UNCLASSIFIED J-CODE CODING AND BILLING

UNCLASSIFIED/MISCELLANEOUS CODES

- Used when no existing national code adequately describes the item or service being billed
- Allows suppliers to begin billing immediately for a service or item as soon as the Food and Drug Administration (FDA) allows it to be marketed
- Used during the period of time a request for a new code is being considered under the HCPCS review process1

CODING FOR PHYSICIAN ADMINISTERED DRUGS

- Drugs are typically reported using a HCPCS code (Jxxx) assigned by Centers for Medicare and Medicaid Services (CMS)[2]
- Until a permanent J-Code is assigned, an unclassified code is normally used

HCPCS Code[1]	Descriptor
J3490	Unclassified Drugs
J3590	Unclassified Biologics
J9999	Not otherwise classified, antineoplastic drugs
C9399	Unclassified drugs or biologics (Medicare Outpatient Hospital POS)

1. Centers Alpha Numeric biologicals (Medicare hospital outpatient setting) for Medicare and Medicaid Services, 2012 HCPS HCPCS File. http://www.cms.gov/HCPCSReleaseCodeSets/Downloads/12anweb.zip. Accessed January, 23, 2012.
2. CMS. Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures. http://www.cms.gov/MedHCPCSGenInfo/02_HCPCSCODINGPROCESS.asp. Accessed 9/29/2010

ADDITIONAL INFORMATION MAY BE REQUESTED BY PAYERS

Claim Form	Approval Documents	Pricing
• Branded/generic name • Strength/dose/route of administration • National Drug Code (NDC)	• Package Insert • FDA approval letter • Documentation to support medical necessity	• WAC • AWP • Invoice

MEDICAID BILLING UNCLASSIFIED CODES

Physician Office

- Bill using the CMS-1500 or electronic equivalent
- HCPCS J3490 or J3590 (check payer guidance)
- Medicaid FFS will require an NDC on all claims
  - CMS-1500, electronic 837P, Web Interchange claims and Medicare crossover claims
- Payer guidance may vary

Providers will need to report the NDC in the standard 11 digit format of 5-4-2

Example: 13456 – 123 – 12 would be reported as

12345012312

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N4XXXXXXXXXX Drug Name UN1													N	1B	12345678901
11	01	YY	11	01	YY	11		J3590		1	XXX xx	1	N	NPI	12345678901

PRIVATE PAYERS BILLING UNCLASSIFIED CODES

Physician Office	Hospital Outpatient

• Bill on the CMS 1500 or the electronic equivalent
  • J3490 – unclassified drugs
  • J3590 – unclassified biologics
• Additional information required in Box 19 on the CMS 1500 form will vary by payer
	• Bill on the UB-04/CMS 1450 or electronic equivalent
	  • J3490 – unclassified drugs
	  • J3590 – unclassified biologics
	• Additional information required in Field 80 (Remarks) will vary by payer

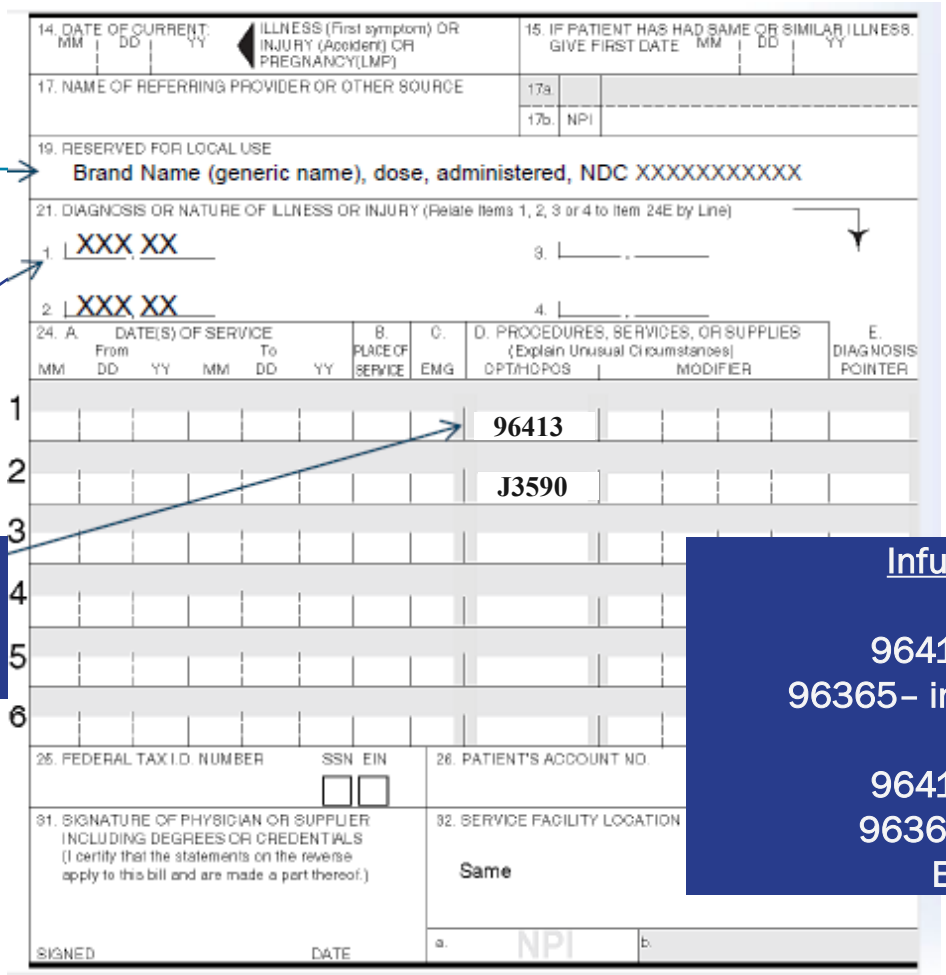
Centers for Medicare and Medicaid Services, Transmittal 1924, February 26,2010.http://www.cms.hhs.gov/transmittals/downloads/R1924CP.pdf. Accessed November 24,2010.

