

Medical Oncology/ Hematology Services

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

2022

optum360coding.com

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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 version XX.X, 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 2022 edition password is: **XXXXXXXX22**. 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.

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*.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and the patient is sent to an outside testing facility, modifier 26 must be appended to the procedural code to indicate the clinician performed only the professional component.

Similarly, when only a technical component is performed, without the professional interpretation service, such as by a facility, modifier TC should be appended to the appropriate code. In those instances when both the professional and technical components are provided, no modifier is required.

Specialty-Specific Guidelines

Injections, Infusions, and Chemotherapy

A concurrent infusion is the administration of multiple infusions at the same time through the same IV line. Sequential infusions describe administration of multiple drugs that are administered immediately following another infusion. Sequential and additional hours refer to continued services through the same vascular site.

Example

If drug A is administered at the same time as drug B using the same IV line with Y connector, the drug B infusion is concurrent. If drug B was administered through the same IV line, but after the drug A infusion finished, then drug B infusion is sequential.

Note: Sequential and additional infusion hours may be more difficult to track particularly when a patient moves between hospital departments.

CMS allows only one initial drug administration service per encounter for each vascular site, regardless of the types of infusion services provided. Additional medications administered through those vascular sites should be reported with the sequential, concurrent, or additional hour codes. Although CPT guidelines differ regarding the initial administration, CMS will continue to adhere to its current guidelines. If an infusion or injection is of a subsequent or concurrent nature, report the drug administration code as subsequent or concurrent even if it was the first drug administered.

Example

If using the same IV line and an IV push drug is administered first but the main encounter is for a chemotherapy infusion, the

chemotherapy infusion is reported as the initial infusion and the IV push is reported as sequential. When protocol requires two different vascular sites for drug administration or when the route of administration is different, more than one initial drug administration codes may be reported.

Official hierarchy has been developed by CMS for facility reporting of drug administration and is followed by most payers for physician administration as well. The following hierarchy applies: chemotherapy services are primary over therapeutic, prophylactic, or diagnostic services, which are primary over hydration services. Infusions are primary to pushes, which are primary to injections.

Chemotherapy Hierarchy

- Chemotherapy Infusions
- Chemotherapy Injections
- Therapeutic, prophylactic and diagnostic infusions
- Therapeutic, prophylactic and diagnostic intravenous pushes—IVP
- Hydration

Note: Chemotherapy services are always primary and will always be reported as the initial administration when performed.

When timing an infusion for reporting purposes, use the actual time that the infusion was administered and documented. Additional hour add-on codes should be reported only when an infusion runs more than 30 minutes.

Example

An infusion that runs 1 hour and 20 minutes is reported only with the initial hour drug administration code. If the infusion was administered over 91 minutes (1 hour and 31 minutes), then the initial hour infusion would be reported as well as one additional hour add-on code. Infusions that are of 15 minutes duration or less should be reported as an intra-arterial or intravenous push injection.

