2015 HCPCS CODE ADDITIONS

Bolded Codes
Bolded codes indicate notation of special billing policy.

Chemotherapy

A9606, C9442, J9267, J9301

A9606
Billing is for males only.

C9442
Belinostat is used for the treatment of recipients with relapsed or refractory peripheral T-cell lymphoma. The recommended dose is 1,000 mg per m2 once daily, on days one through five of a 21 day cycle. Billing is for recipients 18 years of age and older. An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

DME

A4602, A7048

A4602
Providers must document the equipment is patient-owned. Modifier NU is required when billing. Billing frequency is limited to one in six months. Reimbursement is determined “By Report.” This item is taxable.

A7048
Providers must document the equipment is patient-owned. Modifier NU is required when billing. Billing frequency is limited to one per month. Reimbursement is determined “By Report.” This item is non-taxable.

Evaluation and Management

99490, 99497, 99498

99490
Billing frequency is limited to once per month.

99497
Billing frequency is limited to twice a year with a TAR override.

99498
Billing frequency is limited to once a year with a TAR override.

Immunization

90630, **90651**

90651
Billing is for females 10 through 25 years of age.

Laboratory

80163, 80165, 80300 – 80304, 80320 – 80377, **81288,** 81420, **81435, 81436, 81519,** 87505 – 87507, **87624, 87625, 87806,** 88341, 88344, 88364, 88366, 88369, 88373, 88374, 88377, **G0472**

81288
Billing frequency is limited to once in a lifetime, a TAR documenting the following criteria is required:

- Recipient with colon cancer, and
- The tumor demonstrates microsatellite instability or immunohistochemistry results indicating loss of MLH1 protein expression

81435, 81436
Billing frequency is limited to once in a lifetime with a TAR override. These codes are only reimbursable with one of the following ICD-10-CM diagnosis codes:

- C18.0, C18.2 – C18.9, C19, Z80.0, Z85.030 – Z85.038, Z85.040 – Z85.048 and Z86.010

81519
Providers must document on the claim form or on an attachment that all of the following criteria of early stage breast cancer have been met. Failure to document the criteria below will result in the claim being denied:

- The recipient is estrogen receptor (ER) positive
- The recipient is HER2-receptor negative
- The recipient is lymph node negative
- The recipient has stage I or stage II breast cancer
- The recipient is a candidate for chemotherapy
- The assay is used within six months of diagnosis
- The intention to treat or not to treat with adjuvant chemotherapy will be contingent, at least in part, on the test results

This benefit applies exclusively to use of the Oncotype DX test. Other tests are not benefits of the Medi-Cal program.

This once-in-a-lifetime benefit may be billed more than once for the same recipient if the provider can prove via documentation that the recipient has a new second primary breast cancer that meets the same criteria listed above.

87624, 87625
Billing is for recipients 15 through 65 years of age. Billing frequency is limited to once every three years. A TAR override is allowed.

87806
This code is reimbursable when billed with any ICD-10-CM diagnosis code, including nonspecific diagnosis codes.

G0472
The determination of high risk for HCV is identified by the primary care physician or practitioner who assesses the recipient's history, typically as part of an annual wellness visit, and considers risk of infection in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

Indications for adults at high risk of HCV infection include:

- A current or past history of illicit injection drug use, and
- Receiving a blood transfusion prior to 1992

Repeat screening for high risk adults is covered annually only for recipients who continued their illicit injection drug use since the prior negative screening test. Recipients who do not meet the high risk criteria defined above, but who were born from 1945 through 1965 may receive a single, once-in-a-lifetime screening test.

Medicine

91200
An approved TAR is required for reimbursement. Code is split billable and must be billed with modifier 26 and TC. Allowable modifiers are 22, 24, 25, 99, SA, SB and U7.

Performance of transient elastography more than twice per year or within six months following a liver biopsy is considered not medically necessary.

Documentation is recommended and may include the following ICD-10-CM codes:

K70.2	K70.41	K73.2	K74.1	K74.5	K75.81
K70.30	K70.9	K73.8	K74.2	K74.60	K76.0
K70.31	K73.0	K73.9	K74.3	K74.69	K76.89
K70.40	K73.1	K74.0	K74.4	K75.4	K76.9

93260, 93261
These codes are split billable, and must be billed with modifier TC and/or 26. No modifier is required if billing for the global service. Allowable modifiers are 22, 25, 99 and U7.

