Optum

Coding &
Payment Guide

Medical Oncology/ Hematology Services

An essential coding, billing and reimbursement guide for medical and radiation oncology and hematology services

2027

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Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Medical Oncology/Hematology Services* is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and services and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to oncology and hematology are listed first in the *Coding and Payment Guide*. All other CPT/HCPCS codes in *Coding and Payment Guide* are listed in ascending numeric order, including surgery, radiology, laboratory and medicine codes. Each CPT/HCPCS code is followed by its official code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes are not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding and Payment Guide* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific HCPCS Level II and CPT code(s) and its narrative is a combination of features.

Appendix Codes and Descriptions

Some CPT/HCPCS codes that are not commonly used in oncology/hematology, are presented in a less comprehensive format in the appendix, followed by an easy-to-understand explanation, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

CCI Edits, RVUs, and Other Coding Updates

The Optum *Coding and Payment Guide* includes the list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from the version 32.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is https://www.optumcoding.com/ProductUpdates/. The 2027 edition password is: **XXXXX**. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

Bone
Marrow
Aspiration, 38220, 38222
Biopsy, 38221-38222
Harvesting, 38230-38232
Allogeneic, 38230
Autologous, 38232

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xv of the CPT book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified healthcare professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Facilities

Many of the procedures and services in this *Coding and Payment Guide* are performed in an outpatient department of a hospital or in free standing outpatient facilities. In some instances the coding and or payment requirements are different than that reported by a healthcare provider. When the information provided is specific to the facility, the term **Facility Reporting**, will precede the facility-specific information provided.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting. Because payment guidelines may vary by payer to payer or even geographical location, only the drugs or other complex drug or highly complex biologic agents are provided in this *Guide*.

96542

96542 Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

Explanation

The physician or supervised assistant prepares and administers a chemotherapeutic medication to combat malignant neoplasms or microorganisms. This code applies to medication infused into the central nervous system through a catheter leading from a subcutaneous reservoir of medication in the brain's subarachnoid or intraventricular space.

Coding Tips

For radioactive isotope therapy, see 79005. For subcutaneous or intramuscular administration of chemotherapy, nonhormonal, antineoplastic, see 96401; hormonal, antineoplastic, see 96402. For intralesional chemotherapy administration, up to and including seven lesions, see 96405; more than seven lesions, see 96406. To report intravenous chemotherapy, push technique, single or initial substance/drug, see 96409; each additional substance or drug, see 96411. For chemotherapy administration, via IV infusion technique, up to one hour, single or initial substance/drug, see 96413; each additional hour, report 96415 in addition; initiation of prolonged chemotherapy involving more than eight hours, requiring the use of a portable or implantable pump, see 96416; each additional sequential infusion thereafter, up to one hour, report 96417. For provision of a chemotherapy agent, see the appropriate HCPCS Level II code. Medicare and some other payers may require HCPCS Level II codes Q0083, Q0084, and Q0085 be reported for this service.

Documentation Tips

Documentation should include the direct supervision as well as special considerations for preparation, dosage or disposal, frequent monitoring, and any complications that occur. The documentation must indicate the substance, dosage, and administration.

Reimbursement Tips

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain
C79.31	Secondary malignant neoplasm of brain
C79.49	Secondary malignant neoplasm of other parts of nervous system
Z51.11	Encounter for antineoplastic chemotherapy

Associated HCPCS Codes

Q0083	Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit
Q0084	Chemotherapy administration by infusion technique only, per visit
Q0085	Chemotherapy administration by both infusion technique and other technique(s) (e.g. subcutaneous, intramuscular, push), per visit

AMA: **96542** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015, 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96542	0.75	2.89	0.08	3.72
Facility RVU	**Work**	**PE**	**MP**	**Total**
96542	0.75	0.38	0.08	1.21

	FUD	Status	MUE	Modifiers				IOM Reference
96542	N/A	A	1(3)	N/A	N/A	N/A	80*	100-03,110.2; 100-04,4,230.2

* with documentation

Terms To Know

chemotherapy. Treatment of disease, especially cancerous conditions, using chemical agents.

direct supervision. Situation in which the physician must be present in the office suite and immediately available to provide assistance and direction throughout a given procedure. The physician is not, however, required to be present in the room when the procedure is performed.

intraventricular space. Fluid-filled areas near the center of the brain that are within the ventricles.

subarachnoid. Space located between the arachnoid membrane and the pia mater that contains cerebrospinal fluid.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding and Payment Guide for Medical Oncology/Hematology* is updated with CPT and HCPCS codes for year 2027. The following icons are used in the *Coding and Payment Guide*:

- ● This CPT code is new for 2027.
- ▲ This CPT code description is revised for 2027.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same provider on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services. Note: This icon is not appended to the synchronous audio-video visit codes 98000–98007.

Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96041
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

2. Explanation

Every CPT/HCPCS code or series of similar codes is presented with its official code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding and Payment Guide for Medical Oncology/Hematology*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the medical or radiation oncologist is included and defined. *Coding and Payment Guide for Medical Oncology/Hematology* describes the most common treatments.

3. Coding Tips

Coding tips provide information on how the code should be used, provide related procedure codes, and offer help concerning common billing errors and modifier usage. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

4. Documentation Tips

Documentation tips provide code-specific tips to the coder regarding the information that should be noted in the documentation in order to support code assignment.

