NDC reporting requirement creates burden for hospitals

Understand that NDC requirement applies to Medicaid claims

The use of the national drug code (NDC) to report medications is not a new concept for Medicaid claims, but it recently has become a more acute requirement.

State Medicaid programs are required as of January 2008 to start reporting NDCs. If these Medicaid programs do not report NDCs to CMS and the drug companies, CMS will not provide reimbursement to hospitals.

Unfortunately, meeting this requirement will not be easy; chargemaster updates and manual auditing requirements could create headaches for hospital coding and charging staff members.

The NDC reporting problems

According to Claudia Birkenshaw, executive vice president of BridgeFront in Portland, OR, the NDC number serves as a universal product identifier for drug products. It is 11 digits long and can be located on a drug’s packaging, on the FDA Web site (www.fda.gov), or by contacting the drug’s manufacturer.

A problem arises when a drug has several manufacturers and, therefore, several NDC numbers. It’s extremely vital that hospitals report the NDC of the administered drug and not another manufacturer’s product, even if the chemical name is the same.

For example, J code 7192 (Factor VIII recombinant) has 16 NDC numbers, five labeler drug names, and three label names.

Although everyone may recognize the label names (Bayer, Baxter, and Aventis Behring), the large amount of NDC numbers for the same drug types can lead to confusion, Birkenshaw says.

“If their system is able to supply an NDC number, it might be an NDC number for that drug, but it may not be an NDC number for the drug given or administered,” Birkenshaw says. “Typically, they’ll bill with just one manufacturer. Hospitals and pharmacies are trying to
get the best prices, and therefore, different labelers will have different NDC codes for the same drug.”

For example, when a facility purchases a drug, staff members may administer to Patient A a drug from one manufacturer with one NDC number. Later in the day, they may administer the same drug (after the original quantity of the drug is used) but actually dispense a different manufacturer's drug (same actual drug, but from a different manufacturer, so it has a different NDC code). According to Birkenshaw, there’s no easy way to get the correct NDC number onto the UB-04 claim.

The Deficit Reduction Act of 2005

You might ask, why does our facility have to report an NDC in the first place? Birkenshaw explains that it’s due to legislation implemented in the Deficit Reduction Act of 2005 (DRA) to help curb Medicaid program spending. Drug companies for many years have registered with the U.S. Department of Health and Human Services (HHS) for drug rebates. In order to receive a drug rebate for low-income patients, state Medicaid programs have to supply the NDC code to the drug companies. In return, the drug companies will reimburse state Medicaid programs. CMS estimates that there’s a huge savings if providers can supply all NDC numbers for certain physician-administered drugs.

State Medicaid programs must also collect NDC numbers for 20 multiple-source physician-administered drugs with the highest dollar volume in Medicaid, says Birkenshaw.

The physician-administered multiple-source HCPCS codes, which correspond to the list of top 20 drugs, are:

- J9265 • J7190 • J7050
- J9045 • J9000 • J2550
- J0696 • J1885 • J1631
- J9217 • J9390 • J7644
- J1260 • J1100 • J9060
- J7192 • J0640 • J9040
- J2430 • J3010

The administrative burden

Finding a way to include the NDC number on the UB-04 claim forms will place a huge administrative burden on pharmacies and chargemaster specialists, according to Birkenshaw and William Malm, ND, RN, practice director of revenue cycle management consulting for HCPro, Inc., in Marblehead, MA.

Birkenshaw says that most facilities’ computer systems include a charge description number through which the system is able to determine which J code to place on the bill.

Unfortunately, the system does not allow most facilities to also enter the NDC number.
Birkenshaw says that “there’s no easy way to actually put [the NDC number] into the chargemaster right now. It’s truly a highly manual process.”

However, Malm points out it isn’t just about the software; now, more than ever, chargemaster analysts and pharmacies will need to cooperate on a daily basis to have any chance of getting the correct NDC on the claim.

This change also means that only drugs dispensed through the formulary will have a mechanism for getting the NDC where it belongs. “When you’re updating your chargemaster, you have to pick the right [NDC] or choose them all. Your chargemaster will now have to be as big as your formulary,” says Malm.

Previously, there wasn’t a need for a one-to-one ratio, but your system must now include this correlation between the NDC number and the J code in order for the charge to appear on the bill. “In order to list every single NDC code in a chargemaster, it would increase the chargemaster exponentially, and it would be a never-ending task to keep,” says Birkenshaw. “When we talk about the administrative burden for this, that’s where the cost is astronomical.”

Birkenshaw adds that entities, providers, and organizations submitted comments to CMS about its June proposed NDC rule (www.cms.hhs.gov/MedicaidGenInfo/downloads/CMS2238FC.pdf), in which they stated that the estimated cost to implement chargemasters that could handle the NDC number would be approximately $200,000 per facility.

