37.9 CLAIM SUBMISSION

Overview

Introduction

This Section describes claim submission requirements, including expression of drug quantities, overrides and time limits for claim submission. T his Section also describes methods of claim submission.

In This Section

This Section contains:

National Drug Code (NDC)
Drug Quantities and Units of Measurement
Prescriber Numbers
Diagnosis Codes
Overrides
Types of Pharmacy Claims
Point of Sale (POS) Claim Submission
Electronic Claim Submission (Batch)
Hard Copy Claim Submission
Claim Adjustments
Time Limit for Submission of Medicaid Claims
Billing for Spend Down Medically Needy Recipients

37.9.1 NATIONAL DRUG CODE (NDC)

Drugs are identified on Medicaid claims and the Medicaid computer system drug file by the National Drug Code (NDC). The NDC is an eleven-digit number. The first five digits identify the manufacturer or supplier, the next four digits identify the product, and the last two digits identify the package size.

Use of NDCs

The provider must enter the entire eleven-digit NDC for the **actual product dispensed** on the claim. Billing an NDC number other than the one for the product dispensed is a false claim and a violation of Medicaid policy.

NDC Code Not on the Drug File

Medicaid can only reimburse drugs whose NDC codes are on the Medicaid computer system drug file. If the NDC code is not on the Medicaid drug file, the provider can call the Medicaid Pharmacy Benefits Management Section at 225-342-9768 and request that the drug be added.

37.9.2 DRUG QUANTITIES AND UNITS OF MEASUREMENT

Billing Unit Standard

Medicaid has adopted the National Council for Prescription Drug Programs (NCPDP) unit of measurement for the billing unit standard.

The NCPDP standard uses only three billing units to describe all drug products: "each," "ml," and "gm."

The use of "tablet," "patch," "kit," etc. is not appropriate, since these are dosage forms or package descriptions.

Dosage Forms Expressed as "Each"

The dosage forms that are expressed as "each" are:

- Solid oral medications such as tablets, capsules, etc., even when presented in dose packs or cycles;
- Suppositories;
- Transdermal patches;
- Powder packets;
- Disposable syringes; and
- Powder-filled vials, ampules and syringes for injection; irrigation; or inhalation (the quantity is the total number of vials dispensed, not the mls or gms of the final product).

Dosage Forms Expressed as "ml"

Dosage Forms that are expressed as "ml" are:

- Liquid oral medications;
- Ophthalmic and otic drops and suspensions;
- Reconstitutable oral products (the quantity is the number of milliliters in the bottle after reconstitution);
- Topical lotions or solutions;
- Liquid-filled vials, ampules, or syringes for injection, irrigation or inhalation (the quantity is the total number of milliliters dispensed); and
- Inhalers and aerosols that are specified in milliliters by the manufacturer on the labeling.

Dosage Forms Expressed as "gm"

Dosage forms that are expressed as "gm" are:

- Topical or ophthalmic ointments and creams;
- Inhalers and aerosols that are specified in grams by the manufacturer on the labeling.

Exceptions to the NCPDP Standard

The following are examples of exceptions to the NCPDP billing unit standard:

- Antihemophilic products must be expressed as the number of antihemophilic units dispensed, which will vary from vial to vial;
- Cordran® Tape and EpiPen® must be expressed as "each";
- One Imitrex® or Diastat® kit with two syringes must be expressed as one "each";
- One tube of Emla® cream with Tegaderm® patches must be expressed as one "each";
- One heparin flush kit containing one syringe of heparin and two syringes of saline packaged in the same bag must be expressed as one "each"; and
- Helidac® combination therapy must be expressed as 56 dosing units.

Metric Decimal Quantities

Metric decimal quantity is used to express quantity dispensed. Providers must bill for drug quantities using decimal numbers—whole drug numbers are no longer required. The provider must ensure that his software enters the correct quantity in the metric decimal field (i.e., 0.030 does not equal 30.000). Rounding is not allowed (i.e., 3.500 cannot be billed as 4.000).

