CLAIMS CLUES

A Publication of the AHCCCS Claims Department

JULY 2012

IMPORTANT ARIZONA DEPARTMENT OF CORRECTION (ADOC) INFORMATION

Wexford Health has been awarded the ADOC contract. They will be the new third party administrator for ADOC **effective July 1, 2012**. AHCCCS will continue to process run out claims for dates of service prior to June 30, 2012. Claims with dates of service July 1st and after must be sent to Wexford. Providers may continue to contact AHCCCS for questions and submit claims to us for dates of service prior to June 30th. Below is contact information that providers will use to file a claim and/or contact the new third party administrator.

Wexford Health Claims Department
425 Holiday Drive
Foster Plaza 2
Pittsburgh, PA 15220
Kathy Ohleger – Manager 412.937.8590 x223
kohleger@wexfordhealth.com

Jeannie Burke – Claims Supervisor 412.937.8590 x252 –
jburke@wexfordhealth.com

Customer Service:
Phone: 1.877.939.2884 Option #1 (customer service)
Fax: 412.920.1776

Claims Submission Address:
Wexford Health Sources, Inc.
PO Box 16268
Pittsburgh, PA 15242-0268

IMPORTANT 5010 CHANGES

Please be aware of an upcoming 5010 change. When we fully implement the 5010 maps and process (07/01/12), the Ordering Provider will come in on the 2420E Ordering Provider loop, as per the transaction implementation guides. We have noted in our companion document to distinguish between the current method as outlined in the October/November/December 2011 Claims Clues, where it indicates how to identify an Ordering Provider in a claim, and for the Electronic claim submissions, to use the ordering provider 2310A loop (referring provider). While this is okay during the Reverse Map period, when 5010 is fully implemented, the Ordering Provider should be identified in the Ordering Provider loop beginning 07/01/12.
The above information also applies to MDC crossover claims.

This is just a heads up reminder of the need for providers to put the Ordering Provider information at the 2420E Ordering Provider loop **effective 7/1/12.**

MREP UPGRADE NEEDED FOR 5010 CHANGES

With the implementation of the 5010 change on **July 1, 2012** anyone using Medicare Read Easy Print (MREP) will need to upgrade to 3.2.2 in order to view the 835 remits. The new version of MREP 3.2.2. can be found at:

http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html

The new version of MREP will not affect the download/save process in the SFTP server. The new version will allow providers to process the 5010 version of the 835 in MREP.

PERM UPDATE- MEDICAL DOCUMENTATION REQUESTS

The CMS PERM audit is moving along very quickly. The CMS contractor A Plus Government Solutions is actively requesting medical documents from Providers & conducting medical reviews.

If you receive a request for documentation, please be responsive to that request. Please follow the letters submission instructions very carefully.

If a Provider fails to submit the requested documentation or the PERM contractor fails to receive the documentation, the State of Arizona will incur

an audit error. We will try to dispute the error, but we will need to visit the billing Providers office to obtain the needed documentation. If we are unable to dispute the error, CMS mandates that the Providers payment be recouped. Providers will be unable to resubmit claims for these recoupments.

WHERE TO FILE CLAIM DISPUTES

For AHCCCS Fee for Service, American Indian Health Plan and *Medicaid eligible* inmates, a provider can file a claim dispute with:

AHCCCS Office Administrative Legal Services
Mail Drop 6200
P O Box 25520
Phoenix, AZ 85002

For *ADOC inmates*:
Providers file claim disputes directly with the Arizona Department of Corrections. A provider must file an ADOC inmate claim dispute with:

ADOC Budget Administrator
Program Services Division
1601 West Jefferson Street
Phoenix, Arizona 85007-3002

NOTICE OF CHANGES TO BILLING REQUIREMENTS FOR DRUGS ADMINISTERED IN OUTPATIENT CLINICAL SETTINGS

Effective July 1, 2012, AHCCCS is implementing new billing requirements for drugs administered in outpatient clinical settings. These requirements are in accordance with and support of the Federal Deficit Reduction Act of 2005, which mandates that all providers submit the National Drug Code (NDC) on all claims with procedure codes for physician-administered drugs in outpatient clinical settings. These services are currently represented on submitted claims by the use of the Healthcare Common Procedure Coding System (HCPCS) codes. AHCCCS will begin reviewing data submitted on 7/1/12. However, AHCCCS will begin editing on this data requirement beginning 10/1/12.

