

Overview of coding

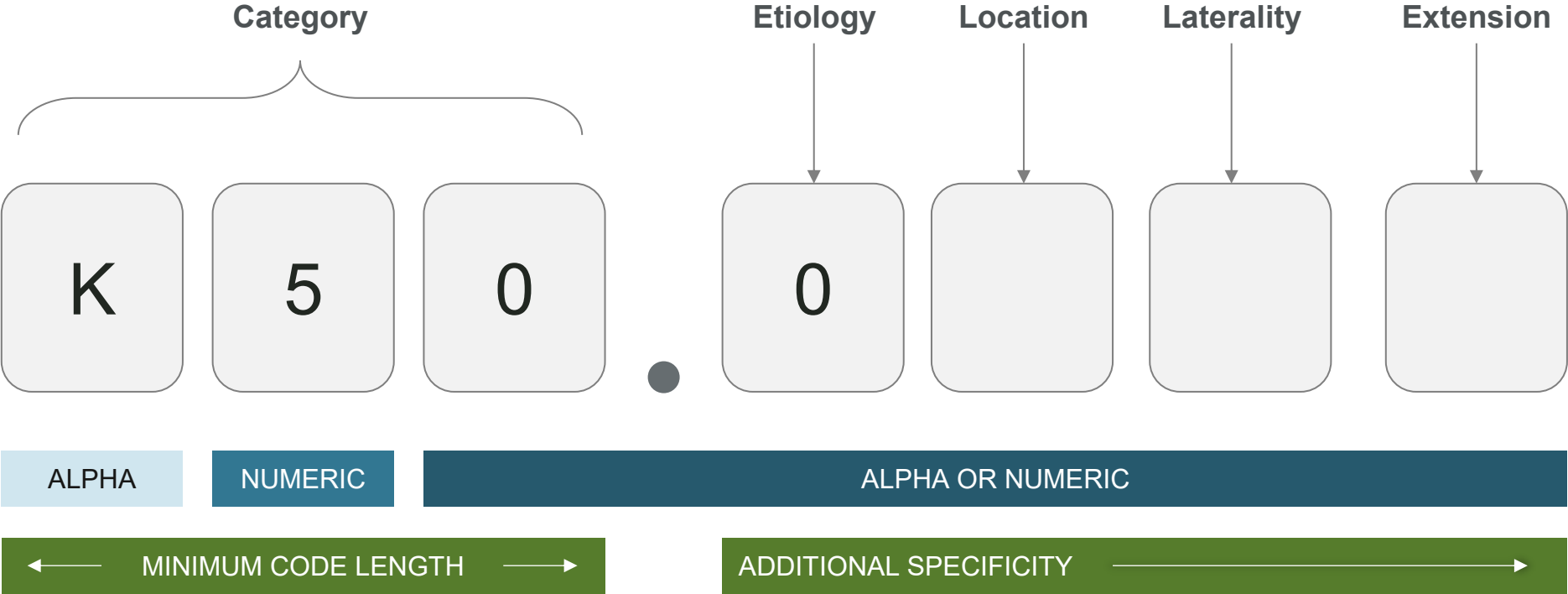
Coding System	ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) ¹	HCPCS (Healthcare Common Procedure Coding System) ^{2,3}	
		Level I CPT® (Current Procedural Terminology)	Level II (e.g. J-codes)
Use		Identifies medical services and procedures furnished by physicians and other healthcare professionals for which they bill public or private health insurance programs	Identifies products, supplies, and services not included in the CPT® codes , such as certain drugs and biologicals, ambulance services or durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office
Format	3-7 alpha and numeric characters	5 numeric digits	1 alphabetical letter + 4 numeric digits
Type of Claim Information	Diagnosis	Procedure (infusion, SC administration) Evaluation and management (E&M)	Product (biologic)

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1. CMS. ICD-10-CM Official Guidelines for Coding and Reporting FY 2025. Accessed May 9, 2025. <https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf> 2. CMS. Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures. Accessed May 9, 2025. <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2018-11-30-HCPCS-Level2-Coding-Procedure.pdf> 3. CMS. Accessed May 9, 2025. <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update>

Understanding ICD-10 code structure¹⁻³

ICD-10-CM uses 3-7 alpha and numeric characters to achieve a high degree of detail when describing patient conditions.



While many ICD-10 codes do not use all 7 characters, coding to the highest level of specificity is required.

