State of New Mexico
Medical Assistance Program Manual

Supplement

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TO: ALL PRACTITIONERS AND HOSPITALS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: CAROLYN INGRAM, DIRECTOR

THROUGH: ROBERT STEVENS, BUREAU CHIEF, BENEFITS BUREAU

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SUBJECTS: I. EFFECTIVE SEPTEMBER 1, 2010, NEW REQUIREMENTS WHEN BILLING FOR DRUG ITEMS ADMINISTERED IN PRACTITIONERS' OFFICES, OUTPATIENT CLINICS AND HOSPITALS

II. EFFECTIVE SEPTEMBER 1, 2010, NEW REQUIREMENTS WHEN BILLING FOR DRUG ITEMS OBTAINED UNDER THE FEDERAL 340B DRUG PRICING PROGRAM

This supplement contains important information for providers who administer drug items such as injectables in office, clinic, or outpatient hospital settings. The information is intended to remind providers of federal requirements and to announce the implementation of these requirements for the New Mexico Medicaid Program.

I. NEW REQUIREMENTS WHEN BILLING FOR DRUG ITEMS ADMINISTERED IN PRACTITIONERS' OFFICES, OUTPATIENT CLINICS AND HOSPITALS

The federal Deficit Reduction Act of 2005 (signed in 2006) requires Medicaid providers to report the 11-digit National Drug Code (NDC) on the CMS1500 and UB04 claim forms as well as on the 837 electronic transactions when billing for injections and other drug items administered in outpatient offices, hospitals, and other clinical settings.

Providers were first notified of this upcoming requirement in November 2007, in the supplement information available on the Medical Assistance Division (MAD) website at:

http://www.hsd.state.nm.us/mad/pdf_files/Supplements/MAD_REG_S_07-09.pdf

MAD is now implementing the requirement that providers must include the appropriate NDC and other essential information on the claim when billing for drug items. If a provider has not already done so, it may be necessary to contact the software vendors to modify billing software.

The new billing requirement will be implemented in two phases.

The first phase, to be effective September 1, 2010, will require NDC codes for the "top twenty" practitioner administered drugs as determined by CMS to be included on the claim form. The second phase, to be effective January 1, 2011, will require the NDC code for all practitioner administered drugs to be included on the claim form. Specific information on each of the phases is provided below.

Understanding the National Drug Code (NDC)

The NDC code, which is found on the label of a prescription drug item, must be included on the CMS 1500 or UB04 claim form or in the 837 electronic transaction. The NDC is a universal number that identifies a drug. The complete NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2 format such as "12345-1234-12."

However, sometimes the NDC as printed on a drug item omits a leading zero in one of the segments, requiring a leading zero to be entered on the claim form and the hyphens to not be used. Instead of the digits and hyphens being in a 5-4-2 format, the NDC may be indicated in a 4-4-2 as in "1234-1234-1", or in a 5-3-2 format as in "12345-123-12", or less commonly in a 5-4-1 format as in 12345-1234-1."

A leading zero must be added to make the 5-4-2 format. See the following examples:

- NDC 12345-1234-12 is complete – it is reported as 12345123412
- NDC 1234-1234-12 needs a leading zero in the first segment to be in the 5-4-2 digit format, to become 01234-1234-12 – it is reported as 01234123412
- NDC 12345-234-12 needs a leading zero in the second segment to be in the 5-4-2 digit format, to become 12345-0234-12 – it is reported as 12345023412
- NDC 12345-1234-1 needs a leading zero in the third segment to be in the 5-4-2 digit format, to become 12345-1234-01 – it is reported as 12344512301

PHASE I

The first phase will be effective September 1, 2010 and will require NDC codes only for the 20 drug items listed below to be entered on claims. A claim with a date of service on or after that date and which does not indicate the NDC code for any one of the following drugs will be denied by ACS, the Medicaid Fiscal Agent.

For the UB04 claim form, a CPT or HCPC procedure code must be reported when using a pharmacy revenue codes 0250, 0251, 0252, 0254, 0631, 0632, 0633, 0634, 0635, or 0636. When the CPT or HCPC procedure code associated with these revenue codes is on the list below, the NDC code must also be on the claim.

J0570 Injection, penicillin G benzathine, up to 1,200,000 units
J0640 Injection, leucovorin calcium, per 50 mg.
J0696 Injection, ceftriaxone sodium, per 250 mg.
J1100 Injection, dexamethzaone sodium phosphate, 1 mg
J1170 Injection, hydromorphone, up to 4 mg.
J1626 Injection, granisetron HCl, 100mg.
J2430 Injection, pamidronate disodium, per 30 MG
J2405 Injection, ondansetron HCl, per 1 mg.
J3010 Injection, teriparatide, 10 mcg.