Background

The Deficit Reduction Act of 2005 (DRA) included new provisions regarding State collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for physician-administered drugs. Section 6002 of the DRA adds section 1927(a)(7) to the Social Security Act to *require* States to collect rebates on physician-administered drugs. In order for Federal Financial Participation (FFP) to be available for these drugs, the State must provide collection and submission of utilization data in order to secure rebates. Since there are often several NDCs linked to a single HCPCS code, the Centers for Medicare and Medicaid Services (CMS) deem that the use of NDC numbers is critical to correctly identify the drug and manufacturer in order to invoice and collect the rebates.

NDC Definition

The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer. Some packages will display less than 11 digits, but leading "0's" can be assumed and need to be used when billing. For example:

XXXX-XXXX-XX = 0XXXX-XXXX-XX
XXXXX-XXX-XX = XXXXX-0XXX-XX
XXXXX-XXXX-X = XXXXX-XXXX-0X

The NDC is found on the drug container, i.e. vial, bottle, tube. The NDC submitted to the AHCCCS FFS Program and/or MCO Contractors must be the actual NDC number on the package or container from which the medication was administered. Claims may *not* be submitted for one manufacturer when a different manufacturer's product was administered. It is considered a fraudulent billing practice to bill using an NDC other than the one assigned to the drug administered.

When submitting a Medicaid claim for administering a drug, providers must submit the 11-digit NDC **without dashes or spaces** between the numbers. Claims submitted with NDCs in any other configuration may fail.

Providers of "physician-administered" drugs

Providers of "physician-administered" drugs include any AHCCCS registered provider whose license and scope of practice permits the administration of drugs, such as a medical doctor (MD), doctor of osteopathic medicine (DO), nurse practitioner (NP), physician assistant (PA), ambulatory surgery centers (ASCs), hospital outpatient clinic/services and skilled nursing facilities (SNFs).

Exception: IHS /tribally operated 638 facilities reimbursed at the federally the published all-inclusive rate.

HCPCS codes that will require the NDC information on the claim submission

Drugs billed using HCPCS codes include:

- A, C, J, Q and S codes as applicable.
- "Not otherwise classified" (NOC) and "Not otherwise specified" (NOS) drug codes (e.g., J3490, J9999, and C9399).
- CPT codes, 90281-90399 for immune globulins
- CPT Codes 90476-90749 for vaccines and toxoids

In order to comply with this mandate, contractors and providers **must** do the following, effective for the dates of service on or after July 1, 2012:

- Providers **must** submit a valid 11-digit NDC when billing a HCPCS drug or CPT procedure code as defined above.
- The qualifier "N4" must be entered in front of the 11-digit NDC. The NDC will be submitted on the same detail line as the CPT/HCPCS drug procedure code in the pink shaded area.

Revenue Center Codes affected

To support the NDC claims submission requirements, the following Revenue Center Codes may require a CPT or HCPCS code for administration of the drug and reporting of the specific NDC and quantity:

- 0250-259
- 0262
- 0263
- 0331
- 0332
- 0335
- 0634-0637

NDC quantity to be billed and claims elements required

NDC units are based on the numeric quantity administered to the patient and the unit of measurement. The actual metric decimal quantity administered and the unit of measurement is required for billing. If reporting a fraction, use a decimal point. The units of measurement codes are as follows:

- NDC of the drug administered as described above
- NDC Unit of Measure
    - **F2** = International Unit
    - **GR** = Gram - usually for products such as ointments, creams, inhalers, or bulk
      This unit of measure is typically used in the retail pharmacy setting.

