

March 7, 2008

# Montana Healthcare Programs Notice

Outpatient Hospital, Emergency Room, Podiatry,  
Physician, Mid-Level Practitioner, IDTF,  
Free-Standing Dialysis Clinic, Birthing Center,  
Laboratory and X-Ray, Pharmacy, Public Health  
Clinic, Psychiatry, Ambulatory Surgery Center  
(excludes Inpatient Hospital, FQHC, RHC, DME,  
Ambulance, Indian Health Service, Dentist, and all  
others not mentioned above)

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## 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 (NDCs) 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. A list of drug manufacturers who have a rebate agreement can be found at:

[http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10\\_DrugComContactInfo.asp](http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp)

This list is updated every April.

### Remittance Advice

Remittance advices (RAs) 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 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. This 11-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 11-digit series of numbers in order to be valid. **Claims will be denied for drugs billed without a valid 11-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 11 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 11-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 NDCs for each CPT/HCPCS line code.

The following information must be reported on the 837:

- National Drug Code – Enter the valid 11-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/Volume	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 that 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 11-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 11-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:

NDC Dose/Volume	Unit Qualifier
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
.95g	1.0mg
26.5mg	27.0mg

The N4 qualifier, 11-digit NDC, unit of measure, and quantity are 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 11-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 NDCs 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 a 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 two positions on the left side of the field.
- Enter the 11-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 – Units

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

NDC Dose/Volume	Unit Qualifier
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 24 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 CTP/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 toll-free in- and out-of-state: 1-800-624-3958**

**Helena: (406) 442-1837**

**Fax: (406) 442-4402**

**Written inquiries addressed to:**

**Provider Relations**

**Box 4936**

**Helena, MT 59604**

**EDI Technical Help Desk toll-free in- and out-of-state: 1-800-987-6719**

**Helena: (406) 442-1837**

**Fax: (406) 442-4402**

**Written inquiries addressed to:**

**ACS**

**Attn: MT EDI**

**Box 4936**

**Helena, MT 59604**

Medicaid Only Coverage — Healthcare Providers

Fill Colors (shaded areas are slightly darker):

- Required Fields
- Conditional Fields
- Other

Border Colors

- Client Fields
- Provider Fields
- Billing Fields

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Flintstone, Fred T		3. PATIENT'S BIRTH DATE MM DD YY 08 30 60 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 112 Rocky Rd.		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE Bedrock BC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>	
ZIP CODE TELEPHONE (Include Area Code) 54321-1234 (406) 765-4321		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE 123456789	
		11. INSURED'S POLICY GROUP OR FECA NUMBER	
		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
		b. EMPLOYER'S NAME OR SCHOOL NAME	
		c. INSURANCE PLAN NAME OR PROGRAM NAME Medicaid	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 01 01 07

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
Great Gazoo MD

17a. 9954321

17b. NPI 1234567890

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?  YES  NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 285.21

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
N4 55513009701 ML1								ZZ	36LP00000X
01 01 07 01 01 07	11		J0881	1	1500 00	500	6	NPI	1213456789
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN

26. PATIENT'S ACCOUNT NO. 123456789

27. ACCEPT ASSIGNMENT?  YES  NO

28. TOTAL CHARGE \$ 1500 00

29. AMOUNT PAID \$

30. BALANCE DUE \$ 1500 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  
Rocky Shalestone, MD 01/01/07

32. SERVICE FACILITY LOCATION INFORMATION  
a. NPI b. \_\_\_\_\_

33. BILLING PROVIDER INFO & PH # (406) 555-1234  
Yabba-Dabba Center  
2121 Granite Slab Dr.  
Bedrock, BC 54321-1234  
a. 9876543210 b. ZZ 400RT0010X

Medicaid Only  
**Required Fields are Highlighted**

1 Take Time Medical Center 104 Time Square Helena, MT 59601-0104		2	3a PAT. CNTL # 4806	4 TYPE OF BILL 131
			b. MED. REC. # Grisw97531	6 STATEMENT COVERS PERIOD FROM 010108
			5 FED. TAX NO.	THROUGH 010108
				9912345

8 PATIENT NAME a Griswold, Ellen	9 PATIENT ADDRESS a 1313 Mockingbird Lane. Metropolis. MT 59601-1313
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10 BIRTHDATE 03/26/76	11 SEX F	12 DATE 010108	13 HR 11	14 TYPE 1	15 SRC	16 DHR	17 STAT 01	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
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31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	37
38 Griswold, Ellen 1313 Mockingbird Lane Metropolis, MT 59601-1313						
39 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	42 VALUE CODES AMOUNT	43 VALUE CODES CODE	44 VALUE CODES AMOUNT	45

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
636	N400009074635ML1	J1055		1	65 00		
940	THER/PROPH/DIAG INJ SC/IM	90772		1	42 00		
PAGE OF					CREATION DATE 010208	TOTALS	107 00

50 PAYER NAME Medicaid	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1876543210
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58 INSURED'S NAME Griswold, Ellen	59 P.FEL.	60 INSURED'S UNIQUE ID 123456789	61 GROUP NAME	62 INSURANCE GROUP NO.
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63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
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69 ADMIT DX V25 49	70 PATIENT REASON DX	71 HIPPS CODE	72 ECI	73
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74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI 1766554433	QUAL ZZ	207Q00000X
77 OPERATING NPI			QUAL	LAST Munster		FIRST Herman

80 REMARKS	81CC a. B3 282N0000X	78 OTHER NPI	QUAL	LAST	FIRST
	b.	79 OTHER NPI	QUAL	LAST	FIRST
	c.				
	d.				

- Fill Colors (shaded areas are slightly darker):
- Required Fields
  - Conditional Fields
  - Other
- Border Colors:
- Client Fields
  - Provider Fields
  - Billing Fields