State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

Volume 6 No. 10 **March 1996**

TO: Providers of Pharmaceutical Services

SUBJECT: Implementation of a Real-Time, On-Line Point-Of-Sale (POS)/Prospective Drug Utilization Review (PDUR) Claims Processing System

EFFECTIVE: Claims with Service Dates on or after March 18, 1996

BACKGROUND: The New Jersey Medicaid Management Information System (NJMMIS) currently processes pharmacy claims for the New Jersey Medicaid program, the General Assistance (GA) program, the AIDS Drug Distribution program (ADDP), the Cystic Fibrosis (CF) program, and the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program after covered pharmacy services have been provided by a pharmacy. Various NJMMIS edits are applied during claims processing to determine, for example, beneficiary eligibility, or claim payments. Currently, pharmacy claims may be submitted as hard-copy claims (MC-6), or as Electronic Media Claims (EMC) on tape, diskette, or through a modem. Regardless of the method of claim submission, pharmacists receive a Remittance Advice (RA) statement which details the outcome of claims processing activities for a payment period.

Currently, certain pharmacies have contracted with a billing service which facilitates claim transmission to Unisys, and provides value-added services, including an on-line POS/PDUR claims response and eligibility verification system. This system is not sponsored, nor operated by the State of New Jersey.

This Newsletter announces the intentions of the New Jersey Division of Medical Assistance and Health Services to implement a State-operated POS/PDUR claims processing system for all pharmacy claims currently processed by Unisys for the State pharmacy benefits programs described above. The State will process claims through the State-operated POS/PDUR system without any additional charge to participating pharmacies. However, pharmacies will experience either a direct or indirect claim transaction charge for the cost of services provided by a telecommunications system, or "switch," selected by a pharmacy, or contracted billing service.

ACTION: Pharmacies may continue to submit pharmacy claims through their current billing arrangements, or choose to submit pharmacy claims through the new State-operated POS/PDUR system. **All pharmacy claims with service dates on or after March 18, 1996, except for claims reflecting those situations described below, including hard-copy and EMC claims, shall be adjudicated in a prospective claims processing environment. All claims with these service dates will be subject to all POS/PDUR claims processing edits, regardless of the method of claim submission to Unisys.**

It is important to note that nursing facility pharmacy claims reflecting 24-hour unit-dose, or 30-day unit dose services, are exempt from POS/PDUR claims processing requirements. However, traditional pharmacy services provided in nursing facilities may be submitted through the State-operated POS/PDUR claims processing system.

The State-operated POS/PDUR system will only accept claims transmitted to Unisys in the NCPDP claim format, Version 3.2C, "Medicaid Claim/Reversal". The current NJMMIS claim format for **EMC claims** will not change.

The billing arrangements currently used by pharmacies to submit claims to Unisys are important in determining whether a pharmacy must complete any further agreements with the State. If a pharmacy decides to submit their pharmacy claims through the State-operated POS/PDUR system, and as a result of this decision, there is no change in its current billing agent, no further agreements with the State must be completed by the pharmacy. If a pharmacy makes a similar decision, and there is a change in billing agents, the pharmacy must complete the "EMC Provider/Billing Agent" Agreement (see attachment).

If a pharmacy's computer system currently generates claims in the NCPDP claim format, Version 3.2C, and the pharmacy currently submits EMC claims to Unisys, and the pharmacy decides to submit claims through a telecommunications network or "switch" to the State-operated POS/PDUR system, no further agreements with the State must be completed by the pharmacy. However, the pharmacy must enter into an agreement with the "switch", or software vendor offering "switching" services.

If a pharmacy computer system currently generates the NCPDP claim format, Version 3.2C, and the pharmacy does not currently submit EMC claims to Unisys and decides to submit claims to the State-operated POS/PDUR system, the pharmacy must complete an "EMC Provider Agreement" (see attachment).

New "EMC Provider/Billing Agent Agreements" and new "EMC Provider Agreements" must be returned to Unisys prior to submitting claims through the new billing agent, or directly to Unisys. Please return completed agreements to:

Unisys
P.O. Box 4804
Trenton, New Jersey 08625-4804
Attention: UNISYS Provider enrollment

Pharmacies interested in contacting a telecommunications vendor or "switch", approved by the State of New Jersey, or pharmacists with any questions regarding this Newsletter, please contact the Chief, Pharmaceutical Services, at (609) 588-2724.

RETAIN THIS NEWSLETTER BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")

NEW JERSEY MEDICAID PROVIDER ELECTRONIC BILLING AGREEMENT FOR PROVIDERS WITH BILLING AGENTS

1) _____ elects to submit requests for payment via electronic billing media using the services of:
(Provider Name)

2) _____ 3) EIN/TIN #: _____
(Billing Agent)

4) _____ 5) _____
(Billing Agent Address) (City/State/Zip)

6) EMC Contact Person: _____ 7) Title: _____

8) Phone #: (_____) _____ - _____ ext. _____ 9) FAX #: (_____) _____ - _____

who will be requesting payment on behalf of the provider for services rendered to Medicaid Recipients.

