NDC required when billing for drugs

Section 6002 of the Deficit Reduction Act of 2005 (DRA) requires States to collect rebates on physician-administered drugs. In order for Federal Financial Participation (FFP) to be available for these drugs, WV must provide data in order to secure rebates. Since there are often several NDCs linked to a single Healthcare Common Procedure Coding System (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. Since 1991, it has been required that outpatient Medicaid pharmacy providers dispense only rebateable drugs and bill with the NDCs. Now, with the Deficit Reduction Act of 2005, this requirement is being expanded to include physician-administered drugs.

As of July 1, 2007, for dates of service 7/1/07 and after, drugs that are not rebate eligible and drugs billed without NDC information are posting “warning” edits on the remittance advice. On January 1, 2008, for dates of service 1/1/08 and after, the edits will be set to deny so claim lines billed for certain drugs that are not rebateable or that do not include the NDC qualifier, the NDC, the NDC units of measure and/or the NDC units.

The BMS webpage, www.wvdhhr.org/bms, under “Information” has a section named Practitioner/Outpatient Facility Administered Drugs which contains a Provider Notice, FAQ’s, Drug Code Lists and Billing Instructions. Billing Instructions may also be found on the BMS website in Appendix H of the Provider Manuals and on Unisys’ website under Manuals. The Drug Code List has information regarding coverage, service limits and whether an NDC is required when billing. Remember though, that even if a drug is listed as covered, that coverage ultimately depends on if the NDC is rebate eligible.

Medicare HMO Plans

Due to the advent of numerous Medicare Advantage plans or Medicare HMO’s, BMS and Unisys are working to develop additional programming that will allow claims billed to the Medicare Advantage plans as primary to process through Unisys as secondary without denying for “other insurance”. If you bill your secondary claim on paper, you can help minimize the errors by writing on the EOMB that it is a Medicare Advantage or Medicare HMO plan.

Please note: Claims processed by Medicare HMOs are treated the same as claims from all other Medicare carriers in that the system will calculate the Medicaid allowed amount and then compare the co-insurance/co-pay amount and the deductible amount to the difference between the paid amount and the Medicaid allowed amount and pay the lesser of these amounts. See Section 620 of Chapter 600 of the Provider Manuals.
Tamper-resistant Prescription Pads

Section 7002(b) of the U.S. Troop Readiness, Veterans’ Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law on May 25, 2007, and requires states to enforce the use of tamper-resistant prescription pads for prescriptions written for Medicaid members. The original date of implementation was October 1, 2007. However, on Saturday, September 29, 2007, President George W. Bush signed the “Extenders Law,” delaying the implementation date until April 1, 2008.

WV Medicaid’s failure to enforce this requirement will result in the loss of Federal financial participation relating to covered drugs.

Effective for dates of service on and after April 1, 2008, a prescription pad must contain one of the characteristics listed below:

For services on and after October 1, 2008, it is required that a prescription pad contain all three of these characteristics:

<table>
<thead>
<tr>
<th>Required tamper-resistant characteristics</th>
<th>Examples include but are not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more industry-recognized features designed to:</td>
<td></td>
</tr>
<tr>
<td>1 Prevent unauthorized copying of a completed or blank prescription form</td>
<td>• High security watermark on reverse side of blank</td>
</tr>
<tr>
<td>2 Prevent erasure or modification of information written on the prescription by the prescriber</td>
<td>• Tamper-resistant background ink shows erasures or attempts to change written information</td>
</tr>
<tr>
<td>3 Prevent the use of counterfeit prescription forms</td>
<td>• Sequentially numbered blanks</td>
</tr>
</tbody>
</table>

This requirement applies to all non-electronic prescriptions, legend and over-the-counter, written for WV Medicaid members, when Medicaid is the primary or secondary payer.

Drug Enforcement Administration and West Virginia Board of Pharmacy laws and regulations pertaining to written and electronic prescriptions for drugs still apply.

West Virginia Medicaid will not endorse specific vendors that supply tamper-resistant pads.

West Virginia Medicaid will not purchase compliant prescription pads for Medicaid prescriptions nor provide them to prescribers.