93355
Allowable modifiers are 25, 99, SA, SB and U7.

93644
Required modifiers are TC and/or 26. No modifier is required if billing for the global service. Allowable modifiers are 25, 99, SA, SB and U7.

93702
This is a Medicare non-covered code. Billing frequency is limited to two times per year.

96127
Billing frequency is limited to three times per year.

99188
Billing frequency is limited to three times per year for recipients through 5 years of age.

Orthotics and Prosthetics

L3981, L6026, L7259

L3981, L6026, L7259
Billing frequency is limited to one in five years. Bill with modifier LT or RT. Item is non-taxable.

Physician Administered Drugs

C9444, C9446, C9447, J0153, J1071, **J1322, J1439,** J2274, J2704, **J3145, J7181, J7200, J7327, J7336**

C9444
Minimum age for billing is 18 years of age. Maximum dosage is 1,200 mg per day.

C9446
Minimum age for billing is 18 years of age. Maximum dosage is 200 mg per day.

C9447
Minimum age for billing is 18 years of age. Maximum dosage is 4 ml per day.

J1322
An approved TAR is required for reimbursement and must include a diagnosis of Mucopolysaccharidosis IV A. Recommended dosage is 2 mg/kg once a week.

J1439
Minimum age for billing is 18 years of age. Maximum accumulative dosage is not to exceed 1500 mg per course.

J3145
Billing is for males 18 years of age and older. Maximum dosage is 750 mg every four weeks.

J7181, J7200
A TAR is required for reimbursement.

J7327
A TAR is required for reimbursement. One billing unit equals the entire dose administered.

J7336
Billing is for recipients 18 years of age and older.

Radiology

76641, 76642, 77061 – 77063, 77085, 77086, 77306, 77307, 77316 – 77318, 77385, 77386, **77387,** G0279, G6001 – G6017

76641, 76642
These codes are split billable and must be billed with modifiers 26 and TC. Billing is allowed for up to two units.

77061 – 77063, 77085, 77086, 77306, 77307, 77316 – 77318
These codes are split billable and must be billed with modifiers 26 or TC.

77387
This is a Medicare non-covered code. Medicare denial is not required for claims processing.

Surgery

20604, 20606, 20611, 20983, 21811, 21812, 21813, 22510, 22511, 22512, 22513, 22514, 22515, 22858, 27279, 33270 – 33273, 33418, 33419, 34839, 37218, 43180, 44381, 44384, 44401 – 44404, 44405, 44406 – 44408, 45346, 45347, 45349, 45350, 45388 – 45390, 45393, 45398, 45399, 46601, 46607, 47383, 52441, 52442, 62302 – 62305, 64486 – 64489, 66179, 66184, C2624, **C9742,** L8696

20604, 20606
A TAR is required for reimbursement to podiatrist, not reimbursable to assistant surgeon.

20611, 20983
Not reimbursable to assistant surgeon.

21811, 21812
Reimbursable to primary surgeon and assistant surgeon.

21813
Reimbursable to primary surgeon and assistant surgeon.

22510, 22511
Reimbursable to primary surgeon and not reimbursable to assistant surgeon. A TAR is required.

22512
Reimbursable to primary surgeon and not reimbursable to assistant surgeon. A TAR is required. Exempt from modifier 51 cutback.

22513, 22514
A TAR is required for reimbursement to the primary surgeon. Assistant surgeon services do not require a TAR.

22515
A TAR is required for reimbursement to the primary surgeon. Assistant surgeon services do not require a TAR. Exempt from modifier 51 cutback.

22858
A TAR is required for reimbursement to the primary surgeon. Assistant surgeon services do not require a TAR. Exempt from modifier 51 cutback.

27279
Reimbursable to primary surgeon and assistant surgeon. For recipients undergoing minimally invasive sacroiliac joint (SIJ) fusion, the following must be documented in the recipient's medical record and available on request. A TAR must include the following documentation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or on a claim attachment:

- A complete history and physical documenting the likely existence of SIJ pain
- Performance of a fluoroscopically guided intra-articular SIJ block using local anesthetic on the affected side (or both sides) which shows at least a 75 percent acute reduction in pain
- A course of conservative treatment that includes use of non-steroidal anti-inflammatory drugs and/or opioids (unless contraindicated) and one of the following:
  - An adequate period of rest, or
  - An adequate course of physical therapy wherein the physical therapist specifically documents a lack of response to treatment, or
  - SIJ steroid injections into the affected joint with inadequate response or a return of pain in the weeks to months following the injections, or
  - Radiofrequency ablation of the affected SIJ with either inadequate response or a return of pain in the weeks to months following the procedure
- SIJ pain has continued for a minimum of six months
- All other diagnoses that could be causing the recipient's pain have been ruled out
- Within one month after surgery, pain level and/or functional disability is continuing, and it is the surgeon's opinion SIJ fusion is the only treatment option that will provide long term relief

33270 – 33273
Not reimbursable to assistant surgeon.

