CHANGE REQUEST 2544

SUBJECT: Single Drug Pricer (SDP)

Scope

This Program Memorandum (PM) clarifies instructions contained in Transmittal AB-02-174 (CR 2381) issued on December 3, 2002.

The Single Drug Pricer (SDP) instruction applies to blood clotting factors furnished to hospital inpatients.

All hospital outpatient drugs are excluded because the payment allowance for such drugs is determined by a different procedure from that described in PM AB-02-075.

Provider Education

Carriers and Intermediaries must include the following statement in all media used to address the SDP:

The presence or absence of a particular drug on the SDP file does not represent a determination that the Medicare program either covers or does not cover that drug. The amounts shown on the SDP file indicate the maximum Medicare payment allowance, if the Medicare contractor determines that the drug meets the program's requirements for coverage. Similarly, the absence of a particular drug from the SDP file means that if the Medicare contractor determines that the drug is covered by Medicare, the local contractor must then determine the program's payment allowance by applying the program's standard drug payment policy rules. Medicare contractors separately determine whether a particular drug meets the program's general requirements for coverage and, if so, whether payment may be made for the drug in the particular circumstance under which it was furnished. Examples of this latter determination include but are not limited to determinations as to whether a particular drug and route of administration are reasonable and necessary to treat the beneficiary's condition, whether a drug may be excluded from payment because it is usually self-administered, and whether a least costly alternative to the drug exists.

This information must be shared with providers through your Web site within two weeks and published in your next regularly scheduled bulletin.

The *effective date* for this PM is February 7, 2003.

The *implementation date* for this PM is February 14, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2004.

If you have any questions, contact your regional office.

Attachment

CMS-Pub. 60AB

NDC Billed	Claim Units		NDC Strength Per ML	NDC Total Strength	Billed Strength/Dosage
	NCPDP Defined Unit Billed Each, Per ML, Per Gram				
00186115903	2		0.5	1	1
00186115903	1		0.5	1	0.5
00186115002	10		0.5	5	5
00186115002	5		0.5	5	2.5
00186116003	2		1	2	2
00186116003	1		1	2	1
00186115102	10		1	10	10
00186115102	5		1	10	5

Color coding of NDC Billed, illustrates conversions based on partial use of total vial volume, e.g. multi dose vials

NCPDP Defined Unit Billed (Each, Per ML, Per Gram) - Variable (value can be different on each claim)
NDC Total Strength - Literal (Value is specific to each NDC and remains unchanged)
NDC Strength Per ML - Literal (Value is specific to each NDC and remains unchanged)
Billed Strength/Dosage = **Formula (NDC Strength per ML*Volume Billed)**
HCPCS Unit of Measure - Literal (Unit of Measure defined by HCPCS Code)
HCPCS Code = HCPCS code that corresponds to the NDC
HCPCS Price Per Unit = Medicare allowance for HCPCS
Pricing Unit = **Formula (Billed Strength or Dosage/HCPCS Unit of Measure)**
Allowed Amount = Formula (HCPCS Price Per Unit *Pricing Unit)

Note: For up to drugs, the *HCPCS Unit of Measure* would represent the literal measure described by the up to strength, ex. Up to 10 mg would equate to a *HCPCS Unit of Measure* = 10

1 Gram = 1000 milligrams
1 Liter = 1000 milliliters
Units = each
International Units = each

CONVERSION TABLE

HCPCS Unit of Measure	HCPCS Code	HCPCS Price per Unit	Pricing Unit	Allowed Amount
10	J2275	$2.38	0.1	$0.24
10	J2275	$2.38	0.05	$0.12
10	J2275	$2.38	0.5	$1.19
10	J2275	$2.38	0.25	$0.60
10	J2275	$2.38	0.2	$0.48
10	J2275	$2.38	0.1	$0.24
10	J2275	$2.38	1	$2.38
10	J2275	$2.38	0.5	$1.19