H Alabama Medicaid Physician Administered Drugs

Effective October 1, 2010, the NDC is required on all physician-administered drugs in J, S, and Q code ranges. Physician-administered drugs include any covered outpatient drug billed either electronically or on paper CMS-1500 or UB-04 claim forms.

H.1 Policy

H.1.1 Injections

Medicaid covers physician drugs when billed by a physician using the new list of approved HCPCS codes.

The HCPCs drug codes are intended for use in Physician office and Outpatient billing of manufactured medications given in each respective place of service. The Alabama Medicaid Agency only reimburses for compounded medications by the billing of NDC numbers through the Pharmacy Program directives.

Appropriate administration code(s) in the Current Procedural Terminology (CPT) may be billed in addition to the HCPCS drug codes and office visit codes for the same date of service. Please refer to the following section "Evaluation and Management Codes Billed in Conjuction With Drug Administration Codes" for details concerning office visits, chemotherapy administration, hydration therapy and chemotherapy, and date specific changes.

Pricing of Physician Administered Drugs

For Dates of Service prior to July 1, 2005, physician drug prices were updated semi-annually by HP. Medicaid reimbursement was calculated by averaging the Average Wholesale Prices (AWP) from the *Red Book or 80-95% of DIMA (Drug, Improvement, and Modernization Act).*

Effective for Dates of Service July 1, 2005 and thereafter, the Alabama Medicaid Agency will adopt Medicare's Drug Pricing Methodology using the Average Sale Price (ASP) for HCPCS injectable drug codes.

Compound Drugs for Non-Pharmacy Providers

The compound drug must not be commercially available, and the active ingredient of the compound drug must follow coverage policy of drugs (FDA approved, non-DESI, not obsolete, etc).

When a provider administers a drug that must be purchased from a compounding pharmacy because it is no longer commercially available (e.g. due to the manufacturer no longer marketing the product), the applicable claim form may be submitted for consideration of payment. The billed amount should represent the lesser of the actual acquisition cost for the drug or Medicaid rate on file (ASP CMS pricing) at the time of service.

When billing the HCPCS code for a purchased compounded drug, only one NDC can be used per procedure code. Providers must use the HCPCS procedure code, billing units and corresponding covered NDC number on the claim form; for example, J1094 Injection, dexamethasone acetate, 1 mg. The NDC billed should be the one that represents the drug as described in the HCPCS code definition, in this case dexamethasone acetate. See the section entitled “Calculation of Billing Units and Wastage” for information on calculating billing units.

The Agency does not reimburse non-pharmacy providers for prescription compounding time or non-covered ingredients used in the compounding process. The Alabama Medicaid Agency only reimburses for the compounding time by the billing of NDC numbers through the Pharmacy Program.

Mandatory National Drug Codes (NDC) for ALL Physician Administered Drugs

In compliance with the Deficit Reduction Act (DRA) of 2005, Alabama Medicaid (AMA) began accepting and later began requiring the NDC number for the top 20+ physician-administered multiple source drugs. Information on this requirement may be found in the July 2008 and April 2009 issues of the Provider Insider on the Agency’s website.

Effective October 1, 2010, the NDC number became mandatory on **ALL** physician-administered drugs in the following ranges: J0000 – J9999, S0000 – S9999, and Q0000 – Q9999. Physician-administered drugs include any covered outpatient drug billed either electronically or on a paper CMS-1500 or UB-04 claim forms. This is for both straight Medicaid and Medicare/Medicaid crossover claims. The 11-digit NDC submitted must be the actual NDC number on the package or container from which the medicine was administered. The NDC is a number that identifies a prescription drug.

Medicaid provided a **grace period from** August 15, 2010 **to** September 30, 2010, to allow providers sufficient time to acclimate to the change. During this grace period, Medicaid validated the data and set informational denial codes, but DID NOT deny the claim.