“CMS basically dismissed it in their final rule and didn’t think the cost would be that high,” says Birkenshaw.

Not only would most systems have to be updated, Malm says, but the addition of full-time employees to maintain the NDC requirement within the chargemaster and to audit the claims would add to the cost.

The potential solutions

The National Uniform Billing Committee (NUBC) published instructions for reporting NDC numbers on October 10.

Before this release, Birkenshaw says, individual states were instructing entities about how they needed to report the number, which added to the confusion.

According to Birkenshaw, the NUBC instructs facilities to use the revenue description field (form locator 43) on the UB-04 paper form. The description field is 24 characters long.

Follow these instructions:

1. Report the N4 qualifier in the first two positions (which should be left-justified).
2. Report the 11-digit NDC number directly after the N4 qualifier. Do not include hyphens.
3. Report the unit of measurement qualifier immediately following the last digit of the NDC number. The unit of measurement qualifier codes are F2 (international unit), GR (gram), ML (milliliter), and UN (unit).
4. Following the unit of measurement qualifier, report the unit quantity with a floating decimal for fractional units limited to three digits (to the right of the decimal).
5. Leave unused spaces for the quantity blank.

Birkenshaw says that hospitals should obtain a list of drugs that are affected by this requirement. “These are the ones that are absolutely mandated to start listing the NDC code. Put a certain indicator on the claim or put a certain dummy charge in the chargemaster, so when it hits the bill, the biller can call the pharmacy or department that administered the drug to get the NDC code,” she says.

Birkenshaw notes that some facilities have compiled a manual list of drugs from the pharmacy that they fax to the business office whenever a patient receives a drug affected by this rule. The facility will include the patient’s account number, and the business office will find the patient’s account, stop it, and put the NDC code on the file. The drawback of this practice is that business offices receive hundreds or thousands of
accounts each day. Malm says that this suggestion may present another problem as well. “The pharmacies may not be up to date on the use of their NDC numbers. They may have gotten the NDC number from the last purchase bid,” he says. “If the pharmacy doesn’t remember to manually update the NDC number by lot, then it will not be accurate.”

For example, if your facility bought a stock of Brand A aspirin, used it up in December, and then bought Brand B aspirin, the product would be the same compound but would have a different NDC number because it’s a different package and from another manufacturer.

The uninspiring question of units, waste

Birkenshaw and Malm say that drug units for the NDC number are not equivalent to the J code units, which can lead to unnecessary waste or incorrectly billed units.

For example, if a physician opens a special vial for a patient and administers 10 units, but the only vial your facility has is a 50 unit/mg vial, you’re not going to be able to use the remaining 40 mg for any other patient due to the drug’s short shelf life.

“You could bill for all the units because you could not use the rest. But how do you report the NDC code? Do you report the units for the NDC code for the entire vial or not? There’s a discrepancy regarding the units that NUBC is also trying to get clarification on,” Birkenshaw says. Malm and Birkenshaw say that providers must engage in one-on-one communication with their state Medicaid program.

“I would really encourage [providers] to not wait until January 1, but to contact their state Medicaid program now, if they’ve not already been in contact with them, to see what they are expecting of providers,” says Birkenshaw.

Editor’s note: You can view NUBC’s full NDC instructions by visiting the NUBC Web site at www.nubc.org. Click on What’s New, then click on the October 10 guidance.

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Educate or retrain your coding and clinical staff members on documentation needs to prevent ED revenue loss

Medical professionals can relate to the concepts of meticulousness, consistency, and accuracy. For example, for physicians and nurses, these words are a mantra for saving lives. Coders, on the other hand, understand that these concepts are necessary to ensure accurate coding and compliant reimbursement.

William Malm, ND, RN, practice director of revenue cycle management consulting for HCPro, Inc., in Marblehead, MA, and Glenn Krauss, RHIA, CCS, CCS-P, CPUR, an independent consultant from Maryville, TN, spoke about these concepts during a recent HCPro audioconference, “ED Procedure Coding: A team approach to compliant coding and documentation.”

Malm and Krauss gave practical, sometimes overlooked advice about how ED nurses and physicians can correctly capture necessary information in a hectic environment, thus ensuring correct code assignment and full, accurate reimbursement.

Krauss also provided insights about why EDs incur lost revenue and methods to recoup those losses.

Retrain nursing staff members about documentation

Both Malm and Krauss agreed that nurses lack a fundamental understanding of why complete documentation is crucial for reimbursement and compliance. “Right now, many facilities have not educated [nurses] on the requirements of coding and the appropriate feedback to run the business process,” Malm said.

As simple as it seems, hospital HIM directors need to take a step back and educate their ED nursing staff members about what they need to document and to what extent.

