OPTUM360®

CODING & PAYMENT GUIDE

Medical Oncology/ Hematology Services

An essential coding, billing and reimbursement resource for oncology and hematology services

2021

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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 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 codes in *Coding and Payment Guide* are listed in ascending numeric order, including surgery, radiology, laboratory and medicine codes. Each CPT code is followed by its official CPT 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.

Resequenced CPT codes within the *Optum360 Coding and Payment Guide* series display in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as the diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of healthcare in mind. New features have been added, and conditions have been reorganized although the format and conventions of the classification remain unchanged for the most part. In this Coding and Payment Guide, we have also included the official ICD-10-CM Neoplasm Table to assist you in finding the appropriate ICD-10-CM codes for the service provided.

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 coded and its narrative is a combination of features. A sample is shown on page 6. The black boxes with numbers in them correspond to the information on the page following the example.

Appendix Codes and Descriptions

Some CPT codes that are not commonly used in Oncology/Hematology, are presented in a less comprehensive format in the appendix. The CPT codes are also followed by the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure. Category III codes are included in the main body of the book.

CCI Edit Updates

The *Optum 360 Coding and Payment Guide* series 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 most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the *Coding and Payment Guide* series and posts updated CCI edits on this website so that current information is available before the next edition.
The website address is https://www.optum360coding.com/ProductUpdates/. The 2021 edition password is: XXXXXXXX. Please note that you should log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

