

Practical Strategies for the Use of Miscellaneous J Codes in Urology Practice



Developed in collaboration with the AUA and Johnson & Johnson



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INTRODUCTION TO MISCELLANEOUS J CODES

Medical providers use the Healthcare Common Procedure Coding System (HCPCS) as the means of communication to indicate services and procedures performed. The codes are included in healthcare insurance claims to request payment from third-party payers, including Medicare and Medicaid. HCPCS Level I codes are the Current Procedural Terminology (CPT®) codes developed and maintained by the American Medical Association used to bill payers for the actual medical, surgical, and diagnostic procedures performed by a physician or other healthcare provider.¹ Level II HCPCS codes describe what was used to provide the services performed by the healthcare provider.¹

HCPCS Level II codes are alphanumeric codes used to file claims for medical devices, medical supplies, durable medical equipment, medications, and other items and services that are not included in the CPT codes.¹ Within HCPCS Level II codes, each category of items or services is assigned a letter. For example, codes for medications begin with the letter “J,” and each medication has its own code.² HCPCS Level II codes are used in conjunction with HCPCS Level I codes (the CPT codes that describe the procedure that was performed) and ICD-10-CM codes, which indicate the patient’s diagnosis.

HCPCS Level II codes that begin with the letter J are used to designate and bill for drugs that are not administered by mouth, such as many chemotherapy drugs. The J code (indicating the drug used in a procedure, for example) plus the CPT code (which describes the procedure used to administer the drug), and any necessary modifiers and additional required information, is submitted to the payer as a claim for

payment or reimbursement.

The Centers for Medicare and Medicaid Services (CMS) maintains HCPCS Level II codes and collaborates with other stakeholders to handle requests for new Level II codes or changes to existing Level II codes.³ There are also miscellaneous J codes (not otherwise classified; sometimes called unlisted codes) that are used when an item or service has not yet been assigned a specific J code.⁴ These miscellaneous J codes allow for billing products that are newly approved by the FDA. This allows healthcare providers to make new drugs and devices available to patients, rather than waiting for new J codes to be added by CMS, which can take several months.⁴ Miscellaneous J codes that may be used before a specific code is assigned include:

- J3490—unclassified drugs
- J3590—unclassified biologics
- J9999—not otherwise classified, antineoplastic drugs

Payers typically require additional documentation when providers use miscellaneous J codes. Claims that include miscellaneous J codes (such as J9999, J3490, and/or J3590) must include additional information that demonstrates that FDA labeling indications have been met.⁵ See <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=54880> for more information about documentation requirements for these codes.

MEDICARE ADMINISTRATIVE CONTRACTORS

Importantly, third-party payers have different policies and guidelines for how to manage miscellaneous J codes. Claims for payment under Medicare are managed differently depending on which Medicare Administrative Contractor (MAC) is responsible for handling claims in the specific region. A MAC is a private organization contracted by CMS to administer Medicare benefits and payments within specific geographic jurisdictions.⁶ MACs perform administrative services, including processing and making payment for Medicare claims services.⁶ (Medicare Advantage is also administered by private companies, but these are separate from MACs.)

There are seven (7) MACs for processing Part A and Part B claims, operating across twelve (12) distinct regions of the country.⁶ While each MAC has the ability to develop Local Coverage Determinations (LCDs), coverage is typically determined by what is considered

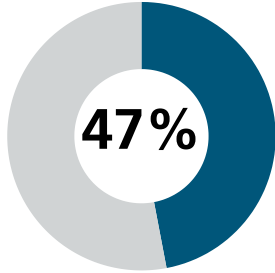
“reasonable and necessary” for the diagnosis and treatment of illness or injury. However, while coverage is consistently based on what is “reasonable and necessary,” differences in MAC processes may contribute to variability in documentation requirements, review and reimbursement timelines, and, at times, payment determinations based on either invoice or WAC (Wholesale Acquisition Cost) based pricing methodologies.⁷ Providers are encouraged to contact their MAC or other applicable third-party payers for guidance on the appropriate use of miscellaneous or unlisted HCPCS codes.

For a listing of all MACs, visit <https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs>

This report shares results of research conducted by AUA to assess current practice patterns for the use of miscellaneous J codes for new medications in a variety of urologic practice settings. AUA convened an expert panel of urologic coding experts, comprised of a community-based urologist, an academic urologist, two practice administrators, and a professional coder, to provide oversight and subject matter expertise (see page 15). Based on the guidance from this expert panel, AUA conducted two virtual focus groups, fielded a member survey, and interviewed three practice sites.

