Q2 HCPCS Level I and II Update (April 1, 2025)

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.

Chemotherapy

The following Chemotherapy codes have special billing policies:

C9301, C9302, C9303, J9024, J9054, J9161, Q2057

C9301

Obecabtagene autoleucel (AUCATZYL®)

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

Age must be 18 years or older.

Maximum billing is once in a lifetime.

Required ICD-10-CM Diagnosis Codes: C91.00, C91.02

Modifiers UD and 99 are allowed.

C9302

Zanidatamab-hrii (ZIIHERA®)

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

Age must be 18 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

C9303

Zolbetuximab-clzb for injection, for intravenous use (VYLOY®)

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

Age must be 18 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

J9024

Atezolizumab and hyaluronidase-tqjs (TECENTRIQ HYBREZA)

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

Must be 18 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

J9054

Bortezomib (BORUZU)

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

Age must be 18 years or older.

Required ICD-10-CM Diagnosis Codes: C83.10 thru C83.19, C90.00 thru C90.02.

Modifiers SA, UD, U7 and 99 are allowed.

J9161

Denileukin diftitox-cxdl (LYMPHIR)

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

Must be 18 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

Q2057

Afamitresgene autoleucel (TECELRA)

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

Must be 18 years or older.

Frequency of billing is equal to once in a lifetime.

Required ICD-10-CM Diagnosis Codes: C38.0 thru C38.8, C48.1 thru C48.8, C49.0 thru C49.9

Administration code: CPT code 96413 (chemotherapy administration, intravenous infusion; up to 1 hour, single or initial substance/drug).

Modifiers UD and 99 are allowed.

Durable Medical Equipment (DME)

The following DME codes have special billing policies:

E0201, E1022, E1023, E1032, E1033, E1034

E0201

Sex restriction is male only.

Must be 18 years or older.

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

Frequency of billing is equal to once every three weeks.

Suggested ICD-10-CM Diagnosis Code: N48.6

Modifier NU is required.

This code is taxable.

E1022, E1023

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

TAR Criteria:

- Documentation that beneficiary requires a wheelchair and wheelchair accessories.

Frequency of billing is equal to once every five years.

Modifier NU, RR and RB is required.

This code is nontaxable.

E1032, E1033, E1034

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

TAR Criteria:

- Documentation that beneficiary requires a wheelchair and wheelchair accessories.

Frequency of billing is equal to once every five weeks when billed with modifier NU.

Modifier NU, RR and RB is required.

These codes are nontaxable.

Injection

The following Injection codes have special billing policies:

C9304, J0281, J1072, J1271, J1299, J1308, J1938, J2351, J2428, J2804, J2865, J9038, Q5151, Q5152, Q9999

C9304

Marstacimab-hncq (HYMPAVZI)

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

Age must be 12 years or older.

Frequency of billing is equal to weekly.

Maximum billing unit(s) is equal to 300 mg/ 600 units weekly.

Modifiers SA, UD, U7 and 99 are allowed.

J0281

Aminocaproic acid injection (AMICAR)

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

Age must be 18 years or older.

Modifiers SA, UD, U7 and 99 are allowed.

J1072

Testosterone cypionate (Azmiro)

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

Age must be 12 years or older.

Frequency of billing is equal to every two to four weeks.

Maximum billing units is equal to 400 mg / 400 units every two weeks.

Modifiers SA, UD, U7 and 99 are allowed.

J1271

Doxycycline hyclate (Vibramycin)

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

Must be 8 years or older.

Maximum billing units is equal to 300 mg / 300 units per day.

Modifiers SA, UD, U7 and 99 are allowed.

<u>J1299</u>

Eculizumab

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

Frequency of billing equals 1200 mg/600 units weekly.

Maximum billing unit(s) is equal to 1200 mg/600 units.

Modifiers SA, UD, U7 and 99 are allowed.

<u>J1308</u>

Famotidine injection

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

Modifiers SA, UD, U7 and 99 are allowed.

<u>J1808</u>

Folic acid

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

Modifiers SA, UD, U7 and 99 are allowed.

<u>J1938</u>

Furosemide

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

Modifiers SA, UD, U7 and 99 are allowed.

<u>J2351</u>

Ocrelizumab and hyaluronidase-ocsq

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

Must be 18 years or older.

Maximum billing unit(s) is equal to 920 mg / 920 units.

