Pharmacy Reimbursement Policy

Medical Drug Reimbursement: Outpatient and Inpatient

PHARMACY REIMBURSEMENT POLICY NUMBER: ORPTCPRM150.0624

Original Effective Date: 7/1/2024

Effective Date: 7/1/2024

Last Review Date: 6/2024

Next Annual Review: 6/2025

Approved By: Oregon Region Pharmacy and Therapeutics Committee

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☒ Professional Claims

☐ DMEPOS Suppliers

☐ All health care services billed on CMS 1500 forms

Plan Product:

☒ Commercial

☒ Medicare

☒ Medicaid/Oregon Health Plan

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

☐ All health care services billed on CMS 1500 forms, and when specified to those billed on UB04 forms

☒ Facilities

☐ All health care services billed on UB04 forms (CMS 1450)

Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

☐ DRG

☐ Modified DRG

☐ Percentage of billed charges/per diem

POLICY STATEMENT

I. National Drug Code (NDC) Billing Requirement for Medically Administered Drugs: Outpatient and Inpatient

A. The Companies require the use of National Drug Codes (NDCs) and related information such as Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT®) codes, when drugs are billed on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims and institutional/facility electronic (ANSI 837I) and paper (UB-04) claims.

1. This includes drug-related revenue codes to report drug products used for services rendered at medical outpatient facilities as well as unlisted HCPCS/CPT codes that require additional NDC information.
2. Vaccines supplied by the Department of Health (DOH) do not require an NDC. To designate a DOH supplied vaccine, providers must add an SL modifier to the vaccine procedure code.

II. Injectable Drugs Administered in Physician's Office

A. Injectable drugs given to a patient as a form of treatment by a physician or their staff in the office or clinic setting are reimbursed as a supply item.

1. The provider may not ask members to use their prescription benefit to obtain drugs at a participating pharmacy for use in the provider's office. Exceptions may be approved by Company on a case-by-case basis for unique or specialized circumstances. (See also Coding Policy 34 – Administration of Immunizations and Injections

B. Prior Authorization may be required for coverage of drugs administered by a healthcare professional, as deemed necessary by the Oregon Region Pharmacy and Therapeutics Committee (ORPTC).

1. Newly FDA approved injectable drugs and drugs with new Food and Drug Administration (FDA)-approved indications may require prior authorization within the first twelve (12) months of coming to market or until reviewed by the ORPTC.

III. Compound Medications Administered in Physician's Office

A. Medications compounded by a pharmacist in accordance with the Federal Food, Drug, and Cosmetic Act may be covered when their use meets all other criteria for services incident to a physician's service:

1. Compounded medication must be furnished by a physician and administered by the physician or by auxiliary personnel employed by the physician and under the physician's personal supervision.
2. The charge, if any, for the compounded medication must be included in the physician's bill and the cost of the drug must represent an expense to the physician.

IV. JW and JZ Modifier Billing and Reimbursement Guidelines

A. The Companies follow Centers for Medicare and Medicaid Services (CMS) requirements for all claims and all lines of business.
   1. Providers and suppliers are required to report the JW modifier on all professional and outpatient facility claims for separately reimbursable drugs and biologicals (hereafter, drugs) with unused, wasted, and/or discarded amounts (hereafter, discarded amounts or wastage) from single-dose vials, single-dose containers or single- use packages (hereafter, single-dose containers).
      - Additionally, the amount of discarded drug(s) must be clearly documented in the medical record.
   2. Effective July 1, 2023, providers and suppliers are required to report the JZ modifier on all professional and outpatient facility claims for separately reimbursable drugs from single-dose containers when there are no discarded amounts.
   3. Practitioners and facilities are expected to care for and administer drugs and biologicals to patients in such a way as to use the drugs in the most efficient manner, minimize waste, and in a clinically appropriate manner.

POLICY GUIDELINES

DEFINITIONS

I. **Medical Drugs** - Medications that are administered in the outpatient/inpatient setting under healthcare professional supervision. These drugs are covered under the member's medical benefit rather than their outpatient pharmacy benefit. For Medicare members, these drugs are covered under their Part B benefit.