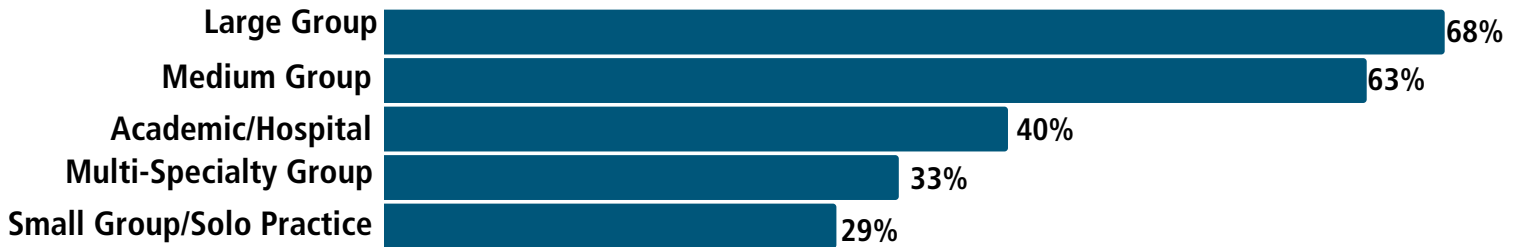
Findings from an email survey of 138 urology professionals to assess current practice patterns around the use of miscellaneous J-codes in a variety of urologic practice settings.

Usage of Miscellaneous J-Codes by Urologic Practice Setting

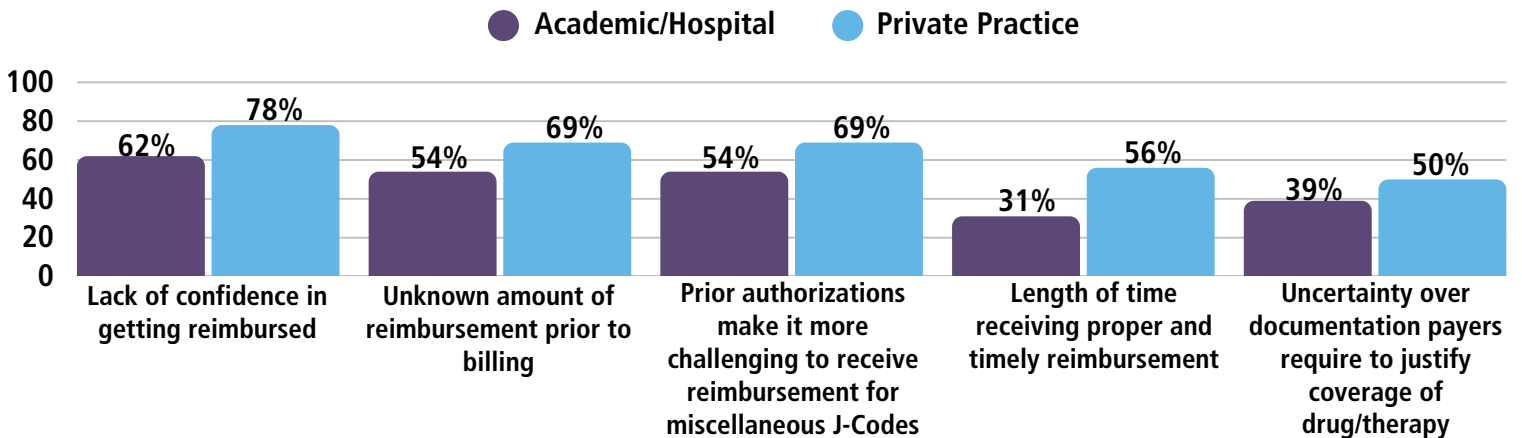


Less than half of the survey respondents (47%) indicated that they currently bill for miscellaneous J-Codes, which limits patient access to new therapies.