Required ICD-10-CM Diagnosis Code: G35

Modifiers SA, UD, U7 and 99 are allowed.

<u>J2428</u>

Paliperidone Palmitate (ERZOFRI)

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

Must be 18 years or older.

Suggested ICD-10-CM Diagnosis Codes: F20, F20.0, F20.1, F20.2, F20.3, F20.5, F20.8, F20.9

Modifiers SA, UD, U7 and 99 are allowed.

<u>J2804</u>

Rifampin (RIFADIN)

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

Frequency of billing is equal to 600 mg / 600 units daily.

Maximum billing unit(s) is equal to 600 mg / 600 units.

Modifiers SA, UD, U7 and 99 are allowed.

J2865

Sulfamethoxazole and trimethoprim

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

Modifiers SA, UD, U7 and 99 are allowed.

J9038

Axatilimab-csfr (NIKTIMVO)

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

Modifiers SA, UD, U7 and 99 are allowed.

Q5151

Eculizumab-aagh (EPYSQLI)

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

Must be 2 months of age or older.

Maximum billing unit(s) is equal to 1200 mg / 600 units every week.

Modifiers SA, UD, U7 and 99 are allowed.

Q5152

Eculizumab-aeeb (BKEMV)

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

Eculizumab-aeeb is considered medically necessary in appropriate patients when the following criteria are met:

Universal criteria:

- Must be used for FDA approved indications and dosages.
- Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients with complement deficiencies.
- Patient must be vaccinated against meningococcal infections within three years prior to, or at the time of initiating eculizumab-aeeb (at least two weeks prior to treatment, if not previously vaccinated). In emergent situations, antibiotics may be appropriate with vaccination less than two weeks prior to treatment.

Prescriber is enrolled in the BKEMV REMS program.

A. Paroxysmal Nocturnal Hemoglobinuria (PNH)

- Confirmed Diagnosis of PNH by flow cytometry showing detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or greater than or equal to 10 percent PNH cells

- Patient is 18 years of age or older.
- Provider must submit the documentation for the followings:
  - Patient has at least four transfusions in the prior 12 months, and platelet counts of at least 100,000 per microliter.
    - ❖ To confirm the need for RBC transfusion and to identify the hemoglobin concentration, patient must meet ONE of the following:
      - Hemoglobin less than or equal to nine g/dL in patients with anemia symptoms
      - Hemoglobin less than or equal to seven g/dL in patients without anemia symptoms.
  - Patient has at least one transfusion in the prior 24 months and at least 30,000 platelets per microliter

Initial authorization for up to six months

Continued Therapy:

Continuation of therapy is considered medically necessary for the treatment of a patient with PNH who is currently receiving treatment with Eculizumab-aeeb and all the following (documentation is required):

- Improved hemolysis (for example, reduced serum LDH levels)
- Hemoglobin stabilization
- Reduced RBC transfusion
- Less fatigue

Reauthorization for up to 12 months.

B. Atypical Hemolytic Uremic Syndrome (aHUS)

- Documentation that patient does not have the following:
  - Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).
- Patient is two months of age or older.
- Confirmed diagnosis of atypical hemolytic uremic syndrome (aHUS) showing signs of thrombotic microangiopathy (TMA) by all the following (documentation is required):
  - Platelet count less than or equal to 150 times 10^9 /L.
  - Evidence of hemolysis such as an elevation in serum LDH and serum creatinine above the upper limits of normal, without the need for chronic dialysis.
  - A disintegrin and metalloproteinase with thrombospondin type 1 motif, member 13 (ADAMTS13) activity level above five percent.

Initial authorization for up to six months.

Continued Therapy:

Continuation of therapy is considered medically necessary for the treatment of a patient with aHUS who is currently receiving treatment with Eculizumab-aeeb and all the following (documentation is required):

- Improvement in platelet count.

- Improved measures of hemolysis (e.g., reduced serum LDH).
- Reduced need for dialysis.
- Reduction in thrombocytopenia.

Reauthorization for up to 12 months.

Maximum billing unit(s) is equal to 1200 mg/ 600 units.

Modifiers SA, UD, U7 and 99 are allowed.

Q9999

Ustekinumab-aauz (OTULFI)

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

Must be 6 years of age or older.

Modifiers SA, UD, U7 and 99 are allowed.