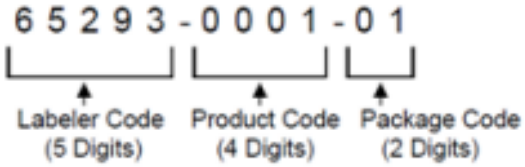
II. **National Drug Code (NDC)** - Is a unique eleven-digit identifier assigned to a drug product by the labeler/manufacturer under Federal Drug Administration (FDA) regulations. It is comprised of three segments configured in a 5-4-2 format.

III. **Compounded Drugs** - Compounded medications created by a pharmacist in accordance with the Federal Food, Drug, and Cosmetic Act may be covered under Medicare. A compounded drug is defined as a combination of drugs mixed by a pharmacist. This definition does not include a simple reconstitution of a drug as directed by the package insert.

NATIONAL DRUG CODE (NDC) BILLING REQUIREMENT FOR MEDICALLY ADMINISTERED DRUGS: OUTPATIENT AND INPATIENT

In order to provide an effective and accurate review, the correct NDC must be submitted. Guidelines for selecting the appropriate NDC:

1. NDC must be the code of the actual administered drug for the date of service.
    - A drug may have multiple manufacturers, so it is vital to use the NDC of the administered drug and not another manufacturer's product, even if the chemical name is the same. It is not permissible to bill Providence Health Plan with any NDC other than the one administered.
    - Invalid and discontinued drugs are not acceptable for payment.
2. Location of NDC
    - The NDC is usually found on the drug label or medication's outer packaging. If the medication comes in a box with multiple vials, using the NDC on the box (outer packaging) is recommended. The number on the packaging may be less than 11 digits. An asterisk may appear as a placeholder for any leading zeros.
    - The Labeler Code is the first five digits assigned by the Food and Drug Administration (FDA) to uniquely identify each firm that manufactures, repackages, or distributes drug products. The Product Code is the next four digits that identify the specific drug, strength, and dosage form. The Package Code is the last two digits that identify the package size.



3. Data Elements Required to Report NDC
    a. Service Procedure Information, if applicable/required (HCPCS or CPT code)
    b. Drug Information (NDC)
        i. NDC must match HCPCS or CPT description
    c. Drug Quantity (Units Billed)
        i. Determined by HCPCS code for professional claims (HCFA 1500)
        ii. Determined by NDC for institutional claims (UB-04)
        iii. Accepted units of measure
            - F2 = International Unit
            - GR=Gram
            - MG=Milligram
            - ML=Milliliter
            - UN=Unit

    On the claim, enter the N4 Qualifier code followed by the 11-character NDC, the unit of measure qualifier, and quantity, without hyphens or spaces. See Appendix I for more information regarding billing of NDC on claims

INJECTABLE DRUGS ADMINISTERED IN PHYSICIAN'S OFFICE

Background

New injectable drugs and drugs with new Food and Drug Administration (FDA)-approved indications enter the marketplace weekly. These new drugs may or may not have a designated Healthcare Common Procedure Coding System (HCPCS) code or Current Procedural Terminology (CPT) code right away, thus they may need to be billed with a Not Otherwise Classified (NOC) or Not Otherwise Specified (NOS) procedure code (i.e., J3490, J3590, J7699, J9999).

National Drug Code (NDC) billing is required for all medications billed medically for all lines of business. All servicing providers must follow the company NDC Billing Requirement in the section above.

COMPOUND MEDICATIONS ADMINISTERED IN PHYSICIAN'S OFFICE

Background

Compounded medications do not have a National Drug Code (NDC) number, an average sales price (ASP) or an average wholesale price (AWP). Accordingly, the specific HCPCS codes for the drugs in the compounded formulation may not be submitted. Instead, providers must use HCPCS code J7999 (Compound drug, NOC) effective with dates of service January 1, 2016, and after for reimbursement of the compound.

Whether a single agent or a combination of agents is used, the compounded medication must be submitted with HCPCS code J7999 (Compound drug, NOC) for effective with dates of service January 1, 2016 and after, even if the compounded medication is similar to or includes a drug with a specific HCPCS code (e.g., HCPCS code J2275 for preservative free morphine or J9035 for bevacizumab prepared for intravitreal injections).