Facility Reporting

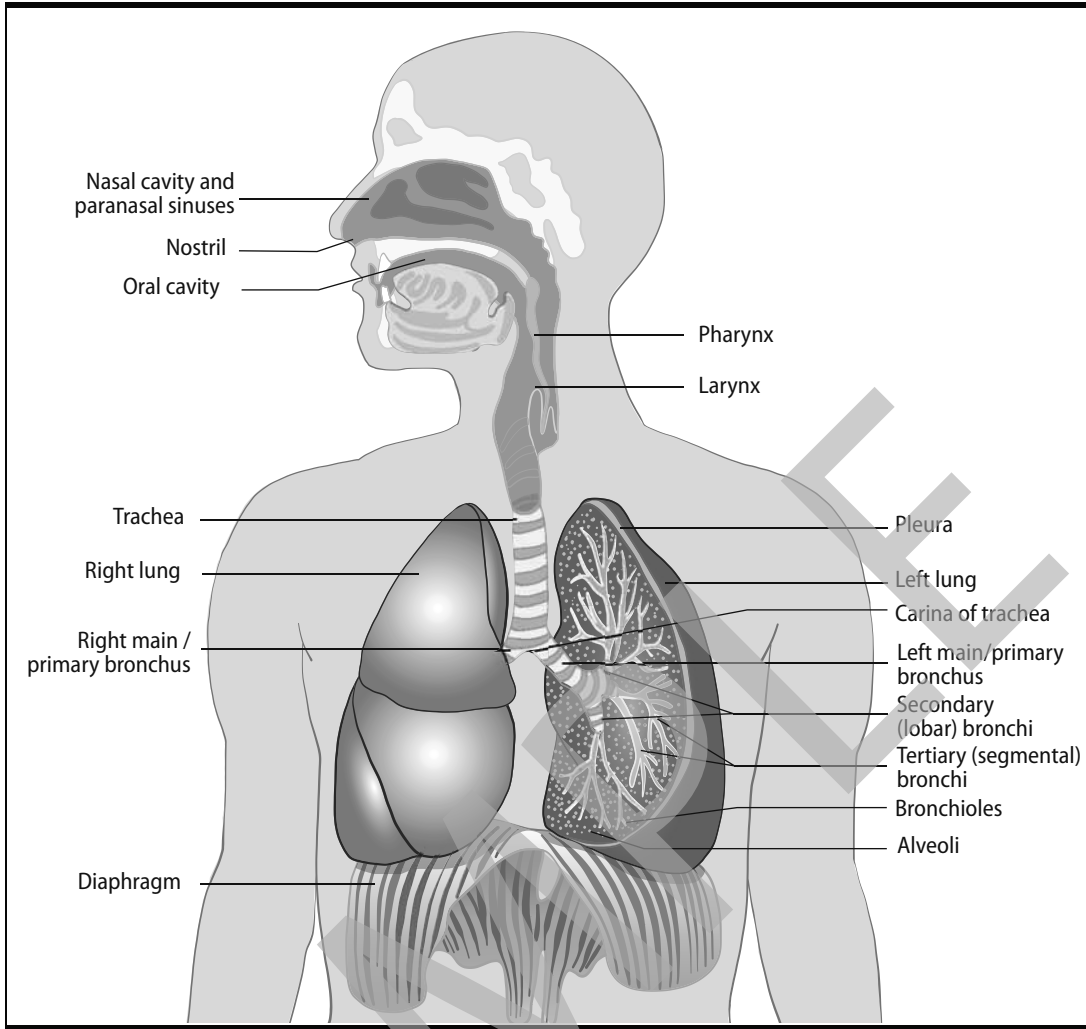
For facilities reporting drug administration effective January 1, 2018, low-cost drug administration services are unconditionally packaged. CMS determined based on its analysis of claims data that the geometric mean cost for APC 5691 Level 1 Drug Administration, is approximately \$40 and the geometric mean cost for APC 5692 Level 2 Drug Administration, is approximately \$63. Additionally, Medicare data show that these drug administration services are currently being provided as part of another separately payable service for which two separate payments are made, and support that packaging these services when they are reported with another separately payable service, is appropriate. Drug administration services assigned to APC 5693 Level 3 Drug Administration, and APC 5694 Level 4 Drug Administration, are not being packaged.

The following procedures are unconditionally packaged:

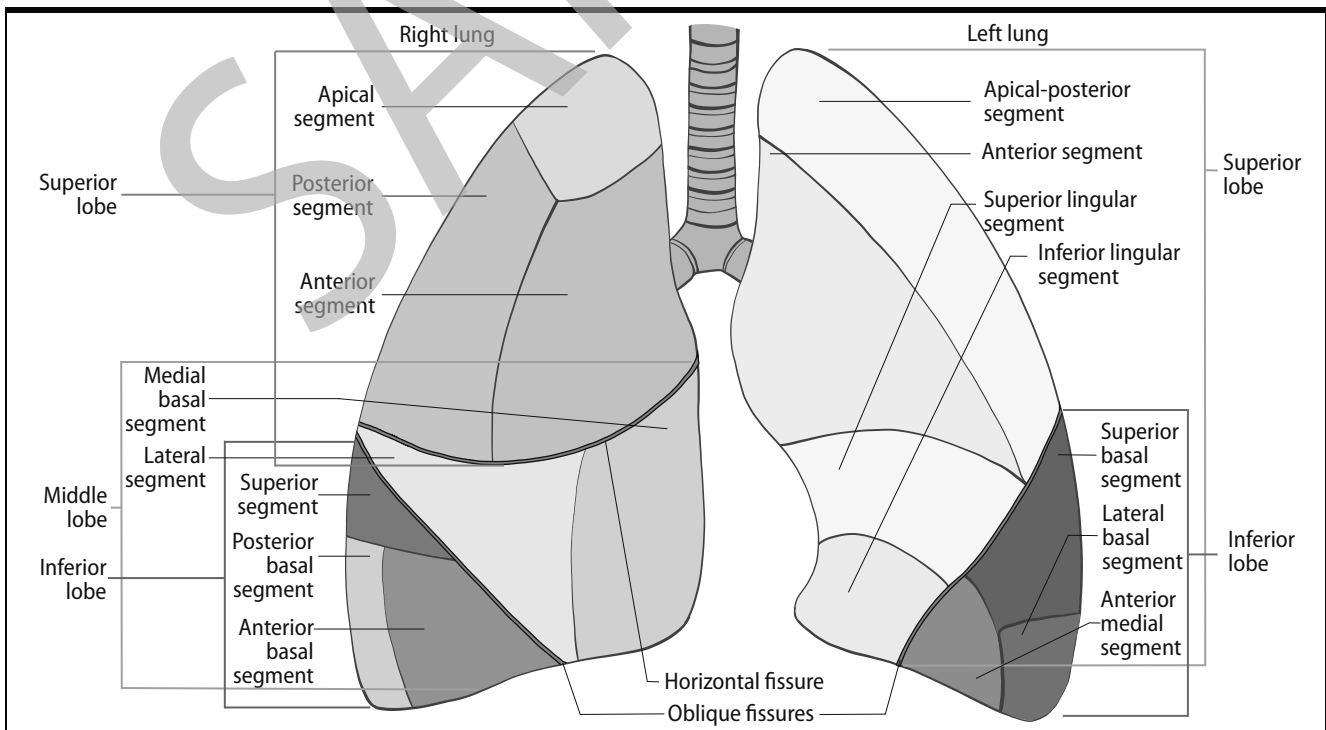
APC 5691—Level 1 Drug Administration

96361 Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)

Respiratory System



Lung Segments



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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
- ▲★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 time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
- ▲★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 time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
- ▲★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 time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

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/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, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 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 no longer used when determining the level of service. Codes should be selected based upon the CPT revised 2021 Medical Decision Making table. Alternately, 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. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes. Services at the origination site are reported with HCPCS Level II code Q3014.

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 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99204** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99205** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3

77306-77307

- 77306** Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
- 77307** complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)

Explanation

For the initial setting of the treatment portals, an isodose distribution of the beams is required. Usually done by computer, a teletherapy isodose plan plots the lines of the same dosage levels to be delivered within the treatment field, usually from a combination of beams converging upon the treatment field. Only one plan may be reported per any therapy course to a specific treatment field. A simple teletherapy isodose plan, reported in 77306, consists of one or two unmodified ports directed to a single area of interest. A complex teletherapy isodose plan, reported in 77307, consists of multiple treatment areas, tangential ports, blocking, the use of wedges, and rotating or special beam considerations. Both of these codes include basic dosimetry calculations.

Coding Tips

Isodose teletherapy planning is only part of a series of procedures performed on a patient receiving radiation therapy. Clinical treatment planning, simulation-aided field setting, medical radiation physics, treatment delivery, and treatment management are billed separately in addition to this code.

Teletherapy treatment planning can only be reported once per therapy on a treatment area. A treatment area is a contiguous anatomic location that will be treated with the radiation therapy. Discontinuous anatomic locations should be considered as distinct and separate treatment areas. However, if the patient's treatment plan is significantly revised, it may be necessary to prepare a new isodose plan for teletherapy for the same treatment area. In these instances, when supported by medical necessity, the appropriate CPT code may be reported a second time. Check with third-party payers for their requirements.

These codes include basic dosimetry calculations. To report a simple teletherapy isodose plan when there are one or two unmodified ports directly at one volume of interest report, 77306. To report complex teletherapy isodose plan when multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beams, or special beam considerations will be used report 77307.

Do not report 77306–77307 with 77300.

Documentation Tips

Whenever a patient's treatment plan is revised significantly, it may be necessary to prepare a new isodose plan for teletherapy or to perform new isodose calculations for brachytherapy. When such work is supported by medical necessity, report with the appropriate CPT codes.