This requirement applies to:

- All fee-for-service providers who bill physician-administered drug codes
- HCPCS codes in the ranges J0000 – J9999, S0000 – S9999, and Q0000 – Q9999.
- Both electronic and paper submissions

This requirement does **NOT** apply to:

- 340-B Providers enrolled on the HHS website
- Vaccines or other drugs in the CPT code ranges 01000 – 99999.
- HCPCS that do not have an NDC
- HCPCS that are considered devices
- HCPCS that are considered radiopharmaceuticals
- Providers paid on a per diem, encounter, or other type of rate, which includes, but may not be limited to:
    - Inpatient Hospitals
    - Nursing Facilities
    - Federally Qualified Health Centers
    - Rural Health Centers
    - Ambulatory Surgical Centers
    - Home Health Agencies

To identify if a product is a drug, look for these three items:

1. NDC- the package or container that held the drug would have an NDC on it
2. Lot and Expiration Date- All drugs have both a lot number and expiration date on the vial or container
3. Legend- This refers to statements such as, “Caution; Federal law prohibits dispensing without prescription, “Rx only” or similar words. All prescription drugs have these types of statements

As this process is to facilitate Medicaid drug rebates from manufactures for physician-administered drugs, providers are required to utilize drugs manufactured by companies who hold a federal rebate agreement. These NDCs will be the only ones Medicaid will cover for payment. A link to a list of those drug manufacturers who hold a federal rebate agreement, as well as their labeler codes (the first 5 digits of the NDC number), are available on the Medicaid website at: http://www.medicaid.alabama.gov/programs/pharmacy_svcs/resources_providers.aspx?tab=4 . Select the **Click Here** link to access the list of covered labelers (manufacturers) available from CMS.

The Alabama Medicaid Agency implemented a Drug Lookup System effective October 5, 2010. The system allows non-pharmacy providers needing NDC information for the billing of HCPCS codes to search for drugs by drug name or NDC and will display coverage information. Providers can access the Drug Lookup feature by visiting the Alabama Medicaid website and clicking on the following link: http://aldrug.rxexplorer.com/http://aldrug.rxexplorer.com/

Please note that pricing, PA requirements, and maximum quantity limits apply to pharmacy claims only.

Questions should be directed to the Provider Assistance Center at 1-800-688-7989 for instate providers or (334) 215-0111 for out-of-state providers.

Multiple NDCs for a Single HCPCS Drug Code

At times it may be necessary for providers to report multiple NDCs for a single procedure code. If two or more NDCs are to be submitted for a procedure code, the procedure code must be repeated on separate lines for each unique NDC. On the first line, the procedure code, NDC and procedure quantity are reported with a **KP modifier** (first drug of a multi drug). On the second line, the procedure code, NDC and procedure quantity are reported with a **KQ modifier** (second/subsequent drug of a multi drug). When reporting more than two NDCs per procedure code, the KQ modifier is also used on the subsequent lines.

Unclassified Drugs

A provider who administers a physician drug not listed should use the following J codes:

- J3490 - Unclassified Drugs
- J3590- Unclassified Biologics
- J9999 - Not otherwise classified, antineoplastic drugs.

The claim must be sent on paper with a description of the drug attached. Providers should submit a claim with the complete name of the drug, dosage and a National Drug Code (NDC) number. Please be sure to search the Physician Drug List to see if the drug is possibly under a generic name. The claims containing the unclassified procedure code must be sent to: HP, Attn: Medical Policy, PO Box 244032, Montgomery, AL 36124-4032. HP will determine the price of the drug.

Breathing/Inhalation Treatment: J2545 Pentamidine Isethionate (Nebupent)

Current coverage policy for breathing or inhalation treatments utilizing drugs such as Albuterol does not allow for the drug to be billed for separately as it is considered a component of the treatment charge. The exception to this policy is the administration of Pentamidine Isethionate.

Pentamidine isethionate (J2545), given by inhalation, is an anti-microbial agent specifically indicated for the prevention of Pneumocystis carinii pneumonia (PCP) in high-risk HIV infected patients. Administration of Pentamidine is done via the Respirgard II nebulizer which utilizes a series of one-way valves and a filter to minimize the release of aerosol droplets into the air. CPT code 94642 (aerosol inhalation of Pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis) is the appropriate code to bill for administration of the drug. This therapy is generally given on a monthly basis and given in the hospital or clinic/office by a health care professional. The administration code does not include

the cost of the drug. The inhalation drug code and the administration of the drug should both be reported on the same claim, same date of service.