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

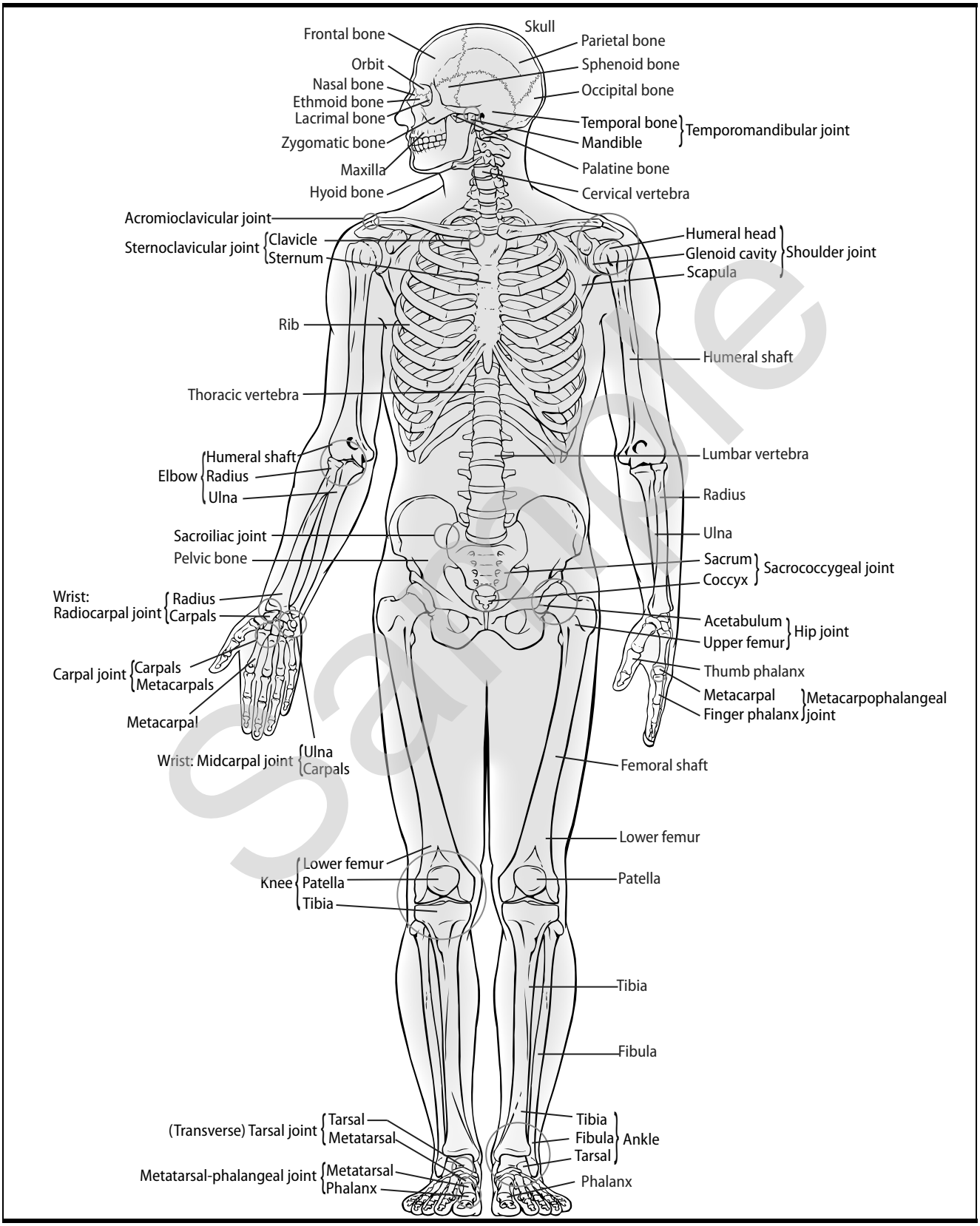
Providers

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 xiii 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.

Anatomical Illustrations

Musculoskeletal System

Bones and Joints



Procedure Codes

The Physicians' 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.
- 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.

99238-99239

99238 Hospital discharge day management; 30 minutes or less

99239 more than 30 minutes

Explanation

Hospital discharge services are time-based codes that, when reported, describe the amount of time spent by the qualified clinician during all final steps involved in the discharge of a patient from the hospital on a date that differs from the date of admission, including the last patient exam, discussing the hospital stay, instructions for ongoing care as it relates to all pertinent caregivers, as well as preparing the medical discharge records, prescriptions, and/or referrals as applicable. Time reported should be for the total duration of time spent by the provider even when the time spent on that date is not continuous. For a hospital discharge duration of 30 minutes or less, report 99238; for a duration of greater than 30 minutes, report 99239. There are no key components associated with these services.

Coding Tips

These codes are used to report all discharge day services for the hospital inpatient, including patient examination, discharge and follow-up care instructions, and preparation of all medical records. These are time-based codes and time spent with the patient must be documented in the medical record. For observation discharge on a different date of service than the admission, see 99217. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236.

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. When a complication associated with a neoplasm, such as dehydration, is the reason for the treatment the complication is reported as the principal/first listed condition and the neoplasm is reported as an additional code. However, official guidelines indicate that when the admission/encounter is for the management of anemia associated with malignancy and the only treatment is for the malignancy, the malignancy is reported as the principal/first listed condition and the anemia is reported additionally.

Reimbursement Tips

Report place-of-service code 21 for the inpatient setting.

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: **99238** 2018,Jan,8; 2018,Dec,8; 2018,Dec,8; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Jan,13; 2016,Dec,11; 2015,Jan,16; 2014,Oct,8; 2014,Jan,11; 2013,Jun,3-5; 2013,Aug,13 **99239** 2018,Jan,8; 2018,Dec,8; 2018,Dec,8; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Jan,13; 2016,Dec,11; 2015,Jan,16; 2014,Oct,8; 2014,Jan,11; 2013,Jun,3-5; 2013,Aug,13

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99238	1.28	0.69	0.09	2.06
99239	1.9	1.0	0.12	3.02
Facility RVU	**Work**	**PE**	**MP**	**Total**
99238	1.28	0.69	0.09	2.06
99239	1.9	1.0	0.12	3.02

	FUD	Status	MUE	Modifiers				IOM Reference
99238	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,12,30.6.4; 100-04,12,30.6.9; 100-04,12,30.6.9.1; 100-04,12,30.6.9.2; 100-04,12,100
99239	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

discharge plan. Treatment plan by the provider for continued patient care after discharge that may include home care, the services of case managers or other health care providers, or transfer to another facility.

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.

AMA: **77280** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2015,Apr,10; 2014,Jan,11; 2013,Nov,11 **77285** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2015,Apr,10; 2014,Jan,11; 2013,Nov,11 **77290** 2018,Jan,8; 2017,Jan,8; 2016,Sep,9; 2016,Jan,13; 2015,Jan,16; 2015,Apr,10; 2014,Jan,11; 2013,Nov,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
77280	0.7	7.11	0.04	7.85
77285	1.05	12.03	0.07	13.15
77290	1.56	12.44	0.08	14.08
Facility RVU	**Work**	**PE**	**MP**	**Total**
77280	0.7	7.11	0.04	7.85
77285	1.05	12.03	0.07	13.15
77290	1.56	12.44	0.08	14.08

	FUD	Status	MUE	Modifiers				IOM Reference
77280	N/A	A	2(3)	N/A	N/A	N/A	80*	100-04,4,200.3.2
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.