5. Reimbursement Tips

Reimbursement tips offer Medicare and other payer guidelines that could affect the reimbursement of this service or procedure.

6. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ☑ Laterality

Please note that in some instances, the ICD-10-CM codes for only one side of the body may have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to a right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

7. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

8. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

9. Relative Value Units/Medicare Edits

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

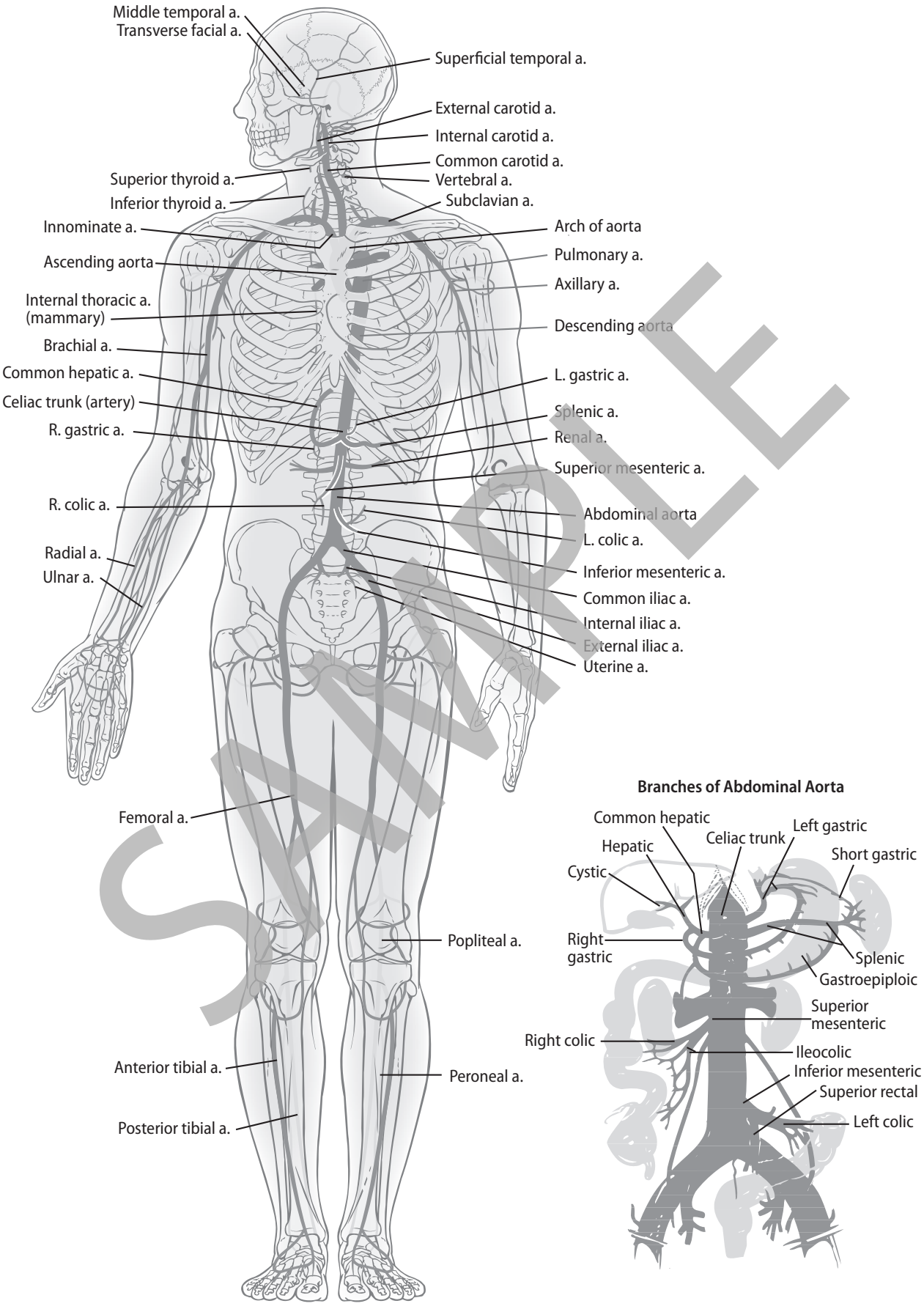
- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) insurance component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for nonfacilities, which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The second RVU group is for facilities, which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities.

Medicare Follow-Up Days (FUD)

Information on the Medicare global period is provided here, even though it is not relevant to oncologist or hematologists' coding. These services, then, have a value of 0. The global period includes all the necessary services normally furnished before, during, and after a procedure. This includes preoperative visits after the decision is made to operate and follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery. These types of services cannot be separately reported.

Arterial System



Procedure Codes

The *Current Procedural Terminology* (CPT®) coding system was developed and is updated annually by the American Medical Association (AMA). The AMA owns and maintains the CPT coding system and publishes updates annually under copyright.

CPT codes predominantly describe medical services and procedures performed by physicians and nonphysician professionals. These codes are classified as Level I of the Healthcare Common Procedure Coding System (HCPCS). Typically, physicians use CPT codes to describe their services. Government studies of patient care evaluate utilization of services by reviewing CPT codes. Because payers may question or deny payment for a CPT code, direct communication is often useful in educating payers about qualified health care provider services and practice standards. Accurate coding also can help an insurer determine coverage eligibility for services provided.