Billing Questions

Billing questions regarding the correct unit type should be directed to the Molina Point of Sale Help Desk at 800-648-0790 or 225-216-6381 from 8am to 5pm, Monday through Friday.

37.9.3 PRESCRIBER NUMBERS

All prescription claims must indicate a valid **individual** Louisiana Medicaid prescriber number or NPI until only the NPI is required. Group practice numbers, hospital numbers and clinic numbers are not acceptable.

Note: Refer to Section 37.4 Prescribers for detailed prescriber policy.

37.9.4 DIAGNOSIS CODES

Some pharmacy claims require ICD-9 CM diagnosis codes as a condition for program coverage and override of monthly prescription limits.

Note: Refer to Section 37.5 Covered Services, Limitations and Exclusions for specific program policy involving ICD-9 CM diagnosis codes.

37.9.5 OVERRIDES

Listed below are the detailed policies regarding overrides of the Louisiana Medicaid Pharmacy Benefits Management Section. Refer to Appendix D Point of Sale User Guide for details regarding claims submission requiring overrides.

FUL/LMAC Limitations

A prescriber may certify that a specified brand is medically necessary for a particular recipient. The FUL or LMAC limitations for that medication will not apply.

The certification must be written either directly on or must be a signed Limitations, attachment (which may be faxed) to the prescription. The certification must be continued in the prescriber's handwriting. The only acceptable phrases are "brand necessary" or "brand medically necessary."

Note: Also refer to Section 37.6.4 Multiple Source Drugs for detailed information.

Four Prescriptions Monthly Limit

The four prescription monthly limit can be overridden when the prescribing practitioner authorizes the medical necessity of the drug and communicates to the pharmacist the following information in his own handwriting or by telephone or other telecommunications device noted on or attached to the hard copy prescription:

- "Medically Necessary Override"
- A valid numeric ICD-9-CM diagnosis code that directly relates to each drug prescribed that is over the four prescription limit. (An ICD-9-CM literal description is not acceptable.)

Early Refills

If the patient has requested the same medication at the **same pharmacy** seven or more days early for a thirty day supply or prior to seventy-five percent of medication being utilized, a claim is denied for early refill. Narcotic analgesics will deny for an early refill edit when less than eighty-five percent of the medication has been utilized. This translates into a three (3) day window based on a thirty (30) day supply.

In some cases, the pharmacist may have knowledge of dosage changes which would warrant a patient's request for medication earlier than previously reported in the estimated days supply. With those requests, pharmacists may override this edit by documenting the circumstances on the prescription hard copy and reference the Point of Sale User Guide for detailed claims filing instructions.

Ingredient Duplication

A claim denial will occur as the patient attempts to obtain the same drug from a **different pharmacy** sooner than is anticipated based on the estimated days supply.

After consultation with a physician, patient and/or the POS help desk, the provider must determine whether there are extenuating circumstances which substantiate the dispensing of a duplicate claim. If extenuating circumstances exist, the provider must use procedures to initiate an override of the denial for the duplicate ingredient.

The provider must document on the prescription hard copy the circumstances for the override and reference the Point of Sale User Guide for detailed filing instructions.

Duration of Therapy

The Louisiana Medicaid Pharmacy Benefits Management (LMPBM) program has duration of therapy modules for the H2 antagonists, proton pump inhibitors (PPIs), sucralfate and palivizumab (Synagis®).

Acute dosage guidelines for these H2 antagonists, PPIs and sucralfate are being monitored. The chronic use of these agents at full therapeutic dosages is generally not indicated. The duration of therapy period begins every calendar year. An acceptable ICD-9-CM diagnosis code which indicates the condition identified by the prescriber warranting the continuation of the acute dosage is required.

Synagis® claims with dates of service outside of Respiratory Syncytial Virus (RSV) season will deny. Additionally, claims billed for Synagis® outside the allowable number of doses will also deny. Based upon the diagnosis code submitted, the maximum number of doses any recipient should receive is five (5).