96401-96402

96401 Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic

96402 hormonal anti-neoplastic

Explanation

The physician or supervised assistant prepares and administers non-hormonal medication to combat diseases such as malignant neoplasms or microorganisms. These codes apply to medication injected under the skin (subcutaneous) or into a muscle (intramuscular) often in the arm or leg. Report 96402 for a hormonal medication administered to combat diseases such as malignant neoplasms or microorganisms.

Coding Tips

When the medical record documentation clearly identifies that it is medically necessary to separate a substance into two doses (i.e., two injections or infusions 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.

To report the intramuscular or subcutaneous administration of antiemetics, narcotics, or analgesics administered, see 96372. The substance used when providing this procedure may be reported with the appropriate HCPCS Level II code. Verify the appropriate dosing requirements and units of service. Experimental or non-Food and Drug Administration (FDA) approved treatment may not be covered by the payer. Check with the specific payer for coverage guidelines or limitations. Examples of hormonal anti-neoplastics include degarelix (SC), infergen (SC), and triptorelin (IM).

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 as a subsequent condition.

Documentation Tips

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. Chemotherapy and other highly complex drugs or biologic agent administration involves advanced practice training and competency for all staff members involved in providing these services due to the significant degree of patient risk and ongoing monitoring involved with administering these medications.

Review the documentation to verify the route of administration. Intramuscular injections will note an injection site deep into a muscle in the arm, thigh, or buttock. Subcutaneous injections will be performed just under the skin.

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: **96401** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11 **96402** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96401	0.21	1.96	0.05	2.22
96402	0.19	0.68	0.02	0.89
Facility RVU	**Work**	**PE**	**MP**	**Total**
96401	0.21	1.96	0.05	2.22
96402	0.19	0.68	0.02	0.89

	FUD	Status	MUE	Modifiers				IOM Reference
96401	N/A	A	3(3)	N/A	N/A	N/A	80*	100-03,110.2; 100-03,110.6; 100-04,4,230.2
96402	N/A	A	2(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

antineoplastic. Any agent with the ability to inhibit the growth of new tumors by keeping the proliferation of malignant cells in check.

intramuscular. Within a muscle.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

neoplasm. New abnormal growth, tumor.

subcutaneous. Below the skin.

 ● New ▲ Revised + Add On AMA: CPT Assist [Resequenced] ☑ Laterality

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	D13.9	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
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	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
aryepiglottic fold	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
hypopharyngeal aspect	C32.1	C78.39	D02.0	D14.1	D38.0	D49.1
laryngeal aspect	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
marginal zone	C32.3	C78.39	D02.0	D14.1	D38.0	D49.1
arytenoid (cartilage)	C80.2	—	—	—	—	—
fold — *see* Neoplasm, aryepiglottic associated with transplanted organ	C41.2	C79.51	—	D16.6	D48.0	D49.2
atlas	C38.0	C79.89	—	D15.1	D48.7	D49.89
atrium, cardiac						
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	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
opening	C11.2	C79.89	D00.08	D10.6	D37.05	D49.0
auricle, ear — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
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)						

36512 0213T, 0216T, 0228T, 0230T, 0537T❖, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 36000, 36400-36410, 36420-36430, 36440-36455❖, 36513-36514❖, 36516❖, 36591-36592, 36600, 36640, 43752, 51701-51703, 62320-62327, 64400-64410, 64413-64435, 64445-64450, 64461-64463, 64479-64505, 64510-64530, 69990, 92012-92014, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360-96368, 96372, 96374-96377, 96523, 99155, 99156, 99157, 99201-99255, 99281-99285, 99291-99292, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350, 99374-99375, 99377-99378, 99446-99449, 99451-99452, 99466, 99468-99472, 99475-99480, 99483, 99485, 99495-99497, G0380-G0471