Non-Injection

The following non-injection code has special billing policies:

J7521

J7521

Tacrolimus (PROGRAF)

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

Modifiers SA, UD, U7 and 99 are allowed.

Ophthalmology

The following ophthalmology codes have special billing policies:

Q5147, Q5149, Q5150

Q5147

Aflibercept-ayyh (PAVBLU)

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

Must be 18 years or older.

Frequency of billing is equal to 2 mg /2 units per eye every four weeks.

Maximum billing unit(s) is equal to 2 mg /2 units per eye every four weeks.

CPT code 67028 (intravitreal injection of a pharmacologic agent [separate procedure]) must be billed on the same claim form.

Modifiers LT and RT are required.

Modifiers UD and 99 are allowed.

Q5149

Aflibercept-abzv (ENZEEVU)

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

Must be 18 years or older.

Frequency of billing is equal to 2 mg / 2 units per eye every four weeks.

Maximum billing unit(s) is equal to 2 mg / 2 units per eye every four weeks.

CPT code 67028 (intravitreal injection of a pharmacologic agent [separate procedure]) must be billed on the same claim form.

Modifiers LT and RT are required.

Modifiers UD and 99 are allowed.

Q5150

Aflibercept-mrbb (AHZANTIVE)

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

Must be 18 years or older.

Frequency of billing is equal to 2 mg / 2 units per eye every four weeks.

Maximum billing unit(s) is equal to 2 mg / 2 units per eye administered by intravitreal injection every four weeks.

CPT code 67028 (intravitreal injection of a pharmacologic agent [separate procedure]) must be billed on the same claim form.

Modifiers LT and RT are required.

Modifiers UD and 99 are allowed.

Proprietary Laboratory Analyses (PLA)

The following PLA codes have special billing policies:

0540U, 0543U

0540U

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

For Kidney Transplant Recipients

- There is clinical suspicion for acute kidney allograft rejection and the patient has not been tested with another donor-derived cell-free DNA test for the same episode, and
- The test must be ordered by a nephrologist or kidney transplant surgeon, and
- Patient is at least one month post-kidney transplant, and
- Patient is 18 years of age or older, and
- Patient is not pregnant, and
- Patient has not received a kidney transplant from their twin, has not undergone multiple organ transplants, and has not undergone bone marrow transplantation.

Modifiers 33, 90 and 99 are allowed.

0543U

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

For Somatic Testing

- The patient has recurrent, relapsed, refractory, metastatic, or advanced stage III or IV cancer, and
- Either the patient has not been previously tested using the same next-generation sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and
- The decision for additional cancer treatment is contingent on the test results.

Independent of the above criteria, somatic testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.

Frequency limit is once in a lifetime.

Modifiers 33, 90 and 99 are allowed.

Radiology

The following Radiology codes have special billing policies:

A9611, C8004, C9300, G0183, G0566, S4024

A9611, C9300, G0183, G0566

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

Modifiers SA, U7 and 99 are allowed.

C8004

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

Suggested ICD-10-CM Diagnosis Codes: C22.0, C22.1, C7A.1, C7A.8, C7A.094

Modifiers SA, U7 and 99 are allowed.

S4024

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

Sex restriction is female only.

Modifiers SA, U7 and 99 are allowed.

Skin Substitute

The following Skin Substitute codes have special billing policies:

A2030, A2031, A2032, A2033, A2034, A2035, Q4354, Q4355, Q4356, Q4357, Q4358, Q4359, Q4360, Q4361, Q4362, Q4363, Q4364, Q4365, Q4366, Q4367

A2030, A2031, A2032, A2033, A2034, A2035, Q4354, Q4355, Q4356, Q4357, Q4358, Q4359, Q4360, Q4361, Q4362, Q4363, Q4364, Q4365, Q4366, Q4367

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

Modifiers SA, U7 and 99 are allowed.

Q2 Code Deletions

Table of HCPCS Q2 Code Deletions

Effective March 31, 2025

Subject	Deleted Code
California Children's Services (CCS)	J1094, J1810
Injection	J1300 (replaced with J1299), J1890, J1940 (replaced with J1938), J9037, J9247, Q5139 (replaced with Q5152), S0017 (replaced with J0281), S0032
Orthotics and Prosthetics	L8010
Radiology	G0564, Q4231

Effective December 12, 2024

Subject	Deleted Code
Injection	M0222, M0223