Provider Billing Instructions for Drugs on the MS Select High-Cost Drug List

I. Introduction

Pursuant to State Plan Amendment MS 25-0006, the Mississippi Division of Medicaid will reimburse select drugs provided in an inpatient hospital setting separately from the APR-DRG payment. A separate claim must be submitted to receive reimbursement for select drugs during the time of inpatient services. These drugs will be reimbursed using the provider's invoice price. Invoice price must be the actual net price paid for the drug.

To ensure proper payment, providers must follow special billing instructions outlined in this document.

II. Identification of Carved Out Drugs

Only drugs listed on the MS Select High-Cost Drug list, located at Fee Schedules and Rates - Mississippi Division of Medicaid, are subject to the principles outlined in this billing instruction guide. Other drugs may be added to this list in the future at the discretion of the Mississippi Division of Medicaid. All other covered outpatient drugs shall follow standard payment methodology.

Drugs administered in the inpatient setting do not qualify for 340B discounts even if, because they are directly reimbursed, they are considered "covered outpatient drugs" for the purposes of the Medicaid Drug Rebate Program.

III. Centers for Medicare and Medicaid Services Cell and Gene Therapy Access Model

The Cell and Gene Therapy Access Model is a multi-year, voluntary model for states and manufacturers to test whether a CMS-led approach to developing and administering outcomes-based agreements for cell and gene therapies increases Medicaid beneficiaries' access to innovative treatment, improves their health outcomes, and reduces healthcare costs and burden to state Medicaid programs.

The Mississippi Division of Medicaid is participating in this Model effective January 1, 2026. Under the Cell and Gene Therapy Access Model, administration of gene therapy for sickle cell disease (SCD) will be for individuals who are inpatient. Providers cannot claim 340B discounts on Model drugs.

Members Eligible for Sickle Cell Disease Cell and Gene Therapies

Members must receive prior authorization approval to receive cell and gene therapies for sickle cell disease.

The clinical access or prior authorization criteria can be found at the following link: Drug Prior Authorization (PA) - Mississippi Division of Medicaid.

Providers Eligible to Bill for Sickle Cell Disease Cell and Gene Therapies
To be eligible to bill for sickle cell disease cell and gene therapies, providers must be qualified to administer cell and gene therapies. A provider submitting a claim for a Model beneficiary who was administered a State-Selected Model Drug must be registered with the CMS-designated patient registry for the Model and must also seek beneficiary consent for participation in a CMS-specified study.

A provider submitting a claim for these agents must follow the billing instructions below. Payment is contingent upon compliance with these Model requirements.

IV. Billing
Only one provider per claim should pursue billing for these products. The instructions for the two billing options are listed below.

Option 1: The Inpatient Hospital provider will submit an Outpatient (UB04) claim with Type of Bill (TOB) **13x** - *Outpatient hospital services* , using their Billing NPI/Taxonomy. The detail Date of Service (DOS) will reflect the date when the cell and gene therapy is administered to the member. The Cell or Gene Therapy drug will be submitted under a specified Revenue Code (options such as Revenue Code **636** - *Drugs that require detail coding* or **892**- *Special processed drugs – FDA approved Gene Therapy*), along with the appropriate 'J' code (HCPCS) and NDC. Providers must also submit on the claim the number of units of the drug administered. This should be the only charge (detail) payable on the outpatient claim. If other details are submitted, they will deny. The claim will require an invoice showing the actual net price for the drug. An invoice must be attached to the claim to support the drug cost. The invoice must reflect actual acquisition cost after discounts. The drug will be reimbursed at the submitted invoice price with no markup. The claim will be suspended for manual review, and the claims processor will price the claim using the attached invoice.

Option 2: The Specialty Pharmacy provider supplying the drug will submit the claim on a CMS 1500 form. The Specialty Pharmacy will submit using their Billing NPI /Taxonomy. The detail Date of Service (DOS) will reflect the date when the cell and gene therapy is administered to the member. The Place of Service (POS) will reflect '**21** – *Inpatient Hospital*'. The appropriate 'J' code (HCPCS), the NDC number, and the number of units administered must be submitted on the claim. This should be the only charge (detail) payable on the Professional claim. If other details are submitted, they will deny. The claim will require an invoice showing the actual net price for the drug. An invoice must be attached to the claim to support the drug cost. The invoice must reflect actual acquisition cost after discounts. The drug will be reimbursed at the submitted invoice price with no markup. The claim will be suspended for manual review, and the claims processor will price the claim using the attached invoice.