Optum

Coding &
Payment Guide

Medical Oncology/ Hematology Services

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

2025

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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.

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 29.3, 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 2025 edition password is: **XXXXXX**. 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*.

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 affective 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)
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)
96549	Unlisted chemotherapy procedure

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,Jan,1; 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 2024. The following icons are used in the *Coding and Payment Guide*:

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ 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

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	96040
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
- ♂ Male only
- ♀ Female Only
- ☑ 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

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX**.

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:

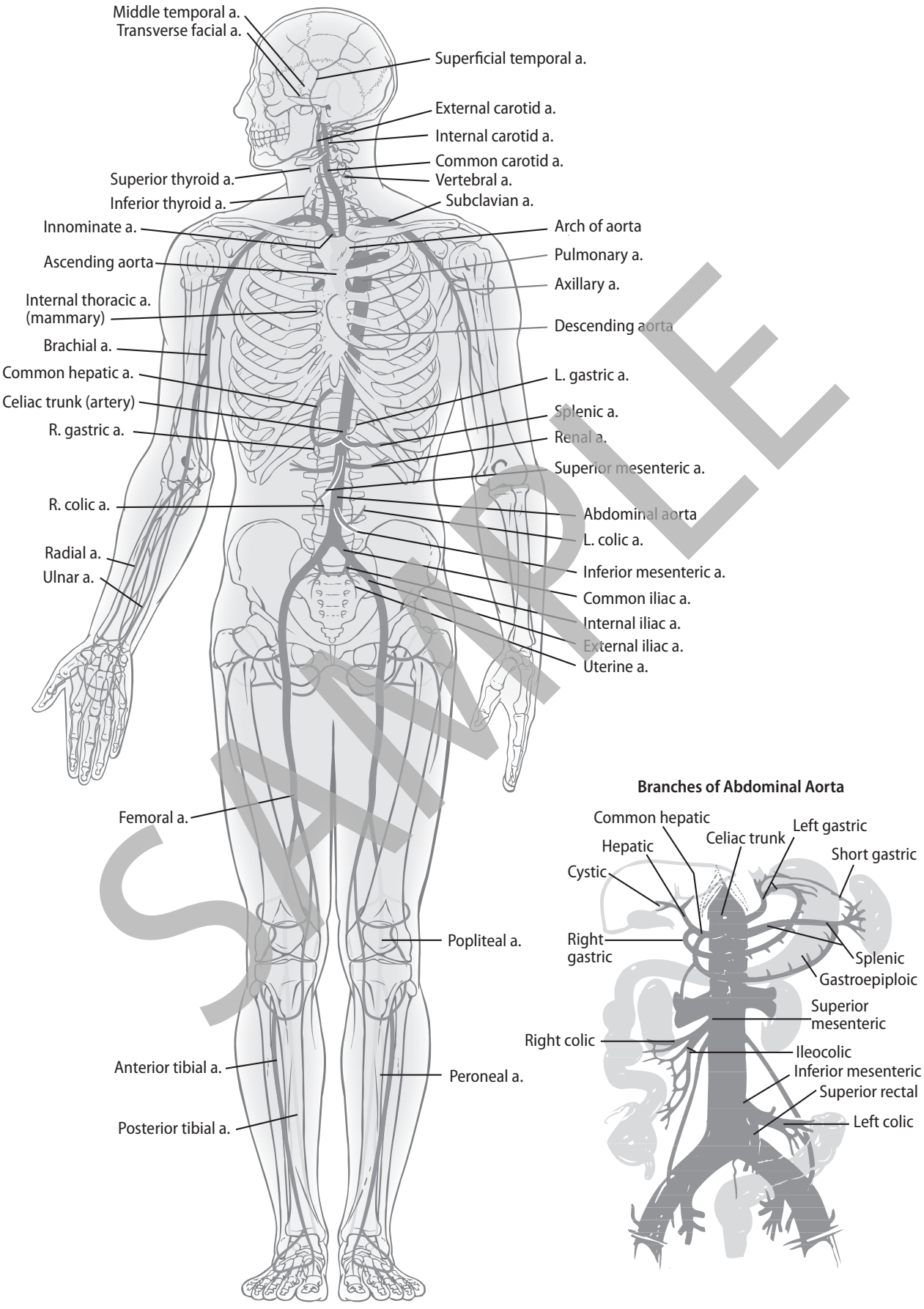
- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) insurance component, reflecting the relative risk or liability associated with the service
- Total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



Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

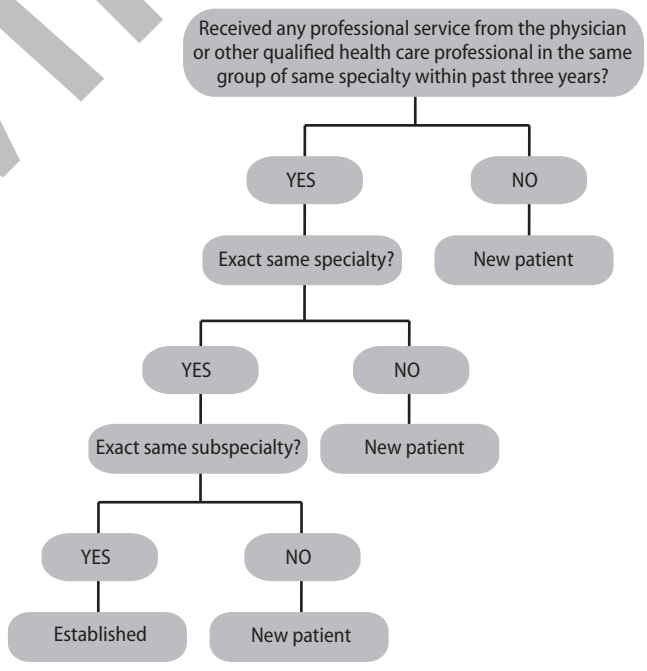
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶ ◀ = Contains new or revised text

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 levels 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 and the CPT code book have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place-of-service (POS) indicator; POS 02 for telehealth 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** 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; 2017,Aug; 2017,Jun **99203** 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; 2017,Aug; 2017,Jun **99204** 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; 2017,Aug; 2017,Jun **99205** 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; 2017,Aug; 2017,Jun

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

36593

36593 Declotting by thrombolytic agent of implanted vascular access device or catheter

Explanation

To remove a clot from an implanted vascular access device or catheter, the physician injects a thrombolytic agent (e.g., Streptokinase) into the catheter to dissolve the clot. The patient is observed for any abnormal signs of bleeding.

Coding Tips

Do not report 36593 with 36595–36596. The thrombolytic agent may be reported separately using the appropriate HCPCS Level II J code. For example, J2995 would be reported to indicate that streptokinase was administered. Check with the specific payer to determine coverage.

Documentation Tips

Documentation should include the anatomical site, the name of the medication, the dose administered, and any complications that may have occurred.

Reimbursement Tips

When 36593 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51.

ICD-10-CM Diagnostic Codes

T82.818A Embolism due to vascular prosthetic devices, implants and grafts, initial encounter

T82.868A Thrombosis due to vascular prosthetic devices, implants and grafts, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
36593	0.0	0.97	0.02	0.99
Facility RVU	**Work**	**PE**	**MP**	**Total**
36593	0.0	0.97	0.02	0.99

	FUD	Status	MUE	Modifiers				IOM Reference
36593	N/A	A	2(3)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

embolism. Obstruction of a blood vessel resulting from a clot or foreign substance.

implantable venous access device. Catheter implanted for continuous access to the venous system for long-term parenteral feeding or for the administration of fluids or medications.

thrombolytic agent. Drugs or other substances used to dissolve blood clots in blood vessels or in tubes that have been placed into the body.

thrombosis. Condition arising from the presence or formation of blood clots within a blood vessel that may cause vascular obstruction and insufficient oxygenation.

36600

36600 Arterial puncture, withdrawal of blood for diagnosis

Explanation

The physician inserts a needle through the skin and punctures the artery to withdraw blood for testing. No catheter is left in the artery. Pressure is applied to the puncture site to stop the flow of blood.

