Reimbursement Policy

Medical Drug Billing and Reimbursement: Professional and Facility

REIMBURSEMENT POLICY NUMBER: 77

Effective Date: 6/1/2026

Last Review Date: 4/2026

Next Annual Review: 5/2027

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

☒ 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 Product:

☒ Commercial

☒ Medicare

☒ Medicaid/Oregon Health Plan (OHP)

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

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

☒ DRG

☒ Modified DRG

☒ Percentage of billed charges/per diem (applies only to unplanned readmissions)

POLICY STATEMENT

- **National Drug Code (NDC) Billing Requirement for Medically Administered Drugs, Diabetic DME devices, Diabetic Supplies, Enteral Nutrition and Oral Nutrition: Outpatient and Inpatient**
    - 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.
        - 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.
        - 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.

Drugs and Biologicals

Pharmaceuticals – though an essential part of health care – are among the biggest contributors to medical expense. As such, controlling the cost of pharmaceuticals is important to payer organizations. Moreover, the payment for pharmaceuticals by payers is subject to various policies as well as regulations and laws at federal and state levels.

Payment Integrity

Payment Integrity (PI) solutions that aim to help control the cost associated with drugs and biologicals.

- Clinical edit logic and review criteria are based on widely accepted sources, including but not limited to:
    - United States Food and Drug Administration (FDA) pharmaceutical package inserts, policies, and publications
    - Centers for Medicare and Medicaid Services (CMS) policies and publications
    - American Medical Association CPT guidelines and code descriptions
    - American Hospital Formulary Service Drug Information (AHFS-DI)
    - DRUGDEX system
    - State and other governmental regulations, policies, and publications

Clinical editing examples include, but are not limited to:

- **Drug Waste – JW/JZ Modifier**

- For reimbursement, CMS requires providers and suppliers to include a JW modifier and the corresponding wasted units on all claims where drug waste occurs while using appropriate single-dose containers.
- Per the U.S. Food and Drug Administration (FDA) and CMS policy, certain drugs do not warrant any waste due to the approved dosage, drug form, and/or preparation requirements. Drug-specific information on the manufacturer's drug label listed in the FDA's database is used to determine instances where drug wastage is not appropriate.

- **Dosage Limits, Frequency, Route of Administration, Unconventional Use of Drug**
  - To ensure drugs are safely and appropriately administered, the U.S. Food and Drug Administration (FDA) approves all drug labeling from drug manufacturers, including recommended dosing guidelines. All maximum recommended doses, frequencies, routes of administration, and conventional use of each drug are based on the manufacturer's proposed dosing to the FDA, along with additional, widely accepted practices within the medical community.
  - When available, these drug-specific recommendations can be found in many places, including but not limited to the following: FDA Label Database, the American Hospital Formulary Service-Drug Information (AHFS-DI), and Merative Micromedex DRUGDEX®.

Injectable Drugs Administered in Physician's Office

- 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.
  - 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
- 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).
  - 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.

Compound Medications Administered in Physician's Office

- 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:
  - 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.
  - 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.

POLICY GUIDELINES

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

Background

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. A drug may have multiple manufacturers, so it is vital to use the NDC of the administered drug and not another manufacturer 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.
    b. Invalid and discontinued drugs are not acceptable for payment.
2. Location of NDC
    a. 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.
    b. 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 ***BILLING AND CODING GUIDELINES*** *section I* for more information regarding billing of NDC on claims.

DRUGS AND BIOLOGICALS - PAYMENT INTEGRITY CLINICAL EDIT LOGIC AND CLAIM REVIEW
Background

DRUG WASTE
For reimbursement, CMS requires providers and suppliers to include a JW modifier and the corresponding wasted units on all claims where drug waste occurs while using appropriate single-dose containers. Per the U.S. Food and Drug Administration (FDA) and CMS policy, certain drugs do not warrant any waste due to the approved dosage, drug form, and/or preparation requirements. Drug-specific information on the manufacturer's drug label listed in the FDA's database is used to determine instances where drug wastage is not appropriate.