Usage of Miscellaneous J-Codes by Practice Type



Top 5 Challenges Using Miscellaneous J-Codes in Practice (Those Currently Using)



Top Benefits of Using Miscellaneous J-Codes

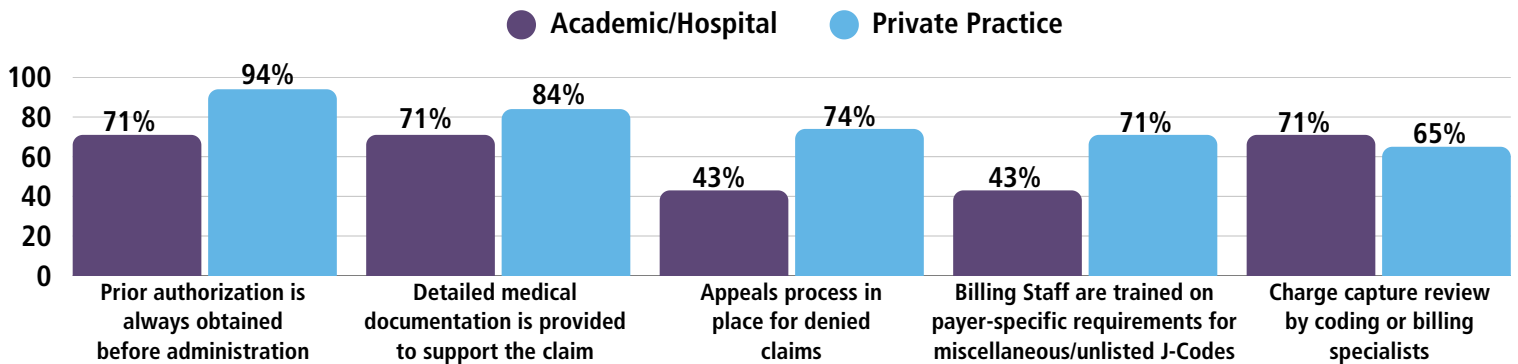
Benefit	Academic/Hospital (%)	Private Practice (%)
Increased pool of available drugs/therapies to patients	54%	59%
Improved patient outcomes	69%	50%
Improved patient satisfaction	54%	53%
Quicker access to drugs/therapies for patients	23%	53%
Increased Patient Retention – no need to refer out	15%	38%

(SURVEY RESULTS CONTINUED ON NEXT PAGE)

Private practice users of miscellaneous J-Codes are significantly more aware than academic/hospital users of the required approval process to use new therapies and, once approved, the process for successfully billing miscellaneous J-Codes.

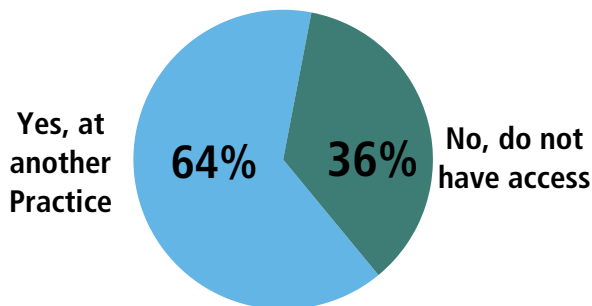
However, regardless of awareness, private practice (78%) and academic/hospital (73%) users both agree that the billing/reimbursement processes for using miscellaneous J-Codes at their practice/institution are successful.

