

Medicare Part B Drugs and Biologicals

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Objective

During this webinar, we'll focus on coverage and billing information for drugs and biologicals that are covered by Medicare Part B.

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Agenda

- [Medicare Part B Coverage](#)
- [Drug Pricing and Reimbursement](#)
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- [Drug and Biological – Clinical Trial](#)
- [Not Otherwise Classified and Compound Drugs](#)
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Medicare Part B Drug Coverage

Medicare Part B Coverage - Drugs and Biologicals

- Drugs and biologicals are covered only if all the following requirements are met
 - Meet definition of drugs and biologicals
 - Meet all general requirements for covered items as incident to physician's service
 - Reasonable and necessary for diagnosis or treatment of illness or injury for which are administered
 - Type that are not usually self-administered
 - Not excluded as noncovered immunizations
 - Not been determined by FDA to be less than effective
- [CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 50](#)

Medicare Part B Coverage

- Below are examples of covered Medicare Part B drugs and biologicals, not be inclusive, along with a resource for coverage information
 - Antigens
 - Blood clotting factors
 - Drugs used with DME
 - Erythropoiesis Stimulating Agent
 - Injectable and infused drugs
 - Injectable osteoporosis drugs
 - Oral antinausea drugs
 - Intravenous Immune Globulin
 - Oral ESRD drugs
 - Oral cancer drugs
 - Transplant drugs
 - IVIG and Rituximab
- [Medicare Part B Drug Coverage](#)

Medicare Part B Coverage

- Skin Substitutes
 - Total manufacturer's invoice cost
 - Ensure rebates/discounts are reflected
 - Excluded from JZ requirement
 - Only the JW modifier applies
 - High Dollar Claims
 - Append modifier 76 to subsequent claims and comment claim one of four, two of four, etc.
 - Ensure units are billed in square units except when a circular product used
 - For example, 3x3 = 9 units, 4x3 = 12 units, etc.
 - Include wound DX
- [LCD - Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound \(L39139\)](#)

Drug Pricing and Reimbursement

Average Sales Price

- CMS prices drugs based on Average Sales Price
 - ASP files are updated by CMS quarterly
 - [Medicare Part B Drug Average Sales Price](#)
- **Note:** NOC and compound drugs not listed on ASP files are priced by MAC

Wholesale Acquisition Cost/Invoice Pricing

- Payment allowance limits for drugs and biologicals that are not included in ASP or NOC files are based on published WAC and includes invoice pricing
- NGS has the discretion to determine how many invoices are necessary to determine reimbursement amounts for drugs subject to invoice pricing
 - Separate invoice for each claim
 - OR -
 - Establish payment amounts based on a smaller number of invoices that are representative of providers' costs

Mandatory Assignment on Claims

- Payment for drugs and biologicals covered under Medicare Part B is made on an assignment basis
 - All claims processed as assigned
- Patients can only be billed for applicable Medicare Part B deductible and coinsurance amounts
- [CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 17, Section 50](#)

Claim Corrections

- Once a claim is paid you must either
 - Submit an appeal
 - Voluntary refund and rebill
 - Timeliness standards

Medicare Part B Vaccinations and Administration

Vaccinations and Administration

- G0008 – Influenza Administration Code
 - [Influenza Virus Vaccine and Administration](#)
- G0009 – Pneumococcal Administration Code
 - [Pneumococcal Vaccine and Administration](#)
- G0010 – Hepatitis B Administration Code
 - [Hepatitis B Virus Vaccine and Administration](#)
- COVID –
 - [COVID-19 Vaccines & Monoclonal Antibodies](#)
 - COVID vaccine administration code is dependent upon the vaccine and dosage being given

Drug and Biological – Clinical Trials

Drug and Biological – Clinical Trials

- A clinical trial is an interventional study where treatment is evaluated by qualified researchers who have developed an approved protocol
 - Interventions include both diagnostic and therapeutic services
 - The administration of drugs included in a clinical trial may be covered by Medicare Part B
- [Clinical Trial Services and Modifiers Q0 and Q1](#)