J3370 Injection, vancomycin HCl, 500 mg.
J9000 Injection, doxorubicin HCl, 10 mg.
J9045 Injection, carboplatin, 50mg
J9060 Cisplatin, powder or solution, per 10 mg.
J9062 Cisplatin, 50 mg.
J9178 Injection, epirubicin HCl, 2mg.
J9190 Injection, fluororacil, 500 mg.
J9206 Injection, irinotecan, 20 mg.
J9293 Injection, miltoxantrone HCl, per 5 mg.
J9265 Injection, paclitaxel, 30 mg.
J9390 Injection vinorelbine tartrate, per 10 mg.

Alternatively, a provider may enter all NDC codes for all administered drug items rather than just for the above codes.

PHASE II - Effective January 1, 2011, ACS will deny all claims that do not indicate a valid NDC for the following HCPCS or CPT codes. NDC codes are required whenever the provider bills one of the following HCPCS or CPT codes:

Codes in the range J0120 - J9999 (various injections and chemotherapy)
Codes in the range S0012 - S0197 and S4990 - S5014 (various items)
Codes in the range S5550 - S5571 (insulin injections)
Codes in the range 90281 – 90399 (immune globulins)

The same requirement applies to providers billing revenue codes on the UB04 claim form. HCPCS or CPT codes are required whenever the provider bills one of the following revenue codes and the claim is an outpatient hospital, emergency room facility, dialysis facility, other outpatient facility which uses the UB04 claim form. When the reported HCPCS or CPT code is one of the above, the NDC code must also be reported:

Pharmacy revenue codes 0250, 0251, 0252, and 0254
Pharmacy revenue codes 0631, 0632, 0633, 0634, 0635, and 0636

A provider paid on the basis of an encounter rate such as an FQHC, an IHS or tribal compact facility or a bundled rate such as drugs included in a dialysis cap charge does not need to supply an NDC code because they are not reimbursed using one of the above revenue codes.

INSTRUCTIONS FOR BILLING DRUG ITEMS ADMINISTERED IN PROVIDER OFFICES, OUTPATIENT CLINICS AND HOSPITALS

Because reporting the NDC code requires providers to use both the upper and lower rows on a claim line, be certain to line up the information accurately so that all characters fall within the proper box and row.

CMS1500 FORM

Beginning at the left edge of the shaded area of field 24A, enter the 2-digit qualifier "N4" immediately followed by the 11-digit NDC. For example, the entry for the NDC code 00054352763 will be: N400054352763.

Even though an NDC is entered, a valid HCPCS or CPT code must be entered in the non-shaded area of 24D. The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code. For example, J0610 "Injection Calcium Gluconate, per 10 ml" is billed as 1 unit for each 10 ml ampul used.

Optional Information:
While the minimal new information required by MAD is the qualifier, the NDC and correct reporting of units for the HCPCS or CPT code, there are additional national standards for reporting more information on drug items that other payers may eventually require. MAD is also capable of receiving the additional information when submitted on a claim but it is not required at this time. A provider changing their billing system may want to also add information according to the following format:

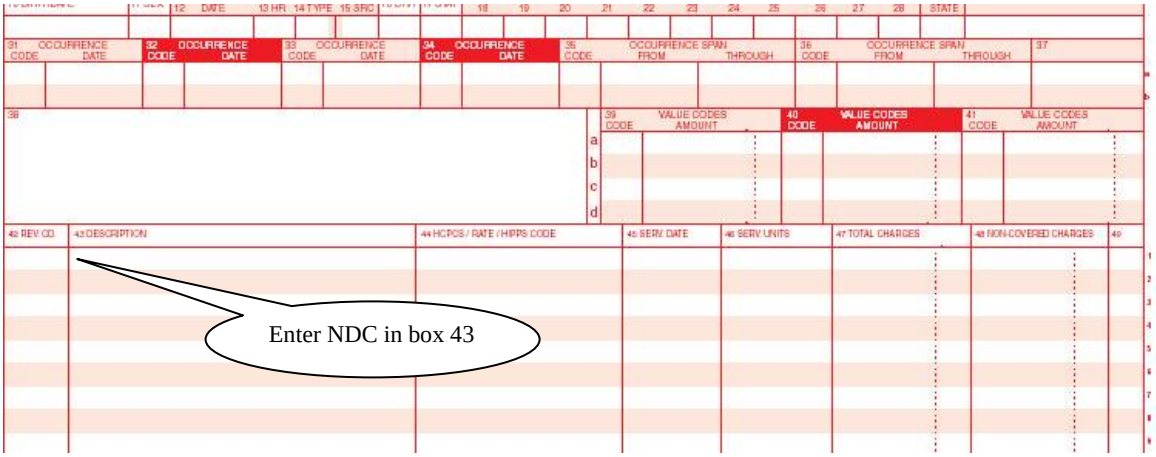
- At the left edge of the shaded area of field 24A, enter the 2-digit qualifier "N4" immediately followed by the 11-digit NDC, followed by 3 spaces, followed by one of the four (4) qualifiers for unit of measurement followed immediately by the quantity.