Top 5 Processes In Place to Ensure Miscellaneous J-Codes Billed Successfully

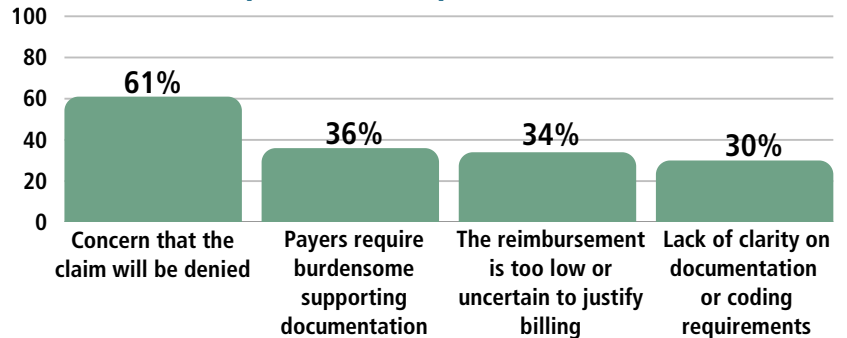


Assess Reasons for NOT Billing Miscellaneous J-Codes and Available Options

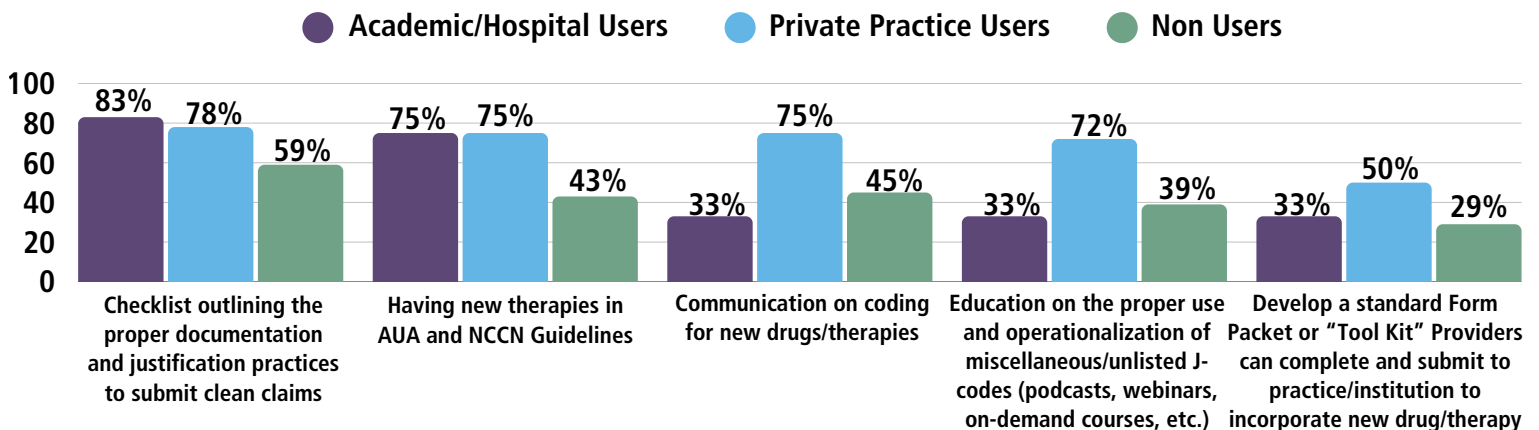
Do Patients Have Access to Therapies with Miscellaneous J-Codes through Referral?



Main Reasons Practice Chooses NOT to Work with Therapies that Require Misc. J-Codes:



Top Education/Tools to Help Practices Offer Therapies that Require Miscellaneous J-Codes



This survey was conducted by the American Urological Association (AUA), in collaboration with Johnson and Johnson, online via Survey Monkey from 6/16/25 through 7/18/25. The survey was distributed to AUA membership of 1,051 with valid emails. Results are based on responses from 138 AUA members (58 Urologists, 36 coders, 27 practice managers, 20 billers, 7 C-suite, 5 APPs, 12 Other - multiple responses accepted). Copyright © 2025, American Urological Association Education and Research, Inc. All Rights Reserved.

AUA Member/Practice Managers' Network Subscriber Focus Groups

One focus group included participants from academic practice settings, and one included participants from community/private practices. Focus groups were intentionally composed of participants from varied professional backgrounds—urologists, advanced practice providers, practice administrators, coders and billers—to capture a range of expertise, perspectives, and experience. Notably, none of the academic participants were familiar with miscellaneous J codes, nor were they aware of their practice using miscellaneous J codes. Participants from academic settings reported that typically a Pharmacy & Therapeutics Committee and/or a Value Analysis Committee determines whether to offer a newly approved therapy within the practice setting. They noted that physicians may choose to champion a new medication that they want to use in the practice; however, the decision-making process is lengthy. Thus, a J code is often assigned to the product before it is approved for use in the institution and there is no need to use miscellaneous J codes.

Community-based providers observed that the financial viability of a practice is undermined when insurers deny reimbursement for the administration of a medication that costs the practice tens of thousands of dollars.

A DEEPER DIVE: CONVERSATIONS WITH PRACTITIONERS

AUA conducted interviews with three community-based practice sites to gain a deeper understanding of the strategies and processes in place for the use of miscellaneous J code billing for new therapies for urologic oncology.