- Drug Waste Billed Without Identical HCPCS Code.
  Modifier JW is used on a claim line to indicate that a drug or biologic has been discarded or not administered to a patient. If a provider submits a claim for drug waste with a JW Modifier, there should be a corresponding claim line for the drug code without the JW modifier. If there is no corresponding claim line without a JW Modifier, the edit will deny the claim line with the JW Modifier.
- Drug Waste Billed and HCPCS Code for Amount Administered Not Payable.
  Modifier JW is used on a claim line to indicate that a drug or biologic has been discarded or not administered to a patient. This edit will look for the original administration drug code and the billing of the same code with the JW Modifier. When the original administration of the same drug is either missing or denied, the claim line with the JW modifier will be denied.
- Inappropriate Drug Waste Submitted for Drug or Biological.
  The Centers for Medicare and Medicaid Services (CMS) requires providers and suppliers to include a JW modifier and the corresponding units wasted on all claims where drug waste occurs. Per the U.S. Food and Drug Administration (FDA) and CMS policy, certain drugs do not warrant any waste due to the approved dosage, drug form, and/or preparation requirements. Any of these specific drugs billed with a JW modifier will be denied reimbursement for all corresponding drug wastage lines.

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.

See ***BILLING AND CODING GUIDELINES*** *section III* for more information regarding billing JW/JZ modifiers.

MAXIMUM DOSAGE CLINICAL EDITING FOR PROFESSIONAL AND OUTPATIENT FACILITY CLAIMS
Per Company policy, each drug or biological HCPCS code has an expected maximum number of units that are medically likely per day. The maximum is based on expert clinical analysis of industry guidelines, pharmaceutical standards, and drug literature. When the units billed on a claim line exceed the medically likely units threshold per day, the claim line will be denied.

FREQUENCY OF SERVICE CLINICAL EDITING FOR DRUGS AND BIOLOGICALS ON PROFESSIONAL AND OUTPATIENT FACILITY CLAIMS
Per Company policy, drug or biological HCPCS codes submitted should not exceed the expected frequency within a time period. The expected frequency is based on expert clinical analysis of industry guidelines, pharmaceutical standards, and drug literature. When a drug or biological HCPCS code is billed earlier than expected, the claim line will be denied.

UNCONVENTIONAL USE OF DRUG FOR PROFESSIONAL AND OUTPATIENT FACILITY CLAIMS

The Company policy is based on expert clinical analysis of industry guidelines, regulatory publications, pharmaceutical standards, and drug literature.

This edit considers diagnosis codes submitted by the same provider, on the same date of service as a drug code. If the provider bills a drug code without a diagnosis code indicating conventional use, the drug code will be rejected.

ADMINISTRATION PROCEDURE CODE CLINICAL EDITING

- **Administration Codes will be denied:**
  - **when a drug administration code is inconsistent with the drug(s) billed.**
    - Per the Centers for Medicare and Medicaid Services (CMS), Current Procedural Terminology (CPT), and Company policy, drug administration procedure codes should be consistent with the drugs billed and reported with the drug that was administered.
  - **when the administration procedure is billed without a drug.**
    - Per Current Procedural Terminology (CPT) guidelines and Company policy, CPT drug administration codes should be reported with the drug that was administered.
    - This edit addresses drug administration codes submitted on professional and outpatient facility claims. If the provider did not bill a drug code or pharmacy Revenue Code on the same Date of Service, the drug administration code will be denied.
  - **when the drug, biological or other products/implants are non-covered.**
    - Refer to Associated Services and Related Claims - Reimbursement Policy 9.0
      - For the purposes of this policy, terms or phrases such as “denied,” “non-covered services,” “non-covered procedures,” or “non-covered items” refers to any service, procedure, or item denied with any of the following denial reasons: Not medically necessary, not a covered benefit or a member benefit exclusion, a benefit limit (maximum) has been reached, investigational, cosmetic, or provider or supplier contract exclusion. However, denial reasons may not be limited to this list alone and other scenarios at the discretion of the Company when upon review of medical records, it is determined that charges are associated with non-covered services.
    - Refer to CMS IOM Publication 100-02, Medicare Benefit Policy Manual -60.1 Incident-to Physician’s Professional Services Chapter 15, Sections 50 Drugs and Biologicals

