Physician-Administered Medication: Billing Requirements

Policy

For physician-administered medication, effective April 1, 2012, Mass General Brigham Health Plan requires National Drug Codes (NDC) on claims in addition to the corresponding CPT/HCPCS codes, and the units administered for each code.

Member Cost-Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any.

Definitions

340B Drug Pricing Program: A program managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA) to limit the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes, and qualified hospitals. The purpose is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.

Crossover Claim: Dual-eligible claims billed to Medicare with an NDC code will cross to Medicaid (MassHealth) with the NDC.

Deficit Reduction Act (DRA) of 2005: The Deficit Reduction Act of 2005 is a United States Act of Congress concerning the budget. It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. It requires States to collect rebates for physician – administered drugs. States must collect the 11-digit National Drug Code (NDC) that appears on the product administered.

Medicaid Drug Rebate Program: The Medicaid Drug Rebate Program was originally created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) and became effective January 1, 1991. The law required drug manufacturers to enter into an agreement with CMS to provide rebates for their drug

products that are paid for by Medicaid. Outpatient Medicaid pharmacy providers have billed with NDCs and requested rebates since 1991. The DRA of 2005 expanded the rebate requirement to physician-administered drugs.

HCPCS Level II "J" Codes: Drugs administered by other than an oral method that cannot be self-administered, including immunosuppressive drugs, inhalation solutions, and other miscellaneous drugs and solutions, including **J7050** (normal saline, 250 cc).

Massachusetts Medicaid Drug Rebate Program: Effective January 1, 2012, providers participating in the 340B program are required to submit NDC information when they submit claims for all drugs administered in the office or clinic setting, including 340B drugs.

NDC (National Drug Code)

A universal product identifier for human drugs by which drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), consisting of 11 digits in a **5-4-2** format. The first 5 digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The remaining digits are assigned by the manufacturer and identify the specific product and package size.

Since there are often several NDCs linked to a single HCPCS code, the Centers for Medicare and Medicaid (CMS) deems that the use of NDC numbers are critical to correctly identify the drug and manufacturer in order to invoice and collect the drug rebates.

Some packages will display less than 11 digits, but **leading zeroes** can be assumed and **must be used.** For example:

NDC Package Display	11- Digit NDC Format
XXXX-XXXX-XX	0XXXX-XXXX-XX
XXXXX-XXX-XX	XXXXX-0XXX-XX
XXXXX-XXXX-X	XXXXX-XXXX-0X

NDC Units: These units are based on the numeric quantity administered to the patient and the unit of measurement. The unit of measurement (UOM) codes follow:

UOM Code	Descript or
F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit (each)

The actual metric decimal quantity administered, and the units of measurement are required for billing. If reporting a fraction (part of a unit), use a decimal point. (I.e. If three 0.5 ml vials are dispensed, report 1.5 ml.).

Examples of how units of measure qualifiers relate to NDC dose/volume:

NDC Dose	Volume Unit
1,000ML	ML
50,000IU	F2
1Unit	UN
50mg	GR
100mg/4ml	ML

How to bill a physician administered vial of medication, using NDC units in grams, millimeters, or units (rule of thumb):

- If a drug is supplied in a *vial* in *powder form*, and must be *reconstituted* before administration, bill each vial (unit/each) used. (**UN**)
- If a drug is supplied in a *vial* in *liquid form*, bill in millimeters. (**ML**)
- Grams are usually used when an ointment, cream, inhaler, or bulk powder in a jar are dispensed. This unit of measure will primarily be used in the retail pharmacy setting and not for physician-administered drug billing. (**GR**)
- International Units will mainly be used when billing for Factor VIII-Antihemophilic Factors. (**F2**)

Reporting multiple NDCs on a Professional claim: If the drug administered is comprised of more than one ingredient, each NDC must be represented in the service lines. The HCPCS code should be repeated as necessary to cover each unique NDC code.

Submitting a paper claim:

- Enter modifier **KP** (first drug of a multiple drug unit dose formulation) for the first drug of a multiple drug formulation.

- Enter modifier **KQ** (second or subsequent drug of a multiple drug unit dose formulation) to represent the second or subsequent drug formulations.

Submitting an electronic claim:

- The compound drug should be reported by repeating the LIN and the CPT segments in the 2410 identification loop.

Mass General Brigham Health Plan Requires Reporting of Physician-Administered Medications

- Based on the exact NDC appearing on the product administered (with leading zeros, when necessary),
- The corresponding HCPCS code,
- Units for both code sets (NDC and HCPCS), for medications and medication/drug containers administered by physicians in the office and/or clinic setting.

Mass General Brigham Health Plan Reimburses

- The provider for physician administered medications based on the HCPCS code and units of service.

Mass General Brigham Health Plan Does *Not* Reimburse

- Physician-administered medications billed/reported with **only** HCPCS codes.
- Claims for physician administered medications submitted without the valid NDC that follows the 5-4-2 format, **no hyphens**.
- Claims submitted for physician administered medications without BOTH the HCPCS and NDC codes, and their corresponding units. Provider Payment Guidelines and Documentation.