- The four (4) units of measure qualifiers are:

F2 – International Unit	GR – Gram
ML – Milliliter	UN – Units

UB04 FORM
Even though an NDC is entered, a valid revenue code must be entered in form locator 42 and a HCPCS or CPT code must be entered in form locator 44.

The NDC must be entered in box 43, which is currently labeled as "description". Beginning at the left edge of form locator 43, enter the 2-digit qualifier "N4" immediately followed by the 11-digit NDC. An example of an entry for the NDC code 00054352763 will be: N400054352763.



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837 P and 837 I

You will need to notify your billing or software vendor that the NDC code is to be reported in the following fields in the 837 format:

loop 2410
seg LIN
field LIN02: use the qualifier "N4"
field LIN03: place the 11 digit NDC here

Follow the companion guides for more information.

If you have questions on this policy, please call (505) 827-3171.

SUBJECT II PHYSICIAN AND CLINIC BILLING FOR DRUGS OBTAINED UNDER THE 340B DRUG PRICING PROGRAM

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of covered outpatient drugs to certain federal grantees, including federally-qualified health centers and look-alikes, qualified disproportionate share hospitals, some state and local government clinics, family planning projects, and some other types of clinics. Significant savings on pharmaceuticals may be seen by those entities that participate in this program.

Oversight of the 340B program is the responsibility of The Health Resources and Services Administration (HRSA). Under the 340B program pharmaceutical manufacturers agree to charge at or below statutorily defined prices, known as the 340B ceiling prices, for sales to qualified entities. When pharmaceutical manufacturers make their drug products available at the discounted 340B rate, a state Medicaid program cannot invoice the manufacturer for drug rebates for drug items purchased.

Furthermore, when a drug item is purchased at 340B prices, the provider cannot bill the Medicaid program more than the actual ingredient cost plus the Medicaid dispensing fee. In order for the provider to bill correctly as required by law and for the Medicaid program to appropriately limit the payment to a hospital and not invoice the manufacturer for rebates, the hospital must adhere to the following billing procedures when dispensing 340B pharmacy items.

Effective September 1, 2010, MAD requires all physicians, regional health centers, family planning organizations, or other clinics that bill for drug items obtained under 340B drug pricing agreements to:

1. Not submit claims to Medicaid for pharmaceutical items acquired through the 340B drug program; OR

2. If submitting claims for Medicaid recipients for pharmaceutical items acquired through the 340B program, the provider must identify drug items obtained through the 340B program as the billed amount using one of the following methods:

    a. UB04 Claim: For all pharmaceuticals acquired at 340B rates, for each claim line for the following revenue codes pharmacy revenue codes 0250, 0251, 0252, 0254, 0631, 0632, 0633, 0634, 0635, and 0636 include the HCPCS or CPT code immediately followed by the modifier UD in form locator 44. An example for HCPCS J0135 will be J0135UD.

    b. CMS1500 Claim: For all pharmaceuticals acquired at 340B rates by entering the HCPCS code in form locator 24C followed by the modifier UD

    When using the 837 transaction, the UD modifier is reported as follows:

    <u>837I</u>
    Loop 2400 SV2, can send up to 4 modifiers in SV202-3, SV202-4, SV202-5, SV202-6

    <u>837P</u>
    Loop 2400 SV1, can send up to 4 modifiers in SV101-3, SV101-4, SV101-5, SV101-6

    The billed charge for any drug item obtained through the 340B program cannot be more than the 340B acquisition cost plus $2.50. This applies to all providers using either the UB04 or CMS1500 claim form. Charging more than is allowed by the 340B rules is considered an abuse of the HSD/MAD program.

Should you have any questions on the 340B coding requirements, please contact ACS at 800-299-7304 or 505-246-0710 and select option 2.

Thank you. We appreciate your participation in the New Mexico Medicaid program.