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HCPCS Code	Generic Name	Brand Name	FDA Approved Usage
J8540	Dexamethasone, oral, 0.25 mg	AK-Dex, Cortastat, Cortostat, Dalalone, Decadrol, Decadron, Decadron phosphate, Decaject, Dexacen, Dexacorten, DexaMeth, Dexamethasone Intensol, Dexasone, Dexone, Hexadrol, Hexadrol phosphate, Mymethasone, Oradexon, Primethasone, Solurex.	Prevention of chemotherapy-induced nausea and vomiting
J8560	Etoposide, oral, 50 mg	VePesid, Toposar	Small cell lung cancer, testicular cancer
J8562	Fludarabine phosphate, oral, 10 mg	Oforta	Chronic lymphocytic leukemia
J1454	Fosnetupitant 235 mg and palonosetron 0.25 mg	Akynezo	Nausea and vomiting associated with chemotherapy
J8565	Gefitinib, oral, 250 mg	Iressa	Non-small cell lung cancer
J9202	Goserelin acetate implant, per 3.6 mg	Zoladex	Breast, prostate cancer
J9226	Histrelin implant (supprelin LA), 50 mg	Supprelin LA	Palliative treatment for advanced prostate cancer
J9225	Histrelin implant (Vantas), 50 mg	Vantas	Palliative treatment for advanced prostate cancer
J9354	Injection, ado-trastuzumab emtansine, 1 mg	Kadcyla	HERZ positive metastatic breast cancer
J9015	Injection, aldesleukin, per single use vial	Proleukin, IL-2, Interleukin	Melanoma, renal cancer
J9017	Injection, arsenic trioxide, 1 mg	Trisenox	Acute promylocytic leukemia
J9019	Injection, asparaginase (erwinaze), 1,000 iu	Erwinaze	Acute lymphoblastic leukemia
J9020	Injection, asparaginase, not otherwise specified, 10,000 units	Elspar	Acute lymphoblastic leukemia
J9022	Injection, atezolizumab, 10 mg	Tecentriq	Non-small cell lung cancer, urothelial carcinoma
J9023	Injection, avelumab, 10 mg	Bavencio	Merkel cell carcinoma, urothelial carcinoma
J9025	Injection, azacitidine, 1 mg	Vidaza	Myelodysplastic syndromes
J9032	Injection, belinostat, 10 mg	Beleodaq	Peripheral T-cell lymphoma
J9034	Injection, bendamustine hcl (bendeka), 1 mg	Bendeka	B-cell non-Hodgkin lymphoma, chronic lymphocytic leukemia
J9033	Injection, bendamustine hcl (treanda), 1 mg	Treanda	B-cell non-Hodgkin lymphoma, chronic lymphocytic leukemia
J9036	Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg	Belrapzo	Chronic lymphocytic, indolent B-cell non-Hodgkin lymphoma
J9035	Injection, bevacizumab, 10 mg	Avastin, Mvasi	Cervical, colorectal, blioblastoma, nonsquamous non-small cell lung, ovarian epithelial, fallopian tube, renal cell
Q5118	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg	Zirabev	Metastatic colorectal cancer, in combination with intravenous fluorouracil-based chemotherapy for first- or second-line treatment, metastatic colorectal cancer, in combination with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients who have progressed on a first-line bevacizumab product-containing regimen
J9040	Injection, bleomycin sulfate, 15 units	Bienoxane	Hodgkin lymphoma, non-Hodgkin lymphoma, penile, squamous cell of cervix, squamous cell of head and neck, squamous cell vulva, testicular

G6003-G6006

G6003 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev

G6004 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev

G6005 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 mev

G6006 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 mev or greater

Explanation

Radiation treatment delivery involves the delivery of a beam of high-energy radiation from an external treatment machine distanced from the treatment area. External radiation is often delivered by linear accelerator, which can deliver x-rays (photons) or electrons to a targeted area. Cobalt teletherapy units and cesium teletherapy units are also used to direct gamma rays from a distance to the targeted area. Photons can target deeper lying tumor tissue, while electrons are used for the maximum dose of radiation near the skin surface, making the method suitable to treat skin, superficial lesions, and shallow tumor volumes where underlying tissues need to be protected. These codes are dependent upon the number and complexity of treatment areas, as well as the energy level, measured in megavolts (MeV). Report G6003 for a single treatment area, single port or parallel opposed ports, simple or no blocks, up to 5 MeV; G6004 for 6-10 MeV; G6005 for 11-19 MeV; and G6006 for 20 MeV or greater.