Appropriate Codes for Services and Procedures

The CPT book is divided into six major sections by type of service provided (evaluation and management, anesthesia, surgery, radiology, pathology and laboratory, and medicine). These sections are subdivided primarily by body system.

CPT Symbols

There are several symbols used in the AMA's CPT book:

- A bullet (●) before the code means that the code is new to the CPT coding system in the current year.
- A triangle (▲) before the code means that the code narrative has been revised in the current year.
- The symbols ▶ ◀ enclose new or revised text other than that contained in the code descriptors.
- The ★ icon means that this CPT code is identified by CPT as appropriate for telemedicine services.
- Codes with a plus (✚) symbol are "add-on" codes. Procedures described by "add-on" codes are always performed in addition to the primary procedure and should never be reported alone. This concept is applicable only to procedures or services performed by the same provider to describe any additional intraservice work associated with the primary procedure such as additional digits or lesions.
- The symbol ⃠ designates a code that is exempt from the use of modifier 51 when multiple procedures are performed even though they have not been designated as add-on codes.
- The number (#) symbol indicates that a code is out of numeric order or "resequenced." The AMA employs a numbering methodology of resequencing. According to the AMA there are instances where a new code is needed within an existing grouping of codes and an unused code number is not available. When the existing codes will not be changed or have minimal changes, the AMA will assign a code that is not in numeric sequence with the related codes. However, the code and description will appear in the CPT book with the other related codes.

  To facilitate the code sequence and maintain a sequential relationship according to the description of the codes, the CPT codes in this grouping will be resequenced. Resequencing is the practice of displaying the codes outside of numerical order according to the description relationship.

Modifiers

A system of two-digit modifiers has been developed to allow the provider to indicate that the service or procedure has been altered by certain circumstances or to provide additional information about a procedure that was performed, or a service or supply that was provided. Fee schedules have been developed based on these modifiers.

Addition of the modifier does not alter the basic description for the service, it merely qualifies the circumstances under which the service was provided. Circumstances that modify a service include the following:

- Procedures that have both a technical and professional component were performed
- More than one provider or setting was involved in the service
- Only part of a service was performed
- Unusual events occurred

Note that the CPT book uses the term "physician" when describing how a modifier is to be used. This does not limit the use of the modifiers to physicians; any qualified healthcare professional may use a modifier as long as the service or procedure to be modified can be performed within that practitioner's scope of work. The following is a list of modifiers used most often by the oncologist and hematologist:

22 **Increased Procedural Services.** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).

Note: This modifier should not be appended to an E/M service.

25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.** It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant or separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M services to be reported (see Evaluation and Management Services Guidelines for instructions or determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 **Professional Component.** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

51 **Multiple Procedures.** When multiple procedures, other than E/M services, services, procedures and the provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified

99202-99205

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211–99215.

Documentation Tips

Medicare allows only the medically necessary portion of the visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level of an E/M code. Medical necessity must be clearly stated and support the level of service reported.

Reimbursement Tips

The place-of-service (POS) codes used for reporting these services are the same as those for a new patient: POS code 11 represents the clinician's office environment and POS code 22 represents the outpatient setting. When a separately identifiable E/M service is reported at the same time as another procedure or service, modifier 25 should be appended to the E/M service to indicate the service is distinct from the other service performed.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99203** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99204** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99205** 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar

38205-38206

38205 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic

38206 autologous

Explanation

Hematopoietic progenitor cells, or stem cells, harvested for transplantation are used to regenerate bone marrow and immune systems destroyed by chemotherapy and/or radiation therapy. These progenitor cells are not only acquired from bone marrow, but are also found in peripheral blood, collected by apheresis. For stem cell harvesting from peripheral blood by apheresis, the donor is often given a hematopoietic growth factor to mobilize progenitor cells into the blood stream. The patient is prepared much the same as giving a regular blood donation. Whole blood is drawn out of one arm and into an instrument called a cell separator. A column in the separator sorts out the desired cells from the other cells with the help of computerized calibration. The stem cells are collected while the remainder of the blood is returned to the donor through a tube and needle in the other arm. More than one collection session may be required to acquire the amount needed for transplanting. Blood-derived progenitor cells may also be harvested from placental and umbilical cord blood after delivery for transplantation to the neonate later in life or to others. Report 38205 when the cells are collected from a donor for transplantation to another person and 38206 when the cells are harvested from the patient. Report the appropriate code for each collection done.

Coding Tips

For management of recipient hematopoietic progenitor cell donor search and cell acquisition, see 38204. For transplant preparation of hematopoietic progenitor cells, cryopreservation and storage, see 38207; thawing of previously frozen harvest, see 38208.