340B Drug Pricing

When an eligible 340B entity submits a bill to the Medicaid Agency for a drug purchase by or on behalf of a Medicaid recipient, the amount billed shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992. Covered entities are identified to Medicaid by the Department of Health and Human Service. These providers are required to bill at actual invoice cost. As manufacturer price changes occur, providers must ensure that their billings are updated accordingly.

Medicare/Medicaid Drugs

Medicare Part B covers some drugs in a physician's office. If the recipient is dually eligible for Medicare and Medicaid, the Drug code as required by Medicare should be billed first to Medicare. The claim should crossover to Medicaid for consideration of payment. If the claim does not crossover to Medicaid, providers will need to submit the appropriate HCPCS code to Medicaid on a Medical Medicaid/Medicare Related Claim (aka Crossover Form 340) with Medicare allowance/payment/coinsurance/ and deductible.

Medicare Part D drugs are a pharmacy benefit and should not be billed to Medicaid by physicians or outpatient facilities. Part D drugs are billed to Medicare on a pharmacy claim with the NDC number.

Not all drugs listed on the Physician Drug Fee Schedule are considered Part B drugs. Self Administered drugs are generally considered non-covered for Part B benefits. Coverage of Physician Drugs may be found on Medicaid's website at www.medicaid.alabama.gov or by AVRS or Provider Assistance Center at 1-800-688-7989.

Site-Specific Injections

Both the relevant CPT and J codes are billed. For example, a subconjunctival injection to the eye would be billed as 68200 (CPT) with a separate J code for the drug; thus, site specific injections are submitted as two lines.

EVALUATION AND MANAGEMENT CODES BILLED IN CONJUNCTION WITH DRUG ADMINISTRATION CODES

Effective for Dates of Service 01/01/2006 and Thereafter

When an Evaluation and Management Code (E & M) is billed, medical record documentation must support the medical necessity of the visit as well as the level of care provided. CPT Guidelines are utilized to determine if the key components of an Evaluation and Management Code are met. When an Evaluation and Management service is provided *and* a Drug Administration code (96372, 96373, 96374, 96375 and 96376) is provided at the same time, the E & M code, Drug Administration Code, and the HCPCs Code for the drug may be billed.

However, when no E & M service is actually provided at the time of a Drug Administration, an E & M code should not be billed. In this instance, the Drug Administration Code and the HCPCs Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without an E & M service being provided.

There have been 2009 CPT Code changes to describe other Administration Codes for Hydration (96360, 96361), Therapeutic, Prophylactic, and Diagnostic Infusions (96365, 96366, 96367 and 96368) and Chemotherapy Administration Codes (96401-96542). A Significant Separately Identifiable Service must be performed in conjunction with these administration codes for consideration of payment for an Evaluation and Management Code to occur. A **Modifier 25** must be appended to the E & M service for recognition as a **"Significant Separately Identifiable Service".** Procedure Codes 99211 will not be allowed with Modifier 25 or in conjunction with the administration codes for the same date of service. Medical record documentation must support the medical necessity and level of care of the visit. These services are subject to post payment review.

Chemotherapy Injections

For Dates Of Service January 1, 2006 And Thereafter

Effective for Dates of Service January 1, 2006 and thereafter, the Alabama Medicaid Agency will adopt the new CPT's Chemotherapy and Non-Chemotherapy administration codes. Alabama Medicaid will also discontinue coverage of the temporary G codes designated for Chemotherapy and Non-Chemotherapy administration codes effective December 31, 2005. The temporary G codes are effective for services provided on or after July 1, 2005 and before January 1, 2006. The crosswalk between the previous codes and the new codes is outlined on page 2 of this Alert. The following CPT drug administration codes will remain in effect and covered for 2009. Please refer to the CPT 2009 guidelines for Hydration, Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy) and Chemotherapy Administration codes. The following CPT code ranges are:

- CPT code ranges 96360 through 96376 and
- CPT codes ranges 96401 through 96542.