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. If performed on two distinct, separate treatment areas, payers may require modifier 59 or the appropriate an X{EPSU} modifier on the second treatment area.

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: 77306 2018,Jan,8; 2017,Jan,8; 2016,Feb,3 77307 2018,Jan,8; 2017,Jan,8; 2016,Feb,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
77306	1.4	2.76	0.07	4.23
77307	2.9	5.14	0.16	8.2
Facility RVU	Work	PE	MP	Total
77306	1.4	2.76	0.07	4.23
77307	2.9	5.14	0.16	8.2

	FUD	Status	MUE	Modifiers				IOM Reference
77306	N/A	A	1(3)	N/A	N/A	N/A	80*	None
77307	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.

isodose. Equivalent dose of radiation delivered to two or more body areas.

tangential port. Radiation beam that glides across the body surface.

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

wedge. Standard, commonly-used beam-modifying device that upgrades and increases or manipulates the patient's target volume dose distribution in radiation therapy.

94760-94762

94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination

94761 multiple determinations (eg, during exercise)

94762 by continuous overnight monitoring (separate procedure)

Explanation

A sensor is placed on the earlobe or finger to measure oxygen levels in the blood for a pulse oximetry. A light shines through the capillary bed for the measurement. Report 94760 for a single measurement; 94761 for multiple measurements; and 94762 for a continuous overnight measurement.

Coding Tips

This service is included in critical care services and should not be reported separately. Most payers only provide coverage for ear or pulse oximetry for oxygen saturation (94760–94761) when the patient has a condition resulting in hypoxemia and there is a need to assess the status of a chronic respiratory condition, supplemental oxygen requirements, and/or a therapeutic regimen. Otherwise, the service is bundled into the evaluation and management service, such as part of recording the patient’s vital signs. Coverage for overnight monitoring (94762) usually requires that the patient has a condition for which intermittent arterial blood gas sampling is likely to miss variations and a condition resulting in hypoxemia and there is a need to assess supplemental oxygen requirements and/or a therapeutic regimen. Do not report 94760-94761 with 94617-94621.

Documentation Tips

When documenting neoplasm conditions, indicate the morphology (i.e., benign, malignant, uncertain), the specific type of the disease, the anatomical location including laterality, and if primary or secondary (metastatic).

Reimbursement Tips

Note that 94762, a separate procedure by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services, it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier.

ICD-10-CM Diagnostic Codes

- C33 Malignant neoplasm of trachea
- C34.01 Malignant neoplasm of right main bronchus
- C34.02 Malignant neoplasm of left main bronchus
- C34.11 Malignant neoplasm of upper lobe, right bronchus or lung
- C34.12 Malignant neoplasm of upper lobe, left bronchus or lung
- C34.2 Malignant neoplasm of middle lobe, bronchus or lung
- C34.31 Malignant neoplasm of lower lobe, right bronchus or lung
- C34.32 Malignant neoplasm of lower lobe, left bronchus or lung
- C38.1 Malignant neoplasm of anterior mediastinum
- C38.2 Malignant neoplasm of posterior mediastinum
- C38.4 Malignant neoplasm of pleura
- C78.01 Secondary malignant neoplasm of right lung
- C78.02 Secondary malignant neoplasm of left lung
- C78.1 Secondary malignant neoplasm of mediastinum
- C78.2 Secondary malignant neoplasm of pleura
- C7A.090 Malignant carcinoid tumor of the bronchus and lung
- D02.21 Carcinoma in situ of right bronchus and lung

- D02.22 Carcinoma in situ of left bronchus and lung
- J95.84 Transfusion-related acute lung injury (TRALI)
- J96.01 Acute respiratory failure with hypoxia
- J96.02 Acute respiratory failure with hypercapnia
- J96.21 Acute and chronic respiratory failure with hypoxia
- J96.22 Acute and chronic respiratory failure with hypercapnia