Reimbursement Tips

Facility reporting: According to the AMA, all allogeneic donor transplant services, including the professional service(s), should be reported on the same claim as the donor evaluation and collection services with the revenue code 0815. Note that this requires the claim to be held until all donor-related services have been provided and may be reported with the transplant recipient's claim. Check with third-party payers for their specific guidelines.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **38205** 2018,May **38206** 2018,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
38205	1.5	0.89	0.1	2.49
38206	1.5	0.84	0.1	2.44
Facility RVU	**Work**	**PE**	**MP**	**Total**
38205	1.5	0.89	0.1	2.49
38206	1.5	0.84	0.1	2.44

	FUD	Status	MUE	Modifiers				IOM Reference
38205	0	R	1(3)	51	N/A	N/A	80*	None
38206	0	R	1(3)	51	N/A	N/A	80*	

* with documentation

Terms To Know

allogeneic. Tissue, cells, blood, or blood components (genes) from individuals of the same species who may or may not be related to one another. Allogeneic collection was formerly termed homologous collection.

autologous. Tissue or structure derived from the same individual. A. cultured chondrocytes: Mature cartilage cells derived first from the patient's own normal, articular cartilage and then cultured in a laboratory setting to grow a higher volume of cells needed for transplant. Cells are taken from the lesser-weight bearing area of the knee and used to repair knee defects from damage to the hyaline cartilage. May be sold under the brand name Carticel.

hematopoietic progenitor cells. Blood producing cells, progenitor cells are considered more specific than a stem cell and are limited in the number of times they may divide. Some sources consider progenitor and stem cells to be nearly identical. These cells are harvested from bone marrow, umbilical or cord blood, or apheresis of peripheral blood.

transplantation. Grafting or movement of an organ or tissue from one site or person to another.

77280-77290

77280 Therapeutic radiology simulation-aided field setting; simple

77285 intermediate

77290 complex

Explanation

Simulation-aided field setting is done prior to beginning the course of radiation treatment. This is done to determine the size and location of the ports to be used so that they surround the tumor. A port is the site where the treatment beam will enter the skin and concentrate upon the malignant area(s). Simulation can be done on a dedicated simulator, a radiation therapy treatment unit, an x-ray machine, or CT scanner. Simulation allows visualization and definition of the exact treatment area(s). Simple simulation, reported in 77280, is done for a single area of malignancy with a single port or opposing ports parallel to each other and basic or no blocking. Intermediate simulation, reported in 77285, is done for two separate areas of malignancy with three or more ports and multiple blocks. Complex simulation, reported in 77290, is done for three or more areas of malignancy with tangential ports and complex blocking that may require customized shielding blocks, rotation or arc therapy, brachytherapy source and hyperthermia probe verification, and use of contrast materials.

Coding Tips

Simulation-aided field setting is only part of a series of procedures performed on a patient receiving radiation therapy. Clinical treatment planning, dosimetry, medical radiation physics, treatment delivery, and treatment management are services/procedures that will be billed separately, in addition to this code.

Facility reporting: According to the AMA, it is inappropriate to report 77014 (CT images) in addition to radiation oncology simulation codes 77280–77290 when performed on the same date of service. The CT service is considered an integral part of the stimulation-aided field setting services.

Documentation Tips

The typical course of radiation therapy requires between one and three simulations. Simulations are classified as simple, intermediate, and complex. Simple involves a single treatment area; two or more separate treatment areas are considered intermediate. Complex is three or more treatment areas OR any number of treatment areas IF they involve any of the following: particle, rotation/arc therapy, complex blocking, custom shielding blocks, brachytherapy simulation, hyperthermia probe verification, or the use of any contrast material. Frequency in excess of three simulations should be supported by documentation in the medical record.

Reimbursement Tips

These codes have both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier.

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

This code is associated with general malignancies and associated codes are too numerous to list here. Refer to the ICD-10-CM Neoplasm section.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
77280	0.7	7.34	0.04	8.08
77285	1.05	12.12	0.06	13.23
77290	1.56	11.77	0.1	13.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
77280	0.7	7.34	0.04	8.08
77285	1.05	12.12	0.06	13.23
77290	1.56	11.77	0.1	13.43

	FUD	Status	MUE	Modifiers				IOM Reference
77280	N/A	A	2(3)	N/A	N/A	N/A	80*	None
77285	N/A	A	1(3)	N/A	N/A	N/A	80*	
77290	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

block. Device made of portions or sections of some form of heavy metal that is utilized to shape the radiation beam and also function as a barrier to protect healthy surrounding tissue from the radiation beam.

brachytherapy. Form of radiation therapy in which radioactive pellets or seeds are implanted directly into the tissue being treated to deliver their dose of radiation in a more directed fashion. Brachytherapy provides radiation to the prescribed body area while minimizing exposure to normal tissue.

particle beam. Treatment using subatomic proton and neutron particles to deliver high-energy radiation.

radiation therapy simulation. Radiation therapy simulation. Procedure by which the specific body area to be treated with radiation is defined and marked. A CT scan is performed to define the body contours and these images are used to create a plan customized treatment for the patient, targeting the area to be treated while sparing adjacent tissue. The center of the area to be treated is marked and an immobilization device (e.g., cradle, mold) is created to make sure the patient is in the same position each time for treatment. Complexity of treatment depends on the number of treatment areas and the use of tools to isolate the area of treatment.