33418
Reimbursable for primary and assistant surgeon services.

33419
Reimbursable for primary and assistant surgeon services. Exempt from modifier 51 cutback.

34839
Not reimbursable to assistant surgeon.

37218
Reimbursable for primary and assistant surgeon services.

43180, 44381
Not reimbursable to assistant surgeon.

44384, 44401 – 44404
Not a Medicare benefit. Not reimbursable to assistant surgeon.

44405
Not a Medicare benefit. Not reimbursable to assistant surgeon. Must be billed with modifier 59 for each stricture dilated.

44406 – 44408
Not a Medicare benefit. Not reimbursable to assistant surgeon.

45346, 45347, 45349
Not reimbursable to assistant surgeon.

45350, 45388 – 45390, 45393, 45398
Not a Medicare benefit. Not reimbursable to assistant surgeon.

45399
Not a Medicare benefit. A TAR is required for reimbursement to the primary surgeon. Assistant surgeon services do not require a TAR. Unlisted procedure and requires TAR.

46601, 46607
Not a Medicare benefit. Not reimbursable to assistant surgeon.

47383, 52441
Not reimbursable to assistant surgeon.

52442
Not reimbursable to assistant surgeon. Exempt from modifier 51 cutback. Limited to 3 implants.

62302 – 62305, 64486 – 64489
Not reimbursable to assistant surgeon.

66179, 66184
Reimbursable for primary and assistant surgeon.

C9742
Not reimbursable to assistant surgeon.

2015 HCPCS CHANGE CODES

Bolded Codes
Bolded codes indicate notation of special billing policy.

DME

A9279, E0986, E1002 – E1008, E1010, E1014 , E1029, E1030, E1161, E1232 – E1238, E2227, E2230, E2310 – E2313, E2321, E2322, E2325 – E2330, E2373, E2376 – E2378, E2500, E2502, E2504, E2506, E2508, E2510, E2599

A9279
Now a Medicare non-covered code.

E0986, E1002 – E1008, E1010, E1014 , E1029, E1030, E1161, E1232 – E1238, E2227, E2230, E2310 – E2313, E2321, E2322, E2325 – E2330, E2373, E2376 – E2378, E2500, E2502, E2504, E2506, E2508, E2510, E2599
No longer Medicare non-covered codes.

Evaluation and Management
99487, 99489

Laboratory
86900, 86901, 87501, 87502, 88342

Medicine
90654, 93282, 93283, 96110

Orthotics and Prosthetics
L7367

Physician Administered Drugs
J7195, J7301

Radiology
77402, 77407, 77412, G0204, G0206

Surgery
20982, 27370, 33218, 33220, 33241, 33262 – 33264, 37215, 37216, 43194, 43215, 44363, 44380, 44382, 44386, 44388 – 44392, 44799, 45332, 45379, 45391, 45392, 62284

Vision Care
V2799

2015 HCPCS DELETED CODES

Chemotherapy

Deleted Code	Replacement Code
C9021	J9301
J9265	J9267

Laboratory

Deleted Code	Replacement Code
82055	80320, 80321
82101	80323
82145	80325, 80326
82205	80345
82520	80353
83840	80358
83925	80361 – 80364
87621	87624, 87625

Medicine

Deleted Code	Replacement Code
99481, 99482	99184

Physician Administered Drugs

Deleted Code	Replacement Code
C9133	J7200
C9134	J7181
J0150, J0151	J0153
J1070, J1080	J1071
J2271, J2275	J2274
J7335	J7336
Q9970	J1439
Q9974	J2274
S0144	J2704

Radiology

Deleted Code	Replacement Code
76645	76641, 76642
77082	77086
77403, 77404, 77406	77402
77408, 77409. 77411	77407
77413, 77414, 77416	77412

Surgery

Deleted Code	Replacement Code
22520 – 22525	22510 – 22515
69401	99201 – 99205, 99211 – 99215
C9735	46999