Reporting Clinical Trial

1500 Claim Field	ANSI 837 v5010 Loop and Segment	Information Required
19	2300 REF02 & qualifier REF01 = P4	Key the Clinical Trial Number, preceded by "CT" Example: CT XXXXXXXXX
23	2300, REF02 & qualifier REF01=LX	IDE Number
24D (line 1)	2400, SV101-2	HCPCS code for clinical trial drug
24D (line 2)	2400, SV101-2	Administration code
24 D (lines 1 and 2)	2400, SV101-3	Q0 modifier - must be appended to both admin and drug code
28 (line 1)	2300, CLM01	Total charge for drug code = \$0.01 (one penny)
28 (line 2)	2300, CLM01	Total charge for administration code

Not Otherwise Classified and
Compound Drugs

Not Otherwise Classified

- Use appropriate NOC code
 - J3490 – Unclassified drug
 - J3590 – Unclassified biological
 - J9999 – Not otherwise classified, anti-neoplastic drug
- Bill one service unit
 - 2400/SV1-04 data element or in line item 24G of CMS-1500 form
- These details must be included in the notes section of the claim
 - Name of the drug
 - Dose administered (mg, cc, etc.)
 - Route of administration (IV, IM, SC, PO, etc.)
 - Invoice price (for new drugs if WAC is unavailable, or for compounded drugs)

Compound Drugs – J7999

- Compound drugs is the process of combining or mixing two or more individual drugs to create a medication that is tailored to the needs of a specific patient
 - Examples – patient has allergies, cannot swallow a pill, cannot have dyes in their medications, etc.
- These details must be included in the notes section of the claim
 - Each drug name
 - Each drug dosage
 - Route of administration
 - Invoice price

Claim Notes Section

- CMS 1500 – Paper claim
 - Item 19
- 837P, version 5010
 - Not otherwise classified (NOC) Drug
 - [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)

Units of Service for Drugs and Biologicals

Units of Service

- Each drug/biological defines dosage amount in its description
- For Medicare Part B billing purposes, the units of service on the claim for a drug/biological are entered in multiples of the units shown in the HCPCS narrative description
- Example
 - [Billing and Coding Hyaluronans Intra-articular Injections \(A52420\)](#)
 - Use drug code description to determine the correct units to submit on the claim
 - “1mg” = total number of milligrams dosed
 - “per dose” = one unit, always
 - J7320 – Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
 - There are 25 mgs per dose; therefore, each dose is 25 units
- More examples
 - [CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 17, Section 70](#)

Billing Correct Units J7320 and J7322

- The number of units is calculated by milligrams; each unit being equal to one milligram
- J7320 – Hyaluronan or derivative, GenVisc[®] 850, for intra-articular injection, one mg
 - There are 25 mgs per dose; therefore each dose is 25 units
 - [Proper Billing Units for HCPCS Code J7320](#)
- J7322 – Hyaluronan or derivative, hymovis, for intra-articular injection, one mg
 - There are 24 mgs per dose; therefore each dose is 24 units

Billing Correct Units for Q2028

- Q2028 - Injection, Sculptra, 0.5 mg
- Sculptra is calculated as 0.5mg and is packaged as a single dose vial (SDV) containing 367.5mg per vial; and cannot be split up for payment
 - Each billing unit = 0.5 mg
 - One vial is 367.5 mg = 735 units
 - Two vials are 735 mg = 1470 units
- Depending on how many vials were administered, total quantity/units billed would be noted as 735 or 1470
- [Dermal Injections for Treatment of Facial Lipodystrophy Syndrome](#)

Discarded Drugs and Biologicals

Payment for Unused Portion of Single Dose Container – JW Modifier

- Medicare Part B payment may be made for the unused portion of a single dose vial of a drug/biological
 - Medicare Part B will pay for the dose that was administered to the patient as well as the remaining dose that had to be discarded
 - Report JW modifier to be eligible for payment
- Example
 - A single use container is labeled 100 units, patient received 95 units leaving five units as waste
 - 95 units is billed on one line
 - Five units is billed on a separate line using the JW modifier to identify as waste/discard