96365-96368

96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour

\+ **96366** each additional hour (List separately in addition to code for primary procedure)

\+ **96367** additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)

\+ **96368** concurrent infusion (List separately in addition to code for primary procedure)

Explanation

A physician or an assistant under direct physician supervision injects or infuses a therapeutic, prophylactic (preventive), or diagnostic medication other than chemotherapy or other highly complex drugs or biologic agents via intravenous route. Infusions are administered through an intravenous catheter inserted by needle into a patient's vein or by injection or infusion through an existing indwelling intravascular access catheter or port. Report 96365 for the initial hour and 96366 for each additional hour. Report 96367 for each additional sequential infusion of a different substance or drug, up to one hour, and 96368 for each concurrent infusion of substances other than chemotherapy or other highly complex drugs or biologic agents.

Coding Tips

Report 96365 for the initial hour and 96366 for each additional hour. Report 96366 with either 96365 or 96367. Report 96367 for each additional sequential infusion of a different substance or drug, up to one hour, and 96368 for each concurrent infusion of substances other than chemotherapy or other highly complex drugs or biologic agents. Report 96367 with codes 96365, 96374 (intravenous push), 96409 (intravenous push chemotherapy or other highly complex drugs or agents) or 96413 (chemotherapy administration) when a new drug or substance in administered through the same IV access. Codes 96365 and 96366 should never be used to report infusion for hydration (96360–96361), the transfusion of blood platelets or other blood products (36430–36516), or the infusion of chemotherapeutic drugs (96401–96549).

Facility reporting: Outpatient physician involvement for hydration, therapeutic or diagnostic injections and intravenous (IV) infusions (other than hydration); and chemotherapy administration in a Method II critical access hospital (CAH) is included in the physician's evaluation and management (E/M) services. Bills must include an appropriate outpatient hospital visit E/M CPT code with revenue code 096X, 097X or 098X on TOB 085X. Adjunct chemotherapy drugs are covered when administered during chemotherapy or within 48 hours of administration. Report HCPCS Level II codes with revenue code 0636 Drugs that require detailed coding, for outpatients. Chemotherapy adjunct drugs used on an inpatient basis should be billed using revenue code 0250.

Documentation Tips

The medical record documentation should indicate the following:

- The site of the injection or infusion
- The route of administration (e.g., subcutaneous, intramuscular, intravenous, intradermal)
- The substance administered (e.g., fluids, medication, sequential, combined)
- The number of units

In the instance of infusions the documentation should also include:

- If the IV therapy was the main service
- The amount of time
- Technique (i.e., push or drip)
- If for hydration

Documentation should state why the patient required these services to support the medical necessity.

Reimbursement Tips

Code 96365 may be billed multiple times with the modifier 59 appended. For code 96366, indicate the number of hours in the unit column of the claim. An hour can be reported when 31-60 minutes elapse. Report 96367 with a unit of 1 on the claim form per sequential infusion of same infusate mix. As add-on codes, 96366–96368 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code.

Do not report 96365–96379 with codes where the IV push or infusion is an inherent component of the procedure, for example, administration of contrast material for a diagnostic imaging study.

Only **one** initial service code is to be reported other than in cases where either protocol or patient condition necessitates the use of two distinct IV sites be used. Reporting of the service must include appending modifier 59 to the *initial* service code in order to denote the distinction in both time and effort in providing the secondary IV access site.

All sequential infusions are described as any infusion or IV push of a new substance that follows the initial or primary service. In order to qualify as a sequential service, a new substance or drug must be introduced with one exception; facilities are permitted to report a sequential IV push of the same drug using CPT code 96376.

Concurrent infusions are those in which a new substance or drug is infused at the same time as another substance or drug. These services are not time based and should only be reported once daily regardless of whether an additional new substance or drug is being administered at the same time. Do not report hydration services with any other services.

Determining which service should be reported when more than one type of service is provided is done using hierarchies; these hierarchies are different depending on whether the service is reported by a clinician or a facility. When reported by a clinician, the initial service code selected should be based on key or primary reason for the encounter, regardless of the order in which the infusions/injections occur. Facility reporting is based on a structural algorithm and the initial code should be chosen following a hierarchy that states chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services, which are primary to hydration services. Infusions are primary to pushes, which are primary to injections. This ranking is followed by facilities and replaces any CPT parenthetical instructions for add-on codes that might refer an add-on code of a higher hierarchical position be reported with a base code of a lower position. For example, hierarchy would not allow the reporting of CPT code 96376 with 96360; 96376 is a higher order service. (IV push is primary to hydration.)

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **96365** 2022,Dec; 2021,Mar; 2020,Nov; 2018,Dec; 2018,Sep; 2018,May **96366** 2022,Dec; 2021,Mar; 2020,Nov; 2018,Sep **96367** 2021,Mar; 2020,Nov; 2018,Sep **96368** 2022,Dec; 2021,Mar; 2020,Nov; 2018,Sep

96416

96416 Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump

Explanation

The physician or supervised assistant prepares and administers a chemotherapeutic medication to combat malignant neoplasms or microorganisms. This code applies to initiating an infusion that will take more than eight hours and requires using an implanted pump or a portable pump to infuse the medication slowly through catheter tubing placed in a vein.

Coding Tips

The following services are performed in the infusion or injection procedure and should not be reported separately:

- Administration of local anesthetic
- Initiation of the IV
- Access to indwelling IV, subcutaneous catheter, or port
- Flush at beginning or conclusion of infusion
- Standard supplies

Only one hour of hydration is reported regardless of the number of hours administered when provided in conjunction with chemotherapy.