Exceptions to Tamper-resistant Rx Pads

Exempt from the tamper-resistant requirement are Medicaid prescriptions that are:

- Paid by managed care organizations (MCOs)
- Provided in specified institutional and clinical settings* for which the drug is not separately reimbursed, but is reimbursed as part of a total service
  * Institutional and clinical settings: nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR): inpatient and outpatient hospital, hospice, dental, laboratory, x-ray and renal dialysis services
- E-prescribed, faxed to the pharmacy from the provider’s office, or telephoned to the pharmacy by the provider
- Refills for which the original prescription was filled before April 1, 2008

Emergency Fills

Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription. In this situation, prescriptions may be filled with the entire prescribed quantities within the coverage limits.
Additional Resources

U.S. Troop Readiness, Veterans’ Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (H.R. 2206), section 7002(b)

Centers for Medicare & Medicaid Services (CMS) Letter to State Medicaid Director (SMDL #07-012, 8/17/2007)

Billing for Services that Require Prior Authorization

In order to assure proper claim adjudication, be sure to bill with the prior authorization number on the claim. The system will try to populate a claim with the correct prior authorization number but frequently there are multiple authorizations for the member for different services so the system is unable to determine the correct PA. Many claims are denied for Reason code 197 which says “Payment adjusted for absence of precertification/authorization”. This change effective 1/1/2008. Payment adjusted for absence of precertification/authorization/notification, when billed without a prior auth number.

WV MMIS Clinical Auditing Solution

In July 2007, effective with dates of service 7/1/07, a “Clinical Auditing Solution” was implemented to audit professional (CMS 1500) claims via a McKesson product called Claim Check. This has allowed the claims processing system to audit with standard bundling, age, gender, pre and post op edits as well as some custom edits specific to WV Medicaid. Institutional (UB) claims will be added to the process at a later date.

The clinical auditing solution prevents much of the post audit reviews performed previously to assure correct claim payment according to claims processing rules. Coding claims correctly with procedure codes and modifiers is imperative to assure that claims are adjudicated correctly. Read modifier information carefully and use in conjunction with the RBRVS spreadsheets on the BMS website under Manuals and Instructions. (See article in this Bulletin on RBRVS Spreadsheet.)

A few rules to keep in mind are:

- Repeat lab tests performed on the same day, whether the repeated test was included in panel or billed as a separate procedure in the first performance, must be billed with modifier 59, not 91, to be considered for payment.
- Modifier 57 will not be recognized for payment of pre-surgical visits the day before or the day of surgical procedures. (See section 507.5 CONSULTATIONS of the Practitioner Services Manual.)
- DME claims will be audited with the information in the DME/Supplies Manual for procedures that are not covered when billed on the same day. (See Attachment I of the DME/Medical Supplies Manual.)
- Ambulance claims will be audited with the information in the Transportation Manual for procedures that are not payable on the same ambulance run. (See Attachment 3 of the Transportation Manual.)
- Modifier 51, multiple procedures modifier, will be added by the claims processing system based on the procedure’s assigned RVUs and does not have to be billed. (The modifier will only be added to claims for dates of service on and after 7/1/07.)
- Bundled services provided by a psychiatrist and a Master’s Level Social Worker (employed by the psychiatrist) or Master’s Level counselor (employed by the psychiatrist) on the same day will be allowed only by the use of modifier 59, distinct procedural service, in addition to modifier AJ, clinical social worker. Modifier 59 may be added to either service code; however, modifier AJ MUST be added to the service provided by the social worker.
RBRVS Spreadsheet Information on the BMS website

Are you aware that the BMS website, www.wvdhhr.org/bms, under Manuals and Instructions, has a spreadsheet of CPT/HCPCS codes that contains some useful information for providers? It lists whether a code is covered; if it is priced by RBRVS (status A); if priced with carrier price (status C); if the code is divided into professional (modifier 26) and technical (modifier TC) components; the RVUs used to calculate the fee when the service is provided in an office setting or facility setting, the global period and whether the code is subject to the multiple surgical modifier (51), bilateral modifier (50); or if assistant surgeons (modifiers 80, 81, 82 or AS), co-surgeons (modifier 62) or team surgeons (modifier 66) are allowed to bill for the service. There are separate documents listed below the spreadsheets, listing the conversion factors used in calculating the fee (multiply the RVUs by the conversion factor) and a key for values of the indicators. As of 7/1/07 the claims processing system will add modifier 51 to the claim when it is applicable but all other modifiers must be billed by the provider when applicable.