The change to the new codes brings about an improvement in billing and reporting codes through the creation of new codes to identify initial infusions and additional sequential infusions. There are also new codes to identify additional non-chemotherapy sequential intravenous pushes and intravenous chemotherapy pushes for additional drugs.

Alabama Medicaid has established the following new guidelines that should be utilized by physicians when billing for administration codes.

- For non-chemotherapy injections, services described by CPT codes 96372, 96374, and 96375may be billed in addition to other physician fee schedule services billed by the same provider on the same day of service.

- For IV infusions and chemotherapy infusions, if a significant separately identifiable E & M service is performed, the appropriate E & M CPT code should be reported utilizing modifier 25.

- When administering multiple infusions, injections, or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code.

- "Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

- If the patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol, these services are considered separately billable with a modifier 76.

- Medicaid will not pay for chemotherapy administration in a hospital setting, and claims for these codes with modifier 26 will not be recognized.

Please refer to Chapter 19 (Hospitals) for details on chemotherapy administration and infusion therapy.

Procedure Code Changes For Sodium Hyaluronate (Hyaluronan)
The Agency received CMS notification that the following temporary Q codes listed below have been assigned permanent J codes beginning January 1, 2008.

J7321 replaces Q4083 Hyaluronan or Derivative, Hyalgan or Supartz, for intra-articular injection, per dose,
J7322 replaces Q4084 Hyaluronan or Derivative, Synvisc, for intra-articular injection, per dose,
J7323 replaces Q4085 Hyaluronan or Derivative, Euflexxa, for intra-articular injection, per dose, and/or
J7324 replaces Q4086 Hyaluronan or Derivative, Orthovisc, for intra-articular injection, per dose.

Effective January 1, 2010 J7325 replaces J7322. The description has changed to "Hyaluronan or derivative, Synvisc or Synvisc-one, for intra-articular injection, 1mg".

Please refer to the Physicians' Drug Fee Schedule on Medicaid's website at www.medicaid.alabama.gov or call the HP Provider Assistance Center 1-800-688-7989 for reimbursement and guidelines.

Drugs Requiring Prior Authorization

EXAMPLE:

Effective September 1, 2006, injectable drugs Orencia (New Code in 2007 - J0129) and Kineret will require prior authorization as Biologicals through Health Information Designs (HID) prior to treatment. Although kineret has not been assigned HCPCS codes, you must request the Prior Authorization using procedure code J3490. After receiving authorization from HID, a CMS-1500 paper claim must be submitted to HP including the dosage and NDC number. The letter of approval from HID must be attached to the claim, and “attachment” in block 19. These drugs must be approved through HID prior to administering and billing. HID may be contacted at 1-800-748-0130. The Prior Authorization forms are located on our website at www.medicaid.alabama.gov.

Immune Globulin Replacement Codes

The Agency received CMS notification that the following temporary Q codes have been assigned permanent J codes beginning January 1, 2008.

J1568 replaces Q4087 Injection, Immune Globulin, (Octogam), Intravenous, non-lyophilized, (e.g., liquid), 500 mg.
J1569 replaces Q4088 Injection, Immune Globulin, (Gammagard), intravenous, non-lyophilized, (e.g. liquid), 500 mg.
J2791 replaces Q4089 Injection, RHO (D) Immune Globulin (Human), Rhophylac), intravenous, 100 I.U.
J1571 replaces Q4090 Injection, Hepatitis B Immune Globulin (Hepagam B), intramuscular, 0.5 ML
J1572 replaces Q4091 Injection, Immune Globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid) 500 mg.
J1561 replaces Q4092 Injection, Immune Globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg.

Please refer to the Physicians’ Drug Fee Schedule on Medicaid’s website at www.medicaid.alabama.gov or call the HP Provider Assistance Center 1-800-688-7989 for reimbursement and guidelines.