Key Findings

- Due to the high cost of certain newer therapies, often exceeding \$50,000 per dose, practices face considerable financial risk when administering these treatments without guaranteed reimbursement. As a result, they must carefully weigh patient access against the need for fiscal sustainability.
- Billing under miscellaneous J codes is more complex and resource-intensive than billing with established J codes. It requires extensive documentation and often involves navigating coverage denials and appeals.
- Physicians who believe a patient would benefit from the use of a new medication initiate requests to utilize the medication; practices have formal processes and procedures to assess the appropriateness and feasibility of implementing the medication in the practice before physicians may prescribe it.
- Obtaining coverage from Medicare is pivotal to broader coverage but does not guarantee that other payers will provide reimbursement, and there is variability among specific plans and employer groups.
- If Medicare reimburses a practice for a product with a miscellaneous J code, private insurers in the area tend to follow suit. However, Medicare Advantage and Medicaid may have additional restrictions on miscellaneous J code use.
- Practices have varying success in ultimately obtaining reimbursement for products before a permanent J code is assigned.
- To provide patients with access to breakthrough medications, practices that are unable to offer products with miscellaneous J codes may refer patients to providers in other settings that have different billing opportunities.

The concern about the potential for denials is a critical barrier that impedes the use of medications before a permanent J code is assigned. Thus, the timeline for the assignment of J codes can slow patient access to newly approved therapies.

The academic participants reported that they may refer patients to other providers who use miscellaneous J codes if needed to provide patients with access to therapies. Community-based providers were more likely to continue to manage patients in-house but also refer as needed. In some cases, practices may continue to manage the patient but collaborate with a specialty pharmacy (which has fewer barriers to reimbursement) for drug administration.

Participants who do use miscellaneous J codes noted that there is significant administrative work that must be completed before providers can prescribe medications that must use these codes. Practices have specific protocols, processes, and procedures in place to follow for facilitating the billing process and reducing the likelihood of having claims denied, including obtaining prior authorizations and verifying the documentation that must be submitted with the claim, and ensuring effective coordination with prescribers so that all necessary information is submitted with the claim.

CASE STUDY 1: ASSOCIATED MEDICAL PROFESSIONALS OF NY (AMP OF NY)

AMP of NY Interviewees

David M. Albala, MD

*Chief of Urology, Crouse Hospital
Treasurer, AMP Physician Clinical Council*

Carol Grey

Billing Supervisor

Lisa Stevenson, CPC

Certified Professional Coder

Decision-Making for New Drugs

AMP of NY is a large, multispecialty group practice in central New York with more than 30 providers. The practice has a formal process in place to guide the use of new medications when they are approved for use. When a new high-cost product is approved that is relevant to the treatment of patients in the practice, one of the champion physicians brings it to the practice's governing board for discussion from both a clinical and financial standpoint. "On a clinical level, the board reviews available literature regarding the risks and benefits of the product for patients," explains Dr. Albala. Following the clinical review, the board explores the cost to obtain the medication and the expected reimbursement for the product to determine whether it is feasible to offer it within the practice.

Medicare is the largest payer for the practice and most other payers follow Medicare for determining coverage and reimbursement. "Usually once we get Medicare to pay, the other payers will follow suit," notes Ms. Grey. Therefore, the practice starts investigating coverage by researching the Medicare allowed amount and the amount that the practice can expect to be reimbursed and determining whether that will cover the acquisition cost. "It just doesn't make sense economically to prescribe a drug if the practice will lose thousands of dollars each time," explains Ms. Grey.

Initiating Medication Use and Seeking Reimbursement

If the board approves the use of the medication, physicians can begin to prescribe the product on a limited trial basis with careful financial tracking before it is broadly adopted by the practice. The medication is initially tested with patients who have

Medicare or other major private payers that typically follow Medicare. The billing staff will communicate with the providers so that they know what diagnosis codes must be associated with a particular product to ensure that the medication is only administered to appropriate patients. Medicaid does not typically cover miscellaneous J codes and will only reimburse for a product once the HCPCS code is assigned. There is a statewide process for determining whether a product will be covered by Medicaid; once it is approved through this process, then the plans administering the program will begin to cover it. The Medicaid system is updated on a quarterly basis, and approved codes can be viewed on their website.

Payers typically require additional documentation when a miscellaneous J code is used to bill for a product, including the patient's diagnosis, the indication for the medication, and FDA-approved labeling for the product. Insurers are strict in ensuring that the patients who receive the treatments have conditions that align with the approved indications for the product, and it is critical that providers include that information in the documentation.

"We have to put what that code is and what it means in the narrative line, and we'll build the claim. And sometimes they reject it. Then we have to again contact them with all the medical documentation to support why it is an unlisted code. And then usually we can get it paid," notes Ms. Stevenson. "Sometimes we have to fight for it but ultimately we have success in getting paid." Other information that is required includes the NDC number, the units, and how the product is measured (e.g., milliliters, milligrams).

