MONTANA
Department of Public Health & Human Services

September 1, 2009

Montana Healthcare Programs Notice

Outpatient Hospital, Inpatient Hospital, Freestanding Dialysis Clinic, Birthing Center (excludes Rural Health Clinic, FQHC, Indian Health Service)

Billing Procedures Regarding National Drug Code (NDC) When Using a UB-04

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 for drugs manufactured by companies that have a signed rebate agreement with CMS.

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, 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 **third grouping** of two digits describes the packaging size.

Group One	Group Two	Group Three
05891	4328	01
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 omit any leading zero(s) in any of the NDC groups 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 grouping. By doing so, the NDC will be reported as a valid 11-digit code following the 5-4-2 format. In the above example, the labeler may show the NDC as 5891-4328-1. The provider must add the leading zeros in groups one and three and report the NDC as 05891432801.

Reporting NDC on the Electronic 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.

The NDC is reported in Loop 2410, Segment LIN, Data Element 03 of the 837I. You may report up to 25 NDCs for each CPT/HCPCS line code. Do not submit the drug name when recording the NDC.

The following information is required and must be reported on the 837I:

- National Drug Code — Enter the valid 11-digit code following the 5-4-2 format.
- Drug Unit Price — Entered in Loop 2410, Segment CTP, Element CTP03.
- Quantity — Entered in Loop 2410, Segment CTP, Element CTP 04.
- Unit of Measurement (qualifier) — Entered in Loop 2410, Segment CTP, Element CTP 05.

There are four acceptable units of measurement to be reported with the NDC. Report the applicable unit of measure qualifier per NDC:

- F2 — International Unit
- GR — Gram (includes mg, mcg)
- ML — Milliliter
- UN — Units (includes "each")

The prescription number may be reported on the 837I, but is not required.

More than one NDC may be reported per line when billing electronically.

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 apply to physician-administered drugs must include the NDC(s).

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 (includes mg, mcg)
  - ML — Milliliter
  - UN — Units (includes "each")
- Enter the NDC quantity (the administered amount) with up to three decimal places.

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 for Paper Claims Using an Attachment and a Modifier

The paper UB-04 will accept one NDC for each of its 24 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, the NDC that lists the **greatest** number of units should be listed on the claim form. The modifier KP (first drug of multi drug) will indicate that there is an attachment with additional NDC information. The CPT/HCPCS code must have the KP modifier attached to it. Additional drugs should be listed on the NDC attachment. The attachment must include the following information:

- Patient's name and I.D. number
- Rendering NPI and taxonomy
- Date(s) of service
- CPT/HCPCS code
- N4 qualifier with the 11-digit NDC
- Unit of measure
- NDC quantity

When reporting the NDC using the attachment, please remember to enter a space between the 11-digit NDC code and the unit of measure. Other than this one exception, enter the NDC information without hyphens, commas, or spaces. Use one line per NDC when filling out the attachment.

A copy of the attachment is enclosed with this update (Attachment 1). DO NOT list the actual name of the physician-administered drug or the cost of the drug when recording the NDC on either the attachment or the paper UB-04.

Compound Drugs

Professional providers that bill compound drugs using the paper UB-04 must bill them using the corresponding CPT/HCPCS codes to include the KP modifier on paper claim forms and must attach the supplier's invoice. The invoice must contain an NDC for each component of the compound. Invoices that do not include NDCs will be denied. Payment will be made from the NDCs listed on the invoices that qualify for rebates.

Single Dose / Multi-Dose Vials

When billing a single dose vial, bill the entire quantity including any waste. For example, if the NDC quantity is 50mg in a single dose vial, but the CPT/HCPCS code billing unit is 1mg of which the provider gave 152mg, report the NDC quantity for 200mg (152mg + 48mg of waste).

When billing a multi-dose vial, bill for the actual amount administered. For example, if the CPT/HCPCS code billing unit is 1mg and the provider gave 152mg, report the NDC quantity for 152mg.

Bill a pre-filled syringe as a single dose vial.

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. The procedure code unit is based on the designated strength of the procedure code. Both the NDC quantity and the procedure code quantity reflect the amount administered to the client. The NDC quantity may be reported using up to three decimal places.

The following is an example of calculating the **NDC quantity:**

- Dosage of 100 mg given to client
- Drug is packaged in a multi-dose vial of 500mg
- NDC unit of measure would be recorded as UN representing "each vial"
- NDC quantity would be 0.2 UN (units), or two tenths of a vial

  Dosage / NDC Qualifier = NDC Quantity
  (Dosage of 100mg divided by the NDC qualifier of 500mg = 0.2 units)
- Enter the valid 11-digit NDC on the UB-04 with the NDC quantity:

  01234567899UN0.2

*Please note that a drug may be packaged in multiple quantities. For example, packaging for syringes may be in quantities of 10 per package. If one syringe was used, the NDC qualifier would be UN (units) with the number of units being "one."

The following is an example of calculating **billed units:**

- Dosage of 100 mg given to client
- CPT/HCPCS quantity = 10mg
- If the dosage is 100mg, the CPT/HCPCS billed amount would be 10 units

  Dosage / CPT/HCPCS Quantity = Units Billed
  (100mg dosage divided by CPT/HCPCS quantity of 10mg = 10 units billed)

Crossover Claims

Dual-eligible claims billed to Medicare with an NDC will cross to Medicaid with the NDC. Any claim with a physician-administered drug 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.

If You Are Billing as a 340B Provider

Providers approved by CMS to participate in the 340B Drug Pricing Program must submit their Medicaid provider number(s) (NPI) to the Office of Pharmacy Affairs (OPA). This will ensure that the state will not request a rebate for the already discounted 340B drugs which are exempt from the NDC requirement. Providers must also notify Provider Relations within 30 days of being approved by CMS of their intent to participate in the 340B Drug Pricing Program.

- **Do not** submit an NDC for claim lines that are billed for 340B priced drugs (you must still submit a CPT/HCPCS code).
- When billing 340B drugs, Montana Medicaid **cannot** be billed for an amount greater than the **actual acquisition price** plus the Medicaid dispensing fee.

Reimbursement Policy

Payment to the provider for physician-administered drugs is currently made using the reimbursement methodology for facility type based on the billed CPT/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