Coding Tips

Routine venipuncture for collection of specimens is reported with 36415–36416. This procedure does not include laboratory analysis. Report 36600 only once when multiple tests are performed on the same arterial blood draw. For handling or conveyance of a specimen transported to an outside laboratory, see 99000. Supplies used when providing this procedure may be reported with HCPCS Level II code A4649. Check with the specific payer to determine coverage.

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: **36600** 2022,Jan; 2019,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
36600	0.32	0.48	0.02	0.82
Facility RVU	**Work**	**PE**	**MP**	**Total**
36600	0.32	0.1	0.02	0.44

	FUD	Status	MUE	Modifiers				IOM Reference
36600	N/A	A	4(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

artery. Vessel through which oxygenated blood passes away from the heart to any part of the body.

puncture. Creating a hole.

77316-77318

77316 Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)

77317 intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)

77318 complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)

Explanation

Brachytherapy is the application of radioactive isotopes for internal radiation therapy that is used to treat cancer. Some radioactive material is encapsulated in metal seeds, wires, tubes, or needles for intracavitary or interstitial implantation and some are prepared in solutions for instillation or oral administration. Sealed sources are inserted by the physician in or around the tumor. Sources are intracavitary or permanent interstitial placements and ribbons are temporary interstitial placements. Brachytherapy gives greater control over localized malignancy while preserving function and reducing damage to surrounding tissue. Brachytherapy isodose plans are necessary to determine the amount of radiation that the tumor will absorb and the distribution of radiation around the sources. Report 77316 for a simple calculation made from one to four sources/ribbons or remote afterloading, one channel. Report 77317 for an intermediate calculation made from five to 10 sources/ribbons or remote afterloading, two to 12 channels. Report 77318 for a complex calculation made from more than 10 sources/ribbons or remote afterloading, more than 12 channels. These codes include basic dosimetry calculations.

Coding Tips

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 brachytherapy 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 should not be reported with basic radiation dosimetry calculations (77300). Brachytherapy isodose planning should not be reported with radiation treatment delivery (77401), or high dose rate electronic brachytherapy (0394T or 0395T).

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.

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
77316	1.4	5.8	0.1	7.3
77317	1.83	7.63	0.14	9.6
77318	2.9	10.53	0.2	13.63
Facility RVU	**Work**	**PE**	**MP**	**Total**
77316	1.4	5.8	0.1	7.3
77317	1.83	7.63	0.14	9.6
77318	2.9	10.53	0.2	13.63

	FUD	Status	MUE	Modifiers				IOM Reference
77316	N/A	A	1(3)	N/A	N/A	N/A	80*	None
77317	N/A	A	1(3)	N/A	N/A	N/A	80*	
77318	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

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.

dosimetry. Component in the administration of radiation oncology therapy in which a radiation dose is calculated to a specific site, including implant or beam orientation and exposure, isodose strengths, tissue inhomogeneities, and volume.

isotope. Chemical element possessing the same atomic number (protons in the nucleus) as another, but with a different atomic weight (number of neutrons).

radiotherapy afterloading. Part of the radiation therapy process in which the chemotherapy agent is actually instilled into the tumor area subsequent to surgery and placement of an expandable catheter into the void remaining after tumor excision. The specialized catheter remains in place and the patient may come in for multiple treatments with radioisotope placed to treat the margin of tissue surrounding the excision. After the radiotherapy is completed, the patient returns to have the catheter emptied and removed.

ribbons. In oncology, small plastic tubes containing radioactive sources for interstitial placement that may be cut into specific lengths tailored to the size of the area receiving ionizing radiation treatment.

seeds. Small (1 mm or less) sources of radioactive material that are permanently placed directly into tumors.

96360-96361

96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour

\+ **96361** each additional hour (List separately in addition to code for primary procedure)

Explanation

A physician or an assistant under direct physician supervision infuses a hydration solution (prepackaged fluid and electrolytes) for 31 minutes to one hour through an intravenous catheter inserted by needle into a patient's vein or by infusion through an existing indwelling intravascular access catheter or port. Report 96361 for each additional hour beyond the first hour. Intravenous infusion for hydration lasting 30 minutes or less is not reported.