For the declotting of a catheter or port, see 36593. To identify therapeutic prophylactic or diagnostic drugs by infusion or injection, see codes 96367 and 96375 when administered as a secondary or subsequent service in conjunction with 96413 through the same IV access site. Do not report 96416 with 36823.

For refilling and maintenance of a portable pump or implantable infusion pump or reservoir for drug delivery, see 96521–96523.

When the encounter is solely for the administration of chemotherapy, immunotherapy, or radiation therapy, assign the appropriate code from category Z51 Encounter for other aftercare and medical care, as the principal or first-listed diagnosis. The specific malignancy code is assigned and reported as an additional condition.

When the medical record documentation clearly identifies that it is medically necessary to split a substance into two doses (i.e., two injections or infusion in different sites), it is appropriate to code both doses with modifier 59 or the appropriate X [E, S, P, U] modifier. The preparation of chemotherapy agent(s) is included in the service for administration of the agent and is not reported as a separate service.

Drugs used when providing this procedure may be reported with the appropriate HCPCS Level II code. Verify the appropriate dosing requirements and units of service. Check with the specific payer to determine coverage.

Documentation Tips

Stop and start times should be clearly identified and notated in the medical record with as much specificity as possible, including total amount of time calculated. Reporting only the total time is insufficient to determine correct reporting and sequencing. These services are considered highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intraservice supervision of staff. Documentation should include the direct supervision as well as special considerations for preparation, dosage or disposal, frequent monitoring, and any complications that occur. Sequential infusion is a new substance administered by infusion or IV push. The documentation must indicate the substance, dosage, and administration.

Reimbursement Tips

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

This code is associated with general malignancies and associated codes are too numerous to list here. Refer to the ICD-10-CM Neoplasm section.

AMA: 96416 2022,Oct; 2022,May; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96416	0.21	3.54	0.07	3.82
Facility RVU	**Work**	**PE**	**MP**	**Total**
96416	0.21	3.54	0.07	3.82

	FUD	Status	MUE	Modifiers				IOM Reference
96416	N/A	A	1(3)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

chemotherapy. Treatment of disease, especially cancerous conditions, using chemical agents.

infusion. Introduction of a therapeutic fluid, other than blood, into the bloodstream.

intravenous. Within a vein or veins.

portable. Movable.

pump. Forcing gas or liquid from a body part.

Neoplasm Table

Note: The list below gives the code number for neoplasms by anatomical site. For each site there are six possible code numbers according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior, or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate; e.g., malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri. Where such descriptors are not present, the remainder of the Index should be consulted where guidance is given to the appropriate column for each morphological (histological) variety listed; e.g., Mesonephroma – see Neoplasm, malignant; Embryoma — see also Neoplasm, uncertain behavior; Disease, Bowen's – see Neoplasm, skin, in situ. However, the guidance in the Index can be overridden if one of the descriptors mentioned above is present; e.g., malignant adenoma of colon is coded to C18.9 and not to D12.6 as the adjective "malignant" overrides the Index entry "Adenoma — *see also* Neoplasm, benign, by site." Codes listed with a dash -, following the code have a required additional character for laterality. The tabular list must be reviewed for the complete code.