INJECTABLE DRUGS ADMINISTERED IN PHYSICIAN’S OFFICE

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

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 II below for reporting the invoice cost*

BILLING AND CODING GUIDELINES

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

How to submit the NDC on a medical drug claim:

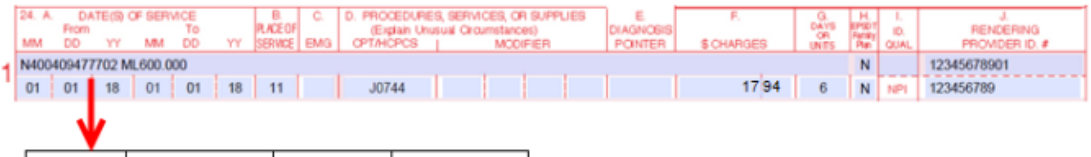
1. Submitting NDCs in electronic or paper claims
   a. Electronic Claims - Professional and institutional (ANSI 837P and ANSI 837I)

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.

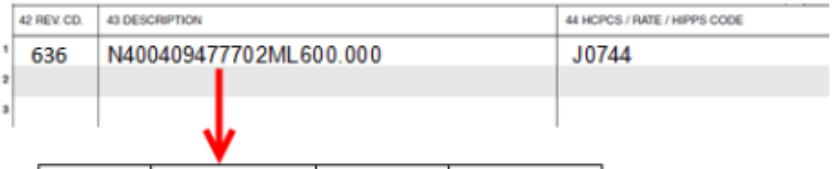
   b. Paper Claims

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

II. 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.
        i. 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.
        i. Covered compounded single or combination drugs should be billed on a single detail line.
        ii. Do not list the drug separately from the dosage, such as "morphine bupivacaine baclofen sufentanil 20mg 6mg 4mcg 5mcg". This format will be denied.

iii. List each drug with the applicable dosing amount, for example "morphine 20mg, bupivacaine 6 mg, baclofen 4 mcg, sufentanil 5 mcg."
iv. 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
i. 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.

III. 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:
      i. HCPCS code for drug given
      ii. No modifier
      iii. Number of units given to the patient
      iv. Calculated submitted price for ONLY the amount of drug given
   b. Claim line #2:
      i. HCPCS code for drug wasted
      ii. JW modifier to indicate waste
      iii. Number of units wasted
      iv. Calculated submitted price for ONLY the amount of drug wasted

   Notes:
   a. 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.
   b. Billing for wastage and/or using the JW modifier for drugs supplied in a multi-dose vial is prohibited.
   c. 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

Coding Policies

- Administration of Immunizations and Injections, CP34.0

Reimbursement Policies

- Incident To Services, RP5.0
- Associated Services and Related Claims, RP9.0

Pharmacy Operations Policies

- Specialty Drug Definition and Benefit Administration, ORPTCOPS061
- Specialty Drugs Shipped from Pharmacies to Providers and Facilities, ORPTCOPS145
- New Drug and or Indication Awaiting P&T Review – Prior Authorization Request; ORPTCOPS047

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

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13. Noridian Jurisdiction F – Medicare Part B – Optometry and Ophthalmology https://med.noridianmedicare.com/web/jfb/specialties/optometry-ophthalmology Accessed April 20, 2026

POLICY REVISION HISTORY

Date	Revision Summary
03/2025	Added language to clarify that if a drug is not payable, a billed admin code corresponding to the non-approved drug will not be reimbursed
04/2024	Policy updated to new format for Pharmacy Reimbursement Policy
05/2025	Policy updated to new Reimbursement Policy template, edited JW modifier section to include additional CMS website links
6/2025	• Template update, policy name change • Policy oversight moved from Oregon Regional Pharmacy and Therapeutics Committee (ORPTC) to PHP Coding Reimbursement Policy Committee (CRPC). • Added Drugs and Biologicals - Payment Integrity and clinical editing for Max Dose, Dose Frequency, Unconventional Use of Drug and Administration Procedure Coding/Editing and updated the JW/JZ language to align.
4/2026	• Annual review. No content changes. Update to references web links as needed.