I certify that the information on these claims will be true, accurate and complete; and agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State agency may request; and that the services covered by these claims and the amounts charged will be in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under these claims has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

I also certify that for each Medicaid service performed and claim submitted for payment, the patient certification will be on file at the provider's location.

10) _____ 11) _____
(Provider Representative's Signature) (Date)

12) _____ 13) _____
(Billing Agent's Signature) (Date)

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

14) Provider: _____

15) Address: _____

16) City, State, Zip Code: _____

17) Phone: (_____) _____ - _____ ext. _____ 18) FAX #: (_____) _____ - _____

19) Provider Number: _____ 20) Claim Type: _____ 21) Group Medicare Number: _____

******** **Please also complete the reverse side of this form.** ********

22) FISCAL AGENT USE ONLY:
Authorized for Electronic Media Processing on _____, 19_____

_____ _____ _____
(Signature) (Title) Submitter ID#

FD-376 (03/92)

Please provide the following information to assist us in planning our EMC resource usage:

23) Planned Media Type	24) Estimated Claim Volume
_____ Magnetic Tape	_____ per Week/Month (circle one)
_____ Diskette	_____ per Week/Month (circle one)
_____ Telecommunication	_____ per Week/Month (circle one)

25) **For Telecommunication users only, please indicate:**

a) Asynchronous: _____ (or) Synchronous: _____

b) Modem Make/Model: _____*

c) Line Speed (BPS): _____ d) Modem phone number (____) ___ -_____

e) Telecommunication package: _____**

f) Telecommunication protocol: _____***

* We are using Hayes V-series ULTRA Smartmodem 9600
** We are using Procomm Plus 2.01 as a Host.
*** We recommend ZMODEM or KERMIT

If you will be creating your claims submission file(s) using software developed by an outside vendor, please furnish the following data:

26) Vendor: _____ 27) Vendor Contact: _____

28) Vendor Address: _____ 29) Telephone #: (____) _____ -_____

EMC submitters with sufficient claim volume may have the option to receive remittance advice (R/A) information on magnetic tape, in addition to the standard hard-copy R/A. If you wish to be considered for the magnetic tape R/A option, please complete the following:

We authorize "_____" to receive our Remittance Information electronically on magnetic tape
30) (Submitter Name) from Unisys.

31) Person to Contact: _____ 32) Telephone: (____) ____-_____ ext._____

33) _____
(Authorized Provider Signature/Title/Date)

NEW JERSEY MEDICAID PROVIDER ELECTRONIC BILLING AGREEMENT

1) _____ *elects to submit requests for payment via electronic billing media.*
(Provider Name)

I certify that the information on these claims will be true, accurate and complete; and agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State agency may request; and that the services covered by these claims and the amounts charged will be in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under these claims has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

I also certify that for each Medicaid service performed and claim submitted for payment, the patient certification will be on file at the provider's location.

2) _____ 3) _____
(Provider Representative's Signature) *(Date)*

NOTICE: *Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".*

4) *Provider:* _____

5) *Address:* _____

6) *City, State, Zip Code:* _____

7) *Phone #:* (___) ____ - _____ *ext.* ____ 8) *FAX:* (___) ____ - _____

9) *Provider Number:* _____ 10) *Modem:* (___) ___ - _____

11) *Claim Type:* _____ 12) *EIN/TIN #:* _____

13) *EMC Contact Person:* _____ 14) *Title:* _____

15) *EMC Contact Phone #:* (___) ____ - _____ *ext.* _____

*** ***Please also complete the reverse side of this form.*** ***

16) ***FISCAL AGENT USE ONLY:***

Authorized for Electronic Media Processing on _____, 19____

_____ _____ _____
(Signature) *(Title)* *Submitter ID#*

FD-375 (01/92)

Please provide the following information to assist us in planning our EMC resource usage:

17) Planned Media Type		18) Estimated Claim Volume	
_____	Magnetic Tape	_____	per Week/Month (circle one)
_____	Diskette	_____	per Week/Month (circle one)
_____	Telecommunication	_____	per Week/Month (circle one)

19) **For Telecommunication users only, please indicate:**

a) Asynchronous: _____ (or) Synchronous: _____

b) Modem Make/Model: _____*

c) Line Speed (BPS): _____ Modem: (___) ___ - _____

d) Telecommunication package: _____**

e) Telecommunication protocol: _____***

* We are using Hayes V-series ULTRA Smartmodem 9600
** We are using Procomm Plus 2.01 as a Host.
*** We recommend ZMODEM or KERMIT

If you will be creating your claims submission file(s) using software developed by an outside vendor, please furnish the following data:

20) Vendor: _____

21) Vendor Address: _____

22) Vendor Contact: _____ 23) Telephone #: (___) _____ - _____

EMC submitters with sufficient claim volume may have the option to receive remittance advice (R/A) information on magnetic tape, in addition to the standard hard-copy R/A. If you wish to be considered for the magnetic tape R/A option, please complete the following:

We authorize "_____" to receive our Remittance Information electronically on magnetic tape from Unisys.
24) (Submitter Name)

25) Person to Contact: _____

26) Telephone: (_____) _____-_____ ext._____

27) _____
(Authorized Provider Signature/Title/Date)