

January 15, 2008  
**Montana Medicaid Notice**  
**Passport Providers**

---

---

## **Billing Procedures Regarding National Drug Code (NDC)**

### **Background Information**

The Federal Deficit Reduction Act of 2005 mandates that all State Medicaid Programs require the submission of National Drug Codes (NDC's) on claims submitted with certain procedure codes for physician-administered drugs. This mandate affects all providers who submit claims for procedure-coded drugs both electronically and manually.

**Effective April 1, 2008**, Montana Medicaid will require all claims submitted for physician administered drugs to include the NDC(s), the corresponding CPT/HCPCS code, and the units administered for each code. Montana Medicaid will reimburse only on drugs manufactured by companies that have a signed rebate agreement with CMS.

1

### **Remittance Advice**

Remittance advice (RA) will not display the NDC submitted on the claim. Providers are encouraged to contact Electronic Data Interchange (EDI) toll free at 800-987-6719, or on the web at [MTEDIHelpdesk@ACS-inc.com](mailto:MTEDIHelpdesk@ACS-inc.com) to obtain additional information about denied claims.

### **NDC Requirements**

#### General

**Effective April 1, 2008**, Montana Medicaid will require all claims submitted for physician administered drugs to include the NDC(s), the corresponding CPT/HCPCS code, and the units administered for each code.

#### Formatting

The NDC is an eleven digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches this code to the product container at the time of packaging. This eleven digit code is composed of a 5-4-2 grouping. The first grouping of five digits is the labeler code as assigned to the manufacturer by the Federal Drug Administration. The second grouping of four digits is assigned by the manufacturer and describes the ingredients, form of the dosage, and strength of the dosage. The last grouping of two digits describes the packaging size.

1	2	3	4	5	6	7	8	9	10	11
Labeler Code					Manufacturer's Code			Packaging Size		

The NDC **must** be recorded (no spaces, no punctuation) as an eleven digit series of numbers in order to be valid. **Claims will be denied for drugs billed without a valid eleven digit NDC.**

It is possible that the labeler may have omitted any leading zeros in the NDC for a particular pharmaceutical which would result in an invalid NDC containing less than eleven digits. To ensure proper payment of the claim, the provider must add the appropriate number of leading zeros to the beginning of the affected segments. By doing so, the NDC will be reported as a valid eleven digit code following the 5-4-2 format.

### Quantity

The procedure code billing units and NDC quantity may not always be the same amounts. The NDC quantity is based upon the strength of the drug administered per unit and the designated strength of the procedure code. The NDC quantity billed must reflect the procedure code quantity billed on the claim.

### **Reporting NDC on the electronic 837P or 837I**

Filing claims electronically is the preferred method of claim filing as it allows for the fewest amount of errors and expedites claim processing and payment. Providers may create electronic claims using the 837 format and send these claims directly to ACS EDI Gateway Inc. at no charge to the provider. The software to facilitate electronic filing (WINSAP 2003, version 5.13) is also provided at no charge. Providers must be enrolled as a Montana Medicaid Provider and must also enroll with ACS EDI Gateway.

The NDC is reported in Loop 2410, Segment LIN, Data Element 03 of the 837. You may report up to 25 NDC's for each CPT/HCPCS line code.

The following information must be reported on the 837:

- National Drug Code – enter the valid eleven digit code following the 5-4-2 format (the N4 qualifier is not applicable for electronic filing).
  - Drug Unit Price – enter the unit price, this is a required field.
  - Unit of Measurement – enter the unit of measurement, this is a required field.
- ❖ F2 – International Unit
  - ❖ GR – Gram
  - ❖ ML – Milliliter
  - ❖ UN – Units

Examples of how unit of measure qualifiers relate to NDC dose/volume:

NDC Dose/Voume

Unit Qualifier

1,000ml	ML
50,000IU	F2
1Unit	UN
50mg	GR
100mg/4ml	ML

- Quantity – enter the quantity, this is a required field.
- Prescription Number – if available, is not required.

Some revenue codes require a procedure code for all outpatient hospital services and the units administered for each code. CPT/HCPCS codes billed under those revenue codes which are for physician administered drugs must include the NDC(s).

**Reporting NDC on the paper CMS-1500**

**The following is a list of potential procedure codes that may apply to physician administered drugs:**

A4216-A4218	A9500-A9699	P9041-P9050	Q3025-Q3026
A4706-A4728	C1716-C1720	Q0112	Q4079-Q4081
A4760-A4766	C2633-C2637	Q0163-Q0181	Q4083-Q4095
A4802	C9003-C9399	Q0515	Q9945-Q9964
A6250	J0120-J9999	Q2004-Q3001	

To report the NDC on the CMS 1500, under Form Locator 24, enter the valid eleven digit NDC in the shaded area on the left side of the form within each procedure line:

- Enter the NDC qualifier of “N4” in the first two positions of the NDC.
- Enter the valid eleven digit NDC following the qualifier (N4).
- Follow the 5-4-2 format when entering the NDC.
- Enter the NDC unit of measure qualifier:

- ❖ F2 - International Unit
- ❖ GR – Gram
- ❖ ML – Milliliter
- ❖ UN – Units

Examples of how unit of measure qualifiers relate to NDC dose/volume:

<u>NDC Dose/Voume</u>	<u>Unit Qualifier</u>
1,000ml	ML
50,000IU	F2
1Unit	UN
50mg	GR
100mg/4ml	ML

- Enter the NDC quantity (the administered amount) to the nearest whole number. For actual units that are less than one (1), please bill these units using the whole number of one (1). Examples would be:

Actual Amount	Billed Amount
.11ml	1.0ml
.95mg	1.0mg
26.5mg	27.0mg

The N4 qualifier, eleven digit NDC, unit of measure, and quantity is entered without hyphens, commas, decimal points, or spaces.

