Nebraska Medicaid

DUR Matters

Newsletter of the Nebraska Drug Utilization Review (DUR) Program

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Complete Coding of Office Visits

The DUR Board examined the number of patients taking stimulants who did not have a medically accepted indication in the medical claims data. For a six-month period, there were 5,150 patients under the age of 18 years and 1,840 patients 18 years of age or older without a documented indication for the stimulant medication prescribed in the medical claims data.

The Centers for Medicare and Medicaid Services (CMS) only reimburse state Medicaid programs for medications which meet the definition of a "covered outpatient drug". For a drug to be covered by Medicaid it must be approved by the Food and Drug Administration (FDA), is medically necessary, and is being used for its indicated purpose. The indicated purpose is listed in the FDA-approved labeling (Prescribing Information), or the use of which is supported by one or more citations included in the compendia which include the American Hospital Formulary Service Drug Information; United States Pharmacopeia-Drug Information (or its successor publications); DRUGDEX Information System; and peer-reviewed medical literature.

A Medicaid plan can deny payment for a drug which is not being used for its indicated purpose, which is why coding medical claims for office visits is extremely important in the care of a patient.

If a patient's medical claims are missing the appropriate coding, a patient may not receive the prescribed medication as it may be considered inappropriate or medically unnecessary. According to the ICD-10-CM Official Guidelines for Coding and Reporting FY 2019 (p 114), chronic diseases which are treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition. Additionally, all documented conditions that coexist at the time of the office visit which require or affect patient care treatment or management shall be coded.

For a patient who has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), each visit should be coded for this chronic disease as it is being treated on an ongoing basis even if the primary reason for the visit is not for the treatment of ADHD. If a patient with ADHD, does not have a documented diagnosis in the medical record it may be assumed by the Medicaid plan that the patient does not have the condition and prescriptions for ADHD may be denied. **Each office visit or encounter should be coded correctly for all documented conditions**. By signing a Service Provider Agreement with Nebraska Medicaid, a provider agrees to submit claims which are true, accurate, and complete.

CONTACT INFORMATION
Nebraska Medicaid
Department of Health & Human Services
(402) 471-9029
dhhs.MedicaidPharmacyunit@nebraska.gov