Reimbursement

Table 1: Bevacizumab compounded for intraocular injection - *when billed by Ophthalmologists**

J7999 - Bevacizumab for intraocular injection		
Begin Date	End Date	Reimbursement per unit
1/1/2018	9/30/2019	$75.00
10/1/2019	7/31/2022	$94.00
8/1/2022		**$150.00**

**For compounded Avastin, Ophthalmologists will no longer be required to submit the invoice cost*

Table 2: All other compounded medications

J7999 - All other compounded medications		
Begin Date	End Date	Reimbursement per unit
5/1/2019		**Invoice cost**† plus $60.00 per compounded prescription

*† Refer to **BILLING AND CODING GUIDELINES** section below for reporting the invoice cost*

JW AND JZ MODIFIER BILLING AND REIMBURSEMENT GUIDELINES

Background

A majority of drugs and biologicals are issued in multi-dose vials. However, some drugs and biologicals do not have the stability needed for multi-dose vials and are packaged in single-dose containers. The package insert for each individual drug or biological will specify the dosing and administration instructions, stability of the product, and time frames when the substance may be safely administered and after which it must be discarded.

CMS encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner. For instance, some chemotherapy drugs are both highly effective and highly expensive. Oncology and chemotherapy clinics

commonly schedule multiple patients to receive treatments of the same drug concurrently. However, there may be occasions when the remainder of a single dose vial or single use package must be discarded after administering a dose/quantity of the drug or biological to a member.

In this policy, both drugs and biologicals are collectively referred to with the generic terms "drug" or "drugs."

Modifier JW was created effective 1/1/2003 and was encouraged to be used. However, effective 1/1/2017 CMS required the use of modifier JW to report the drug wastage for single use vials.

Modifier JZ was created 1/1/2023 and CMS required use of this modifier on 7/1/2023. All claims for separately payable drugs under Part B from single-dose vials must be reported with either modifier JW or modifier JZ. Effective 10/2/2023 CMS will deny line items for these drugs if not submitted with either modifier JW or modifier JZ.

Guidelines for Billing Medical Drugs

1. **When No Drug is Wasted**
   Effective July 1, 2023, modifier JZ must be reported on all claim line items for drugs eligible for separate reimbursement when there is no discarded amount from single-dose containers.
2. **Wastage Status Must Be Declared with Modifier JW or JZ**
   a. CMS requirements for drug wastage are followed for all types of plans.
   b. Effective for dates of service beginning July 1, 2023, all claims for separately reimbursable drugs from single-dose containers must be billed with either modifier JW to declare the amount of wastage or modifier JZ to declare the full amount was given and there was no wastage.
   c. Effective for dates of service beginning October 2, 2023, procedure codes of separately reimbursable drugs with single-dose containers billed without either modifier JW or JZ will be denied for missing a required modifier.
   d. Claims for procedure codes of separately reimbursable drugs with single-dose containers billed without either modifier JW or JZ for dates of service July 1, 2023 through October 1, 2023 may be subject to audit and denial for missing a required modifier.
3. **NDC Numbers**
   National Drug Code (NDC) numbers in addition to the HCPCS code are required when billing for drugs, to facilitate accurate pricing of the drug supply.
4. **Correct Reporting of Units**
   Units of service must be reported correctly.
   Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician or facility should not report units of service for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service. (CMS[2])
5. **Discarded or Wasted Amounts**
   a. Discarded or wasted amounts of drug from multi-dose vials are not eligible for reimbursement.
   b. Discarded or wasted amounts of drug will be reimbursed **only** when <u>all</u> of the following requirements are met:
      i. The drug is only supplied in single-dose containers. The determination of a single-dose or single-use vial is based on FDA-approved labeling.
      ii. The drug must be considered separately payable and eligible for wastage reimbursement under CMS guidelines.

iii. The physician's orders for the drug must be clearly and completely documented in the medical record. When the physician order for the drug is written in terms of patient specific factors (weight, body surface area, etc.), records documenting current measurements of those specific factors must also be included with the records provided for review.

iv. The amount of drug administered, and the amount discarded must be clearly and completely documented in the medical record.