Claims billed for dates of service outside the RSV season and/or in excess of the allowable number of doses will require a hardcopy prescription with justification for Synagis® use handwritten by the prescriber. This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

The pharmacy provider must supply that information accurately as provided by the prescriber and reference the Point of Sale User Guide for detailed claims filing instructions.

Note: Refer to Section 37.5 Covered Services, Limitations and Exclusions and Appendix D Point of Sale User Guide for detailed information.

Therapeutic Duplication

The Medicaid Program denies pharmacy claims for drugs in the following classes if the recipient has an **ACTIVE** paid claim on file for another drug in the same therapeutic class. Antipsychotic agents require two (2) active prescriptions on file to deny for therapeutic duplication.

- Second generation antihistamines and second generation antihistamine combination agents;
- Angiotensin Converting Enzyme (ACE) Inhibitors and ACE Inhibitor/Diuretic Combinations;
- ACE Inhibitors/Calcium Channel Blocker Combinations;
- Angiotensin Receptor Antagonists (ARB) and ARB/Diuretic Combinations;
- ARB/Calcium Channel Blocker Combinations;
- Beta Adrenergic Blocking Agents and Beta-adrenergic Blocking Agent/Diuretic Combinations;
- Calcium Channel Blockers;
- Calcium Channel Blocker/Antihyperlipidemia Agent Combination;
- Potassium Replacement Agents;
- Tricyclic Antidepressants;
- Selective Serotonin Reuptake Inhibitors;
- Antipsychotic Agents (typical and atypical);
- Antipsychotic/Selective Serotonin Reuptake Inhibitor Combinations;
- Anti-anxiety Agents;
- Sedative Hypnotic Agents;
- Attention Deficit Disorder Agents
- Non-steroidal Anti-inflammatory Agents (inclusive of COX-2 selective agent);
- Short Acting Opiate Agents;
- Long Acting Opiate Agents; and
- Proton Pump Inhibitors.

Override provisions will be allowed after contacting the prescriber. If an override is determined appropriate, additional hard-copy documentation on the new prescription is necessary. The reason for service code, professional service code and result of service code are required for audit purposes. Diagnosis codes may be required in some instances.

Note: Refer to Section 37.5 Covered Services, Limitations and Exclusions and Appendix D the Point of Sale User Guide for detailed claims filing instructions.

Unnecessary Drug Therapy

The LMPBM has an unnecessary drug therapy module for the COX-2 selective agent. A valid ICD-9-CM code is required as well as a valid condition warranting the COX-2 selective agent.

Should the recipient not have a valid condition, and the prescriber determines that the drug therapy is necessary, the pharmacy provider must supply the reason for service

code, professional service code and result of service code with the POS submission. This information must be documented on the hard copy prescription.

Note: Refer to Section 37.5.8 Prospective Drug Utilization Policies/Limits/Edits for detailed information.

Drug/Drug Interaction

A valid ICD-9-CM diagnosis code is required for all Sildenafil (Revatio®) and Tadalafil (Adcirca®) prescriptions.

Override provisions for the drug to drug interaction between Sildenafil or Tadalafil and nitrates will be allowed after contacting the prescriber. The pharmacist must document the reason the prescriber required both drugs. Additionally, documentation of the reason for service code, professional service code and result of service code is required on the hard copy prescription and for submission of the Point of Sale claim.

Coordination of Benefits

Certain circumstances allow for the override of edits which allows Medicaid to be the primary payor.

Note: Refer to Section 37.8.7 Override Capabilities and Codes for detailed information on these overrides.

Pregnancy Co-Payment

Services furnished to pregnant women if such services are related to the pregnancy, or any other medical conditions that complicate the pregnancy are exempt from co-payments.

When a prescribing provider issues a prescription to a pregnant woman, he or she shall indicate on the prescription that the recipient is pregnant. In the case of a telephoned prescription, the information that the recipient is pregnant shall be communicated to the pharmacist and the pharmacist must document on the prescription that the recipient is pregnant.

When the prescribing provider authorizes a prescription for a pregnant recipient, the pharmacist shall maintain the proper documentation on the prescription for audit purposes indicating that the individual is pregnant.