Coding Tips

The Centers for Medicare and Medicaid Services (CMS) established HCPCS Level II G codes to describe professional health care services and procedures that would otherwise be coded in the CPT book, but for which there is no CPT code for that particular service or procedure, including radiation treatment delivery services when furnished in the physician office setting. An off-campus, provider-based department (PBD) submitting claims for nonexcepted radiation treatment delivery services must report the HCPCS Level II codes G6001–G6017 to describe radiation treatment delivery procedures. The off-campus PBD must append modifier PN to each applicable claim line for nonexcepted items and services. The payment amount for these services will be based upon the technical component rate for the code under the Medicare physician fee schedule (MPFS).

Radiation treatment delivery is only part of a series of services/procedures that are performed on a patient receiving radiation therapy. Clinical treatment planning, simulation-aided field setting, medical radiation physics, design and construction of treatment devices, and treatment management are services/procedures that may be billed separately in addition to these codes.

Facility reporting: These HCPCS Level II G codes are not recognized under the outpatient prospective payment system (OPPS). CPT code 77402 is used to describe these services when furnished in the hospital outpatient department.

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.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G6003	0.0	5.25	0.01	5.26
G6004	0.0	3.97	0.01	3.98
G6005	0.0	3.97	0.01	3.98
G6006	0.0	3.97	0.01	3.98
Facility RVU	**Work**	**PE**	**MP**	**Total**
G6003	0.0	5.25	0.01	5.26
G6004	0.0	3.97	0.01	3.98
G6005	0.0	3.97	0.01	3.98
G6006	0.0	3.97	0.01	3.98

	FUD	Status	MUE	Modifiers				IOM Reference
G6003	N/A	A	2(3)	N/A	N/A	N/A	80*	None
G6004	N/A	A	2(3)	N/A	N/A	N/A	80*	
G6005	N/A	A	2(3)	N/A	N/A	N/A	80*	
G6006	N/A	A	2(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.

linear accelerator. Device used to increase the energy of ions along a linear path.

teletherapy. External beam radiotherapy or other treatment applied from a source maintained at a distance away from the body.

J7516

J7516 Cyclosporine, parenteral, 250 mg

Explanation

Cyclosporine is used to prevent rejection of skin, pancreas, kidney, liver, heart, small intestine, and bone marrow transplants. When a patient receives an allogenic tissue or organ transplant, lymphocytes in the allograft recipient recognize the foreign tissue and attack the transplanted tissue or organ. Cyclosporine can also be used to treat rheumatoid arthritis that is not responding to methotrexate and severe psoriasis. The exact mechanism of action is not known. T-lymphocytes are preferentially inhibited. The 1-helper cell is the primary target, but the 1-suppressor cell may also be suppressed. Cyclosporine also inhibits lymphokine production and release including interleukin-2 or 1-cell growth factor (TCGF). It should be administered with adrenal corticosteroids but not with other immunosuppressive agents.

Coding Tips

Report the appropriate administration code from the CPT code range 96401–96549. This drug is often combined in chemotherapy combinations including EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, and doxorubicin), CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone), FEC (4-FU, epirubicin, and cyclophosphamide), and CMF (cyclophosphamide, methotrexate, and 5-FU). 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

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
J7516	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
J7516	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
J7516	N/A	E	1(3)	N/A	N/A	N/A	N/A	100-04,17,80.3

* with documentation

J9000

J9000 Injection, doxorubicin HCl, 10 mg

Explanation

Doxorubicin hydrochloride is an anthracycline antibiotic antineoplastic drug isolated from the bacterium *Streptomyces peucetius* var. *caesius*. It binds to DNA and inhibits RNA synthesis, causing cell death. It is utilized to treat many forms of cancer, such as bladder, breast, lung, stomach, and thyroid cancer, as well as Hodgkin's and non-Hodgkin's disease, acute lymphoblastic (ALL) and myeloblastic (AML) leukemia, and Wilms' tumor. The liposome version is the doxorubicin hydrochloride enclosed in a spherical lipid bilayer membrane. Doxorubicin hydrochloride liposome is indicated as a treatment for patients with ovarian cancer whose disease has recurred or progressed after platinum-based chemotherapy, and for patients with AIDS-related Kaposi's sarcoma whose disease has progressed on prior combination chemotherapy or who cannot tolerate such therapy. Both versions are administered via intravenous injection.

Coding Tips

Report the appropriate administration code from the CPT code range 96401–96549. To report doxorubicin hydrochloride, liposomal, imported lipodox, see Q2049. To report doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg, see Q2050. This drug is often combined in chemotherapy drug combinations including EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, and doxorubicin) and CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone).

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

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
J9000	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
J9000	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
J9000	N/A	E	20(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

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