While the RBRVS file is helpful to providers, it can be a little confusing. It lists codes that are covered by WV Medicaid but not all codes are covered to all providers. There are many codes listed that may only be covered to physicians or only covered to physical therapists or perhaps, only covered to physicians with certain specialties. Some codes may have restrictions such as they may only be covered with prior approval or with prior approval when done as an outpatient procedure. Because we pay such a variety of providers by many different payment methodologies, one cannot tell if, or how much, they will be paid for a service simply by it appearing on the list as a covered service. Unisys Provider Relations may be contacted for specific information if needed. Each specific policy manual should be reviewed for coverage prior to rendering services.

The RVUs listed on the RBRVS spreadsheets are not the payment methodology used for all providers. For instance, the ER codes, 99281 thru 99285, pay by the RVUs to physicians but pay by a specific flat fee to hospitals. The surgical codes pay to physicians by RVUs, to outpatient hospitals by a flat fee or calculated by a set fee per 15 minute time units and to Ambulatory Surgical Centers by ASC levels. RVUs are used for calculating fees for radiology and diagnostic procedures and for occupational and physical therapy to all providers. Please see the individual Chapters 500 for each provider type and Chapter 600 of the Provider Manuals for information on reimbursement methodologies.

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<tbody>
<tr>
<td>59000</td>
<td>59000</td>
<td>59000</td>
<td>Amniocentesis, diagnostic</td>
<td>A</td>
<td>3.23</td>
<td>2.13</td>
<td>000</td>
<td>Y</td>
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<td>N</td>
<td>N</td>
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<td>59001</td>
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<td>4.79</td>
<td>000</td>
<td>Y</td>
<td>N</td>
<td>N</td>
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<td>59012</td>
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<td>Fetal cord puncture, prenatal</td>
<td>A</td>
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<td>000</td>
<td>Y</td>
<td>N</td>
<td>D</td>
<td>N</td>
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<td>59015</td>
<td>59015</td>
<td>59015</td>
<td>Chorion biopsy</td>
<td>A</td>
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<td>3.52</td>
<td>000</td>
<td>Y</td>
<td>N</td>
<td>D</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>59020</td>
<td>59020</td>
<td>59020</td>
<td>Fetal contract stress test</td>
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<td>1.67</td>
<td>000</td>
<td>Y</td>
<td>N</td>
<td>D</td>
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<td>N</td>
</tr>
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<td>59020</td>
<td>59020 TC</td>
<td>Fetal contract stress test</td>
<td>A</td>
<td>0.65</td>
<td>0.65</td>
<td>000</td>
<td>N</td>
<td>N</td>
<td>D</td>
<td>N</td>
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<tr>
<td>59020 26</td>
<td>59020</td>
<td>59020 26</td>
<td>Fetal contract stress test</td>
<td>A</td>
<td>1.01</td>
<td>1.01</td>
<td>000</td>
<td>Y</td>
<td>N</td>
<td>D</td>
<td>N</td>
<td>N</td>
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<tr>
<td>59025</td>
<td>59025</td>
<td>59025</td>
<td>Fetal non-stress test</td>
<td>A</td>
<td>1.09</td>
<td>1.09</td>
<td>000</td>
<td>Y</td>
<td>N</td>
<td>D</td>
<td>N</td>
<td>N</td>
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<tr>
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<td>Fetal non-stress test</td>
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<td>0.26</td>
<td>0.26</td>
<td>000</td>
<td>N</td>
<td>N</td>
<td>D</td>
<td>N</td>
<td>N</td>
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<tr>
<td>59025 26</td>
<td>59025</td>
<td>59025 26</td>
<td>Fetal non-stress test</td>
<td>A</td>
<td>0.82</td>
<td>0.82</td>
<td>000</td>
<td>Y</td>
<td>N</td>
<td>D</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
The following provides a summary of the West Virginia Medicaid program cost report submission requirements:

- Section 320.9: Medicaid Cost Report Submissions and Filing Deadlines
  - Cost reports must be filed with OAMR by applicable due date (see chart in 320.9 for due dates and applicable cost report forms). Regardless of whether providers file electronically with their Medicare intermediary, a hard (paper) copy of the cost report with required supporting schedules is required to be filed with OAMR. The filing address is:
    - WV DHHR Office of Accountability & Management Reporting
    - ATTN: Division of Audit & Rate Setting
    - 1900 Kanawha Blvd., East
    - State Capitol Complex
    - Building 3, Room 550
    - Charleston, WV 25305
  - Cost reports must include an original signature on the certification page and include a transmittal letter or memorandum that states that the cost report is intended to satisfy the West Virginia Title XIX Medicaid reporting requirements.
  - For CMS-222-92 Filers: cost report filing should include a settlement summary calculation including the following elements that shows the settlement amount due to or from the WV Medicaid program:
    - (NOTE: the “Provider Number” Line in the calculation below should include all WV Medicaid provider numbers included in the cost report and supplementary summary as shown below. The WV Medicaid provider number is a 10-digit number; do not use the 6-digit Medicare provider number): 

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Provider Number(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculation of WV Medicaid Settlement:</td>
<td>Behavioral Health Encounter</td>
</tr>
<tr>
<td>Rate per Visit</td>
<td>XXXX</td>
</tr>
<tr>
<td>WV Medicaid Visits during the reporting period</td>
<td>XXXX</td>
</tr>
<tr>
<td>Total cost for Covered WV Medicaid Visits</td>
<td>(XXX XXXX)</td>
</tr>
<tr>
<td>Less: Total payments received</td>
<td>XXXX</td>
</tr>
<tr>
<td>Balance due from (or to) WV Medicaid</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

- Section 320.10: Cost Report Extensions
  - Extensions of up to 30 days must be requested in writing prior to the cost report filing deadline; extension request must include a description of the extenuating circumstance which renders the provider unable to comply with the original due date.
  - OAMR will provide a written response approving or rejecting the extension request along with extended due date.
  - OAMR will honor extensions granted by Medicare; provider must notify OAMR in writing (prior to the cost report filing deadline) of the extension and provide a copy to OAMR.

- Section 320.11: Cost Report Exemptions
  - Providers with no WV Medicaid utilization or low WV Medicaid utilization may request an exemption in writing from OAMR.
  - Exemption request must be submitted in writing prior to cost report filing deadline and include facility/provider name and ten-digit WV Medicaid provider number (not the six-digit Medicare provider number) as well as number of WV Medicaid clients served during the fiscal year for which the exemption is requested.
  - Section 320.11 details low utilization criteria (provision of services to five or less WV Medicaid recipients during provider’s fiscal year).
  - Cost report may be required even if provider meets low utilization criteria.

- Section 320.13: Cost Report Late Filing Penalties
  - OAMR will notify providers in writing when cost reports are not received by the cost report filing deadline.
  - Upon the thirtieth day after the cost report filing deadline has passed, the provider becomes subject to suspension of future interim payments until such time as an acceptable cost report submission is made.
  - Continued failure to submit an acceptable cost report may result in termination from the WV Medicaid program (in accordance with section 310.7).
Electronic Claim Response’s

It is imperative to check electronic claim responses. Claims rejected on the TA1, 997 and or 824 responses will not appear on your RA. Access these responses by selecting the “Download File” under “File Exchange” once logged in to the Web Portal. Please allow up to 24 hours after your submission(s) for these responses to be generated.

Responses Generated by Submission Method

<table>
<thead>
<tr>
<th>Direct Data Entry</th>
<th>X12 File Upload</th>
</tr>
</thead>
<tbody>
<tr>
<td>TA1 (X12)</td>
<td>Not Generated</td>
</tr>
<tr>
<td>997 (X12)</td>
<td>Rejected Only</td>
</tr>
<tr>
<td>997 (PDF)</td>
<td>Rejected Only</td>
</tr>
<tr>
<td>824 (X12)</td>
<td>Rejected Only</td>
</tr>
<tr>
<td>824 (TXT)</td>
<td>Rejected Only</td>
</tr>
<tr>
<td>835 (X12)</td>
<td>Determined by EDI Registration</td>
</tr>
<tr>
<td>RA (PDF)</td>
<td>Determined by EDI Registration</td>
</tr>
</tbody>
</table>

TA1 – Interchange Acknowledgement Response
The TA1 acknowledges that the inbound 837 was received
The TA1 can be accepted or rejected
Verify acceptance or rejection by looking at the end of the file
TA1 Example:
ISA*00**00*ZZ*WV_MMIS_4_UNISYS*ZZ*WVSUBID99999*
040616*1751*U*00401*000000001*0*P*:~
TA1*0000000001*20040101*1742*~
IEA*1*0000000001~
The “R” means the file was rejected. If this were an “A”, the file would be accepted. The number after the R indicates the rejection code. If your error code is a 20, contact the EDI Helpdesk, you have not yet been certified to submit production claims. Refer all other rejection codes to your software vendor.