A. If the drug is wasted in the Pharmacy area at the time the infusion is mixed and prepared, the Pharmacy Dispense documentation must reflect the amount of drug prepared for administration and the amount of drug wasted. An example of acceptable documentation is:

Ipilimumab
GIVEN: 276 mg
Pharmacy dispense: NDC: 00003232711 Dispensed/Waste: 76mg/24mg
Pharmacy dispense: NDC: 00003232822 Dispensed/Waste: 200mg/0mg
Pharmacy plan: Dispense/Waste: 276/0mg
Given Dose/Discard: 276/0mg
Given Date: 4/16/2019
Given Time: 10:06 am
Given By: Jane Doe, RN

B. If during administration the drug is discontinued before completion for any reason, and the medication administration record (MAR) must include:
1) The reason for discontinuation.
2) The date and time the additional drug was discarded
3) The amount discarded (an estimate of the amount or cc's remaining is acceptable)
4) The name, licensure, and signature of the person who administered the drug.
5) If a separate person performed the discontinuation and wastage, the name, licensure and signature of that person is also needed.

v. The amount of drug that is actually administered to the member is billed on one line on the claim.

vi. The amount of drug that was wasted or discarded is billed separately on a second line item, with modifier JW attached.

vii. Reimbursement will be allowed for only the minimum amount of drug above what was ordered to arrive at the nearest whole vial using the vial size and dose that result in the smallest possible discarded amount.

A. For example:
1) If the physician orders for the patient to receive 180 mg of the drug in question, and the drug is available in both a 100 mg single-use vial and a 150 mg single- use vial, then we will only reimburse for 20 mg of wastage (the result of using two 100 mg vials).
2) If the provider only has 150 mg single-dose containers on hand on the date of service in question and two 150 mg vials are used for the 180 mg dose, 120 mg will be wasted. In this instance, we will still only reimburse for 20 mg of wastage. The remaining 100 mg of wasted drug is excess wastage that is not eligible for

reimbursement and becomes a business expense or loss incurred by the billing provider due to not having the 100 mg vials available when needed.

B. Any excess wastage amount (billed with modifier JW but greater than the minimum wastage amount possible as described above) will be denied to provider write off as bundled or included in the reimbursement for the drug administered. Should extenuating circumstances not allow for vial optimization and minimizing wastage, a written appeal with an explanation may be submitted for review by Pharmacy Services for a possible rare exception to allow the full amount of wastage.

c. Any excess drug billed without modifier JW which is above what is ordered or administered and documented will be denied to provider write off as not documented or supported in the medical record.

d. Claim reviews and audits for this and other concerns will be conducted by our staff and/or our business associates (contracted claim review vendors). When records are received in response to the records request, the items received are deemed to be the total documentation needed to support the services billed; any items later received are deemed not to have existed at the time the claim was submitted.

   i. Amended records will not be accepted once the audit review is complete. Missing documentation not included in the initial records submitted will be accepted for reconsideration

   ii. Therefore, it is the responsibility of the billing provider to ensure that their responses to records requests are both prompt and complete.

   iii. If the physician's order, drug administered, and amount wasted or discarded are not clearly, completely, and properly documented in the medical records supplied for review, any excess billed amounts will be denied to provider write-off due to the insufficient documentation.

e. Denials of drug amounts following a claim review/audit may be disputed by submitting a written appeal.

   i. The documentation submitted for appeal consideration should include a written explanation of how the records provided for the original review support the items and quantities billed, and how the number of billed units was calculated from those physician's orders and records.

   ii. Additional records not submitted for the original review cannot be considered in the appeal process.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

The following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses billing and reimbursement practices for the healthcare administration of medications:

- Medicare Claims Processing Manual (Pub. 100-4), Chapter 17 – Drugs and Biologicals, § 40.
- National Correct Coding Initiative (NCCI) Policy Manual, Chapter 1 – General Correct Coding Policies

The above criteria and reimbursement methodologies are consistent with the CMS guidance regarding Medical drug reimbursement and billing.

BILLING AND CODING GUIDELINES

NATIONAL DRUG CODE (NDC) BILLING REQUIREMENT FOR MEDICALLY ADMINISTERED DRUGS: OUTPATIENT AND INPATIENT

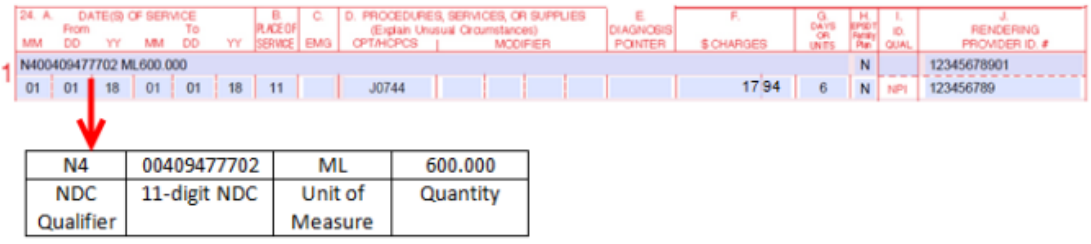
How to submit the NDC on a medical drug claim:

1. Submitting NDCs in electronic or paper claims
   a. Electronic Claims - Professional and institutional (ANSI 837P and ANSI 837I)

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter N4 in this field	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure for the prescription drug given (UN, ML, GR, or F2)	2410	CTP05

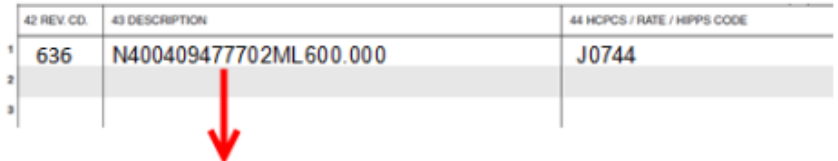
Note: The total charge amount for each line of service also must be included for the Monetary Amount SV102 Segment, 2400 loop.

   b. Paper Claims
      i. Professional Paper Claims (CMS-1500)
      In the shaded portion of the line-item field 24A-24G on the CMS-1500, enter the qualifier N4 (left justified), immediately followed by the NDC. Next, enter one space for separation, then enter the appropriate qualifier for the correct dispensing unit of measure (UN, ML, GR, MG, or F2), followed by the quantity (number of NDC units up to three decimal places), as indicated in the example below.



N4	00409477702	ML	600.000
NDC Qualifier	11-digit NDC	Unit of Measure	Quantity

      ii. Institutional Paper Claims (UB-04)
      In the line-item field 42-46, enter the appropriate drug-related revenue code in field 42. In field 43, report the NDC qualifier N4 (left-justified), immediately followed by the 11-character NDC in the 5-4-2 format (no hyphens). Immediately after the last digit of the NDC, enter the appropriate qualifier for the correct package size, NDC unit of measure (UN, ML, GR, MG or F2), followed by the quantity (number of NDC units up to three decimal places), as indicated in the example below.



N4	00409477702	ML	600.000
NDC Qualifier	11-digit NDC	Unit of Measure	Quantity

Note: Reimbursement for discarded drugs applies only to single-use vials. Multi-use vials are not subject to payment for discarded amounts of the drug

COMPOUND MEDICATIONS ADMINISTERED IN PHYSICIAN'S OFFICE

Billing claims for Compounded Drugs

1. Compounded drugs administered in the physician office must be specific to the individual member for whom the drug is prescribed.
2. Claims must be submitted with the following information:
    a. HCPCS code J7999 on a single claim line.
        1. Compounded medications billed with NOC codes (i.e., J3490, J3590, J7799, J9999, etc.) will be rejected as a billing error.
    b. Quantity = '1' on the line billed for J7999.
    c. Enter the name, total dose (in mg or mcg) of each drug of the refill, and invoice amount in Box 19 of the CMS 1500 or the appropriate comment loop of electronic claims.
        1. Covered compounded single or combination drugs should be billed on a single detail line.
        2. Do not list the drug separately from the dosage, such as morphine bupivacaine baclofen sufentanil 20mg 6mg 4mcg 5mcg. This format will be denied.
        3. List each drug with the applicable dosing amount, for example morphine 20mg, bupivacaine 6 mg, baclofen 4 mcg, sufentanil 5 mcg.
        4. Drug doses used in narrative description must be in grams (gm), milligrams (mgs) or micrograms (mcgs) only. Do not report µgs.
    d. Enter the ICD-10-CM code for each line
        1. The ICD-10-CM code used on each detailed line must represent the condition treated by the drug(s) billed on that detail line.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

JW AND JZ MODIFIER BILLING AND REIMBURSEMENT GUIDELINES

1. To submit claims for a **waste-required claim**, submit two complete claim lines.
    a. Claim line #1:
        - HCPCS code for drug given
        - No modifier
        - Number of units given to the patient
        - Calculated submitted price for ONLY the amount of drug given
    b. Claim line #2:
        - HCPCS code for drug wasted
        - JW modifier to indicate waste
        - Number of units wasted
        - Calculated submitted price for ONLY the amount of drug wasted

    Notes:
    - When the billing units are equal to or greater than the total actual dose and the amount discarded, HCPCS modifier JW may not be submitted.
    - Billing for wastage and/or using the JW modifier for drugs supplied in a multi-dose vial is prohibited.
    - The JW modifier is not used on claims for CAP drugs and biologicals.