After you show nurses how to document from an HIM perspective and that complete documentation equals reimbursement for their facility, Malm said, most nurses are more than happy to comply.

The following are several of Malm’s suggestions for what HIM/coding professionals can do to rectify nurses’ lack of documentation:

- Explain to nurses that they should be able to document certain conditions upon arrival, such as the size, width, location, and number of lacerations. This sets up the framework that their discharge summary and documentation should follow throughout the ED encounter.
- Assist nursing staff members with constructing user-friendly documentation templates.
- Ensure that nurses document each step of the natural flow of patient care within an ED encounter.
- Provide concrete examples of correct documentation versus incomplete documentation.
- Train nurses in groups rather than individually so that no one person feels singled out.
- Implement safeguards before the documentation process is complete. For example, in order to catch documentation errors, charge nurses should review records for completeness and accuracy before completing and turning them in to be coded by HIM staff members. This type of real-time feedback is essential.

Although it may be difficult for nurses to fully document certain aspects of a patient’s case—particularly when the patient is facing a life-or-death situation in the ED—HIM staff members should go the extra mile to provide thorough documentation training.

Give feedback to physicians by using report cards

In conjunction with nurse training, HIM staff members should focus their training efforts on ED physicians. In his experience, Malm said, physicians who read and reviewed ED notes on a retrospective basis found opportunities for improved earned revenue based on simple changes in documentation.

For example, staff members frequently overlook medical necessity with specific diagnostic tests.

When physicians provide all secondary diagnoses at the time of discharge, this step often provides the medical necessity that would have been otherwise lacking.
Educate < continued from p. 5

HIM staff members should provide feedback to physicians regarding the medical necessity of the laboratory and radiology tests they order and supply physicians with copies of local coverage determinations so they know what diagnoses are covered.

It’s essential to provide medical necessity feedback to the medical director as well. A medical director should ask the following:

• How many tests are ordered?
• How many of these tests are really required or necessary?

Many facilities use report cards that show the productivity of a particular physician, the number of tests he or she has ordered, and how well he or she is performing overall. Specifically, report cards could include the number of:

• Medical necessity denials
• Diagnoses that HIM added after record completion that the physician did not initially indicate
• Incorrectly documented records in which the documentation didn’t support the test

Show your staff members what they’ve done right and encourage them before showing them how they can improve, Malm said.

Create easy-to-use E/M forms

In addition to explaining how documentation deficiencies can lead to decreased reimbursement in the ED, Malm and Krauss reviewed particular sources of lost ED revenue. For example, Krauss said he reviewed an ED in which it was clear that the nurses did not have a good grasp of the system the department used to capture E/M information. He found that the following three factors contributed to mischarges and lost revenue:

1. The nursing forms were not conducive to documenting and capturing charges
2. There was a nurse misconception/disconnect between the nurses’ documentation and how the documentation translated into facility-level E/M assignment
3. Nurses did not understand third-party payer reimbursement methodology

Krauss spoke to the nurses in this particular ED and found that the nursing staff members didn’t understand the business portion of their documentation. They also did not understand how their documentation translated into ICD-9 or CPT codes.

Upon reviewing a sample of the facility’s ED records, Krauss found that the nurses did not always follow the hospital’s E/M criteria. The nurses felt that the criteria were not really representative of the services they provided, he said.

Certain procedures (e.g., providing a patient with a blanket or a meal) were so integral to nursing that the nurses didn’t always document them. In addition, he found a lack of nursing documentation for weekends or nights, when the ED was busy.

So what is a nurse to do?

Figure out an attack plan from scratch for deficient documentation

In order to amend the nurses’ lack of documentation, Krauss suggested scrapping the current system of documentation for one that the nurses felt more comfortable with.

Allowing the nurses to provide feedback during this process was extremely important to the successful creation of a new E/M template, as was evaluation and monitoring of the new criteria.

“We also provided feedback and reeducation on a needed basis,” Krauss said. “We continued to review the E/M criteria as a work in evolution.”

In the OPPS proposed rule, CMS stated that it might not release national E/M guidelines in 2008 or future years, so now is the time to review both your ED’s E/M system and your nursing documentation forms.
Q&A: Injections/infusions

Consider any prefilled saline syringes used to flush venous access to be packaged supplies

Can we bill for the prefilled saline syringe that a provider uses at the conclusion of an IV medication administration? I know that we cannot bill the actual task of flushing according to the Medicare Claims Processing Manual 100–4, Chapter 12, Section 30.5, C. If so, should we consider the prefilled saline syringe to be a supply or a drug?

The prefilled saline syringe used to flush the venous access is reportable as a packaged supply on a claim, assuming you have not already included it in the infusion charge. Medicare does not separately reimburse this procedure, but it may be payable by charge-based payers.