Reporting JW Modifier

1500 Claim Field	ANSI 837 v5010 Loop and Segment	Information Required
19	2300 or 2400, NTE02 May also use 2400, SV101-7	NDC, invoice cost, dosage
24D (line 1)	2400, SV101-2	Drug HCPCS code
24D (line 2)	2400, SV101-2	The same drug HCPCS code
24 D (line 2)	2400, SV101-3	JW Modifier
24D (line 3)	2400, SV101-2	Drug administration code
24G	2300, CLM01	Units of service are calculated according to the applicable HCPCS code based on dosage

Reporting Zero Drug Waste – JZ Modifier

- The 2023 Physician Fee Schedule Final Rule included a new requirement for providers to report modifier JZ when zero drug is wasted from a single-dose container, or single-use package
 - This applies to drugs separately payable under Medicare Part B
 - Effective 7/1/2023, providers are required to report JZ modifier
 - Editing began on 10/1/2023
- Example
 - A single use vial is labeled as 100 units, patient received all 100 units leaving zero waste
 - 100 units billed with appropriate HCPCS code
 - JZ modifier is appended to this HCPCS code to indicate no waste

Reporting JZ Modifier

1500 Claim Field	ANSI 837 v5010 Loop and Segment	Information Required
19	2300 or 2400, NTE02 May also use 2400, SV101-7	NDC, invoice cost, dosage
24D (line 1)	2400, SV101-2	Drug HCPCS code
24D (line 1)	2400, SV101-3	JZ Modifier
24 D (line 2)	2400, SV101-3	Drug administration code
24G	2300, SV104	Units of service are calculated according to the applicable HCPCS code based on dosage

Free of Charge Drugs and Biologicals

Free of Charge Drugs

- A drug/biological must represent an expense to the provider to be considered as a separate payment under Medicare Part B
- There is no expense to the provider when
 - The provider received the drug free of charge
 - The patient purchased/supplied the drug on their own
- The provider is entitled to reimbursement for administration of the medication
 - This requires specific billing requirements
 - The drugs HCPCS code total charge must be \$0.01 (one penny)
 - The administration code will be its actual charge to ensure full reimbursement

Reporting Free of Charge

1500 Claim Field	ANSI 837 v5010 Loop and Segment	Information Required
19	2300 or 2400, NTE02	Narrative – “Patient supplied” or “Provided Free of Charge”
24D (line 1)	2400, SV101-2	Covered drug HCPCS code: established or NOC drug code
24D (line 2)	2400, SV101-2	Drug administration code
28 (line 1)	2300, CLM02	Total charge = \$0.01
28 (line 2)	2300, CLM02	Total charge for administration code

Self-Administered Drugs

Self-Administered Drugs

- A drug that is self-administered by more than 50% of the Medicare beneficiary population is an exclusion to coverage
- CMS requires MACs to determine when a drug is excluded under SAD using instruction from
 - [CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 50.2: Determining Self-Administration of Drug or Biological](#)

Self-Administered Drugs - Exclusions

- List of Medicare excluded drugs and biologicals
 - [Self-Administered Drug Exclusion List: Medical Policy Article \(A53021\)](#)
- Criteria used by NGS to determine SAD
 - [Process for Determining Self-Administered Drug Exclusions – Medical Policy Article \(A53020\)](#)

Reporting SAD

1500 Claim Field	ANSI 837 v5010 Loop and Segment	Information Required
24D (line 1)	2400, SV101-2	Drug HCPCS (established code or NOC code)
24D (line 1)	2400, SV101-2	GY modifier
24D (line 2)	2400, SV101-2	Drug administration code
24D (line 2)	2400, SV101-2	GY modifier
28 (line 1)	2300, CLM02	Total charge drug code = \$0.01
28 (line 2)	2300, CLM02	Total charge for administration code

