Priority Health	BILLING POLICY No. 157
Bisphosphonate Drug Therapy	
Date of origin: October 2025	**Review dates:**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Bisphosphonate drug therapy involves the use of bisphosphonate medications to suppress the activity of osteoclasts—cells responsible for bone resorption. By inhibiting these cells, the therapy helps reduce bone loss and enhance bone strength. It is widely used in the management of conditions such as osteoporosis, osteopenia, Paget's disease of bone, and hypercalcemia of malignancy, which results from excessive bone breakdown. Bisphosphonates are absorbed into bone tissue, where they exert a prolonged effect by slowing bone turnover, thereby increasing bone mineral density and lowering the risk of fractures.

MEDICAL POLICY

Please see the Medical Benefit Drug List for information on drug coverage

POLICY SPECIFIC INFORMATION

Documentation requirements

If treating bone metastasis documentation of a primary malignant neoplasm must be included in the patient's medical record and readily accessible upon request.

The medical record must contain diagnostic details and laboratory results that clearly support the medical necessity of the service provided. For each listed indication, specific signs and symptoms must be recorded to justify the use of the drug, whether for FDA-approved or off-label purposes. Additionally, the record should reflect that the patient has been advised to maintain adequate calcium and vitamin D supplementation. All documentation must be readily available upon request, and appropriate diagnosis codes supporting medical necessity should be included with the claim submission.

The medical record must provide clear justification for the intravenous administration of bisphosphonates in the treatment of osteoporosis.

Coding specifics

For intravenous administration by infusion, bill using procedure code **96365** for the initial hour and **96366** for each subsequent hour. If the drug is administered via IV push, use procedure code **96374**.

J3489 Zoledronic acid

To report low bone mass submit diagnosis code M81.0 — Age-related osteoporosis without current pathological fracture. For diagnosis codes listed in the table below that require a 7th character, use the appropriate qualifier:

- A for initial encounter for fracture
- D for subsequent encounter with routine healing
- G for subsequent encounter with delayed healing
- K for subsequent encounter with nonunion
- P for subsequent encounter with malunion
- S for sequela

When reporting any of the following codes: M85.80, M85.811, M85.812, M85.821, M85.822, M85.831, M85.832, M85.841, M85.842, M85.851, M85.852, M85.861, M85.862, M85.871, M85.872, M89.9, or M94.9, and the drug is being used to treat bone loss in women or men undergoing adjuvant therapy with selective estrogen receptor modulators or aromatase inhibitors for breast cancer, the following additional codes must also be reported:

- C50.011–C50.922 *or* Z85.3
- Z79.810 *or* Z79.811

When reporting any of the following diagnosis codes: M85.80, M85.811, M85.812, M85.821, M85.822, M85.831, M85.832, M85.841, M85.842, M85.851, M85.852, M85.861, M85.862, M85.871, M85.872, M89.9, or M94.9, and the drug is being used to treat bone loss in men undergoing androgen deprivation therapy for prostate cancer, the following additional codes must also be included:

- C61 *or* Z85.46
- Z79.899

When submitting claims for osteopenia, use the appropriate ICD-10 diagnosis codes, which may include: M85.80, M85.811, M85.812, M85.821, M85.822, M85.831, M85.832, M85.841, M85.842, M85.851, M85.852, M85.861, M85.862, M85.871, M85.872, M89.9, or M94.9.

J2430 Pamidronate disodium

When reporting any of the following diagnosis codes: M85.80, M85.811, M85.812, M85.821, M85.822, M85.831, M85.832, M85.841, M85.842, M85.851, M85.852, M85.861, M85.862, M85.871, M85.872, M89.9, or M94.9, and the drug is being used to treat bone loss in women or men undergoing adjuvant therapy with selective estrogen receptor modulators or aromatase inhibitors for breast cancer, the following additional codes must also be reported:

- C50.011–C50.922 *or* Z85.3
- Z79.810 *or* Z79.811

When reporting any of the following ICD-10 codes: M85.80, M85.811, M85.812, M85.821, M85.822, M85.831, M85.832, M85.841, M85.842, M85.851, M85.852, M85.861, M85.862, M85.871, M85.872, M89.9, or M94.9, and the drug is being used to treat bone loss in men undergoing androgen deprivation therapy for prostate cancer, the following additional diagnosis codes must also be submitted:

- C61 *or* Z85.46

- Z79.899

J1740 Ibandronate sodium

For diagnosis codes listed in the table below that require a 7th character, use one of the following as appropriate:

- A – Initial encounter for fracture
- D – Subsequent encounter with routine healing
- G – Subsequent encounter with delayed healing
- K – Subsequent encounter with nonunion
- P – Subsequent encounter with malunion
- S – Sequela

When billing for osteopenia, ICD-10 codes M85.80, M85.811, M85.812, M85.821, M85.822, M85.831, M85.832, M85.841, M85.842, M85.851, M85.852, M85.861, M85.862, M85.871, M85.872, M89.9, or M94.9 should be used**.**

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56907&ver=22
https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=34648&ver=29

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
12/16/2025	New Policy, effective 12/16/2025