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
Neoplasm, neoplastic	C80.1	C79.9	D09.9	D36.9	D48.9	D49.9
abdomen, abdominal	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
cavity	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
organ	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
viscera	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
wall — *see also* Neoplasm, abdomen, wall, skin	C44.509	C79.2	D04.5	D23.5	D48.5	D49.2
connective tissue	C49.4	C79.8-☑	—	D21.4	D48.1☑	D49.2
skin	C44.509	—	—	—	—	—
basal cell carcinoma	C44.519	—	—	—	—	—
specified type NEC	C44.599	—	—	—	—	—
squamous cell carcinoma	C44.529	—	—	—	—	—
abdominopelvic	C76.8	C79.8-☑	—	D36.7	D48.7	D49.89
accessory sinus — *see* Neoplasm, sinus						
acoustic nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
adenoid (pharynx) (tissue)	C11.1	C79.89	D00.08	D10.6	D37.05	D49.0
adipose tissue — *see also* Neoplasm, connective tissue	C49.4	C79.89	—	D21.9	D48.1☑	D49.2
adnexa (uterine)	C57.4	C79.89	D07.39	D28.7	D39.8	D49.59
adrenal	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
capsule	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
cortex	C74.0-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
gland	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
medulla	C74.1-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
ala nasi (external) — *see also* Neoplasm, skin, nose	C44.301	C79.2	D04.39	D23.39	D48.5	D49.2
alimentary canal or tract NEC	C26.9	C78.80	D01.9	D13.99	D37.9	D49.0
alveolar	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ridge or process	C41.1	C79.51	—	D16.5	D48.0	D49.2
carcinoma	C03.9	C79.8-☑	—	—	—	—
lower	C03.1	C79.8-☑	—	—	—	—
upper	C03.0	C79.8-☑	—	—	—	—
lower	C41.1	C79.51	—	D16.5	D48.0	D49.2
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C41.0	C79.51	—	D16.4	D48.0	D49.2
sulcus	C06.1	C79.89	D00.02	D10.39	D37.09	D49.0
alveolus	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ampulla of Vater	C24.1	C78.89	D01.5	D13.5	D37.6	D49.0
Neoplasm, neoplastic — *continued*						
ankle NEC	C76.5-☑	C79.89	D04.7-☑	D36.7	D48.7	D49.89
anorectum, anorectal (junction)	C21.8	C78.5	D01.3	D12.9	D37.8	D49.0
antecubital fossa or space	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
antrum (Highmore) (maxillary)	C31.0	C78.39	D02.3	D14.0	D38.5	D49.1
pyloric	C16.3	C78.89	D00.2	D13.1	D37.1	D49.0
tympanicum	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
anus, anal	C21.0	C78.5	D01.3	D12.9	D37.8	D49.0
canal	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
cloacogenic zone	C21.2	C78.5	D01.3	D12.9	D37.8	D49.0
margin — *see also* Neoplasm, anus, skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
overlapping lesion with rectosigmoid junction or rectum	C21.8	—	—	—	—	—
skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
basal cell carcinoma	C44.510	—	—	—	—	—
specified type NEC	C44.590	—	—	—	—	—
squamous cell carcinoma	C44.520	—	—	—	—	—
sphincter	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
aorta (thoracic)	C49.3	C79.89	—	D21.3	D48.1☑	D49.2
abdominal	C49.4	C79.89	—	D21.4	D48.1☑	D49.2
aortic body	C75.5	C79.89	—	D35.6	D44.7	D49.7
aponeurosis	C49.9	C79.89	—	D21.9	D48.1☑	D49.2
palmar	C49.1-☑	C79.89	—	D21.1-☑	D48.1☑	D49.2
plantar	C49.2-☑	C79.89	—	D21.2-☑	D48.1☑	D49.2
appendix	C18.1	C78.5	D01.0	D12.1	D37.3	D49.0
arachnoid	C70.9	C79.49	—	D32.9	D42.9	D49.7
cerebral	C70.0	C79.32	—	D32.0	D42.0	D49.7
spinal	C70.1	C79.49	—	D32.1	D42.1	D49.7
areola	C50.0-☑	C79.81	D05-☑	D24-☑	D48.6-☑	D49.3
arm NEC	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
artery — *see* Neoplasm, connective tissue						
aryepiglottic fold	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
hypopharyngeal aspect	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
laryngeal aspect	C32.1	C78.39	D02.0	D14.1	D38.0	D49.1
marginal zone	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
arytenoid (cartilage)	C32.3	C78.39	D02.0	D14.1	D38.0	D49.1
fold — *see* Neoplasm, aryepiglottic						
associated with transplanted organ	C80.2	—	—	—	—	—
atlas	C41.2	C79.51	—	D16.6	D48.0	D49.2
atrium, cardiac	C38.0	C79.89	—	D15.1	D48.7	D49.89
auditory canal (external) (skin)	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
tube opening	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
auricle, ear — *see also* Neoplasm, skin, ear	C11.2	C79.89	D00.08	D10.6	D37.05	D49.0
auricular canal (external) — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.2
autonomic nerve or nervous system NEC (see Neoplasm, nerve, peripheral)						

HCPCS Level II Definitions and Guidelines

Structure and Use of HCPCS Level II Codes

The main terms are in boldface type in the index. Main term entries include tests, services, supplies, orthotics, prostheses, medical equipment, drugs, therapies, and some medical and surgical procedures.

HCPCS Level II Codes: Sections A–V

Level II codes consist of one alphabetic character (letters A through V) and four numbers. The HCPCS sections most commonly used in oncology services are:

- G codes G0008–G9987 Procedures/Professional Services (Temporary Codes)
- J codes J0120–J9999 Drugs Administered Other Than Oral Method, Chemotherapy Drugs (Exception: Oral Immunosuppressive Drugs)
- Q codes Q0035–Q9995 Miscellaneous Services (Temporary Codes)

How to use these codes is addressed in this section, the HCPCS section, and the appendix.

The Conventions: Symbols and Modifiers

Symbols used in the HCPCS Level II coding system may be presented in various ways, depending on the vendor. In this publication, the pattern established by the AMA in the CPT code book is followed. For example, bullets and triangles signify new and revised codes, respectively.

When a code is new to the HCPCS Level II system, a bullet (●) appears to the left of the code. This symbol is consistent with the CPT coding system's symbol for new codes. The bullet represents a code never before seen in the HCPCS coding system.

Example

● J0893 Injection, decitabine (Sun Pharma) not therapeutically equivalent to J0894, 1 mg

A triangle (▲) is used (as in the CPT coding system) to indicate that a change in the narrative of a code has been made from the previous year's edition. The change made may be slight or significant, but it usually changes the application of the code.

Example

▲ J9041 Injection, bortezomib, 0.1 mg

In certain circumstances, modifiers must be used to report the alteration of a procedure or service or to furnish additional information about the service, supply, or procedure that was provided. In the HCPCS Level I (CPT) coding system, modifiers are two-digit suffixes that usually directly follow the five-digit procedure or service code. In HCPCS Level II, modifiers are composed of two alpha or alphanumeric characters that range from AA to VP.

Chemotherapy Drugs

The table starting on this page identifies J and Q codes representing medications/drugs used in oncology. The table is organized first by route of administration—oral, injectable/intravenous, implantable—and then by code order. Additional drug codes common to oncology can be found in the following HCPCS section in this guide.