1. CMS. ICD-10-CM Official Guidelines for Coding and Reporting FY 2025. Accessed May 9, 2025. <https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf> 2. Hughes C. *Fam Pract Manag.* 2012 Jul-Aug;19(4):27-29. 3. AAPC. ICD-10 Conversion and Mapping. Accessed May 9, 2025. <https://www.aapc.com/icd-10/conversion-mapping.aspx>

Nuances of HCPCS Level I Billing for Biologic Administration



Billing Hierarchy¹

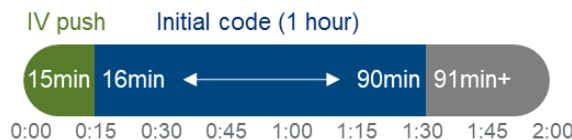
- ❖ Only 1 initial code can be used per billed visit
- ❖ The initial code should represent the highest level of medication administered (using the table below)

Medication Hierarchy		
Complex	Therapeutic	Hydration
HIGH → LOW		
Route of Administration Hierarchy		
IV Infusion	IV push	Injection (SC or IM)
HIGH → LOW		



Infusion Time²

- ❖ The time the patient is physically in the office, infusion chair, bathroom, etc, does not count towards billable infusion time
- ❖ Infusion billing time starts and stops with medication dripping in an IV line
- ❖ To bill a 1-hour infusion, the infusion time must be at least 16 minutes
- ❖ The infusion time must exceed 90 minutes before you can bill the add-on code



Supplies^{2,3}

- Supplies are included in the administration code and cannot be billed separately, including:
- ❖ Local anesthesia
 - ❖ IV start
 - ❖ IV fluids for medication dilution
 - ❖ IV fluids to keep vein open (KVO)
 - ❖ Access to indwelling IV, subcutaneous catheter, or port
 - ❖ Flush at conclusion of infusion
 - ❖ Tubing
 - ❖ Syringes

1. American Medical Association. CPT® 2025, Professional Edition. Chicago, IL: AMA Press; 2024. 2. WeInfuse. The Confusion of Infusion Billing. Accessed May 9, 2025. <https://weinfuse.com/infusion-billing-confusion/> 3. The Rheumatologist. Managing an In-Office Infusion Practice. 2012. Accessed May 9, 2025. <http://www.the-rheumatologist.org/article/managing-an-in-office-infusion-practice/>

Nuances of HCPCS Level I billing for biologic administration



Miscellaneous codes^{1,2*}

- Also known as unlisted, unclassified, not otherwise specified (NOS), or not otherwise classified (NOC) codes
- Used when an item or service is not adequately described by an existing code
- Allow billing to begin immediately for a service or item upon FDA approval in the absence of a specific HCPCS code
- Common miscellaneous J-codes for drugs and biologics include:

C9399

Unspecified drug

J3490

Unclassified drugs

J3590

Unclassified biologics

The # of billing units is always 1 for an unclassified J-code



Permanent J-codes²

- Most infused or injected drugs are classified under J-codes

Typically reported using product-specific HCPCS codes beginning with the letter "J" followed by a 4-digit unique identifier.



- Permanent J-codes are generally assigned 6-9 months after drug approval, at which point the unclassified J-codes should no longer be used
- Once permanent J-codes are available, the manufacturer will issue information with the new J-code to use

*Some payers may require submission of the drug purchase invoice, prescribing information, documentation of medical necessity, or other support for the claim. Because requirements may vary by payer, it is advisable to check local requirements before submitting claims using unclassified codes.
1. CMS. Accessed May 9, 2025. <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2018-11-30-HCPCS-Level2-Coding-Procedure.pdf> 2. CMS. Accessed May 9, 2025. <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update>

National drug code (NDC) reporting requirements



NDC: The NDC is a unique, 3-segment, numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act.¹

In addition to the HCPCS code, many commercial payers are requiring NDC reporting for professional claims (CMS-1500) as well as outpatient facility claims (UB-04/CMS-1450).^{2,3}

CMS requires NDC reporting on claims for patients who are dual eligible for Medicare and Medicaid.⁴

NDCs may appear in a 10-digit or 11-digit format on drug packaging. However, the NDC is typically required to be reported on claims in an 11-digit format. Converting NDCs from a 10-digit to an 11-digit format requires a strategically placed zero, dependent on the 10-digit format.^{1,2}