Allergy Treatments

Physicians may bill for antigen services using only the component codes (i.e., the injection only codes 95115 or 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170). Physicians providing only an injection service must bill for only code 95115 or code 95117. Professional services for allergen immunotherapy multiple injections (procedure codes 95117 and 95125) should be billed using only one unit. Effective April 1, 2003, the Agency will deny claims for these procedure codes when more than one unit is billed.

Physicians providing only the antigen/antigen preparation service would bill the appropriate code in the range of 95144 through 95170. Physicians providing both services would bill for both services. This includes allergists who provide both services through the use of treatment boards.

Physicians will no longer use the "complete" service codes, and instead must bill for both the injection and the antigen services separately, even

though the current CPT definitions of the antigen codes refer to vials and the physicians using treatment boards do not create vials.

Procedure codes 95144 - 95170 are used for the provision of single or multi-dose vials of allergenic extract for single patient use only. These procedures should only be billed at the time that these vials are supplied to the patient.

In the November 2006 Insider, an article was published to announce a change in the maximum number of allowed units for allergen immunotherapy. Medicaid is providing clarification to guide physicians who bill for the provision of allergen immunotherapy. Medicaid allows billing for the allergen at the time an individual vial is first used for a patient, but not for the entire amount of allergen/dilution prepared for the patient at once as this would likely exceed the maximum number of allowed units.

Procedure Code 95165 represents the preparation of vials of non-venom antigens. The reimbursement for procedure code 95165 is based on preparing a vial containing a mixture of all the appropriate antigens plus diluents and calculating the number of 1/2cc billing units in the vial. Using this calculation, a 10cc vial would yield 20 billing units.

Therefore, one-half (1/2) cc equals one (1) billing unit. The actual number of doses received by a patient may differ significantly from the number of billing units. If a physician removes 1/2cc billing units from a 10cc multidose vial, and 20 billing units are obtained from one vial, he/she will still bill Medicaid for 20 billing units (aliquots). Billing for more than 20 billing units per 10cc vial would represent an overpayment and be subject to post payment review and adjustment.

When a multidose vial contains less than 10cc, physicians should bill Medicaid for the number of 1/2cc billing units that may be removed from the vial. If a physician prepares two 10cc vials containing **different allergens**, he/she may bill Medicaid for a total of 40 billing units (20 billing units per vial).

The maximum number of billable units (two-10cc vials) for procedure code 95165 was set as “20” effective November 1, 2006. If multiple vials are prepared at one time, each vial should be billed when that vial is opened for use for the patient. Administration of vaccine may continue to be billed as each dose is given in the physician’s office. Medical record documentation must clearly support the treatment plan, each vial used, antigens, dosage, and changes in the treatment regime.

Claims exceeding 20 billing units (such as two 10cc vials containing different allergens) will require manual processing by sending a clean claim with medical justification, medical records, and supporting fact based documentation to:

Alabama Medicaid Agency
P.O. Box 5624
Montgomery, Alabama, 36104
Attention: Medical Support Programs

Calculation of Billing Units and Wastage

HCPCS code for J0587 reads “per 100 units”. Therefore, 100 units of J0587 will equal one billing unit. However, because of the expense of the drug, physicians are encouraged to schedule patients in a manner that they can use botulinum toxin most efficiently. For example, a physician schedules three patients requiring botulinum toxin type A on the same day within the designated shelf life of the drug (shelf life is four hours). The physician administers 30 units to all three patients and bills 30 units for the first two patients and 40 units for the last patient. The physician would bill 40 units for the last patient because the patient received 30 units but the physician had to discard 10 units.

HCPCS code for J0585 reads “per unit”. Therefore this code requires the units of service on the claim to reflect the number of units used. However, if a physician must discard the remainder of a single does vial (sdv) after administering it to a patient, the Agency will cover the amount of the drug discarded along with the amount administered. For example, a physician administers 15 units of botulinum toxin type A and it is not practical to schedule another patient who requires botulinum toxin. Situations that are impractical to schedule another patient include (a) it is the first time the physician has seen the patient and did not know the patient’s condition or (b) the physician has no other patients who require botulinum toxin injections.