### Billing Requirements

The paper CMS-1500 will accept one NDC for each of its six lines of coding. Claims will be denied without a valid eleven digit NDC that follows the 5-4-2 format. If the line has more than one NDC associated with it and the provider is billing on paper, each ingredient should be billed on a separate line with the appropriate CPT/HCPCS code and the corresponding NDC data. The following modifiers will be used to denote the components:

- KO – single drug unit dose form
- KP – first drug of multiple drugs
- KQ – second or subsequent drug of multiple drugs

### Reimbursement Policy

Payment to the provider for physician administered drugs is currently made using the reimbursement methodology for provider type based on the billed CPT/HCPCS code. These reimbursement methodologies will not change.

Professional providers using the CMS 1500 that bill compound drugs must bill this charge using CPT/HCPCS code J3490 on paper claim forms and must attach an invoice. Payment will be made from the NDC's listed on the invoice that qualify for rebates. These claims and invoices must be mailed to:

Medicaid Physician Services  
P.O. Box 202951  
Helena, MT 59620-2951

Crossover Claims

Dual-eligible claims billed to Medicare with an NDC will cross to Medicaid with the NDC. Any physician administered injectable crossing to Medicaid from Medicare without an NDC will be denied. Claims denied for this reason may be re-billed with the proper NDC within one year of the date of service.

An example of paper CMS-1500 is attached (Attachment A).

**Reporting NDC on the paper UB-04**

To report the NDC on the UB-04, enter the following information into Form Locator 43 in the Revenue Description Field:

- Enter the NDC qualifier of “N4” in the first 2 positions on the left side of the field.
- Enter the eleven digit NDC numeric code in the 5-4-2 format.
- Enter the NDC unit of measure qualifier:
  - ❖ F2 – International Unit
  - ❖ GR – Gram
  - ❖ ML – Milliliter
  - ❖ UN – Unit

Examples of how unit of measure qualifiers relate to NDC dose/volume:

<u>NDC Dose/Voume</u>	<u>Unit Qualifier</u>
1,000ml	ML
50,000IU	F2
1Unit	UN
50mg	GR
100mg/4ml	ML

- Enter the NDC quantity (the administered amount) to the nearest whole number.

The information on the Revenue Description Field is entered without delimiters such as hyphens or commas, and any unused spaces for the entire quantity are left blank. The Description Field allows for a maximum of twenty-four total characters.

Billing Requirements

Some revenue codes require a procedure code for all outpatient hospital services and the units administered for each code. CPT/HCPCS codes billed under those revenue codes which are for physician administered drugs must include the NDC(s). The following is a list of potential procedure codes and revenue centers that may apply to physician administered drugs:

Procedure Codes	Revenue Codes**
A4216-A4218	272
A4706-A4728	822, 832, 842, 852
A4760-A4766	822, 832, 842, 852
A4802	822, 832, 842, 852
A6250	272, 623
A9500-A9699	343, 344, 636,
C1716-C1720	272, 278
C2633-C2637	272, 278
C9003-C9399	278, 636
J0120-J9999	250, 636
P9041-P9050	386, 390, 399, 636
Q0112	300, 306
Q0163-Q0181	250, 636
Q0515	636
Q2004-Q3001	250, 278, 636
Q3025-Q3026	250, 636
Q4079-Q4081	636
Q4083-Q4095	636
Q9945-Q9964	254, 255, 636, 96X, 97X, 98X
	**Check recent Uniform Billing Editor for appropriate revenue centers for each code

Providers that bill compound drugs on the UB-04 paper claim form must bill each specific drug in the compound on separate lines using the appropriate CPT/HCPCS code for each drug. In addition, the appropriate NDC and utilization information must be reported. If the line has more than one NDC associated with it and the provider is billing on paper,

each ingredient should be billed on a separate line with the appropriate CPT/HCPCS code and the corresponding NDC data. The following modifiers will be used to denote the components:

- KO – single drug unit dose form
- KP – first drug of multiple drugs
- KQ – second or subsequent drug of multiple drugs

### Reimbursement Policy

Payment to the provider for physician administered drugs is currently made using the reimbursement methodology for facility type (OPPS or CAH) based on the billed HCPCS code. These reimbursement methodologies will not change.

The department will deny claim lines with dates of service on or after April 1, 2008 that do not report an NDC and/or are not manufactured by companies that have a signed rebate agreement with CMS.

For claims in which a line denied because no NDC was included, providers will have 365 days from the date of service to resubmit or adjust a claim to receive payment.

An example of a paper UB-04 is attached (Attachment B).

### Contact Information

Should providers have questions about the information included in this bulletin, please feel free to contact the following resources:

#### **Provider Relations**

1-800-624-3598 In or out of state  
1-406-440-1837 Helena  
1-406-442-4402 Fax

#### **Written Inquiries addressed to:**

Provider Relations  
Box 4936  
Helena, MT 59604

#### **EDI Technical Help Desk**

1-800-987-6719 In or out of state  
1-406-442-1837 Helena  
1-406-442-4402 Fax

#### **Written inquiries addressed to:**

ACS  
Attn. MT EDI  
Box 4936  
Helena, MT 59604