Improper or incomplete reporting may result in denial of claims.³

How to convert the different 10-digit codes to an 11-digit code²

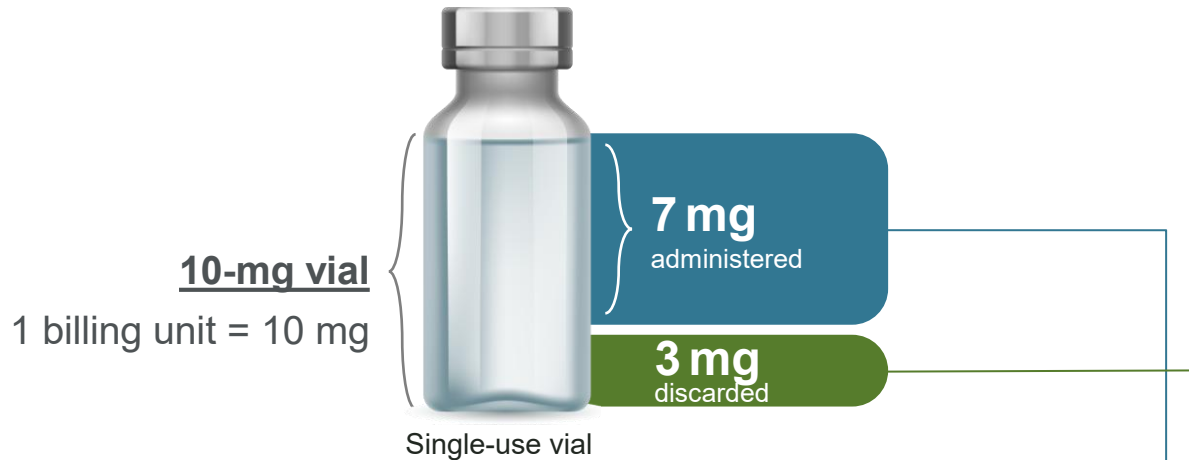
10-digit format	Add zero in..	Report NDC as...
4-4-2 □#####-####-##	1 st position	0#####
5-3-2 #####-□###-##	6 th position	#####0#####
5-4-1 #####-####-□#	10 th position	#####0#

1. FDA. National Drug Code Database Background Information. Accessed May 9, 2025. <https://www.fda.gov/drugs/development-approval-process-drugs/national-drug-code-database-background-information> 2. Anthem BlueCross BlueShield. National Drug Code FAQs. December 2017. Accessed May 9, 2025. https://providers.anthem.com/docs/gpp/NV_CAID_NationalDrugCodeFAQs.pdf?v=202101142238 3. UnitedHealthcare. National Drug Code (NDC) Requirements FAQ. Accessed May 9, 2025. <https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nj/references/NJ-National-Drug-Codes-Req-FAQ.pdf> 4. CMS. Medicare Claims Processing Manual, Pub 100-04 Medical Claims Processing. Accessed May 9, 2025. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r1401cp.pdf>

Documenting wastage using the JW modifier^{1,2}

JW Modifier **Not** Permitted when THE ACTUAL dose is less than the billing unit

In this case, 1 billing unit = 10 mg



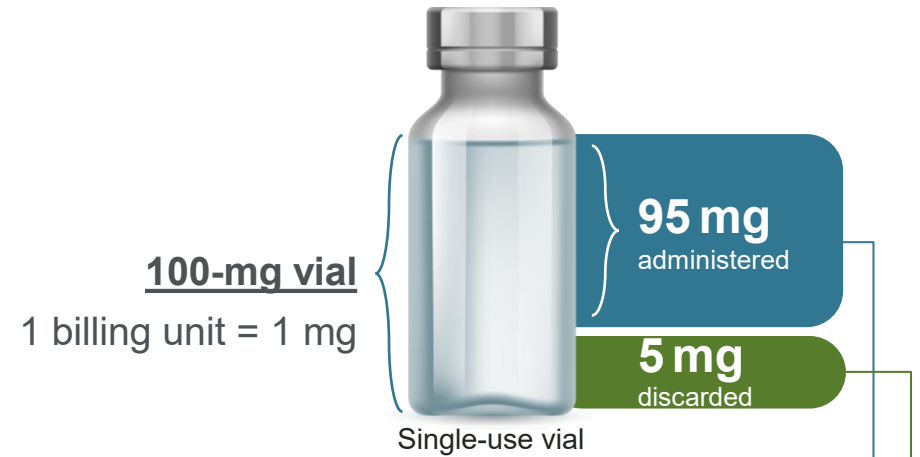
Claim Line 1

- HCPCS code for drug administered
- Number of units administered (1)
- Charge submitted (price of drug administered)
- No modifier

When the billing unit is equal to or greater than the total actual dose plus the amount discarded, the use of the JW modifier is not permitted.

