level of 100 to 125 mg/dL (5.6 to 6.9 mmol/L)
    - ❖ Hemoglobin A1C of 5.7 to 6.4 percent (39 to 47 mmol/mol) OR more than or equal to 10 percent increase in A1C
- Patient does not have any of the following:
  - Stage 3 type 1 diabetes
  - Clinical history consistent with type 2 diabetes
  - An active serious infection or chronic infection, including but not limited to Epstein-Barr virus or cytomegalovirus.
  - Serological evidence of past current or past HIV, hepatitis B, or hepatitis C infection
  - Prior treatment with other monoclonal antibody in past one year
- CBC and liver chemistries do not show any of the following lab abnormalities
  - Lymphocyte count less than 1,000 lymphocytes/mcL
  - Hemoglobin less than 10 g/dL
  - Platelet count less than 150,000 platelets/mcL
  - Absolute neutrophil count less than 1,500 neutrophils/mcL
  - Elevated ALT or AST greater than 2 times the upper limit of normal (ULN) or bilirubin greater than 1.5 times ULN

Initial authorization is for 3 months (14-day treatment course).

Reauthorization is not approvable.

Age must be 8 years of age or older.

Required ICD-10-CM Diagnosis Codes: E10.8, E10.9

Frequency of billing is one treatment in a lifetime.

Modifiers SA, UD, U7 and 99 are allowed.

J0218

Olipudase Alfa-rpcp (Xenpozyme)

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

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages
- Must be prescribed by or in consultation with a specialist familiar with the treatment of lysosomal storage disorders
- Patient has a clinical diagnosis of acid sphingomyelinase deficiency (ASMD) as confirmed by:
  - Genetic testing
  - Enzyme assay showing reduced activity of the enzyme acid sphingomyelinase (ASM)
- Diagnosis consistent with ASMD (Niemann-Pick disease) type B and A/B
- Patient has non-central nervous system (non-CNS) manifestations ASM deficiency
- Patient is not a pregnant or breast-feeding female
- Baseline ALT and AST (within 1 month prior to initiation of therapy; within 72 hours prior to dose escalation; within 72 hours after the end of the infusion if the baseline or preinfusion ALT/AST is more than 2 times ULN; as clinically indicated during maintenance therapy).
- Adult patients (18 years old or older) must have all of the following
  - Baseline diffusion capacity of the lungs for carbon monoxide (DLco) 70 percent or less of the predicted normal value
  - Spleen volume greater than or equal to 6 multiples of normal (MN) measured by MRI
  - Splenomegaly related score (SRS) are greater than or equal to 5
- Pediatric patients (younger than 18 years old) must have all of the following
  - Patient did not have delay of gross motor skills
  - Height was -1 Z-score or lower
  - Patient has a spleen volume greater than or equal to 5 MN measured by MRI.

Initial authorization is for 12 months.

Reauthorization

Patient has shown a positive clinical response as shown by at least one of the following:

- Increase in percentage predicted DLCO from baseline
- Reduction in spleen and liver volumes from baseline
- Mean change in SRS score

- Improvement in percentage predicted forced vital capacity (FVC), forced expiratory volume, and total lung capacity
- Improvement in hematologic and hepatic laboratory values
- Improvement in linear growth progression (as measured by height Z-scores) (pediatric patients only)

Reauthorization is for 12 months

Required ICD-10-CM Diagnosis Codes: E75.241, E75.244

Modifiers SA, UD, U7 and 99 are allowed.

J0612, J0613

Calcium Gluconate

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

Modifiers SA, UD, U7 and 99 are allowed.

J1411

Etranacogene Dezaparvovec-dlb (HEMGENIX)

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

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages
- Must be prescribed by or in consultation with a hematologist
- Patient must be male, 17 years of age or older
- Patient has congenital hemophilia B (congenital Factor IX deficiency), classified as severe or moderately severe, Factor IX deficiency (Factor IX less than or equal to 2 percent of normal)
- Patient is currently on Factor IX prophylaxis, or has current or historical life-threatening hemorrhage, or has repeated, serious spontaneous bleeding episodes
- Patient has had 150 previous exposure days of treatment with Factor IX protein
- Patient has had pretreatment hepatic ultrasound and elastography and has no radiological liver abnormalities and/or sustained liver enzymes
- Patient does not have any of the following:
  - History of Factor IX inhibitors or Positive Factor IX inhibitor test
  - Alanine aminotransferase (ALT), aspartate aminotransferase (AST), alkaline phosphatase (ALP) and total bilirubin more than 2 times upper limit of normal (ULN)
  - Positive human immunodeficiency virus (HIV) test, not controlled with anti-viral therapy
  - Active infection with hepatitis B or C virus
    - ❖ Patients who have a history of hepatitis B or C exposure must not currently be taking antiviral therapy for hepatitis B or C
  - Previous etranacogene dezaparvovec-drlb treatment

- Outpatient administration is restricted to Hospital Outpatient Services only

Authorization: 3 months (one treatment in a lifetime)

Reauthorization: Never

Age must be 17 years of age or older

Required ICD-10 Diagnosis Code: D67

Frequency of billing is one treatment in a lifetime.

Modifiers UD and 99 are allowed.

Maximum dose is 1 treatment dose every 4 units

Billing:

A Provide Notification will be sent out in the coming weeks regarding the special billing and claims processing requirements for Hemgenix due to the high cost, since standard claim forms do not accommodate the large dollar amount of the claim.

