

BOX 42
(837I electronic claim: Loop 2400, Segment type SV2)

List the appropriate revenue code for BAVENCIO.

Revenue code 0636 is required by Medicare. For payers other than Medicare, the revenue code may vary; although some private payers and Medicaid plans accept revenue code 0636, others may require a different revenue code, such as 0250.

Enter an appropriate revenue code for the administration service based on the cost center in which the service is performed.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE
0636		J9023 96413

BOX 43

Enter the corresponding description for the revenue code listed in Box 42.

BOX 44 (837I electronic claim: Loop 2400, Segment type SV2, Service line SV201)

Enter the appropriate HCPCS code for BAVENCIO:

J9023 - Injection, avelumab, 10 mg (effective for dates of service on or after January 1, 2018)^a

If applicable, discarded product should be reported on a separate line with the HCPCS code and JW modifier.^b

If applicable, the TB modifier should be reported by 340B providers submitting claims to Medicare OPPTS for BAVENCIO since BAVENCIO is currently a transitional pass-through drug under Medicare OPPTS.

Enter the appropriate CPT code for the administration service. For example, a 60-minute chemotherapy IV infusion would be reported with CPT code 96413 - *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug.*

BOX 45
(837I electronic claim: Loop 2400, Segment type DTP)

Enter date of service.

BOX 46 (837I electronic claim: Loop 2400, Segment type SV2, Service line SV205)

Enter the number of service units for each line item. For J9023, each unit corresponds to 10 mg of BAVENCIO. One 200 mg single-dose vial would be reported with 20 units. Four 200 mg single-dose vials (800 mg = recommended dosage) would be reported with 80 units.

If applicable for the patient encounter, and required by the payer, enter the number of units discarded, corresponding with the line item with the JW modifier.

BOX 47 (837I electronic claim: Loop 2300, Segment type CLM, Claim Information CLM02)

Enter the total charge for each line item.

BOX 67 (837I electronic claim: Loop 2300, Segment type HI, Diagnosis Information H101-2)

Enter the primary diagnosis code. For example, renal cell carcinoma is most commonly described by ICD-10-CM series C64, and C65. Urothelial carcinoma is most commonly described by ICD-10-CM series C67, C66, C65, and C68.0. Merkel cell carcinoma is described by ICD-10-CM series C4A. Use fields A-Q to report any applicable secondary diagnosis(es).

Example ICD-10-CM code shown; report the ICD-10-CM code(s) that reflect the patient's actual condition. The reported ICD-10-CM code(s) should reflect the highest level of specificity.

BOX 80 (837I electronic claim: Loop 2300, Segment type NTE)

Select payers may require specific information in this remarks field, such as NDC code or other information as required by the payer.

63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX C64.X		68			
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73	
74 PRINCIPAL PROCEDURE CODE	a. OTHER PROCEDURE CODE	b. OTHER PROCEDURE CODE	75	76 ATTENDING	NPI
c. OTHER PROCEDURE CODE	d. OTHER PROCEDURE CODE	e. OTHER PROCEDURE CODE		QUAL	FIRST
80 REMARKS		81 CC			
		a			
		b			
		c			
		d			

^aCenters for Medicare and Medicaid Services (CMS), 2018 Alpha-Numeric Healthcare Common Procedure Coding System File, November 2017.

^bBeginning January 1, 2017, Medicare claims require the use of the JW modifier (drug amount discarded/not administered to any patient) when applicable. (Source: Centers for Medicare and Medicaid Services. Transmittal R3538CP: JW Modifier—Drug amount discarded/not administered to any patient.) Other payers may have similar requirements.

It is always the provider's responsibility to determine the appropriate healthcare setting and to submit true and correct claims for products and services rendered. EMD Serono, Inc. and Pfizer Inc do not guarantee coverage and/or reimbursement for BAVENCIO. Coverage, coding, and reimbursement policies vary significantly by payer, patient, and setting of care. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. Patients and healthcare professionals should always verify coverage, coding, and reimbursement guidelines on a payer- and patient-specific basis.