JW Modifier **REQUIRED** when “billing units” of product are discarded

In this case, 1 billing unit = 1 mg



Claim Line 1

- HCPCS code for drug administered
- Number of units administered (95)
- Charge submitted (price of drug administered)
- No modifier 1

Claim Line 2

- HCPCS code for the discarded drug
- HCPCS JW modifier appended to indicate waste
- 5 units wasted
- Charge submitted (price of drug wasted)

1. CMS. Pub 100-04 Medicare Claims Processing; Transmittal 3538. 2016. Accessed May 9, 2025. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3538CP.pdf> 2. Zweifel R. Billing for Discarded Waste from a SDV: Assign Modifier JW to Retain Revenue. 2016. Accessed May 9, 2025. <http://www.racmonitor.com/rac-enews/2052-billing-for-discarded-waste-from-a-sdv-assign-modifier-jw-to-retain-revenue.html>

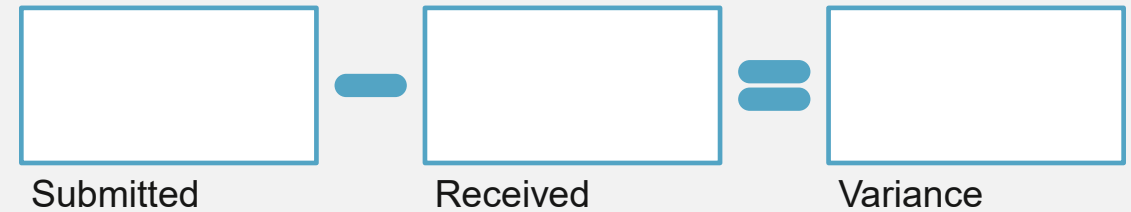
Reconciling claims¹

Track each claim to confirm payment is received.
Ensure the expected payment amount is equal to the actual amount received.

Claims Paid Model



Payment Variance Model



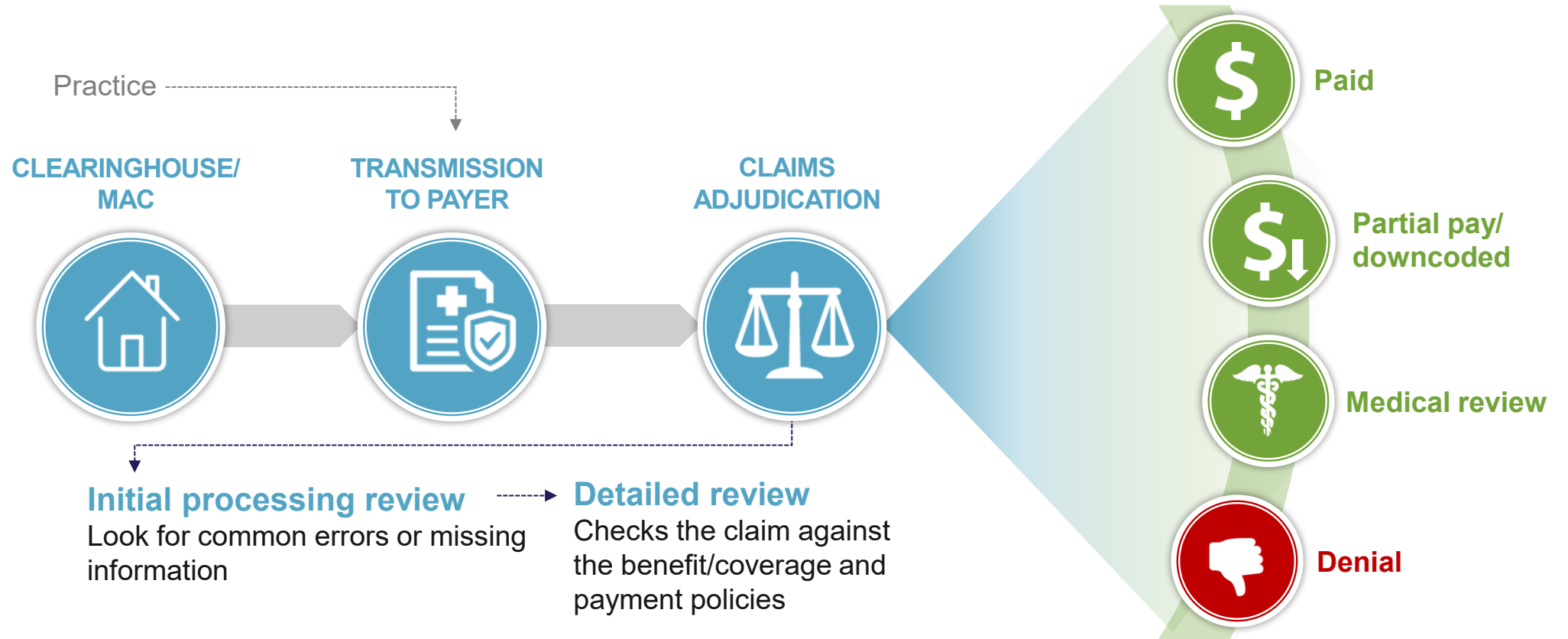
Flag claims where a variance exists to investigate why and initiate quality improvement strategies, if needed.