Clinic Participation in the 340B Program

- Effective January 1, 2012, providers are required to submit NDC information when they submit claims for all drugs administered in the office or clinic setting, including 340B drugs.
- Modifier **UD** (Medicaid level of Care 13, as defined by each State) must be submitted with the HCPCS code to indicate the drug was purchased through the 340B Program.

CMS-1500 Form

On paper forms, use the shaded area of Fields **24A-24G** to report:

- HCPCS Codes,
- NDC units, and
- Descriptors.

UB-04

Use the revenue descriptor field, (**FORM LOCATOR 43**) as follows:

- Report the **N4** qualifier in the first 2 positions, *left justified*;
- Followed by the 11-character NDC in the 5-4-2 format (**NO hyphens, leading zeros**)
- Followed by the unit of measurement qualifier

Electronic claim format

- When submitting the 837 transaction, complete the drug identification and drug pricing segments in Loop 2410 following the instructions in the table below:

Loop	Segment		Element Name	Information
2410	LIN	02	Product or Service ID Qualifier	If billing for a national drug code (NDC), enter the product or service ID qualifier.
2410	LIN	03	Product or Service ID	If billing for drugs, include the NDC. An NDC is not required for vaccines.
2410	CTP	03	Unit Price	If an NDC was entered in LIN03, include the unit price for the NDC billed.
2410	CTP	04	Quantity	If an NDC was submitted in LIN03, include the quantity for the NDC billed.
2410	CTP	05-1	Unit or Basis for Measurement Code	If an NDC was submitted in LIN03, include the unitor basis for measurement code for the NDC billed using the appropriate code qualifier: **F2** - International unit **GR** - Gram **ML** - Milliliter **UN** - Unit

Partial Vial(s) Administered

- Bill using the HCPCS code with the corresponding units administered.
- To calculate the NDC units, the HCPCS code units must be converted to the NDC units, using the proper decimal units.

Physicians must bill waste on a separate claim line, with JW modifier

- The discarded drug amount is the amount of a single use vial or other single use package that remains after administering a dose/quantity of the drug.

Facilities on EAPG and Commercial Outpatient Fee Schedule contracts must bill total units (used plus discarded) on 1 claim line, without JW modifier. Note: total used plus total discarded must be based on a single use vial or other single use package.

- Providers must maintain accurate (medical and/or dispensing) records for all patients as well as accurate purchasing and inventory records for all drugs that were purchased and billed to Mass General Brigham Health Plan.

For each medication, submit:

- The appropriate HCPCS code in addition to the
- NDC number in 11-digit format from the actual NDC number on the package/container from which the medication was administered. Do NOT bill for one manufacturer's product and dispense another,
- Product description,
- Dosage,
- Units administered,
- Duration of infusion (if applicable)

Please Note:

- Use of *only* HCPCS "**J**" codes for drugs will *deny* for missing NDC number.
- Do *not* enter the Red Book value listed in milligrams (ml) in the unit's field associated with the HCPCS code.

Examples

Patient receives 4 mg Zofran IV in the physician's office.

- NDC package display: 00173-0442-02

- Descriptor: Zofran 2 mg/ml in solution form
- 2 ml per vial

  Report:
  - **J2405** (ondansetron hydrochloride, per 1 mg)
    - **4** HCPCS units
  - **001730442025** (NDC Number)
    - **ML2** (2 millimeters NDC units)

Patient receives 1gram of Rocephin IM in the physician/s office.

- NDC for the product used: 00004-1963-02
- Descriptor: Rocephin 500 mg vial in powder form, reconstituted prior to injection.

  Report:
  - **J0696** (ceftriaxone sodium, per 250 mg)
    - **4** HCPCS units
  - **00004196302** (NDC number)
    - **UN2** (NDC units as 2, also called 2 each)

If the patient in the first example above (Example 1) received a partial vial, only 2 mg of Zofran, use the same NDC which is for Zofran 2 mg/ml in a 2 ml vial:

Report:
- **J2405** (ondansetron hydrochloride, per 1 mg)
  - **2** HCPCS units
- **00173044202** (NDC Number)
  - **ML1** (1-millimeter NDC units)

MassHealth Carve-out Drugs

For MassHealth carve-out drug list and billing instructions please refer to MassHealth Billing Tips. Additional information can be found at this link: MassHealth Acute Hospital Carve-Out Drugs List

References

MassHealth Drug List
MassHealth, Learn about National Drug Code (NDC) Requirements
MassHealth Physician Manual
Introduction to 340B Drug Pricing Program

JW Modifier: Drug/Biological Amount Discarded/Not Administered To Any Patient Frequently Asked Questions

Publication History

Topic: Physician Administered Medications	Owner: Network Management

February 1, 2012	*Original documentation*
January 1, 2019	*Document restructure; codes, code descriptor and references updated*
January 1, 2023	*Document rebrand; updated references*
May 31, 2023	*Updated MassHealth references*
January 1, 2024	*Annual review; added MassHealth Acute Carve-Out Drug link*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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