    - o **ML** = Milliliter - for drugs that come in vials which are in liquid form
    - o **UN** = Unit (each) - for unit of use preparations, generally those that must be reconstituted prior to administration.
- Quantity administered equals number of NDC units
- NDC unit price equals detail charge divided by the quantity administered

Note: Providers must also continue to submit Revenue Codes, HCPCS codes and related service units in addition to the required NDC information.

HCPCS to NDC quantity conversion examples:

Note: Payment is based on the quantity of J code units administered.

HCPCS	NDC	Quantity Conversion
J9305	00002762301	HCPCS code is per 10mg and the product comes as a dry powder injection 500mg. NDC units are “each vial” Dose was 100 mg, for example HCPCS quantity = 10 and the NDC quantity = 100/500 = 0.2 Enter: N400002762301 UN0.2 on the CMS-1500.
J3110	00002897101	HCPCS code is for 10mcg and the product comes as 250mcg/ml NDC units are ml Dose was 750mcg HCPCS quantity = 75 and the NDC quantity = 3 Enter: N400002897101 ML3 on the CMS-1500.
J1745	57894003001	HCPCS code is for 10mg and product comes as 100mg powder for injection. NDC units are "each vial" Dose was 200mg HCPCS quantity = 20 (20 x 10mg) = 200mg and the NDC quantity is 2. This is true even if the dry powder was reconstituted to 20ml. Enter: N457894003001 UN2 on the CMS-1500.

Paper Billing Instructions

Beginning with dates of service on or after 7/1/2012, all institutional (UB04/837I) and professional (CMS-1500/837P) claims must include the following information:

- NDC and unit of measurement for the drug billed, and
- HCPCS/CPT code and units of service for the drug billed, and
- The actual metric decimal quantity administered.

UB04 Claim Form

To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above)
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.

The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.
- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00
2				
3				

CMS-1500 Claim Form

To report the NDC on the CMS-1500 claim form, enter the following information:

- In Field 24A of the CMS-1500 Form in the shaded area, enter the **NDC Qualifier** of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.

- The billed units in column **G** (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

Example of CMS1500 Paper Claims

24. A						B	C	D	
DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
N400074115278 ML10									
07	01	12	07	01	12	11		J1642	

Note: Submission of multiple NDCs per HCPCS is not allowed.

Electronic Billing Instructions
837 Claims Submission for NDC:

837 Drug Identification			
Loop	Segment	Field Name	Requirement
2410	LIN02	Prod/Serv ID Qualifier	A value of "N4" is expected.
2410	LIN03	Prod/Service ID	An 11-digit NDC number is expected and will be mapped to the CPDNDC Prod/Service ID.
2410/2400	CTP03/ SV203	Unit Price	The unit price is expected and will be mapped to CPDNDC unit price. If the unit price on segment CTP03 is different than the unit price on the SV102, then map CTP03; otherwise map SV102.
2410/2400	CTP04/ SV104	Quantity	The quantity is expected and will be mapped to CPDNDC quantity. If the unit price on segment CTP03 is different than the unit price on the SV102, then map CTP04; otherwise map SV104.
2410/2400	CTP05/ SV103	Composite Unit of Measure	The composite unit of measure is expected and will be mapped to CPDNDC composite unit of measure. If the unit price on segment CTP03 is different than

			the unit price on the SV203, then map CTP04; otherwise map SV103.

Note: Submission of multiple NDCs per HCPCS is not allowed.

Remittance Advice if NDC is Submitted Incorrectly
If the NDC billing information is missing or invalid, claims may fail. AHCCCS FFS Providers and MCO Contractors will have to resubmit the claim(s) with the required NDC information and/or correct number of units within the time allowed for potential payment.

For Your Information:

- Vendor software submitters please check with your vendor to ensure your software will be able to capture the criteria necessary to submit the 837 with the required NDC information.

- Revised CMS 1500 paper, 837 and on-line billing guidelines will be posted to the AHCCCS website shortly after the release of this notice.

- Training will be provided to FFS providers and MCO staff prior to 7/1/2012 as needed.

If you have any questions or need additional clarification regarding this notice please email:

AHCCCSNDCData@azahcccs.gov.