HUMAN SERVICES
DEPARTMENT

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Letter of Direction #60

Date: **April 20, 2021**

To: **Centennial Care 2.0 Managed Care Organizations**

From: **Nicole Comeaux, Director, Medical Assistance Division**

Subject: **MCO Requirements Regarding a Valid National Drug Code (NDC) for Billing Physician Administered Drug Items, Rebate Collection and Dispute Resolution and 340B Claim Billing**

Title: **NDC Requirement for Drug Rebate Collection and 340B Claim Billing**

The purpose of this Letter of Direction (LOD) is to provide the Centennial Care Managed Care Organizations (MCOs) with the instructions that will be outlined in the MCO Policy Manual on the requirements for billing physician administered drug items and 340B Claim Billing. The federal Deficit Reduction Act of 2005 requires Medicaid providers to report an 11-digit National Drug Code (NDC) on the CMS-1500 and UB-04 claims and 837 electronic transactions when billing for injectable drugs and all other drug items administered in practitioners' offices, outpatient clinics, hospitals, and other clinical settings.

Due to the NDC reporting requirements, all providers are required to accurately identify the NDC on all submitted claims. This requirement applies to crossover claims as well. MAD requires providers to include the NDC when they submit a physician administered drug claim to Medicare/Medicaid, and if the provider does not include the NDC, the co-insurance or deductible on that claim line will be denied. MAD also requires hospital providers to put an NDC on the drug line whether or not the line would be paid under OPPS rules. Medicare/Medicaid considers numerous physician-administered drugs "bundled" in a different procedure code. However, under current CMS clarifications, whether Medicare makes payment on the drug line or not (when it is considered packaged or bundled) the provider must include the NDC code on the drug item line so Medicaid can collect drug rebates for these drugs.

MAD requires that hospitals include the NDC on a drug code billed to Medicare/Medicaid even if Medicare did not reimburse that line item. All claims which do not have a valid NDC code for physician administered drug items should be denied by the MCO's Medicaid Fiscal Agent. If claims are denied, providers can electronically resubmit denied CMS-1500 and UB-04 claims as well as 837 electronic transactions with the corrected information.

The requirement for reporting NDC codes on all professional claims for physician administered or dispensed drugs may have exceptions for certain claims submitted by Indian Health Service facilities, Federally Qualified Health Centers, Rural Health Clinics, Rural Health Clinic Hospital Based facilities, general acute care hospitals and hospital rehab, and renal dialysis facilities.

Pharmacy Section 20 of the MCO policy manual states that HSD's Pharmacy Benefit Manager (PBM) will continue to send drug rebate invoices to manufacturers based on the encounter data for pharmacy and medical claims submitted by the MCOs. HSD's PBM will receive copies of the manufacturers' checks. If the manufacturer does not pay the invoice in full because the manufacturer disputes the data on the invoice, HSD's PBM will refer the manufacturer dispute to the appropriate MCO staff.

When a dispute is reported to the MCO, the MCO is responsible for reviewing their pharmacy claims data to determine if the data needs to be corrected. This entails reviewing claims and potentially contacting pharmacy and medical providers to obtain information to resolve the dispute. The MCO must report the resolution of the dispute to HSD's PBM within 30 calendar days from the date of receiving the notice of the dispute.

HSD's PBM will review the MCO pharmacy and medical drug claims data prior to printing invoices in an attempt to minimize disputes. Often, for specific drug items, failure to report the correct number of units is a common error and the correction may be obvious to HSD's PBM. In such cases it will make the change prior to printing invoices. Usually, the problem occurs when the standard billing units differ from the units that CMS expects to be used on the rebate invoices. A problem may also occur when an MCO allows a provider to bill incorrect units. HSD's PBM will notify the MCO of any situation where the MCO continues to make the same error in data and the MCO will be required to implement corrections in their processing of claims.

The most common reasons for disputes are Unit Type Discrepancies, Data Entry Errors Regarding Incorrect Quantities, Use of Decimals in the units, Inconsistent Units or Quantities, and Invalid or Terminated NDCs. Reference Section 20: Pharmacy of the MCO Policy Manual for further guidance on handling these dispute issues.

340B Claims Billing

When a provider purchases a drug item at 340B prices, the provider must correctly bill as required by law and in order for the Medicaid program to appropriately limit the payment to a 340B entity and not invoice the manufacturer for rebates, the entity must adhere to the following billing procedures when dispensing 340B pharmacy items.

MAD requires all pharmacies, physicians, regional health centers, family planning organizations, state government and other clinics that bill for drug items under 340B drug pricing agreements to:

1. Carve out of Medicaid and not submit claims for pharmaceutical items acquired through the 340B drug program, OR

2. Carve into Medicaid and submit claims for Medicaid recipients for pharmaceutical items acquired through the 340B program, billing drug items with the manufacture assigned NDC identifier along with the "UD" modifier using one of the following methods:

    a. CMS1500 Claims: All pharmaceuticals acquired at 340B rates must be entered using the HCPCS code in form locator 24C followed by the modifier UD.

    b. UB04 Claims: All pharmaceuticals acquired at 340B rates with the following pharmacy revenue codes 0250, 0251, 0252, 0254, 0631, 0632, 0633, 0634, 0635, and 0636 must have the HCPCS or CPT code immediately followed by the modifier UD in form locator 44. Example: HCPCS J0135 will be entered as J0135UD.

    c. The Centers for Medicare and Medicaid Services (CMS) mandate that Medicare providers report either the "JG" (Drug or biological acquired with 340B drug pricing program discount) or TB (Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes) modifiers, and are accepted by Medicaid, however, the "UD" modifier must also be included to identify 340B Medicaid claims.

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

837I
Loop 2400 SV2, can send up to 4 modifiers in SV202-3, SV202-4, SV202-5, and SV202-6

837P
Loop 2400 SV1, can send up to 4 modifiers in SV202-3, SV202-4, SV202-5, and SV202-6

Pharmacy Point-Of-Sale Claims and Encounters: New Mexico Medicaid requires pharmacies to identify claims billed at 340B pricing by providing modifier "08" in the "basis of cost determination" field 423-DN and shall be included on the encounter claims from the MCOs.

This provision is for the purposes of acquiring data and does not dictate pricing. Reimbursement logic is considered confidential based on contractual agreements between each MCO and their providers.

MAD is providing this important information in a supplement as a reminder to providers that they are required to include the appropriate NDC and other essential information on the claim when billing for drug items or claims may be denied or subject to recoupment. Providers should have already modified their billing software and be capable of accommodating this requirement.

This LOD will sunset upon inclusion in the Managed Care Policy Manual.

If you have questions regarding this LOD, please contact Benefits and Reimbursement Bureau at (505) 690-8973.