Provider Bulletin
Volume XX Number XX

Temporary Deactivation of Maximum Daily Limits for Drugs on Crossover Claims

Applies to: Providers Billing for Drugs on Crossover Claims

Effective Date: June 25, 2026

Summary of Policy Revision

The MO HealthNet Division (MHD) previously implemented maximum daily limits for drugs billed on crossover claims, effective March 18, 2026. Refer to **Bulletin 48-48** for more information. However, due to a technical issue with the quantity editing process for these claims, this edit has been temporarily disabled, effective June 25, 2026.

MHD is actively working to resolve the technical issue. Once resolved, the maximum daily limit edit will be reactivated, and claims exceeding the limits will once again be subject to denials.

Claims previously denied due to the maximum daily limit quantity edits may now be resubmitted for payment while the edit is turned off.

Interim Provider Requirements

During the temporary deactivation of the automated system edit, it remains important to maintain diligent and accurate billing practices to support proper reimbursement and drug manufacturer rebate invoicing.

- **Accurate Date Spans:** Providers must continue to bill claims using the correct date span for all products dispensed
- **Dual Unit Reporting:** Report both Healthcare Common Procedure Coding System (HCPCS) and National Drug Code (NDC) units on electronic claims in the appropriate loops
    - **HCPCS Units:** Must be submitted in Loop 2400
    - **NDC Units:** Must be submitted in Loop 2410

Electronic Claim Guidelines (ANSI 837P and ANSI 837I)

Billing systems should be configured to accurately populate the following fields:

Field Name	Field Description	Loop ID	Segment
Days/Units Billed	Enter the appropriate healthcare common procedure coding units	2400	*Standard HCPCS Segments*
Product ID Qualifier	Enter **N4** in this field	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered	2410	LIN03
Decimal Quantity	Enter the quantity (number of NDC units)	2410	CPT04
Unit or Basis of Measurement	Enter the NDC Unit of Measure (UOM) for the prescription drug given	2410	CPT05

For information on Loop ID and Segments refer to the **HIPAA Transaction Standard Companion Guide**.

UOM Reference Table:

UOM	UOM Name	UOM Description
F2	International Unit	Factor drugs or micrograms
GR	Gram	Ointment, cream, inhaler
MG	Milligram	Not typically used for NDC quantity
ML	Milliliter	Vial in liquid form, syringe
UN	Unit	Vial in powder form, tablet, capsule

eMOMED Instructions for Professional Crossover Claims

Providers utilizing **eMOMED** to manually submit professional crossover claims should follow the steps below to verify and update their drug data:

1. Enter the National Provider Identifier (NPI) and locate the appropriate claim
2. Select Copy Claim and Original
3. Under Add Detail Line/Detail Line Summary, select the pencil (edit) icon next to the appropriate line to update
4. Verify the following information in the Detail Line Summary section:

- **Procedure Code:** HCPCS/CPT code
- **Days/Units Billed:** Number of units
- **Revenue Code:** Revenue Code associated with the administered drugs, if applicable *(only visible when required for the claim)*
- **Dates of Service:** Date span (from and to) for the administered drug. The date span must accurately reflect the number of units dispensed and may differ from the dates originally reported to Medicare.
- **NDC Details:**
  - **NDC:** 11-digit NDC in billing format with no hyphens
  - **Decimal Quantity:** Exact number of NDC units dispensed, ensuring it matches the date range submitted **with a decimal point**
  - **Unit or Basis of Measurement:** NDC UOM qualifier (e.g., UN, ML, GR, or F2). Refer to the UOM Reference Table above.

5. If any of the information above is missing or incorrect, enter the correct information and Save Detail Line to Claim, then Submit Claim. For assistance, call Provider Communications at (833) 222-7916 or reach them via **eMOMED**.

eMOMED Instructions for Institutional Crossover Claims

Providers utilizing **eMOMED** to manually submit institutional crossover claims should follow the steps below to verify and update their drug data:

1. Enter the National Provider Identifier (NPI) and locate the appropriate claim
2. Select Copy Claim and Original
3. Under Add Detail Line/Detail Line Summary, select the pencil (edit) icon next to the appropriate line to update
4. Verify the following information in the Detail Line Summary section:
   - **Procedure Code:** HCPCS/CPT code
   - **Days/Units Billed:** Number of units
   - **Revenue Code:** Revenue Code associated with the administered drugs, if applicable *(only visible when required for the claim)*
   - **Dates of Service:** Date span (from and to) for the administered drug. The date span must accurately reflect the number of units dispensed and may differ from the dates originally reported to Medicare.
5. If any of the information above is missing or incorrect, enter the correct information and Save Detail Line to Claim, then Submit Claim. For assistance, call Provider Communications at (833) 222-7916 or reach them via **eMOMED**.

Note for institutional crossover claims: eMOMED does not currently feature input fields for reporting NDC data on institutional crossover claim entry screens. To ensure accurate dual-unit reporting (HCPCS and NDC) required for institutional drug line items, providers must submit the institutional crossover claim via an 837I electronic transaction through their clearinghouse or billing software. This allows full reporting of HCPCS units in Loop 2400 and NDC details in Loop 2410.

Future Reactivation and Override Requests

Once the technical issue is resolved and the edit is reactivated, claims that exceed the established daily limits will be denied. Providers will receive notifications when the edit is reactivated.

If a clinical dosage exceeds the established maximum daily limit after the edit is reactivated, an override request may be submitted by contacting MHD Pharmacy Administration at (573) 751-6963 (8:00 a.m. – 5:00 p.m., Monday through Friday) or by emailing **MHD.PharmacyAdmin@dss.mo.gov**.

For assistance with claim submission, crossover claims, and other billing questions, contact Provider Communications via **eMOMED** or by calling (833) 222-7916.

*MO HealthNet Fee-For-Service (FFS) policies guide basic coverage for Managed Care (MC), though MC plans may add requirements like prior authorization. Some services, including pharmacy, are carved out of MC and paid through FFS. Contact each **MC health plan** to confirm how this Bulletin applies. Unresolved issues may be submitted through the **MC Provider Request for Information** to reach an MHD MC Liaison.*

*Before providing services, verify patient eligibility by swiping the MO HealthNet card, calling Provider Communications at 573-751-2896 or toll-free (833) 222-7916 (Option 1) or using **eMOMED** Direct MC benefit questions about MC benefits to the member's MC health plan.*

*Bulletins remain on the MO HealthNet News page for three years. Providers are encouraged to **subscribe** for updates. Visit **MHD Education and Training** for web-based training and resources, or submit an **MHD Education Request** to schedule training.*