1. Walker Keegan D, et al. *The Physician Billing Process: Navigating Potholes on the Road to Getting Paid*. Englewood: MGMA; 2015.

Understanding the claims adjudication process¹



Claims adjudication: The process of paying claims submitted, or denying them, after comparing the claims to the benefit or coverage requirements.



1. Walker Keegan D, et al. *The Physician Billing Process: Navigating Potholes on the Road to Getting Paid*. Englewood: MGMA; 2015.

Denials by the numbers...



of denials
are recoverable



of denials
are preventable¹



delay in
reimbursement



higher economic
burden
to resubmit a rejected claim than
the original manual submission³













Any omission/error = claim denial²

When denials do occur, it is critically important to actively investigate and appeal them.²

1. HFMA.org. Success in Proactive Denials Management and Prevention. Accessed May 9, 2025. <https://www.hfma.org/topics/hfm/2018/september/61778.html> 2. Walker Keegan D, et al. *The Physician Billing Process: Navigating Potholes on the Road to Getting Paid*. Englewood: MGMA; 2015. 3. Reinventing Claims Management for the Value-Based Era. Accessed May 9, 2025. <https://www.changehealthcare.com/insights/value-based-era-claims-management>

10 reasons for denied claims^{1,2}

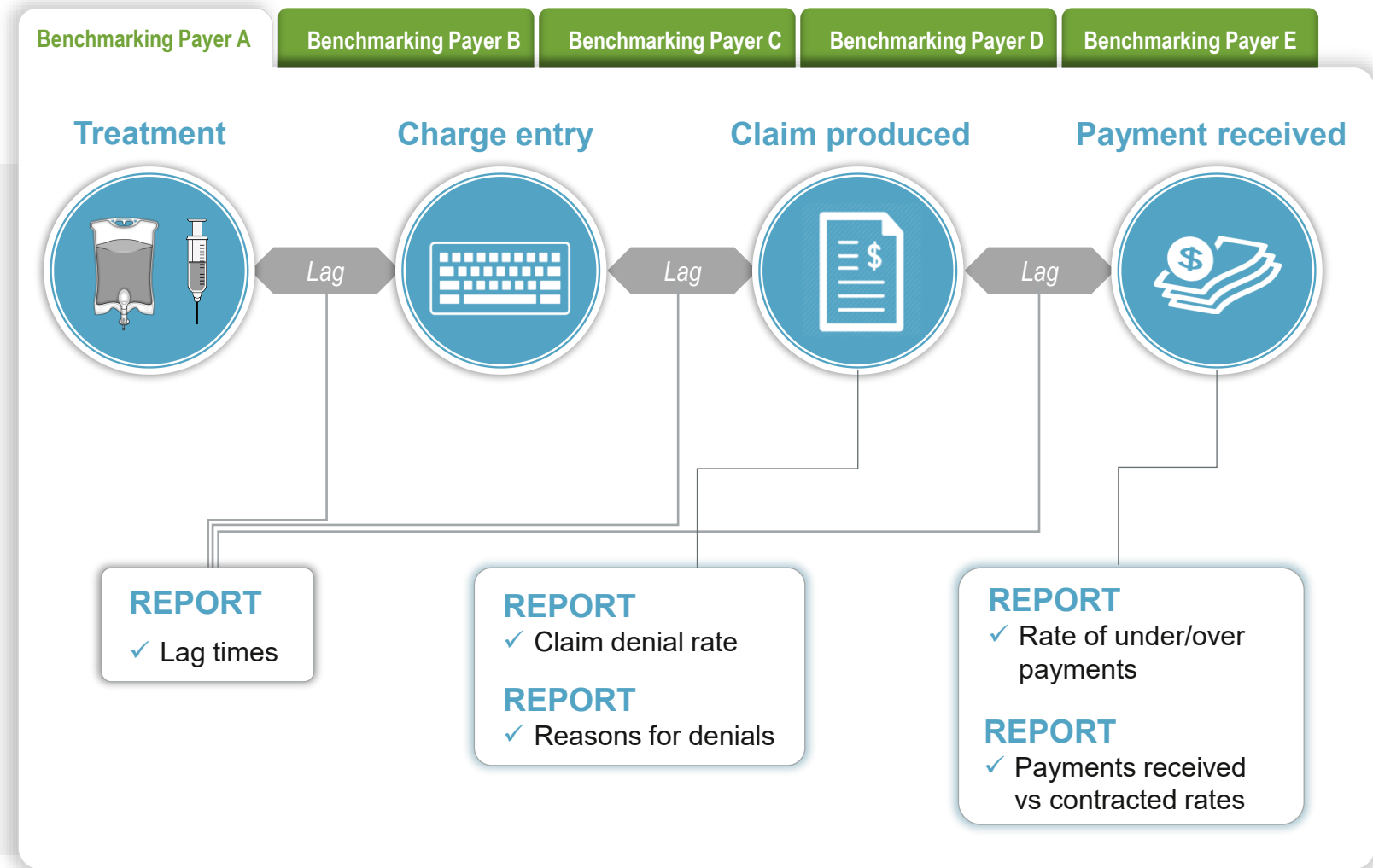
 <p>Prior authorization not secured or submitted</p>	 <p>Missing or incorrect information</p>	 <p>Lack of medical necessity</p>	 <p>Procedure not covered</p>	 <p>Provider out of network</p>
 <p>Duplicate billing</p>	 <p>Patient not eligible on date of service</p>	 <p>Referral not secured or submitted</p>	 <p>Coding-related problem (bundling, global periods, modifiers)</p>	 <p>Coordination of benefits</p>