Note: Refer to Appendix D Point of Sale User Guide for detailed claims filing instructions.

Age and Gender Overrides

Some drugs have age and/or sex restrictions (Examples: Oral Contraceptives for females under 12 and over 55 and Depo-Provera® for men).

Overrides of these restrictions are permitted when medically necessary and documentation is provided by the prescriber.

In these cases it is necessary to contact the Medicaid Pharmacy Benefits Management Section at 225-342-9768 for assistance in processing the claim.

Claims for palivizumab (Synagis®) therapy will only be reimbursed for recipients who are twenty-four (24) months or younger on November 1st of the Respiratory Syncytial Virus (RSV) season. Once a recipient meets the age requirement for Synagis®, subsequent claims during that RSV season will continue to be reimbursed without further age evaluation. Claims for recipients who are twenty-five (25) months of age or older on November 1st will deny.

When justified by the prescriber, pharmacy claims for Synagis® may be reimbursed for recipients twenty-five (25) months of age or older; however, these pharmacy claims will require a hardcopy prescription with justification for Synagis® use handwritten by the prescriber**.** This prescription may be faxed to the pharmacy and must be retained by the pharmacy for audit review.

The pharmacist may override the age restriction edit. The pharmacist must document and supply the reason for service code, professional service code and result of service code.

Note: Refer to Section 37.5.7 Drugs with Special Payment Criteria/Limitations for other criteria and Appendix D Point of Sale User Guide for detailed billing information.

Maximum Dosage

Prescriptions for atypical antipsychotic agents, agents containing tramadol and tapentadol (Nucynta®) will deny when the maximum recommended doses are exceeded.

Due to the potential of hepatotoxicity, claims billed with a dosage of acetaminophen that exceeds four grams per day will deny. Claims for products containing aspirin will deny payment when the maximum daily dosage billed exceeds six grams a day.

The prescriber must be consulted and the reason and override codes must be documented on the hard copy prescription. The pharmacy must supply the reason for service code, professional service code and result of service code with the POS submission.

Quantity Exceeds Program Maximum

Pharmacy claims for oral forms of ketorolac will deny for a quantity greater than twenty (20) or the days supply is greater than five (5) days as exceeding the program's maximum allowed. The pharmacist may override the denial after consultation with the prescriber. The prescriber must supply the ICD-9-CM diagnosis code and the rationale

for using greater than a five day supply of ketorolac. The ICD-9-CM diagnosis code is required for the claim submission.

Pharmacy claims for selected medications used in the management of pain are subject to maximum quantities. Quantity limits are cumulative, are based on a rolling thirty (30) days and apply to all strengths of an agent. If the prescriber chooses to exceed the limit, he/she must provide the reason why the quantity limit needs to be exceeded. After consulting with the prescriber, the pharmacist must document the prescriber's reason and DUR override codes on the hardcopy prescription. The pharmacist should reference the Point of Sale User Guide for detailed claims filing instructions.

Most prescriptions for recipients who have confirmed diagnosis of cancer are exempt from quantity limits. In order to determine which prescriptions should be exempt, all prescriptions for Schedule II narcotic agents require an ICD-9-CM diagnosis code documented on the hardcopy prescription. When a diagnosis code is not on the prescription and the prescriber cannot be reached, the pharmacist can then determine if the recipient cannot wait to receive the medication and override the edit.

Prior Authorization Emergency

This emergency procedure may be used when the Prior Authorization Unit is closed (Sundays; Monday-Saturday before 8am and after 6pm) or when the PA system is unavailable. The pharmacist should also use professional judgement in situations that would necessitate an emergency supply.

Prescriptions indicating emergency situations shall be dispensed in a MINIMUM quantity of a seventy-two (72) hour or a three-day supply. **Refills for the dispensing of the non-preferred products in these emergency situations are not permitted.**

The prescribing practitioner must indicate that the prescription is an emergency Rx on the face of the prescription if hard copy or if the prescription is called in to the pharmacy, the emergency status of the prescription must be communicated to the pharmacist who must indicate "Emergency by Pharmacist" on the hard copy prescription.