Even after going through a pre-approval process, the claim may be initially denied and need to be appealed. "Compliance will work with the medical director to share supporting evidence and demonstrate the appropriateness of the code," explains Dr. Albala. The practice's medical director often plays an active role communicating with the insurer's medical director to address denials. "Usually, our compliance director writes a letter explaining everything about the procedure and sharing supporting documentation that they found. Then we use that for our support to try to get the claims paid," explains Ms. Grey.

Some (but not all) of the insurance carriers have

helpful provider representatives that also are able to offer assistance with obtaining reimbursement. “They want to know how we are using the drug, the documentation for the patient, and any published literature that shows that it might help the patient,” notes Ms. Grey.

The timeline for the initial approval for the code can be lengthy, often taking 6 to 8 weeks before reimbursement is received. However, once Medicare begins to reimburse for a product, the practice feels comfortable offering the product to more patients. “The last one we did, that was very expensive—I think it was \$99,000. So, we started off with a few patients with Medicare and then after we found out it would be reimbursed, then we proceeded and said, okay, you can attempt it for patients with other carriers,” notes Dr. Albala. “You have to make sure they’re going to pay for it before you start billing it for a lot of patients,” agrees Ms. Grey.

It is important to closely track payments and make sure that the medication is reimbursed correctly, and the practice receives the correct amount. For example, the insurance may cover many charges with a single payment, which then automatically posts within the practice’s system. It is critical that the billing team reviews the payments on the back end to ensure that everything is reimbursed correctly.

If physicians believe that a product will be helpful for a patient, but reimbursement appears unlikely, they will refer the patient to another practice that has a different reimbursement structure and is more likely to receive payment. For example, some patients are able to obtain medications without permanent J codes from specialty pharmacies and then bring the product to the practice for infusions. In other cases, another provider may be able to offer a home infusion visit. Clinical trials that may be underway with the product are another option that the practice considers as an opportunity to facilitate access to the medication.

Operational & IT Considerations

When a new product is approved for use within the practice, it must be incorporated into the information technology (IT) system. The practice collaborates with the IT vendor to ensure that all information is properly integrated, including NDC numbers, billing codes, and other requirements.

Other sources of support for obtaining reimbursement for the use of miscellaneous J codes are nationally recognized professional medical coding organizations which can provide billing guidance, code pairing, and forums for peer troubleshooting. Additionally, manufacturers are increasingly recognizing that private practices cannot offer patients high-cost products without reimbursement and are increasingly helpful in providing clinical data, financial and billing support information, and reimbursement hotlines.

CASE STUDY 2: NEBRASKA UROLOGY

Nebraska Urology Interviewees

Erin Conway

Revenue Cycle Manager

Megan Robinson, RN

Clinical Director

Jenna Stratman, MBA, CMPE

Administrator

Decision-Making for New Drugs

Nebraska Urology is a large independent urologic practice with 19 providers. They have made a strategic decision to avoid using miscellaneous J codes, given the financial risk and their past experience with denials. Instead, they wait until a permanent J code is assigned by CMS before initiating the use of a newly approved therapy.

The practice has attempted to obtain reimbursement for medications with miscellaneous J codes on multiple occasions but has been unsuccessful. “I don’t think we have ever successfully gotten reimbursed for using a miscellaneous J code,” remarked Ms. Robinson. Due to repeated denials and the associated lost revenue, even after receiving prior authorization to use the medication, the practice made the decision to abandon the attempts. The practice only considers a product reimbursable after a J code is assigned to it. (Patient assistance programs or grants may be available, but they typically only cover the patient copay portion of the medication and therefore are not a viable solution.)

When a physician in the practice would like to use a newly approved medication (typically with a specific patient in mind), the practice’s medical committee will determine whether it is feasible and appropriate to utilize the medication in the practice. The committee, comprised of four physicians, assesses several factors including clinical merit, financial impact (cost and anticipated payer coverage), and logistical issues such as training requirements and accessibility of the medication (e.g., whether there is a shortage or waitlist). The final decision rests on both clinical benefits and financial feasibility.

If a physician wants to use a new medication, the team will monitor information from CMS so that procedures for using the drug can be implemented once a J code is assigned. Manufacturers also often provide information

to inform the practice when a J code is assigned.