AMA: **94760** 2019,Mar,10; 2019,Jan,6; 2019,Aug,8; 2018,Jan,8; 2018,Feb,11; 2017,Oct,3; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,May,4; 2014,Jan,11
94761 2019,Mar,10; 2019,Aug,8; 2018,Jan,8; 2018,Feb,11; 2017,Oct,3; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,May,4; 2014,Jan,11
94762 2019,Mar,10; 2019,Aug,8; 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,May,4; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
94760	0.0	0.06	0.01	0.07
94761	0.0	0.1	0.01	0.11
94762	0.0	0.73	0.01	0.74
Facility RVU	Work	PE	MP	Total
94760	0.0	0.06	0.01	0.07
94761	0.0	0.1	0.01	0.11
94762	0.0	0.73	0.01	0.74

	FUD	Status	MUE	Modifiers				IOM Reference
94760	N/A	T	1(3)	N/A	N/A	N/A	80*	None
94761	N/A	T	1(2)	N/A	N/A	N/A	80*	
94762	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

hypercapnia. Excess carbon dioxide in the blood.

hypoxemia. Insufficient oxygen in the arterial blood resulting in inadequate delivery of oxygen to the body tissues.

96422-96423

96422 Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour

+ **96423** infusion technique, each additional hour (List separately in addition to code for primary procedure)

Explanation

The physician or supervised assistant prepares and administers a chemotherapeutic medication to combat malignant neoplasms or microorganisms. The drug is administered through infusion technique, a method in which the medication is allowed to slowly enter the body through a catheter already in place within an artery. Report 96422 for the first hour of intra-arterial infusion and 96423 for each additional hour.

Coding Tips

For regional chemotherapy perfusion via membrane oxygenator perfusion pump to an extremity, see 36823.

Report only one sequential infusion. Report 96423 for each additional hour of sequential infusion. Only one initial infusion may be reported for the same date of service regardless of the number of substances administered unless protocol indicates that two separate IV sites must be used. Do not report two initial infusion codes in the case of restarting an IV or port access of indwelling multilumen catheters.

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.

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 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. 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

Add-on codes are not subject to multiple procedure rules, reimbursement reduction, or appending modifier 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures.

Report 96423 in conjunction with 96422.

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: **96422** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Mar,3; 2016,Jan,13; 2015,Nov,3; 2015,Jan,16; 2014,Jan,11 **96423** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Mar,3; 2016,Jan,13; 2015,Nov,3; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96422	0.17	4.53	0.11	4.81
96423	0.17	2.0	0.06	2.23
Facility RVU	Work	PE	MP	Total
96422	0.17	4.53	0.11	4.81
96423	0.17	2.0	0.06	2.23

	FUD	Status	MUE	Modifiers				IOM Reference
96422	N/A	A	2(3)	N/A	N/A	N/A	80*	None
96423	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

infusion. Introduction of a therapeutic fluid, other than blood, into the bloodstream.
intra-arterial. Within an artery or arteries.

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 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 specified type	C44.519	—	—	—	—	—
squamous cell carcinoma	C44.529	—	—	—	—	—
abdominopelvic accessory sinus — see Neoplasm, sinus	C76.8	C79.8-✓	—	D36.7	D48.7	D49.89
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
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

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
— 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
tympenicum	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
anus, anal canal	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 specified type	C44.510	—	—	—	—	—
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	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	D49.1
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. Where possible, entries are listed under a common main term. In some instances, the common term is a noun; in others, the main term is a descriptor.

HCPCS Level II Codes: Sections A–V

Level II codes consist of one alphabetic character (letters A through V) and four numbers. Similar to CPT codes, they also can have modifiers, which can be alphanumeric or two letters. National modifiers can be used with all levels of HCPCS codes.

J Codes - Drugs

The table starting on this page identifies J codes common to medications/drugs used in oncology. They are usually injected/infused, but can be administered orally. They are generally not self-administered.

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

● J9223 Injection, lurbinectedin, 0.1 mg

A triangle(s) 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

▲ J7189 Factor viia (antihemophilic factor, recombinant), (novoseven rt), 1 microgram

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.

