Billing a Miscellaneous/ Unclassified HCPCS Code
• This information is provided for your background education and is not intended to serve as guidance for specific coding, billing, and claims submissions. The decision on which codes best describe the services provided must be made by the individual providers based on specific payor guidance and requirements.
Overview

• Billing and coding for miscellaneous HCPCS* codes
  • Medicare
  • Medicaid
  • Private payors
• Claim form submission
  • Sample CMS-1500
  • Sample UB-04/CMS-1450
• Tips for submitting a clean claim

*HCPCS – Healthcare Common Procedure Coding System
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 process

Coding for Physician Administered Drugs

• Drugs are typically reported using product specific HCPCS codes (e.g., J-code) assigned by the Centers for Medicare & Medicaid Services (CMS).^2

• Until a specific code is assigned, an “unclassified” code is normally used.

<table>
<thead>
<tr>
<th>HCPCS Code^1</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3490</td>
<td>Unclassified drugs</td>
</tr>
<tr>
<td>J3590</td>
<td>Unclassified biologics</td>
</tr>
<tr>
<td>J9999</td>
<td>Not otherwise classified, antineoplastic drugs</td>
</tr>
<tr>
<td>C9399</td>
<td>Unclassified drugs or biologicals (Medicare hospital outpatient setting)</td>
</tr>
</tbody>
</table>


www.amgenassistonline.com
Miscellaneous Coding Implications

Additional information required by most payors on claim form may include:

- Drug name/generic name
- Strength
- Dosage administered
- Route of administration
- National Drug Code (NDC)

Some payors may also request:

- Prescribing Information
- FDA-approval letter
- Any relevant documentation to support medical necessity (chart or laboratory notes, letter of medical necessity, etc)
- Drug purchase invoice

Medicaid - Billing Unclassified HCPCS Codes

Physician Office

- Bill on the CMS-1500 or electronic equivalent
- Example HCPCS: J3590 or J3490
- NDC is required on Medicaid claims including the paper CMS-1500, electronic 837P, Web interChange claims and Medicare crossover claims

Reporting instructions vary by payor

Example:

NDC: 13456-123-12
 would be reported as 12345012312
Private Payors - Billing Unclassified HCPCS Codes

**Physician Office**
- Bill on the CMS-1500 or electronic equivalent. Example:
  - J3590 Unclassified biologics
  - J3490 Unclassified drugs
- Additional information required in Box 19 will vary by payor

**Hospital Outpatient**
- Bill on the UB-04/CMS-1450 or electronic equivalent. Example:
  - J3590 Unclassified biologics
  - J3490 Unclassified drugs
- Additional information required in Field 80 (Remarks) will vary by payor

Centers for Medicare and Medicaid Services, Transmittal 1924, February 26, 2010. 
EXAMPLE CLAIM FORMS
**Physician Office: Sample CMS-1500**

<table>
<thead>
<tr>
<th>Box 19: List drug name (brand/generic), dosage, route of administration, and NDC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brand Name (generic name), dose, administered, NDC XXXXXXXXXXX</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Box 21: Enter ICD-9-CM diagnosis code based on the patient's documented medical record</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>XXX XX</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Box 24 D: Enter CPT / HCPCS code(s) for procedure and other services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>96372</strong></td>
</tr>
<tr>
<td><strong>J3490</strong></td>
</tr>
</tbody>
</table>
Field 44: Enter HCPCS / CPT code(s) for procedures and other services provided

Field 69: Enter ICD-9-CM diagnosis code(s) based on documentation in medical record

Field 80: List drug name, (brand/generic) dosage, and NDC
Reasons for Claim Denial

Common reasons include:

- Incorrect or transposed patient information (e.g., insurance identification number, date of birth)
- Invalid codes – CPT, HCPCS, ICD-9-CM
- Missing or incorrect number of units
- Incorrect modifier or lack of a modifier
- Service not deemed a medical necessity
- Insufficient information to process the claim (e.g., missing NDC, prior authorization number, invalid NPI)
- Site of service mismatch
Billing correctly the first time may prevent a delay in processing your claim

- Provide appropriate documentation in the patient’s medical record to justify the coding
- If submitting an unclassified/miscellaneous code, include additional information as required by the payor
- Verify your computer software is current and consistent with built-in edits
- Track clearinghouse claims to ensure successful transmission
- Monitor payor coding and coverage policies