If there is a new breakthrough medication that the practice is unable to offer but is appropriate for a patient, the practice will refer the patient to another location that does offer it, when possible. Manufacturer representatives can typically provide assistance with identifying other practices that are offering the treatment (often a university health system or another oncology practice with access to grants to assist with new treatments). Providers work collaboratively with the location receiving the patient to ensure continuity of care. Occasionally, patients are also enrolled into clinical trials as another strategy to facilitate access.

Initiating Medication Use and Seeking Reimbursement

When a new J code is assigned, the practice uses a structured, team-based process for implementation. New protocols and workflows are designed and implemented to ensure that all aspects of the medication’s management are addressed in the practice, including those that affect purchasing, policy development, clarification regarding documentation requirements, IT, billing/coding, nursing, and administration procedures. Policies and procedures are then carefully tested to ensure they function correctly before the medication is prescribed to an actual patient.

Medicare is typically the first payer to cover medications once a J code is assigned, and then commercial payers will begin to offer coverage as well. However, even once a J code has been assigned, there are challenges obtaining reimbursement. Each MAC establishes its own policies regarding coverage for the code, which may be burdensome. “I feel like our specific MAC is the last one to provide coverage every time,” remarks Ms. Stratman.

Even when a medication is covered by a payer, it can be challenging to have it reimbursed for a specific patient. For example, payers may request extensive documentation to describe why the medication is medically necessary. In some cases, payers may ask for justification regarding why the medication was selected over other products. “Even when national guidelines from AUA and/or National Comprehensive Cancer Network® (NCCN®) list a treatment as a first-line therapy, payers may have policies that require the use

of other products first," observes Ms. Robinson.

Each patient's benefits are carefully investigated, and there is a thorough review to ensure that the patient meets the requirements for medical necessity before the drug is administered. Then, the medication is initially only offered to one or two qualifying patients to ensure that it is actually reimbursed before it is offered more widely. The practice also monitors information from professional associations and listservs regarding how best to implement new medications in practice and obtain reimbursement.

It can also be challenging to communicate with payers to get details regarding payment requirements. Some payers do not have a phone number for providers to call and/or only have an online portal for access, so it can be very difficult to communicate. Historically, some payers had provider representatives that the practice could communicate with, but many of those positions no longer exist and direct communication with payers is difficult, especially since COVID. "It's challenging just to even start that conversation with a payer. I don't have a strong point of contact for any of our big

payers; I get directed to a generic provider email and sometimes it can be months before I hear back from that," explains Ms. Conway.

Manufacturers have offered support to assist with billing processes. However, their information often is not payer-specific or effective in helping providers obtain reimbursement. In some cases, "manufacturers share information about processes that have worked in other areas of the country, but then we have been unable to obtain reimbursement using the same process or the process might only work with a very specific plan or employer group that is covered through a payer," explains Ms. Stratman.

CASE STUDY 3: UROLOGY OF VIRGINIA

Urology of Virginia Interviewees

Lisa Metten

Chief Administrative Officer (CAO)

Lesley Pleasants, CPC

Billing and Coding Director

Tamail Keeley

Benefits/Prior Auth Specialist

Decision-Making for New Drugs

Urology of Virginia is a large independent practice with more than 60 providers and has 4 locations throughout Virginia. The practice has found that payers are inconsistent regarding how they respond when a claim is submitted with a miscellaneous J code. Therefore, the practice is cautious about offering products that require miscellaneous J codes due to financial and administrative risk and carefully balances patient access with financial sustainability. “If you were paying \$50,000 for a specific drug and your margins are very small and you have to pay for it in 30 to 60 days, you need an answer [about reimbursement],” explains Ms. Metten. Thus, delays in reimbursement are challenging for high-cost drugs even if they are ultimately reimbursed.

When determining whether to use a product with a miscellaneous J code, the practice follows an established policy that applies to all clinical, billing, coding, and administrative staff involved in ordering, administering, documenting, and billing the product. A financial review and reimbursement analysis is conducted before any new drug is administered under a miscellaneous J code. In addition to conducting a pharmacy and therapeutics review of clinical appropriateness, the analysis assesses the cost to obtain the medication, payer-specific reviews of requirements for the medications, and assessment of the budget impact. The practice administrator must approve the anticipated financial viability of the product before it can be utilized in practice.

