Implementation Plan for High-Cost Clinician Administered Drugs (HCCAD): Claims Processing Requirements

HCCAD are drugs or biologics that HHSC has approved to be "carved out" of the All-Patient Refined Diagnosis Related Group (APR-DRG) and can be billed on an outpatient claim.

The following billing guidelines apply to outpatient claims of HCCAD.

Special requirements for transmitting claims for HCCAD

1. The hospital must claim **separate payment** for the HCCAD on an **outpatient claim**. MCOs must ensure that payment to the hospital is direct reimbursement for the HCCAD. Payment for the HCCAD must not be bundled with any other service.
2. The claim for the HCCAD must be **separate** from any facility/institutional claim the hospital submits for **all other** hospital services delivered to the member during the same visit. The associated inpatient or outpatient charges with the same date(s) of service are billed separately and remain part of the APR-DRG.
3. The date of administration of the drug should be used on the HCCAD outpatient claim.
4. Along with the members name, date(s) of service, and other required information, the HCCAD claim **must** include:
    a. The **NDC qualifier** of N4
    b. The appropriate 11-digit **National Drug Code (NDC)** and corresponding **HCPCS code** for the drug; and
    c. The **number of units** of the drug administered to the member that is covered by the claim; and
    d. The **NDC unit of measurement.** There are five allowed values: F2, GR, ML, UN or ME.
5. MCOs should reimburse the hospital at the FFS rate or the actual acquisition cost from the invoice, whichever is less. MCOs must require the hospital to submit an invoice of the **actual acquisition cost** of the drug.