Your hospital procedures will dictate whether you bill the flush under a supply revenue code (027X) or a pharmacy revenue code (025X). Many hospitals dispense the saline flush from the pharmacy, whereas others may consider this a supply and distribute the saline flush from the materials supply department. Either method would be appropriate.

Use the actual time of infusion to beneficiary for time-specific drug administration codes

A nurse sees a patient in the ER and administers a liter of normal saline and states that it was given “wide open.” There isn’t a stop time or rate per hour documented, so can we report 90760 or 90761, or should we code this as a push (90774 or 90775)?

Reporting start and stop times necessary for accurately and properly charging and billing for IV infusions continues to be challenging and problematic for many facilities. Your clinical scenario, in which there is documentation of an infusion “wide open,” yet no stop time, happens quite frequently in the ED. I refer you to the CMS Internet-only Manual 100–4, Chapter 4, Section 230, which points out those hospitals that are to report codes according to CPT instructions. CPT instructions indicate that you should use the actual time the infusion is administered to the beneficiary for time-specific drug administration codes.

Having said this, Wheatlands Administrative Services, the FI for Kansas, has published on its Web site under “FAQ for Injections and Infusions” the following question and answer about the clinical scenario you describe:

Q: If a patient is receiving an IV infusion for hydration and the stop time is not documented in the record, how should that be coded?
A: If the medical record clearly indicates that IV fluids were initiated and infusing (i.e., nurse’s notes indicate bag is infusing), then it would be appropriate to submit CPT code 90760 (Intravenous infusion, hydration, initial). It would not be appropriate to bill this service using CPT code 90774 (Therapeutic, prophylactic or diagnostic injection [Specify substance or drug] intravenous push, single or initial substanceldrug).

Although Kansas’ FI offers guidance to the legitimacy of assigning CPT code 90760 (Intravenous infusion, hydration; initial, up to one hour) for the initial hour of IV hydration in the absence of documented actual start and stop times, this obviously is in direct contrast to the requirements of start and stop time as indicated under the title of the CPT code.

Your FI might provide different guidance. Your best bet is to educate the clinicians responsible for documenting start and stop times about the importance and necessity of documenting start and stop times for infusions. Continuous feedback to each clinician who continues to lack appropriate documentation is essential if you want to have a real chance for improvement.

Although you may choose to assign an initial hour of IV hydration, CPT code 90760, for IV infusion “wide open” for the scenario provided, this policy does not address the problem of a lack of start and stop times for the infusion.

Recognize concurrent vs. sequential coding

How would you code two antineoplastic drugs given at the same time over two hours and 20 minutes?

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Injections/infusions  < continued from p. 7

If a nurse administered the two drugs through one IV site at the same time, then you would consider this a concurrent infusion. In this instance, you would take the time you indicated—two antineoplastic drugs infused at the same time for two hours and 20 minutes—and report this with the following CPT codes:

- 96413—Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug (first hour)
- 96515—Each additional hour (list separately in addition to code for primary procedure) (second hour)

The remaining 20 minutes is a wash, as the guidelines in the 2007 CPT Manual state, “Report 96415 for infusion intervals greater than 30 minutes beyond one-hour increments.”

Because the nurse administered the drugs concurrently, there is no additional reporting for the infusion. You will also need to report the drug(s)/substance(s) using the appropriate HCPCS code(s). If the nurse had administered the patient one infused drug, and then another infused drug (sequential), the coding would change. You would use add-on code 96417, which would indicate the sequential infusion. However, if that were the case, use the following CPT codes:

- 96413—Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug (first hour/first drug)
- 96417—Each additional sequential infusion (different substance/drug), up to one hour (list separately in addition to code for primary procedure) (second hour/second drug)

News in brief

HHS unveils its 2008 OIG Work Plan

The U.S. Department of Health and Human Services (HHS) released its 2008 OIG Work Plan on October 1. According to Kimberly Anderwood Hoy, Esq., JD, CPC, director of Medicare and compliance for Marblehead, MA–based HCPro, Inc., the OIG appears to have switched its focus from certain coding and modifier issues to cost report–based payments, among others.

In addition, the OIG has included audits of the following:

- Capital portion of the inpatient prospective payment system
- Disproportionate share payments
- New technology add-on payments

The OIG plans to continue to evaluate the accuracy of wage data under the current process. In addition, the OIG has added, or is conducting, ongoing audits in nearly every area that continues to be paid on a cost basis. These include:

- Graduate medical education
- Nursing and allied health education

- Organ procurement
- Bad debt reimbursement

Hoy notes that one new addition to the Work Plan involves x-rays in the ER. The OIG cites the Medicare Payment Advisory Commission’s concerns regarding their overuse. Other interesting items added to the Work Plan include an evaluation of the Medicare Secondary Payer procedures and an evaluation of the Joint Commission (formerly JCAHO) accreditation process.


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