Allowable Amount Considerations

The practice pays careful attention to insurers’ allowable amounts for medications. Payers do not always provide information about the allowable charge for a medication. Therefore, even if it is covered, the amount that the insurance company pays might not cover the acquisition cost, and thus the practice might

lose thousands of dollars every time the medication is administered. Payers typically do not determine an allowable amount for a medication until after a permanent J code is assigned. Further, most determine their allowable amount as a percentage of the Medicare allowable amount. Therefore, Medicare must assign an allowable amount first. (Although patient assistance programs exist, they only cover the patient copay or coinsurance amount; they will not cover gaps between the practice’s cost and the payer’s allowable cost, and that gap is a loss for the practice.)

If the allowable amount is less than the amount that the practice must pay to obtain the medication, the patient will be referred elsewhere. For example, hospitals have access to deeper discounts on medications and different reimbursement structures. Therefore, it may be more financially feasible for them to offer the medication. “We try to find the best approach for each patient, and sometimes that means we can meet all of their needs in the office, and sometimes a referral is necessary,” notes Ms. Metten.

Unfortunately, it is more expensive to be treated in the hospital, and patients often have to pay higher copay or coinsurance amounts. Further, it can hinder continuity of care if the patient shifts to a different treatment center. The practice is currently working to collaborate with payers to better align payment structures and incentives so that patients can be treated at the least expensive location that is appropriate for their clinical condition.

Initiating Medication Use and Seeking Reimbursement

Once use of a new medication is authorized, there are several steps that must be taken before it is prescribed. These include integrating medication-specific information within the IT system (for example, to capture necessary documentation, allowable diagnosis codes) and staff training.

Many payers have product-specific guides that include details about how to submit claims for the use of the product. The billing department follows the information obtained through these guides, but even this process does not guarantee that payment will be received. If the payer indicates they will provide reimbursement, the practice will test the process to ensure it works.

The practice’s authorization team is responsible for

obtaining prior authorization before a medication can be administered. However, the practice has experienced high rates of denials with miscellaneous J codes, even after prior authorization has been received. Sometimes the claim is paid after an appeal, but the appeal process is time-consuming and requires extensive documentation. In other cases, the labeling of the product might call for the administration of doses, but the payer might only reimburse for some of those doses. (These challenges can persist even after a permanent J code is assigned.)

“Typically, if a claim is denied, the medical director from the insurance company will be involved with a peer-to-peer review with the provider,” explains Ms. Metten. However, payer representatives have been more difficult to contact following COVID, and payers often require the use of online portals that are more challenging for communication. In other cases, someone from the billing team might spend hours on the phone with a payer trying to resolve a single claim. “Even when you do talk to someone, sometimes the only answer you get is that they need to research it, and then additional follow-up is required,” observes Ms. Metten. Peer networks allow for informal exchanges of billing and coding strategies so that the provider can determine whether others are encountering the same challenges or have identified effective strategies. These peer networks include

listservs and chat boards provided through professional organizations and social media platforms.

When reimbursement is approved, the practice’s careful monitoring of payments to ensure that the right amount is provided is also important. “It is important to do due diligence to ensure that you are being paid the right amount for the medication, because sometimes there are mistakes,” explains Ms. Metten. Because some contracts are based on a percentage of Medicare, the practice must track this quarterly to ensure that the financial risk is identified in advance.

Once the practice receives reimbursement for the product, and ensures that payments were processed correctly, they will begin to offer it to more patients with that payer (Medicare is usually first to provide reimbursement) as well as explore offering it to patients who are covered by other payers. Importantly, even within a payer group, there can be multiple different plans that manage things differently. For example, different Medicare Advantage programs may have different processes for managing miscellaneous J codes. Likewise, different employer groups associated with a single commercial insurer may have different approaches.

SUMMARY

Some urology practices have successfully used miscellaneous J codes to bill for newly FDA-approved medications before permanent codes are assigned, expanding access to breakthrough therapies. However, not all practices have been successful. Further, the use of these codes is complicated by administrative burdens, including extensive documentation, prior authorizations, and frequent appeals, as well as financial risk, and variability among payers in terms of policies, procedures, and coverage.

Successful use of miscellaneous J codes requires strong administrative engagement and oversight, as well as

ongoing communication with payers. Communication with peers can help practices navigate the medical coding/billing environment and develop strategies and processes to support patient access to novel therapies.

Practices who are unable to offer a product that requires the use of a miscellaneous J code may be able to refer patients to other providers who do have the ability to offer access to that product. Maintaining relationships with other providers and awareness of their service offerings can support patient access to these therapies.

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EXPERT PANEL MEMBERS

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Kansas City Urology Care

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Developed in collaboration with the AUA and Johnson & Johnson



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