SAMPLE CMS 1500

Box 19: List drug name (brand/generic), dosage, route of administration, and NDC

Box 21: Enter patients ICD – 10– CM diagnosis code based on the patient's documented medical record

Box 24 D – Enter CPT/HCPCS code for procedure and services provided;

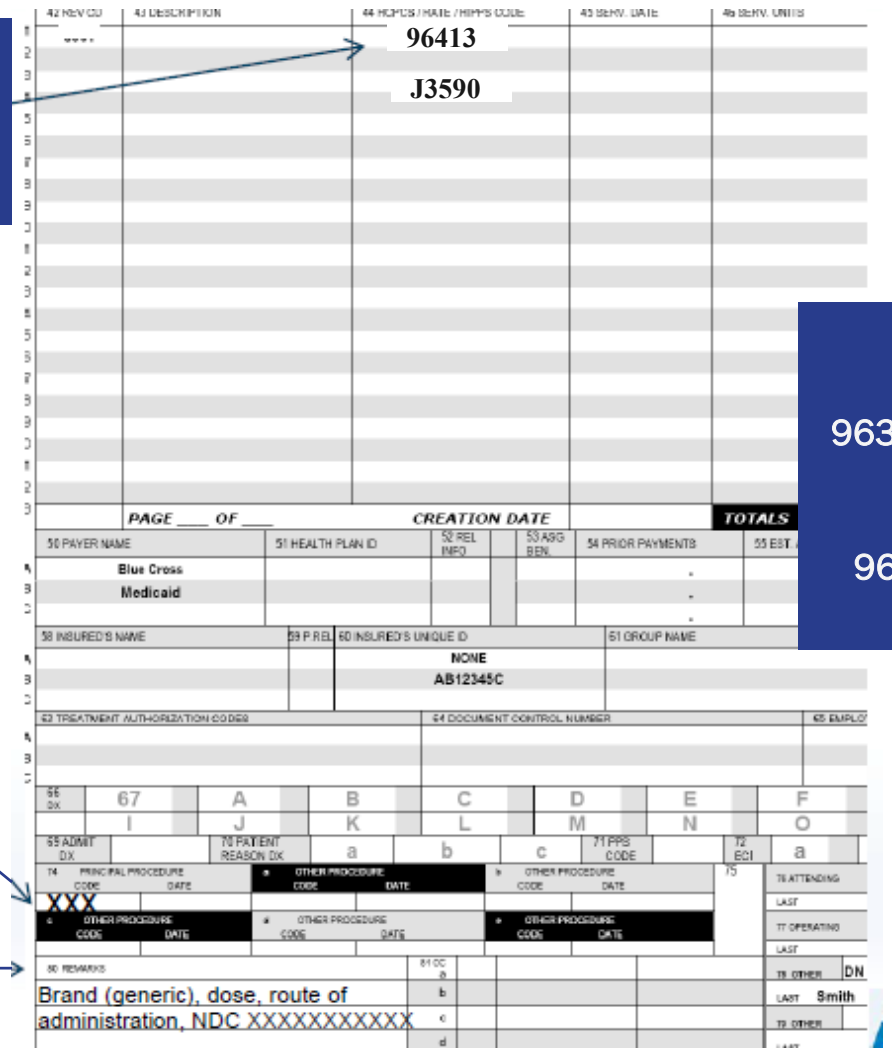


Infusion Procedure Coding

96413 – chemo infusion *OR*
96365– intravenous infusion ; 1st hour
AND
96415 – chemo infusion *OR*
96366 – intravenous infusion
Each additional hour

SAMPLE UB-04

Field 44: Enter HCPCS/CPT code(s) for procedures and services provided;



Field 69: Enter ICD – 10– CM diagnosis code(s) based on documentation in the medical record

Field 80: List drug name (brand/generic) , dosage, and NDC

Infusion Procedure Coding

96413 – chemo infusion *OR*
96365– intravenous infusion ; 1st hour
AND
96415 – chemo infusion *OR*
96366 – intravenous infusion; Each additional hour

REASONS FOR DENIAL

Common Reasons for a denial:

- Incorrect or transposed patient identification (eg, insurance identification number, date of birth)
- Invalid codes (ICD-10, CPT, HCPCS)
- Missing or incorrect number of units
- Incorrect modifier or lack of a modifier
- Service deemed not medically necessary
- Insufficient information to process the claim (eg, missing NDC, PA number, NPI number, etc.)
- Place of Service mismatch

CLEAN CLAIMS SUBMISSION = CLEAN CLAIMS PROCESSING

- Provide appropriate documentation from the patients medical record to justify the coding
- If submitting an unclassified code, insure all of the additional information the payer is requesting is included
- Verify your computer software is up to date and consistent with built in edits
- Track clearinghouse claims to insure successful transmission
- Monitor payer coding and coverage policies for the product you are billing