

# 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 using the UB-04 or CMS1500 form 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](#).

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## **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 must 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) must reflect the date when the cell and gene therapy is administered to the member.
- Along with the appropriate 'J' Code (HCPCS) and 11-digit National Drug Code (NDC), the Cell or Gene Therapy drug must be billed under a specified Revenue Code, such as:
  - **636** - *Drugs that require detail coding or*
  - **892** - *Special processed drugs – FDA approved Gene Therapy*
- 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. Additional details will be denied.
- An invoice showing the actual net acquisition cost for the drug after discounts must be attached with the claim.
- The drug will be reimbursed at the submitted invoice price with no markup.
- The claim will pend for manual review, and the claims processor will price the claim using the attached invoice.

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**Option 2:** The Specialty Pharmacy provider supplying the drug must submit the claim on a CMS 1500 form. The Specialty Pharmacy must submit using their Billing NPI /Taxonomy. Taxonomies eligible for billing under this option are 333600000X Pharmacy, 3336C0003X Pharmacy - Community/Retail Pharmacy, 3336H0001X Pharmacy - Home Infusion Therapy Pharmacy, or 3336S0011X Pharmacy - Specialty Pharmacy. Pharmacy providers who wish to bill for these products should update their enrollment with the appropriate taxonomy.

- The detail Date of Service (DOS) must reflect the date when the cell and gene therapy is administered to the member.
- The Place of Service (POS) must reflect **21** - *Inpatient Hospital*.
- The appropriate 'J' code (HCPCS), the 11-digit National Drug Code (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. Additional details will be denied.
- An invoice showing the actual net acquisition cost for the drug after discounts must be attached with the claim.
- The drug will be reimbursed at the submitted invoice price with no markup.
- The claim will pend for manual review, and the claims processor will price the claim using the attached invoice.