2. To submit claims for a **non-discarded claim**, submit one complete claim line.
    a. HCPCS code for drug given
    b. JZ modifier to indicate no waste
    c. Number of units given to the patient
    d. Calculate submitted price for the amount given

CROSS REFERENCES

NATIONAL DRUG CODE (NDC) BILLING REQUIREMENT FOR MEDICALLY ADMINISTERED DRUGS: OUTPATIENT AND INPATIENT

- Specialty Drug Definition and Benefit Administration, ORPTCOPS061
- Specialty Drugs Shipped from Pharmacies to Providers and Facilities, ORPTCOPS145

INJECTABLE DRUGS ADMINISTERED IN PHYSICIAN'S OFFICE

- Company Coding Policy 34 – Administration of Immunizations and Injections, https://www.providencehealthplan.com/-/media/providence/website/pdfs/providers/medical-policy-and-provider-information/billing-payment-and-coding-policies/php_coding_34.pdf
- New Drug and or Indication Awaiting P&T Review – Prior Authorization Request; ORPTCOPS047, https://fm.formularynavigator.com/FormularyNavigator/DocumentManager/Download?clientDocumentId=0qClpkii4kyX0t1hIOI7ww

COMPOUND MEDICATIONS ADMINISTERED IN PHYSICIAN'S OFFICE

- Incident To Services, Company Reimbursement Policy Number: 5 https://www.providencehealthplan.com/-/media/providence/website/pdfs/providers/medical-policy-and-provider-information/reimbursement-policies/rp5.pdf

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

NATIONAL DRUG CODE (NDC) BILLING REQUIREMENT FOR MEDICALLY ADMINISTERED DRUGS: OUTPATIENT AND INPATIENT

1. CMS Manual System, Department of Health and Human Services, PUB 100-04 Medicare Claims Processing, CMS; December 21, 2007, Available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912 (Accessed May 20,2024)
2. Oregon Health Authority. National Drug Code requirement for physician-administered drugs. Available at https://www.oregon.gov/oha/hsd/ohp/pages/ndc.aspx (Accessed May 20, 2024)

INJECTABLE DRUGS ADMINISTERED IN PHYSICIAN'S OFFICE

1. Provider Manual
2. Current Procedural Terminology (CPT)
3. Providence Health Plan Clinical Coding Edits
4. National Correct Coding Initiative (NCCI) Policy

5. Providence Health Plan Prior-authorization List (published on ProvLink and Providence Health Plan Provider Resources and Member Pharmacy Resources websites); https://www.providencehealthplan.com/-/media/providence/website/pdfs/providers/medical-policy-and-provider-information/prior-authorization/php_prior_authorization_code_list.pdf
6. Providence Health Plan Medical Benefit Drug List websearch tool; https://client.formularynavigator.com/Search.aspx?siteCode=4225844343
7. NDC Billing Requirement Policy listed in the index of this policy

COMPOUND MEDICATIONS ADMINISTERED IN PHYSICIAN'S OFFICE

1. Noridian Jurisdiction F – Medicare Part B – Billing and Coding: Intraocular Bevacizumab (A53009). Accessed 4/1/2024. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=53009
2. Noridian Jurisdiction F – Medicare Part B –Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55323). Accessed 4/1/2024. https://med.noridianmedicare.com/web/jfb/search-result/-/view/10534/billing-and-coding-implantable-infusion-pumps-for-chronic-pain-a55323-r16-effective-january-1-2024
3. Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services - 50.4.7 - Denial of Medicare Payment for Compounded Drugs Produced in Violation of Federal Food, Drug, and Cosmetic Act https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
4. Medicare Claims Processing Manual, Chapter 17 – Drugs and Biologicals: 20.1.2 - Average Sales Price (ASP) Payment Methodology and 20.1.3 - Exceptions to Average Sales Price (ASP) Payment Methodology. Accessed 4/1/2024. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf
5. Provider Manual
6. Provider Contracts
7. Centers for Medicare & Medicaid Services (CMS) / Medicare Rules and Regulations