References

References

- [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 17](#)
- Sections
 - 10 Payment Rules for Drugs and Biologicals
 - 20.1.3 Exceptions to Average Sales Price (ASP) Payment Methodology
 - 20.2 Single Drug Pricer (SDP)
 - 40 Discarded Drugs and Biologicals
 - 50 Assignment Required for Drugs and Biologicals
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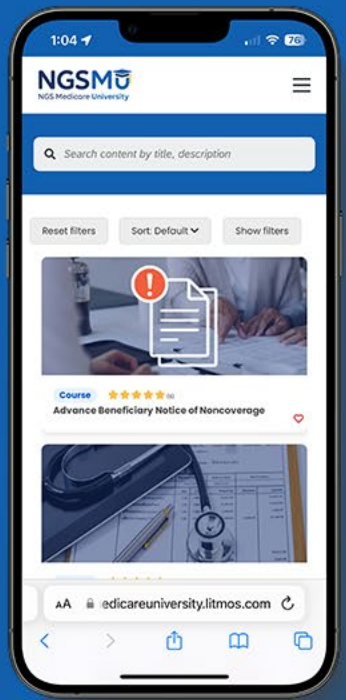
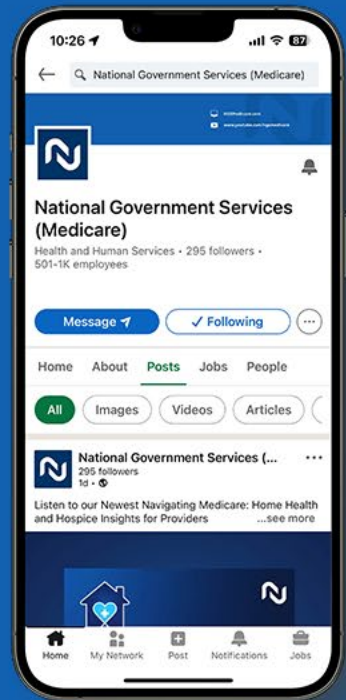
References

- [CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15](#)
- Sections
 - 50–50.4.8 Drugs and Biologicals
 - 50.5–50.6 Self-Administered Drugs and Biologicals
- [Drugs and Biologicals](#)
- [Local Coverage Determination \(LCD\): Drugs and Biologicals, Coverage of, for Label and Off-Label Uses \(L33394\)](#)
- [Drug Coverage under Different Parts of Medicare](#)
- [JW Modifier and JZ Modifier FAQs](#)




Questions?

Thank you!



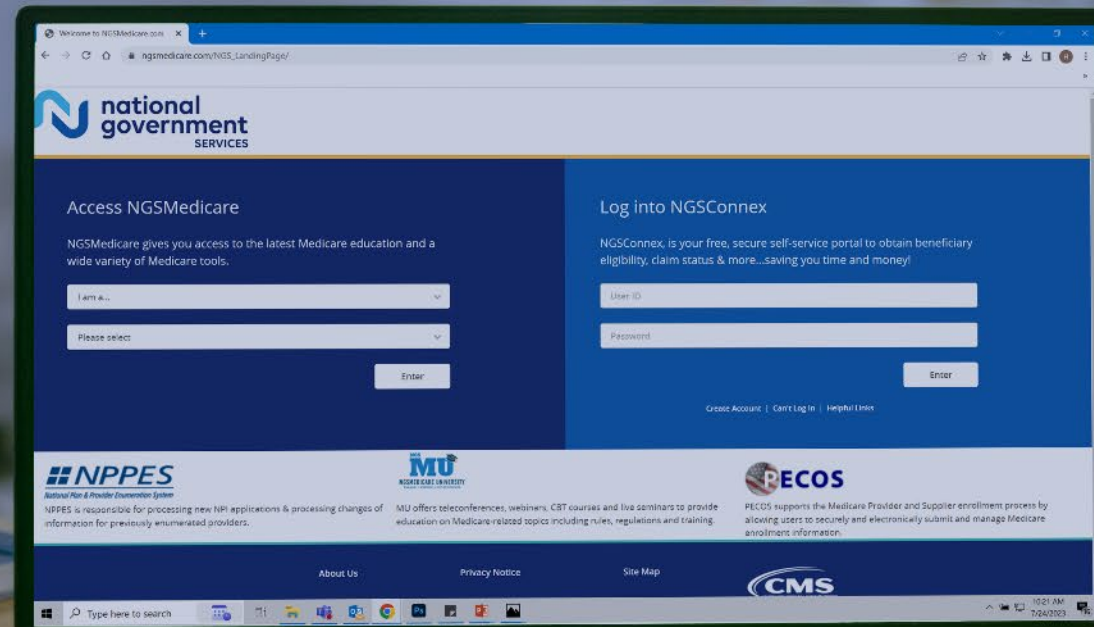
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