Coding Tips

Basic intravenous fluids such as prepackaged fluid and electrolytes (e.g., normal saline, D5-1/2 normal saline+30mEq KCl/liter) are included in these codes, as well as their administration. Do not report hydration codes when a substance or drug is added to a bag of fluid. When a drug is added to the fluid, the fluid is then considered to be a part of the other infusion.

Physician reporting: Hydration IV infusions typically require direct supervision for purposes of consent, safety oversight, or supervision of staff. These codes are not intended to be reported by the physician or other qualified healthcare professional in the facility setting. These codes are not used to report the infusion of drugs or other substances. To report services such as therapeutic, prophylactic, or diagnostic injections and infusions, see 96365–96379; administration of chemotherapy, highly complex drugs, or highly complex biological agents, see 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.

Facility reporting: When a pump is used with a prolonged infusion (over eight hours), report HCPCS Level II code C8957. Do not report CPT codes when the nonchemotherapy infusion is a necessary and integral part of a separately reported and payable OPPS procedure.

Documentation Tips

The medical record documentation should indicate the following:

- The site of the infusion
- The substance administered (e.g., saline, D5-1/2 normal saline+30mEq KCl/liter)
- The amount of time

Documentation should state why the patient required these services to support the medical necessity. The volume of hydration therapy should be clearly documented. The stop and start time of infusion therapy should be documented in order to support code assignment.

Reimbursement Tips

These services are time based. The actual time of the infusion is used to determine the total time. For continuous services that last beyond midnight, report the date in which the service began and report the total units of time provided continuously. As an add-on code, 96361 is 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.

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 the 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: **96360** 2021,Jul; 2021,Mar; 2019,Jun; 2018,Sep **96361** 2021,Jul; 2021,Mar; 2019,Jun; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96360	0.17	0.79	0.01	0.97
96361	0.09	0.28	0.01	0.38
Facility RVU	**Work**	**PE**	**MP**	**Total**
96360	0.17	0.79	0.01	0.97
96361	0.09	0.28	0.01	0.38

	FUD	Status	MUE	Modifiers				IOM Reference
96360	N/A	A	1(3)	N/A	N/A	N/A	80*	None
96361	N/A	A	8(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

dehydration. Condition resulting from an excessive loss of water from the body.

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	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
autonomic nerve or nervous system NEC (see Neoplasm, nerve, peripheral)	C30.1	C78.39	D02.3	D14.0	D38.5	D49.2

Correct Coding Initiative Update 29.3

❖Indicates Mutually Exclusive Edit

0394T 0213T, 0216T, 0591T-0593T, 0596T-0597T, 11920-11921, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 16000, 16020-16030, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 76873, 77261-77263, 77300, 77306-77307, 77316-77318, 77332-77336, 77427, 77431-77435, 77469-77470, 78012❖, 78072❖, 78226-78227❖, 78579❖, 78582❖, 78597-78598❖, 90832-90834, 90836-90840, 90846-90847, 90863, 92012-92014, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96160-96161, 96360-96377, 96523, 97802-97804, 99151, 99152, 99153, 99155, 99156, 99157, 99202-99215, 99221-99223, 99231-99239, 99242-99245, 99252-99255, 99281-99288, 99291-99292, 99304-99310, 99315-99316, 99341-99342, 99344-99350, 99358-99360, 99366-99368, 99374-99375, 99377-99412, 99418, 99421-99424, 99426-99427, 99441-99443, 99446-99452, 99455-99456, 99460-99472, 99475-99480, 99483-99487, 99489-99498, G0442-G0445, G0459, G0463, G0471, G0500, G0506, G0511-G0512, J0670, J2001

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19297 11000-11006, 11042-11047, 36591-36592, 76000, 76380, 76942, 76965, 76998, 77001-77002, 77012, 77021, 96523, 97597-97598, 97602

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 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.

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	4.56	0.01	4.57
G6004	0.0	3.85	0.01	3.86
G6005	0.0	3.86	0.01	3.87
G6006	0.0	3.84	0.01	3.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
G6003	0.0	4.56	0.01	4.57
G6004	0.0	3.85	0.01	3.86
G6005	0.0	3.86	0.01	3.87
G6006	0.0	3.84	0.01	3.85

	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.

N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only