



How the Deficit Reduction Act Affects Hospitals

**New Challenges in Medicaid Billing
Require Additional Diligence**

SentryResources

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New Challenges in Medicaid Billing Require Additional Diligence

The Deficit Reduction Act of 2005 brings some significant challenges to hospitals with regards to their Medicaid billing practices. As of the second quarter in 2009, most states are beginning to require that the 11 digit National Drug Code (NDC) for all Medicaid physician administered drugs be included on bills that are submitted for payment.

Background

The Deficit Reduction Act, Section 6002, requires all state Medicaid Agencies to collect rebates from drug manufacturers for all outpatient administered drugs. Prior to the DRA, most state Medicaid agencies did not receive specific 11 digit NDC numbers for drugs administered in hospital or other ambulatory care settings, which meant that Medicaid could not go back to drug manufacturers and receive financial rebates for the drugs that were utilized in these settings. Section 6002 of the Deficit Reduction Act seeks to save money for Medicaid by collecting this information from each and every ambulatory care provider to enhance the financial rebates it will receive from drug manufacturers.

Several types of claims that now require a full 11 Digit NDC include:

- All physician-administered drugs in an office/clinic setting (including 340B drugs).
- Claims from certified dialysis treatment centers.
- Outpatient hospital claims and institutional outpatient crossovers (including 340B drugs).
- Professional crossover claims.

It should be noted that 11 Digit NDCs are manufacturer specific, and this is important due to how these rebates will now be processed in accordance with the DRA.

NDCs for physician administered drugs are required because these drugs were historically billed without NDCs, thus preventing states from collecting rebates.
- 72 Fed. Reg. 39142, 39218
(July 17, 2007).

Inquiries may be triggered when manufacturers attempt to discern whether their drugs were truly used within the hospital.

What's Involved in Complying with the DRA?

Outpatient bills for services that include drugs are normally indicated by the presence of a “J-Code”. “J-Codes” are Level II HCPCS codes that begin with the letter “J” and are mapped by the Center for Medicare and Medicaid Services to groups of specific NDCs. Hospitals use an NDC code to purchase drugs from a drug wholesaler or manufacturer, but they identify administrations of those drugs using a Charge Description Master (CDM), or set of proprietary codes that are loosely mapped to specific NDCs. All three of these different code sets must be in sync or serious over reporting or under reporting of utilization will occur.

In addition to matching up several different code sets, there are added complications at each stage of the mapping process. Several common hurdles include:

1. **There can be more than one NDC purchased for a single drug** (for instance, a brand drug and a generic, or different types of generics) and the difference between NDCs is important. Because Medicaid will go back to each individual manufacturer for rebates on that manufacturer’s drugs, an NDC change is a critical point in the process. In the event of a manufacturer triggered audit, a hospital will be required to prove that they bought the exact amounts of the drug they reported to Medicaid.
2. **CDM to NDC mapping tables are hard to maintain**, often are not maintained regularly, and many Hospital Information Systems (HIS) can not manage the complex interactions that regularly exist between multiple CDM codes that relate to multiple NDCs.
3. **CDM to J-Code tables are hard to maintain** due to the fact that these tables are updated quarterly, and there can often be more than one CDM that should be mapped to the same J-Code.
4. **Billing systems and pharmacy systems are often poorly connected** and drugs that should be billed are left off of claims or claims include drugs that were never administered.
5. **A patient’s status and insurance class at the time of administration is key** and can affect compliance. This status often changes over the course of a patient’s care within a hospital.
6. **Billing units can be incorrectly calculated** by the billing system and/or pharmacy systems involved, resulting in inaccurate reporting.
7. **Some states require COG reporting or additional details** that need to be submitted along with the NDC code. These need to be accurately calculated and determined and can introduce additional complexity.
8. **All states have specific 340B reporting requirements** that indicate whether specific drugs were purchased at 340B pricing. This is an important interaction that introduces additional complexity for 340B Qualified Entities.

Manually collecting NDCs is time-consuming and resource-intensive.

What Does Compliance with the DRA Look Like?

Compliance with the Deficit Reduction Act means that a hospital can tie its purchases to dispensations for all Medicaid outpatients. Challenges include providing a visible, auditable, repeatable, and reasonable process for allocating different drugs purchased to patients that flow through the hospital pharmacy.