1. Walker Keegan D, et al. The Physician Billing Process: Navigating Potholes on the Road to Getting Paid. Englewood: MGMA; 2015. 2. Journal of AHIMA. Claims Denials: A Step-by-Step Approach to Resolution. Accessed May 9, 2025. <https://journal.ahima.org/page/claims-denials-a-step-by-step-approach-to-resolution>

Benchmarking payer performance

Track, audit, and adapt

- ✓ Track the claims process, denials, and reimbursements
- ✓ Conduct regular internal audits and develop associated benchmark reports
- ✓ Utilize a process improvement strategy to identify issues and track changes
- ✓ Utilize performance indicators, if available, to benchmark performance and improvement



Claims and denials process considerations

Claims processes optimization

- ✓ Utilize performance indicators to optimize claims submission timelines
- ✓ Review clearinghouse reports and rejections
- ✓ Review Explanation of Benefits (EOB)
- ✓ Track payment posting and denials
- ✓ Regularly generate payment variance reports
- ✓ Look for payment variance (ie, due to contractual under- and overpayments, coding errors, improper benefit verification) and remediate as necessary

Address denials

Problem-solving

- ✓ Check data entry/claim for accuracy
- ✓ Verify referral or pre-authorization data on claim
- ✓ Check with clearinghouse to identify potential information loss

Appealing denied claims

- ✓ File appeal within the required time frame
- ✓ Utilize payer compliance tracking tools to identify appeal opportunities
- ✓ Document all conversations with payers
- ✓ Adhere to the step-by-step appeals process required by each payer
- ✓ Appeals process may be defined by state law

Track and improve denial rate

- ✓ Strive for a denial rate of less than or equal to 5% on first submission¹
- ✓ Track reimbursement and denials
- ✓ Track reasons claims are denied
- ✓ Categorize reasons for denials
- ✓ Track success on reworking denials
- ✓ Calculate staff time and cost for denial management
- ✓ Look at denials by payer
- ✓ Establish formal, nonpunitive feedback loop from biller to management that identifies denial patterns
- ✓ Prioritize tasks for process improvement
- ✓ Track impact of implementing process improvement strategy

Quality improvement

- ✓ Conduct regular internal audits on a select number of claims per full-time employee quarterly
- ✓ Document actions taken, rationale, details
- ✓ Promote quality in addition to productivity
- ✓ Assign quality score based on adherence to policies
- ✓ Set and monitor team and individual goals and establish a reward/incentive system

1. Walker Keegan D, et al. *The Physician Billing Process: Navigating Potholes on the Road to Getting Paid*. Englewood: MGMA; 2015.