JW AND JZ MODIFIER BILLING AND REIMBURSEMENT GUIDELINES

1. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 17 – Drugs and Biologicals, § 40.
2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § A.
3. CMS. "New JZ Claims Modifier for Certain Medicare Part B Drugs." *MLN Matters,* MM13056, June 2, 2023. https://www.cms.gov/files/document/mm13056-new-jz-claims-modifier-certain-medicare-part-b-drugs.pdf .
4. CMS. "Discarded Drugs and Biologicals: Updated FAQs on JW & JZ Modifiers." MLN Connects Newsletter, Friday, July 27, 2023. 2023-07-27-MLNC. https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive/1368246344/2023-07-27-mlnc .
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POLICY REVISION HISTORY

Date	Revision Summary
04/2024	Policy updated to new format

APPENDICES

Appendix I: How to submit the NDC on a medical drug claim:

1. Submitting NDCs in electronic or paper claims

   a. Electronic Claims - Professional and institutional (ANSI 837P and ANSI 837I)

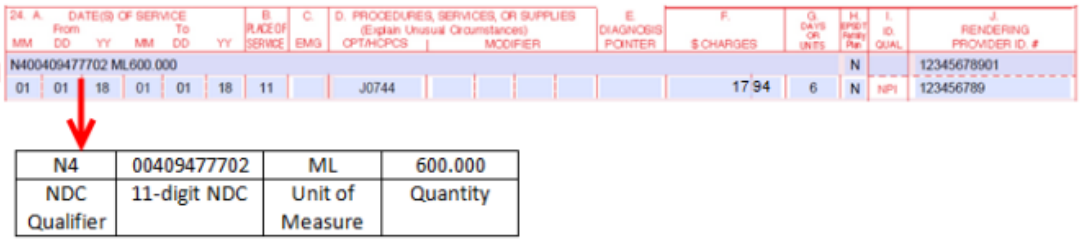
Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter N4 in this field	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure for the prescription drug given (UN, ML, GR, or F2)	2410	CTP05

   Note: The total charge amount for each line of service also must be included for the Monetary Amount SV102 Segment, 2400 loop.

   b. Paper Claims

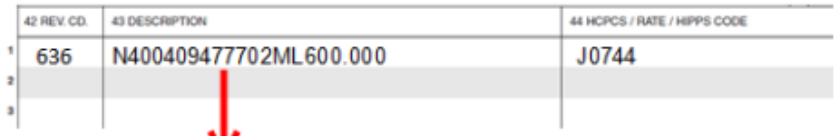
      i. Professional Paper Claims (CMS-1500)
      In the shaded portion of the line-item field 24A-24G on the CMS-1500, enter the qualifier N4 (left justified), immediately followed by the NDC. Next, enter one space for separation, then enter the appropriate qualifier for the correct dispensing unit of

measure (UN, ML, GR, MG, or F2), followed by the quantity (number of NDC units up to three decimal places), as indicated in the example below.



N4	00409477702	ML	600.000
NDC Qualifier	11-digit NDC	Unit of Measure	Quantity

ii. Institutional Paper Claims (UB-04)
In the line-item field 42-46, enter the appropriate drug-related revenue code in field 42. In field 43, report the NDC qualifier N4 (left-justified), immediately followed by the 11-character NDC in the 5-4-2 format (no hyphens). Immediately after the last digit of the NDC, enter the appropriate qualifier for the correct package size, NDC unit of measure (UN, ML, GR, MG or F2), followed by the quantity (number of NDC units up to three decimal places), as indicated in the example below.



N4	00409477702	ML	600.000
NDC Qualifier	11-digit NDC	Unit of Measure	Quantity

Note: Reimbursement for discarded drugs applies only to single-use vials. Multi-use vials are not subject to payment for discarded amounts of the drug

Diagnosis codes for not medically necessary indications include but are not limited to any of the ICD-10 codes listed below. Additional ICD codes may apply.

Code	Description
F064	Anxiety disorder due to known physiological condition
F10180	Alcohol abuse with alcohol-induced anxiety disorder
F10280	Alcohol dependence with alcohol-induced anxiety disorder
F10980	Alcohol use, unspecified with alcohol-induced anxiety disorder

Appendix II:
Diagnosis codes for not medically necessary indications include but are not limited to any of the ICD-10 codes listed below. Additional ICD codes may apply.

Code	Description
F064	Anxiety disorder due to known physiological condition
F10180	Alcohol abuse with alcohol-induced anxiety disorder
F10280	Alcohol dependence with alcohol-induced anxiety disorder
F10980	Alcohol use, unspecified with alcohol-induced anxiety disorder