Documentation requirements must include the exact dosage of the drug given and the exact amount of the discarded portion in the patient’s medical record as well as the corresponding diagnosis. However, if no benefit is demonstrable by two sets of injections, further injections will not be considered medically necessary.

Modifier JW

The Agency supports the avoidance of wasted (discarded) medicine whenever possible. Medicare requests the use of modifier JW on a second line item to indicate the wasted (discarded) amount of medication. Medicaid accepts the use of modifier JW, but total units must not exceed maximum number of allowed units.

Units of Service

Physician drug maximum number of units allowed are calculated based on a “per dose” basis, and by the narrative description of the HCPCS code. Some dosages are inherent in the narrative description of the codes and will assist in determining the number of units to file. When administering a lesser or greater dosage than the narrative description providers should round the billing unit up to the closest amount charted. For example, J0290, Ampicillin, up to 500 mg:

If administering 1000mg, bill 2 units

750 mg, bill 2 units

500 mg, bill 1 unit

125 mg, bill 1 unit

Exception: Bicillin CR and Bicillin LA

Effective January 1, 2011, Bicillin CR and Bicillin LA will be priced on a 100,000 unit per ML basis. As well, the HCPCS codes have been condensed into two vs. six codes:

If administering Bicillin CR, bill J0558 (replaces J0530, J0540 and J0550)

If administering Bicillin LA, bill J0561 (replaces J0560, 05670 and J0580)

One of the two HCPCS codes should be chosen based on the drug description. The number of billing units would then be derived by dividing the dosage by 100,000 units. Fractions of billing units are rounded up to the next whole unit.

Example: If the dosage of Bicillin LA is 1,800,000 units, choose the appropriate procedure code. In this case procedure code J0561 is the appropriate code to be used. Next, take the dosage given (1,800,000 units) and divide by 100,000 units to obtain the billing units. This dosage would yield 18 billing units (1,800,000 /100,000 = 18 units) for code J0561.

Flu Vaccination

Procedure code 90657 is covered for the administration fee under the Vaccine for Children (VFC) program for eligible children under three years of age. Procedure codes 90656 and 90658 are a covered service for the administration fee under the VFC program from age three through age eighteen. Code 90658 is covered fee-for-service (vaccine medication) from age nineteen and above.

Vaccines for Children (VFC)

The Vaccines for Children (VFC) program offers free vaccines to qualified health care providers for children who are 18 years of age and under who are Medicaid eligible, uninsured, American Indian or Alaskan Native, or the under insured. Providers must be enrolled in the VFC Program to receive any reimbursement for the administration of immunizations provided to recipients 0-18 years of age. The Alabama Department of Public Health administers this program.

Medicaid tracks usage of the vaccine through billing of the administration fee using CPT codes. Refer to Section A.6, Vaccines for Children, in the EPSDT Chapter 6 (Appendix A) in this manual, for covered CPT codes.

ImmPRINT Immunization Provider Registry

The Alabama Department of Public Health has established a statewide immunization registry. Please visit their website at https://siis.state.al.us for more information.

Adult Immunizations

Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service. Immunizations that are provided to Medicaid eligible recipients 19 years old and older must submit a claim for the appropriate CPT code. Vaccines are reimbursable on a fee-for-service basis. The administration fee may be billed separately if an office visit is not billed.

H.2 Physician Drug Fee Schedule

Physician Adminstered Drugs are those that are administered in the Physician's office or outpatient facility. A covered outpatient drug is broadly defined as a drug that may be dispensed only upon prescription and is approved for safety and effectiveness by the FDA. Physician administered drugs are not restricted to injectable drugs only but include any drug regardless of the method of administration.

The inclusion or exclusion of a procedure code does not imply Medicaid coverage, reimbursement, or lack thereof. To inquire regarding any restrictions/limits on these procedure codes, please consult the Provider Assistance Center at 1-800-688-7989 or AVRS at 1-800-727-7848. The pricing file must be verified to determine coverage and reimbursement amounts.

The Physician Drug Fee Schedule is located on the Alabama Medicaid website and can be accessed by clicking the following link: http://www.medicaid.alabama.gov/billing/fee_schedules.aspx?tab=6