Pharmaceuticals NDC Billing Requirements Policy

Policy Statement

This policy applies to Participating and Non-participating providers who render services to Neighborhood Health Plan of Rhode Island (Neighborhood) for members. Benefit coverage limits may apply.

Scope

This policy applies to:

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Pharmacy Prior Authorization Criteria and Clinical Medical Policies

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Reimbursement Requirements

Effective November 1, 2010
Neighborhood Health Plan of Rhode Island (Neighborhood) will require National Drug Codes (NDCs) on claims in addition to the standard CPT/HCPCS codes for CMS 1500 claims submission to be compliant with the Federal Deficit Reduction Act of 2005 (DRA).

NDC FOR MEDICAID

Why do I have to start billing with National Drug Codes (NDCs) in addition to HCPCS codes?

The Deficit Reduction Act of 2005 (DRA) includes new provisions regarding State collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for certain administered drugs. Section 6002 of the DRA adds section1927 (a) (7) to the Social Security Act to require States to collect rebates on physician-administered drugs. In order for Federal Financial Participation (FFP) to be available for these drugs, the State must provide collection and submission of utilization data in order to secure rebates. Since there are often several NDCs linked to a single Healthcare Common Procedure Coding System (HCPCS) code, the Centers for Medicare and Medicaid Services (CMS) deem that the use of NDC numbers is critical to correctly identify the drug and manufacturer in order to invoice and collect the rebates.

What is the Drug Rebate Program?

The Medicaid Drug Rebate Program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) which added Section 1927 to the Social Security Act and became effective on January 1, 1991. The law requires that drug manufacturers enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to provide rebates for their drug products that are paid for by Medicaid. Manufacturers that do not sign an agreement with CMS are not eligible for federal Medicaid coverage of their products. Since 1991, it has been required that outpatient Medicaid pharmacy providers dispense only rebate able drugs and bill with the NDCs. Now, with the Deficit Reduction Act of 2005, this requirement is being expanded to include physician-administered drugs.

What is an NDC?

The National Drug Code (NDC) is the number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are assigned by the manufacturer. Some packages will display less than 11 digits, but leading "0's" can be assumed and need to be used when billing.

For example:

XXXX-XXXX-XX = 0XXXX-XXXX-XX

XXXXX-XXX-XX = XXXXX-0XXX-XX

XXXXX-XXXX-X = XXXXX-XXXX-0X

The NDC is found on the drug container, i.e. vial, bottle, tube. The NDC submitted to Neighborhood must be the actual NDC number on the package or container from which the medication was administered. Do not bill for one manufacturer's product and dispense another. The benefits of accurate billing include reduced audits, telephone calls, and manufacturers' disputes of their rebate invoices. It is considered a fraudulent billing practice to bill using an NDC other than the one administered.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

For Medicaid, only claims with valid NDC's that are included in the Medicaid Prescription Drug Rebate program are eligible for payment consideration.

Claim Submission

Requirements for Paper Submission

CMS-1500 form- Enter NDC in the shaded area of box 24A and HCPCS code in 24D.

CMS-1450/UB form- Enter NDC in field locator 43 and HCPCS code in 44.

Enter the NDC qualifier of N4, followed by an 11-digit NDC number (use leading zeros where needed) and followed by the two letter abbreviation for units of measurement and the dosage quantity administered. Do not enter a space between the qualifier and NDC. Do not enter hyphens or spaces within the NDC number. NDC units are not the same as HCPCS units. **The NDC number submitted to Neighborhood must be the actual NDC number on the package or container from which the medication was administered.**

Units of Measure are:

F2 = International Unit
GR = Gram
ML = Milliliter
UN = Unit

Requirements for EDI 837P/837I Submission

Reporting NDC Information in 837 Claim Formats LIN Segment – Drug Identification e.g., LIN**N4*01234567891		
LIN02	N4	N4 Qualifier identifies NDC being billed
LIN03	Actual NDC e.g., 01234 5678 91	Report NDC in 11 digit format (5-4-2). Do not use hyphens or spaces
CTP Segment – Drug Segment e.g., CTP****2*UN		
CTP04	Dispensing Quantity	e.g., 2
CTP05	Unit of measure	Values are: F2, GR, ML, or UN

Reporting Multiple NDCs (Including Compound Drugs)

- To bill a procedure code with multiple NDCs:
    - **Paper** - If drug is comprised of more than one ingredient, repeat the HCPCS code on separate lines for each unique NDC code. Use KP modifier for the first drug of a multi-drug unit dose formulation and KQ modifier for the second or subsequent drug formulation. If dosage requires use of more than one package of the same drug, repeat the HCPCS code on separate lines and list the corresponding NDC codes.
    - **EDI** - Repeat the 2410 Loop up to 25 iterations to report the NDC and its information as instructed above for as many drug components as necessary. The sum of the CTP03 unit price multiplied by the CTP04 dispensing quantity should equal the service line charge amount reported in Loop 2400 SV102.

Reporting Partially Administered Drugs

- Bill using the HCPCS code with the corresponding units administered. When calculating units related to NDC, the HCPCS code units should be converted to the NDC units using the proper decimal units.

Reporting Drugs supplied by the Patient but Administered by Physician

- Submit the appropriate administration code and submit the drug code with charge amount of zero.

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Reimbursement Criteria

Neighborhood will reject the claim if:

- Invalid NDC Code
- Invalid NDC Code Measurement
- Invalid NDC Code Quantity
- Missing NDC Code
- Missing NDC Code Measurement
- Missing NDC Code Quantity
- NDC Code Required for Line
- NDC not appropriate for J-Code

Claims will deny for

- Invalid or missing HCPCS code

Neighborhood will not reimburse

- Discarded drugs from multi-use vials

- NDC's that are not part of the Medicaid Prescription Drug Rebate Program

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
12/11/2024	Policy Review. No content changes
03/29/2023	Policy Review, format change, and updated to all Lines of Business
04/23/2021	Policy Review and format change
07/01/2015	Format change, included additional reimbursement and billing criteria, added list to document
09/01/2010	Policy Created