997 – Functional Acknowledgement Response
The 997 acknowledges that the 837 is syntactically correct. The entire file or specific claims can be rejected depending upon the error. Contact your software vendor or the EDI Helpdesk for more information.

Two versions of this file are available; the X12 format and a PDF document. Open the X12 with a text editor and the PDF “Human Readable” version with the Adobe Reader (see site requirements).

824 – Application Advise Response
The 824 rejects claims based on WV Medicaid business rules, ie., invalid diagnosis codes, revenue codes, etc. Unlike the TA1 and 997, the 824 will only display errors.
Two versions are available; the X12 file format and the “Human Readable” report in .txt format. Use a test editor such as NotePad, UltraEdit, or MS Word to open these files.

835 – Claim Payment Advice Response
Information in the 835 Remittance Advise transaction is generated by the WV MMIS adjudication system. This is an X12 transaction and requires a software program to be translated. Contact your software vendor for more information.

RA – Remittance Advice
Legacy Remittance Advices are posted in PDF format and require Adobe Reader to open, view, print, etc. You may elect to receive an electronic remittance advise by contacting the EDI Helpdesk if you do not already.
EFT Enrollment/Update

Please be advised that all EFT new enrollees and or updates are to be mailed or faxed to the Unisys Provider Enrollment Department. If you are not currently set up to receive EFT and want to be, please visit www.wvmmis.com and download the EFT Authorization document under the “Forms” section.

Charging for Duplicate RA Requests

Effective July 1, 2006, Unisys will be charging $10.00 Per remit for duplicate remit requests for both paper and electronic copies. Paper remits that are less than 25 pages will be mailed or faxed. Paper remits that are over 25 pages will be placed on a CD-Rom and mailed to the Provider.

Providers will not be charged for the first 90 days after the original remit has been mailed or posted.

Unisys AVRS Prompt Tree (1 888 483 0793)

Please make sure that you are utilizing the appropriate prompts when making your selection(s) on the AVRS system to ensure that you will be connected to the appropriate department for your inquiry. Once you have entered in your provider number, the following prompts will be announced:

1. Accounts Payable Information
2. Eligibility Information
3. Claim Status Information
4. Provider Enrollment Department
5. Hysterectomy Sterilization Review
6. EDI Help Desk/Electronic Submission Inquiries
7. LTC Department

Contact Information.

UNISYS

Provider Relations.
888 483 0793
304 348 3360
wvmmis@unisys.com (email)

EDI Helpdesk.
888 483 0793, prompt 6
304 348 3360

Provider Enrollment
888 483 0793, prompt 4
304 348 3365

Unisys PR Pharmacy Help Desk
888 483 0801
304 348 3360

Member Services.
888 483 0797
304 348 3365
Monday-Friday, 8:00 am until 5:00 pm

Provider Services Fax.
304 348 3390

BMS Main Number.
304 558 1700
medclaimdoc@wvdhhr.org (email)

HMO Contacts
Carelink
888 348 2922
302 283 6971

The Health Plan
888 613 8385
same

Unicare
800 782 0095
Advocate-Mitch Collins
304 347 1962

Claim Form Mailing Addresses.
Please mail your claims to the appropriate Post Office Box as indicated below.

Unisys

PO Box 3765
NCPDP UCF Pharmacy
Charleston WV 25327

PO Box 3766
UB-92

PO Box 3767
CMS-1500

PO Box 3768
ADA-2002

Charleston WV 25337

PO Box 2254
Hysterectomy, Sterilization and Pregnancy Termination Forms

Charleston WV 25328-2254

Unisys Mailing Addresses.
Provider Relations & Member Services.
PO Box 2002
Charleston WV 25327-2002
Fax # 304 348 3380

Provider Enrollment & EDI Help Desk.
PO Box 625
Charleston WV 25322-0625
Fax # 304 348 3380
West Virginia Medicaid
Provider Update Bulletin
Q.4, 2007

WEST VIRGINIA
Department of
Health &
Human Resources

PO Box 625
Charleston WV 25322-0625

Imagine It. Done.