J1747

Spesolimab-sbzo (Spevigo®)

Treatment Authorization Request (TAR) is required for reimbursement

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

- Must be used for all FDA-approved indications and dosages
- Patient must have a diagnosis of generalized pustular psoriasis (GPP) flares
- Must be prescribed by or in consultation with a dermatologist
- Patient must be 18 years of age or older
- Patient has no current active infections
- Patient is not currently on retinoids/methotrexate/cyclosporine prior to initiation of spevigo
- Documentation of a negative tuberculosis (TB) infection prior to initiating treatment or pretreatment with antituberculosis therapy in patients with latent TB
- Patient does not have an immediate life-threatening flare of GPP or requiring intensive care treatment
- Patient does not have SAPHO syndrome (inflammatory bone disorders that may be associated with skin changes)

Approval is for 3 months (maximum of 2 doses 1 week apart).

Required ICD-10-CM Diagnosis Code L40.1

Maximum dose: 900 mg/900 units

Frequency of billing: 900 mg/900 units every week for up to 2 doses

Note: Spevigo is available through the following specialty distributor:
Accredo Specialty Pharmacy
1-800-803-2523

Modifiers SA, UD, U7 and 99 are allowed.

Ophthalmology

The following Ophthalmology code has special billing policies.

Q5128

Q5128

Ranibizumab-eqrn (Cimerli)

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

Cimerli is considered medically necessary when all of the following conditions are met:

- 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 ophthalmologist
- Patient has one of the following diagnoses:
  - Neovascular (Wet) Age-Related Macular Degeneration (AMD)
  - Macular Edema Following Retinal Vein Occlusion (RVO)
  - Myopic Choroidal Neovascularization (mCNV)
  - Diabetic Macular Edema (DME)
  - Diabetic Retinopathy
- Patient does not have ocular or periocular infections
- Patient has tried and failed an intravitreal vascular endothelial growth factor (VEGF) inhibitor (for example, bevacizumab, ranibizumab, aflibercept) unless contraindicated or clinically inappropriate
- Documentation of patient's best corrected visual acuity (BCVA) score at baseline and periodically during treatment

Initial authorization is for 6 months (3 months for mCNV)

Continued Therapy

- Patient continues to meet initial approval criteria
- Patient has experienced a clinically significant positive benefit as evidenced by at least one of the following:
  - Improvement in best corrected visual acuity (BCVA) score from baseline
  - Minimal observable CNV lesion growth
  - Detained neovascularization
- Patient has an absence of unacceptable toxicity such as endophthalmitis, retinal detachment, increases in intraocular pressure (IOP) and arterial thromboembolic events

Reauthorization is for 6 months (3 months for mCNV)

Age must be 18 years of age or older

Frequency of billing equals 0.5 mg/5 units once a month (approximately every 28 days), each eye

Maximum billing unit(s) equal 0.5 mg/5 units each eye

Modifier RT or LT is required. Modifiers UD and 99 are allowed.

Proprietary Laboratory Analyses (PLA)

The following PLA codes have special billing policies.

0364U, 0369U, 0371U, 0372U, 0373U, 0374U, 0378U, 0379U, 0381U, 0382U, 0383U,

0364U

Modifiers 33, 90 and 99 are allowed.

Required ICD-10 Diagnosis Codes: C90.00, C90.01, C90.02, C91.00, C91.01, C91.02, C91.10, C91.11 and C91.12

0369U

Modifiers 33, 90 and 99 are allowed.

Frequency is limited to once per year.

0371U, 0372U, 0374U

Modifiers 33, 90, and 99 are allowed.

These codes are reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) program.

0373U

Modifiers 33, 90 and 99 are allowed.

Frequency is limited to twice per year.

This code is reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) program.

0378U

Modifiers 33, 90 and 99 are allowed.

Frequency is limited to once in a lifetime.

Required ICD-10 Diagnosis Codes: G11.0, G11.2, G11.3, G11.4, G11.8, G11.9, G11.10, G11.11, G11.19, G32.81, G60.2, G80.4, R26.0 and R27.0

0379U

Modifiers 33, 90 and 99 are allowed.

Frequency is limited to once in a lifetime.

0381U

Modifiers 33, 90 and 99 are allowed.

Required ICD-10 Diagnosis Codes: E71.0 and E71.2

0382U

Modifiers 33, 90 and 99 are allowed.

Required ICD-10 Diagnosis Codes: E70.0 and E70.1

0383U

Modifiers 33, 90 and 99 are allowed.

Required ICD-10 Diagnosis Codes: E70.20, E70.21, E70.29

Skin Substitutes

The following skin substitute codes have special billing policies:

A2019, A2020, A2021, L8678, Q4265, Q4266, Q4267, Q4268, Q4269, Q4270, Q4271

A2019, A2020, A2021

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

Modifiers SA, U7 and 99 are allowed.

L8678

Modifiers GO, GY, J4, SA, SE and U7 are allowed.

Monthly must be block billed.

Q4265, Q4266, Q4267, Q4268, Q4269, Q4270, Q4271

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

Modifiers SA, U7 and 99 are allowed.

Q2 Code Deletions

Table of HCPCS Q2 Code Deletions

Effective April 1, 2023

Subject	Deleted Code
Injections	J0610 (replaced by J0612), J0611 (replaced by J0613)
Proprietary Laboratory Analyses	0324U, 0325U

Table of HCPCS Q2 Code Deletions

Effective May 12, 2023

Subject	Deleted Code
Pathology: Microbiology	G2023, G2024 U0003, U0004