Because pressure will come to bear from drug manufacturers to substantiate the specific NDCs that are being reported by hospitals, inquiries will likely be triggered after each state submits its rebate requests to each manufacturer. These inquiries will likely focus on comparing the pharmacy purchases a hospital has made to the electronic claims adjudicated to Medicaid. Identification of drugs that were purchased but not reported, or drugs that were reported but never purchased will be gaps that draw attention. It is imperative that all purchases are reported accurately and that a visible, auditable report can be provided to verify claims in the event of an inquiry or audit.

What's the Solution?

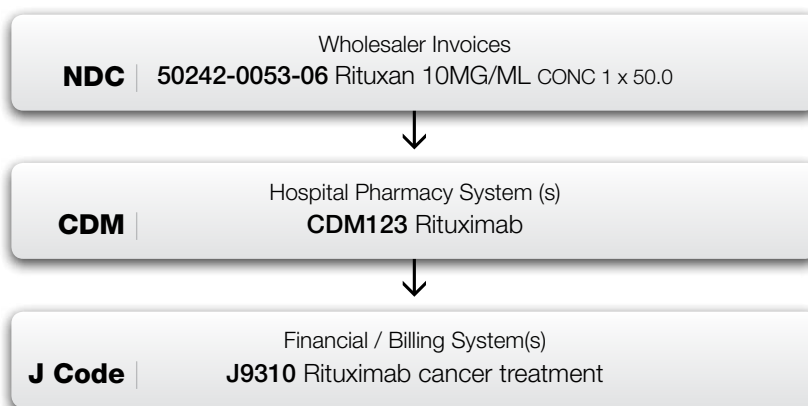
Access more information about the DRA online at www.SentryDS.com/DRA

The DRA reporting process is complicated and involves several different steps requiring conversions between several disparate numbering systems. The only way to ensure accuracy is to invest in tools that clearly identify and illuminate all steps of the process.

Hospitals should look for technology tools that include the following features:

1. Operate under electronically enforced, written, clearly specified 'Policies and Procedures'. A documented policy and procedure becomes a crucial tool in the event of an audit.
2. Provide built-in support for key coding schemes used for pharmacy procurement (NDCs), pharmacy billing (CDMs), and financial adjudication of claims (J-Codes/HCPC Codes).
3. Automatically update mapping tables and crosswalk tools to reflect changes in the regulatory environment, procurement practices, or administration.
4. Electronically provide instant access to a comprehensive "three click" audit trail that ties all steps of the process flow together.
5. In the event a hospital employs a bedside barcoding system, the system should take this information into account and be able to provide formulary updates back to the barcoding system.

Overview of Different Code Sets



Strategies to Avoid

The following strategies could leave your facility open to a time consuming, expensive audit that will find inaccuracies:

- **Manual workarounds or “patches” to existing systems** that do not incorporate all of the critical compliance components.
- **Refusing to submit claims to Medicaid that might include drug codes.** Most states do not allow for these types of selective billing practices.
- **Using “static” NDCs that do not change with purchasing behavior.** This practice immediately opens your operation to audit, as purchase records will not match billing records.
- **Attempting a “Best of Breed” integration involving multiple systems.** This type of integration will cost a significant sum of money, still presents significant challenges during an audit, and often fails to deliver on the promise of tight integration, often requiring poorly documented manual processes.

DRA Compliance is Essential

Compliance with the Deficit Reduction Act is a necessity for today’s Medicaid providers. While there appear to be many obstacles and the challenge seems daunting, there are tools that can safely and accurately guide your organization to overcome the inherent hurdles. Look for solution providers that balance all requirements, as neglecting pieces of the puzzle can have serious long-term ramifications.

About Sentry

Sentry Data Systems, Inc. offers healthcare business intelligence technology solutions that address a variety of operational, workflow, compliance, and financial challenges found within hospitals and pharmacies. These products include the hospital pharmacy management application Sentinel RCM™ (Revenue Cycle Manager), retail pharmacy transaction processing platform Sentrex™, and the healthcare business intelligence application HealthBIT™ (Business Intelligence Technology). These products run on top of Sentry’s healthcare cloud computing platform, Datanex™, which is available to independent software developers and other healthcare entities. Reduce the administrative complications of pharmacy procurement, increase compliance, and gain transparency into your daily operations with Sentry Data Systems.

Headquartered in Deerfield Beach, FL, Sentry Data Systems, Inc. currently serves clients in over 30 states and its systems process millions of healthcare transactions per day.

For additional information or more comprehensive resources regarding the DRA, visit us online at www.SentryDS.com/DRA .

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