HCPCS Code	Generic Name	Brand Name	FDA Approved Usage
J0185	Aprepitant, injection, 1 mg	Emend	Nausea and vomiting associated with chemotherapy
J8501	Aprepitant, oral, 5 mg	Emend	Nausea and vomiting associated with chemotherapy
J8597	Antiemetic drug, oral, not otherwise specified		
J9030	BCG live intravesical instillation, 1 mg	Tice BCG, PACIS BCG, TheraCys	Used in a solution to stimulate the immune system in the treatment of bladder cancer
J8510	Busulfan; oral, 2 mg	Busulfex, Myleran	Chronic myelogenous leukemia
J8515	Cabergoline, oral, 0.25 mg	Dostinex	Hyperprolacteria
J8520	Capecitabine, oral, 150 mg	Xeloda	Breast, colorectal cancer
J8521	Capecitabine, oral, 500 mg	Xeloda	Breast, colorectal cancer
J9070	Cyclophosphamide, 100 mg	cytoxan, Endoxan-Asta	Acute lymphoblastic leukemia, acute myeloid leukemia, breast cancer, chronic lymphocytic leukemia, chronic myelogenous leukemia, hodgkin lymphoma, myeloid plasmacytoma, mycosis fungoides, neuroblastoma, non-Hodgkin lymphoma, ovarian cancer
J8530	Cyclophosphamide, oral, 25 mg	cytoxan	Acute lymphoblastic leukemia, acute myeloid leukemia, breast cancer, chronic lymphocytic leukemia, chronic myelogenous leukemia, hodgkin lymphoma, myeloid plasmacytoma, mycosis fungoides, neuroblastoma, non-Hodgkin lymphoma, ovarian cancer
J9130	Dacarbazine, 100 mg	DTIC-Dome	Hodgkin lymphoma, melanoma

G6017

G6017 Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment

Explanation

Image-guided radiation therapy is a technique in which frequent imaging occurs during the course of a radiation therapy session (intra-fraction) in order to ensure that the radiation is delivered to the correct target location and spares surrounding tissues. Decisions regarding administration adjustments are made on the basis of the imaging results. Various methods of localization and tracking of patient or tumor motion may be used, including gating or 3D positional or surface tracking technology. In one method, an electromagnetic transponder is implanted into the prostate prior to external beam therapy for prostate cancer. This transponder transmits radiofrequency waves to a computerized system, which provides information regarding position and movement of the prostate. This motion data is used by clinicians to assist in radiation therapy setup and as a positional monitor during delivery of treatment, alerting the clinician if the tumor moves outside the pathway of the radiation beam. Report G6017 for each fraction of treatment.

Coding Tips

Do not report other image guided radiation therapy (IGRT) codes when intrafraction tracking is used. Some payers may require CPT code 77837. Check with third-party payers for their guidelines. To report the placement of interstitial device(s) for radiation therapy guidance, use the appropriate anatomical site using 31627, 32553, 49411, or 55876.

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
G6017	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
G6017	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
G6017	N/A	C	2(3)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

radiotherapy. External source of high-energy rays (x-rays or gamma rays) or internally implanted radioactive substances used in destroying tissue and stopping the growth of malignant cells.

J1750

J1750 Injection, iron dextran, 50 mg

Explanation

Iron dextran is used to treat iron deficiency anemia. It is a complex of ferric hydroxide and dextran. It is absorbed from the injection site into the capillaries and the lymphatic system. The iron is bound to the protein and forms iron. This iron is used to resupply the body with iron. Recommended dose of iron dextran varies based on the patient's hemoglobin level. It is administered by IV or intramuscular injection.

Coding Tips

Report the administration service in addition to the code for the medication. For an intramuscular or subcutaneous therapeutic, prophylactic, or diagnostic injection, see 96372. For therapeutic, prophylactic, or diagnostic intravenous infusion, see 96365–96368. If 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 anemia, the malignancy is reported as the principal/first-listed condition and the anemia is reported additionally.

Documentation Tips

When reporting anemia with malignancy, it is important to provide as much specificity as possible. For example, acuity (acute or chronic), blood loss during or after surgery, should be documented as "post-operative anemia due to acute blood loss." For anemia due to nutritional deficiency, document the specific type (e.g., sideropenic iron deficiency anemia, iron deficiency anemia due to inadequate dietary iron intake, B12 deficient due to intrinsic factor deficiency, malabsorption, folate deficiency type anemia due to diet, or drug-induced or protein-deficiency).

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

D50.0	Iron deficiency anemia secondary to blood loss (chronic)
D50.1	Sideropenic dysphagia
D50.8	Other iron deficiency anemias
D50.9	Iron deficiency anemia, unspecified

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
J1750	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
J1750	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
J1750	N/A	E	45(3)	N/A	N/A	N/A	N/A	None

* with documentation