Hospital Discharge Prescriptions for Atypical Antipsychotic Agents

When a recipient is discharged from a hospital with a prescription for an atypical antipsychotic prescription, the prescribing practitioner must indicate on the face of the prescription, if hard copy, that the prescription is a "Hospital Discharge" or if the prescription is called in to the pharmacy, the "Hospital Discharge" status of the prescription must be communicated to the pharmacist who must indicate "Hospital Discharge" on the hard copy of the prescription.

In situations where the prescribing practitioner is unavailable and the pharmacist determines the prescription is "Hospital Discharge" prescription, the pharmacist must indicate "Hospital Discharge" on the hard copy prescription.

Claims for "Hospital Discharge" prescriptions needing prior authorization (PA) will be submitted using the same process used for an emergency override.

Prescriptions for "Hospital Discharge" products shall be dispensed in a MINIMUM quantity of a 3-day supply and refills for the dispensing of the non-preferred products are not permitted. The recipient's practitioner must contact the Prior Authorization Unit to request authorization to continue the medication past the "Hospital Discharge" supply, and a new prescription must be issued.

Lock-In Emergency

This override is provided because DHH recognizes that there maybe unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In recipient when the provider is not the Lock-In provider. Payment will be made to any pharmacist enrolled in Medicaid of Louisiana who grants services to a Lock-In recipient in emergency situations or when life sustaining medicines are required. Prescriptions written as a result of an emergency visit or as a discharge prescription following a hospital admission are applicable for payment if the correct emergency procedure is followed.

The notation "Emergency Prescription" or "Discharge Prescription" should be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist. Please ensure that the notation is included on the hard copy claim for audit purposes.

37.9.6 TYPES OF PHARMACY CLAIMS

Types of Claim Submissions

Providers can submit prescribed drug claims through the Point of Sale system, an electronic batch system upon testing and approval, or on paper claim forms. The paper claim form for Medicaid prescribed drug services is the NCPDP Universal Claim Form.

37.9.7 POINT OF SALE (POS) CLAIM SUBMISSION

Medicaid pharmacy providers can submit Medicaid claims through a DHH authorized electronic switch vendor using on-line, real time, Point of Sale (POS) processing. The transaction is processed through the claims processing cycle, and the disposition of the claim is returned to the pharmacy within seconds of submission.

POS processing is available through authorized telecommunication vendors that are connected to virtually every pharmacy in the United States.

Features of Point of Sale

The POS system is designed to work under the general framework of standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). It uses methods of communication that are in place for other pharmacy POS processing. POS uses the HIPAA approved telecommunication standard, NCPDP D.0.

The POS system is available twenty-four hours per day, seven days per week, except for scheduled downtime for system maintenance.

Authorization to Use Point of Sale

To obtain authorization to submit Medicaid claims through POS, the provider must submit the POS authorization agreements to the Medicaid fiscal agent.

Note: Refer to Section 37.2.8 Point of Sale Enrollment for information on provider enrollment.

37.9.8 ELECTRONIC CLAIM SUBMISSION (BATCH)

Providers interested in using the NCPDP 1.2 Batch version must contact the Point of Sale Help Desk at 800-648-0790. Testing and approval are required.

37.9.9 HARD COPY CLAIM SUBMISSION

When it is necessary to paper bill Louisiana Medicaid for services, pharmacy providers must use the NCPDP Universal Claim Form (UCF) regardless of date of service. No photocopied versions are acceptable.

Ordering the Claim Forms

NCPDP Universal Claim Forms may be purchased from:

Communi Form, LLC
Phone: 1-800-869-6508
www.communiform.com/ncpdp

Claim Submission

All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form. Claims submitted on the UCF claim form should be submitted to the following address for processing:

Molina/LA Medicaid
P. O. Box 91019
Baton Rouge, LA 70821

Retroactive Eligibility Claim Submission

When filing prescription claims for recipients with retroactive Medicaid, with a date of service greater than one year, providers must file these claims hard copy for special handling.

