Missouri Department of SOCIAL SERVICES

MoHealthNet

PROVIDER BULLETIN

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340B Health Care Facility NDC Requirement

CONTENTS

340B Correction

The MO HealthNet Division previously notified providers in provider bulletin Volume 41 Number 42, dated February 15, 2019, that effective April 30, 2019 there would be changes to the NDC requirement and reimbursement for 340B health care facilities. The effective date for these changes has been changed to May 30, 2019.

340B Providers

340B is a drug pricing program that resulted from the enactment of Public Law 102-585 and the Public Health Service Veterans Health Care Act of 1992. The 340B program limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes, and qualified hospitals. 340B also results in additional cost savings to 340B qualified participants. These providers purchase, dispense, and/or administer pharmaceuticals at significantly discounted prices. The significant discount applied to the cost of these drugs makes these drugs ineligible for Medicaid drug rebates.

To avoid duplicate discounts and ensure correct payment, 340B providers that choose to carve-in Medicaid must provide the Health Resources and Services Administration (HRSA) with their National Provider Identification (NPI) and MO HealthNet provider number for each site that carves in for the purpose of inclusion in the Medicaid Exclusion File. In addition to notifying HRSA of carving-in Medicaid, you must also contact the MO HealthNet Division (MHD) and report carve-in status for each facility carved-in.

The MHD considers all claims submitted by a carved-in provider to be a 340B claim. All claims for carved-in providers will be paid at the 340B reimbursement rate and excluded from the Medicaid drug rebate program.

340B contract pharmacies are not covered under this policy and must carve-out Medicaid from its 340B operation.

340B Reimbursement

Effective for dates of service on or after May 30, 2019, 340B health care facilities who carve-in for Medicaid will be reimbursement for covered medications administered in the outpatient hospital setting by applying the following method:

- Wholesale Acquisition Cost (WAC) minus twenty-five percent (25%); or
- The usual and customary (U&C) charge submitted by the provider if it is lower.

National Drug Code (NDC) Required

Effective for dates of service on or after May 30, 2019, the MHD will require 340B health care facilities to submit the National Drug Code (NDC) for all medications administered in the outpatient hospital setting.

Providers will be required to submit their claims with the exact NDC that appears on the product administered. The NDC is found on the medication's packaging and must be submitted in the 5 digits-4 digits-2 digits format. If the NDC does not appear in the 5-4-2 digit format on the packaging, a zero(s) (0) may be entered in front of the section that does not have the required number of digits.

Claim Submission

Drug charges submitted by providers on an electronic Professional or Institutional ASC X12 837 Health Care claim transaction or manually entered on a medical or outpatient claim into the MHD billing Web site eMOMED (www.emomed.com), are to be billed with a valid J-Code and a valid NDC for each medication, including injections, provided to the participant. Medical or outpatient claim lines submitted with a J-Code, without the corresponding NDC will be denied. For medical or outpatient claims correctly submitted with the appropriate J-Code and the corresponding NDC, the system will automatically generate a separate drug claim for the NDC to process as a Pharmacy claim and will appear as a separate claim on your Remittance Advice. The corresponding line with J-Code and NDC will be dropped from the medical or outpatient claim. If an NDC is not provided, the J-Code will remain on the claim to report the denied line. If the drug being provided does not have a J-Code associated with it, the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code should be submitted with an NDC. For drugs without a valid HCPCS procedure code, revenue code 0250 "General Classification: Pharmacy" must be used with the appropriate NDC.

Only drugs and items used during the outpatient care in the hospital are covered. Take-home medications and supplies are not covered by the MHD.

Procedure Code/NDC Validation

A critical component to submitting claims with an NDC is to ensure that the appropriate HCPCS procedure code is billed with each NDC. To ensure accurate billing of drug charges, MHD will use the Noridian crosswalk (www.dmepdac.com) to determine whether the appropriate HCPCS procedure code is billed for the submitted NDC. Claims will be denied if the NDC submitted is not valid for the HCPCS procedure code submitted.

Clinical and Preferred Drug List (PDL) Edits

All drug claims are routed through an automated computer system to apply edits specifically designed to ensure effective drug utilization. The Preferred Drug List (PDL) and clinical edits are designed to enhance patient care and optimize the use of program funds through therapeutically prudent use of pharmaceuticals. The edits are based on evidence-based clinical criteria and available nationally recognized peer-reviewed information. This clinical information is paired with fiscal evaluation and then developed into a therapeutic class PDL recommendation. The PDL process incorporates clinical edits, including step therapies, into the MHD pharmacy program. Claims for drugs will automatically and transparently be approved for those patients who meet any of the system approval criteria. For those patients who do not meet the system approval criteria, the drugs will require a call to the MHD Drug Prior Authorization hotline at (800) 392-8030 to initiate a review and potentially authorize payment of claims. Providers may also use the CyberAccess tool to determine if a drug is a preferred agent or requires edit override; electronically initiate an edit override review, and to review a participant's MHD paid claim history. To become a CyberAccess user, contact the CyberAccess help desk at (888) 581-9797 or (573) 632-9797 or send an E-mail to CyberaccessHelpdesk@conduent.com. More information regarding the clinical edits, the Preferred Drug List and other pharmacy related programs can be found at www.dss.mo.gov/mhd/cs/pharmacy/index.htm.

Quantity Dispensed

The quantity to be billed for injectables and other types of medications dispensed to MHD participants must be calculated as follows:

- Containers of medication in solution (for example, ampoules, bags, bottles, vials, syringes) must be billed by exact cubic centimeters or milliliters (cc or ml) dispensed, even if the quantity includes a decimal (e.g., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill is 1.5 mls).
- Single-dose syringes and single-dose vials must be billed per cubic centimeters or milliliters (cc or ml), rather than per syringe or per vial.
- Ointments must be billed per number of grams even if the quantity includes a decimal.
- Eye drops must be billed per number of cubic centimeters or milliliters (cc or ml) in each bottle even if the quantity includes a decimal.
- Powder filled vials and syringes that require reconstitution must be billed by the number of vials.
- Combination products, which consist of devices and drugs, designed to be used together, are to be billed as a kit. Quantity will be the number of kits used.

- The product Herceptin, by Genentech, must be billed by milligram rather than by vial due to the stability of the drug.
- Non-VFC Immunizations and vaccines must be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

Provider Bulletins are available on the MO HealthNet Division (MHD) Web site at http://dss.mo.gov/mhd/providers/pages/bulletins.htm. Bulletins will remain on the Provider Bulletins page only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at http://dss.mo.gov/mhd/ to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the MO HealthNet card or by calling the Provider Communications Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the MO HealthNet ID card.

Provider Communications Hotline
573-751-2896