Code	*Generic Name*	*Brand Name*	*FDA Approved Usage*
Oral Drugs			
J8510	Busulfan, oral, 2 mg	Busulfex, Myleran	Chronic myelogenic leukemia
J8515	Cabergoline, oral, 0.25 mg	Dostinex	Hyperprolacteria
J8520	Capecitabine, oral, 150 mg	Xeloda	Breast or colorectal cancer
J8521	Capecitabine, oral, 500 mg	Xeloda	Breast or colorectal cancer
J8530	Cyclophosphamide, oral, 25 mg	Cytoxan, Neosar	Acute lymphoblastic leukemia, acute myeloid leukemia, breast cancer, chronic lymphocytic leukemia, chronic myelogenous leukemia, Hodgkin lymphoma, multiple myeloma, mycosis fungoides, neuoblastoma, non-Hodgkin lymphoma, ovarian cancer
J8560	Etoposide, oral, 50 mg	VePesid, Toposar	Small cell lung cancer, testicular cancer
J8562	Fludarabine phosphate, oral, 10 mg	Oforta	Chronic lymphocytic leukemia
J8565	Gefitinib, oral, 250 mg	Iressa	Non-small cell lung cancer
J8597	Antiemetic drug, oral, not otherwise specified		**Note:** Only report this code if a more specific code is unavailable.
J8600	Melphalan, oral, 2 mg	Alkeran	Multiple Myeloma
J8610	Methotrexate, oral, 2.5 mg	Trexall, RHEUMATREX	Acute lymphoblastic leukemia, breast cancer, gestational trophoblastic disease, head and neck carcinoma, lung carcinoma, mycosis fungoides, non-Hodgkin lymphoma, osteosarcoma
J8700	Temozolomide, oral, 5 mg	Methazolastone, Temodar	Anaplastic astrocytoma, glioblastoma multiforme
J8705	Topotecan, oral, 0.25 mg	Hycamtin	Cervical, ovarian, and small cell lung cancers
J8999	Prescription drug, oral, chemotherapeutic, NOS		**Note:** Only report this code if a more specific code is unavailable.

J9036

J9036 Injection, bendamustine HCl, (Belrapzo/bendamustine), 1 mg

Explanation

Bendamustine HCl is an alkylating drug indicated for treatment of pediatric and adult patients with chronic lymphocytic leukemia (CLL) and indolent B-cell non-Hodgkin lymphoma (NHL) that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen. The exact mechanism of action of bendamustine remains unknown. It is supplied in multiple dose vials as a ready-to-dilute solution of 100 mg/4mL. Recommended dosage for CLL is 100 mg/m^2 administered by intravenous infusion over 30 minutes on days one and two of a 28-day cycle, for up to six cycles.

Recommended dosage for NHL is 120 mg/m^2 administered by intravenous infusion over 60 minutes on days one and two of a 21-day cycle, for up to eight cycles.

Coding Tips

Report the appropriate administration code from the CPT code range 96401–96549. When the encounter is solely for the administration of chemotherapy, immunotherapy, or radiation therapy, assign the appropriate code from category Z51 Encounter for other aftercare and medical care, as the principal or first-listed diagnosis. The specific malignancy code is assigned and reported as an additional and secondary condition.

Documentation Tips

These services are highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intraservice supervision of staff. Documentation should include the direct supervision, as well as special considerations for preparation, dosage or disposal, frequent monitoring, and any complications that occur. The documentation must indicate the substance, dosage, and administration.

Reimbursement Tips

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

C85.81 Other specified types of non-Hodgkin lymphoma, lymph nodes of head, face, and neck

C85.82 Other specified types of non-Hodgkin lymphoma, intrathoracic lymph nodes

C85.83 Other specified types of non-Hodgkin lymphoma, intra-abdominal lymph nodes

C85.84 Other specified types of non-Hodgkin lymphoma, lymph nodes of axilla and upper limb

C85.85 Other specified types of non-Hodgkin lymphoma, lymph nodes of inguinal region and lower limb

C85.86 Other specified types of non-Hodgkin lymphoma, intrapelvic lymph nodes

C85.87 Other specified types of non-Hodgkin lymphoma, spleen

C85.88 Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites

C85.89 Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites

C85.90 Non-Hodgkin lymphoma, unspecified, unspecified site

C85.91 Non-Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck

C85.92 Non-Hodgkin lymphoma, unspecified, intrathoracic lymph nodes

C85.93 Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes

C85.94 Non-Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb

C85.95 Non-Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb

C85.96 Non-Hodgkin lymphoma, unspecified, intrapelvic lymph nodes

C85.97 Non-Hodgkin lymphoma, unspecified, spleen

C85.98 Non-Hodgkin lymphoma, unspecified, lymph nodes of multiple sites

C85.99 Non-Hodgkin lymphoma, unspecified, extranodal and solid organ sites

C91.10 Chronic lymphocytic leukemia of B-cell type not having achieved remission

C91.12 Chronic lymphocytic leukemia of B-cell type in relapse

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
J9036	0.0	0.0	0.0	0.0

Facility RVU	Work	PE	MP	Total
J9036	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
J9036	N/A	E	360(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

CLL. Chronic lymphatic leukemia.

NHL. Non-Hodgkin's lymphoma.