Claims less than one year may be submitted on-line, with some exceptions. Claims over one year for recipients with retroactive coverage, e.g., spend-down medically needy recipients, should be sent to the Bureau with a note of explanation or a copy of the recipient's Medicaid identification card as soon as possible. These claims must be sent to the Bureau of Health Services Financing for review and authorization at the following address:

Bureau of Health Services Financing
MMIS Unit
P. O. Box 91030
Baton Rouge, LA 70821

Billing Instructions

All fields of the Universal Claim Form are not numbered; however, all fields are denoted as "Required", "Not Required", or "Leave Blank" as appropriate.

"Required" information must be entered to ensure processing of the claim. "Not required" information is optional, based on entry of a previous field. "Leave Blank" is a field unrelated to pharmacy claims.

Note: Refer to Appendix G for an example of the Universal Claim Form and billing instructions.

37.9.10 CLAIM ADJUSTMENTS

From time to time some claims submitted and paid require adjustments. This can be done through the Point of Sale claim reversal process, which involves reversing the incorrect claim and resubmitting a new, corrected claim via Point of Sale. Claims requiring adjustments may be reversed within the timely filing period by using the pharmacy provider NPI, date of service and prescription number. Upon reversal, the claim may be resubmitted with the corrected information.

In some instances, it is necessary to submit a hard copy adjustment claim form.

Note: Refer to Appendix D Point of Sale User Guide for instructions for both types of claim adjustments.

Note: Refer to Appendix H for Form 211 Drug Adjustment Form and instructions for completion.

37.9.11 TIME LIMIT FOR SUBMISSION OF MEDICAID CLAIMS

Timely Claim Submission	Medicaid providers should submit claims immediately after providing services so that any problems with a claim can be corrected and the claim resubmitted before the filing deadline.
Twelve Month Filing Limit	A claim for services rendered must be received by the department or its fiscal intermediary no later than twelve months from the date of service.
Dates of Service Greater Than Years Old	Claims with dates of service over two years old are not to be submitted to the fiscal intermediary or to Medicaid for overriding of the timely filing edit unless Two one or more of the guidelines listed below is met: • The recipient was certified for retroactive Medicaid benefits; • The recipient won a Medicare or SSI appeal in which he was granted retroactive Medicaid benefits; and/or • The failure of the claim to pay was the state's, rather than the provider's, fault each time the claim was adjudicated.
Medicare/Third Party Payor Insurance Claims	Claims for recipients who have Medicare or other insurance must be submitted to a third party payor prior to sending the claim to Medicaid. A claim coordinated with a third party payor shall be submitted to the fiscal intermediary within twelve months of the date of service. The time limit for filing Medicare crossover claims to Louisiana Medicaid is six months from the date of the Medicare adjudication of the claim, providing the claim was filed timely with Medicare (twelve months from the date of service).
Proof of Timely Filing	Medicaid claims received after the maximum timely filing date cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include the following: • A Remittance Advice indicating that the claim was processed earlier (within the specified timeframe) **OR** • Correspondence from either the state or local Medicaid office of Family Support concerning the claim and/or the eligibility of the recipient. When resubmitting the claim and documentation, providers must be certain that the claim is legible to ensure accurate processing. Documentation must reference the individual recipient and date of service.

37.9.12 BILLING FOR SPEND-DOWN MEDICALLY NEEDY RECIPIENTS

Any provider who has medical bills from the exact date of the recipient's spend-down will receive a **Spend-down Medically Needy Notice (Form 110-MNP)** from the local Medicaid office. This form will notify the provider of the co-payment amount due by the recipient and the amount to be billed to Medicaid. *The provider must attach this form to the claim and submit the claim manually to the fiscal intermediary for processing.* The provider cannot bill the recipient for any amount over the amount specified on the Form 110-MNP under recipient liability. If service(s) were provided on the date of spend-down but does not appear on the 110-MNP form, the provider should contact the local Medicaid office that issued the form to get a corrected form.

Note: Refer to Section 37.3 Medicaid Recipient Eligibility for detailed information.