TO: Hospital Providers

SUBJECT: *NEW* National Drug Codes (NDC) Required for Outpatient Hospital Claims due to the Implementation of the Federal Deficit Reduction Act (DRA) of 2005.

The purpose of this bulletin is to alert providers that effective with claims for dates of service on or after July 1, 2008, the Connecticut Medical Assistance Program will implement new billing requirements to support the Federal Deficit Reduction Act of 2005, which mandates the submission of NDCs.

This mandate requires the submission of National Drug Codes (NDCs) on all claims with procedure codes for physician administered drugs. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

This mandate affects all providers who submit electronically or by paper for procedure-coded drugs. Because the State may pay up to the 20% Medicare B co-payment for dual eligible individuals, the NDC will also be required on Medicare crossover claims for all applicable procedure codes. Outpatient and Outpatient Medicare crossover claims for Revenue Center Codes (RCC) 250-253, 258-260, 273, 634-637 will require a Healthcare Common Procedure Coding (HCPC) code and a corresponding NDC information. The RCC listed above are billable as outpatient services if the RCC is specified on your Medicaid provider contract letter.

**NDC Requirements for Claims Processing**

**Participating labelers**

Connecticut Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a participating labeler with the Centers for Medicare and Medicaid Services (CMS). SAGA Medical clients are excluded from this requirement. A ‘participating labeler’ is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each State a rebate for products reimbursed by Medicaid Programs. A labeler is identified by the first 5 digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first 5 digits of the NDC) to the list of participating labelers which is maintained on the Connecticut Medicaid Web site at [www.ctdssmap.com](http://www.ctdssmap.com).
**NDC Formatting**

When completing a Medicaid claim for administering a drug, providers must submit the HIPAA standard 11-digit NDC without dashes or spaces. The 11-digit NDC is comprised of three segments or codes: a 5-digit labeler code, a 4-digit product code and a 2-digit package code. If the NDC does not contain 11 digits, it must be changed to comply with the HIPAA format.

The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero in one of the three segments. Below is an example of a FDA assigned NDC on a package and how it should be changed to the appropriate 11-digit HIPAA standard format.

Example 1 displays a 10-digit NDC with a labeler code as five digits; the product code as three digits and the package code as two digits. Since the NDC on the label is not configured in the ‘5-4-2’ format, a zero should be placed at the beginning of the second segment of the NDC. Therefore the correct configuration is 65293-0001-01. This change is also reflected in the first row of Table 1.

Example 1:

<table>
<thead>
<tr>
<th>NDC From Label</th>
<th>HIPAA Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>65293-001-01</td>
<td>65293-0001-01</td>
</tr>
<tr>
<td>0703-8771-03</td>
<td>00703-8771-03</td>
</tr>
<tr>
<td>00002-1420-1</td>
<td>00002-1420-01</td>
</tr>
</tbody>
</table>

Note: Because the vial from which the drug is administered is frequently not in the accepted 11-digit format, please refer to Table 1 above for examples on how to format and bill the NDC correctly.

NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers. NDCs submitted in any configuration other than the 11-digit format will be rejected/denied.
The Department of Social Services (DSS) has implemented a Drug Search tool, to assist providers in verifying that the drug they administered and are billing for is valid, rebateable and payable. By going to the Web site at www.ctdssmap.com → Provider → Drug Search, providers can perform the search.

The date of service defaults to the current date and would need to be changed to the administered date on the search panel. Providers will enter either the 11-digit NDC, the name of the drug they administered or the HCPCS followed by the date of service then click search. The following example demonstrates the search results where the NDC is a covered drug.

The NDC, Brand Name, Generic Name, Dose Strength, Dose Form, Package Size, HCPCS (Code, Description and Drug Name), End Date and Rebate Indicator, would be displayed. Additionally, if the rebate status displays an N for the date of service indicated, the NDC would not be payable.

If a drug name was used to execute the search, all NDCs matching the criteria would be displayed in the results. A sampling of the results using “Heparin Flush” for the search criteria, is illustrated below:

Note: EDS is currently developing the HCPCS search criteria. This feature will enable the provider to enter a HCPCS and identify the NDCs associated with that code.
Reimbursement Policy

Although NDC submission is required as a part of the DRA mandate, payment will continue to be based on the RCC code and the corresponding billed amount.

UB-04 Paper Claim Form Billing Instructions:

Changes must be made to the UB-04 to include the NDC Qualifier, the NDC, NDC Units of Measurement Qualifier, NDC Quantity, HCPC and the HCPC units as outlined below.

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

1. Enter the **NDC Qualifier** of N4 in the first 2 positions on the left side of the field.
2. Enter the **NDC 11-digit numeric code** in the ‘5-4-2’ format. Do not use hyphens.
3. Enter the **NDC Units of Measurements Qualifier**.
   - F2 - International Unit
   - GR – Gram
   - ML – Milliliter
   - UN - Unit
4. Enter the **NDC Quantity** (administered amount) with up to three decimal places such as 1234.567.

The information in the Revenue Description field is entered without delimiters, such as commas or hyphens.

The description field on the UB-04 is 24 characters in length. An example of the completed information is shown in figure 1.

<table>
<thead>
<tr>
<th>Field 43 Description</th>
<th>Field 44 HCPCS / Rate / HPPS Code</th>
<th>Field 45 Serv. Date</th>
<th>Field 46 Serv. Units</th>
<th>Field 47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234</td>
<td>J0886</td>
<td>08/11/08</td>
<td>1</td>
<td>1234.00</td>
</tr>
</tbody>
</table>

Figure 1

Field 44 (HCPCS / Rate / HPPS code) –

Enter the corresponding **HCPCS** associated with the NDC.

Field 46 (Serv Units / HCPCS Units) –

Enter the number of **HCPCS units** provided.
Multiple NDCs per RCC/HCPCs

When administering multiple NDCs within a single HCPC each NDC must be identified at the time of billing. This scenario may occur if the physician needs to administer a specific dose of a drug that requires the use of two different vials of a drug (two different NDCs) to make up the total dose. This is accomplished by adding sequence details for each NDC.

Figure 2 below illustrates how this should be accomplished.

Figure 2

<table>
<thead>
<tr>
<th>Detail 1</th>
<th>43 Description</th>
<th>44 HCPCS / Date / HCPCS</th>
<th>45 Serv. Date</th>
<th>46 Serv. Units</th>
<th>47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sequence 1</td>
<td>0036</td>
<td>01455513047101ML2.0</td>
<td>080108</td>
<td>2</td>
<td>125.00</td>
</tr>
<tr>
<td>Sequence 2</td>
<td>0036</td>
<td>0145551302701ML1.0</td>
<td>080108</td>
<td>1</td>
<td>00.00</td>
</tr>
<tr>
<td>Detail 2</td>
<td>0305</td>
<td>Hemogram</td>
<td>080108</td>
<td>1</td>
<td>500.00</td>
</tr>
<tr>
<td>Sequence 1</td>
<td>0036</td>
<td>0145554640910ML2.0</td>
<td>080108</td>
<td>1</td>
<td>25.00</td>
</tr>
</tbody>
</table>

In Figure 2 a detail signifies the RCC (and HCPCS) code, whereas sequence signifies the corresponding additional NDC. If the RCC code had multiple NDCs, there would be one detail with multiple sequences, which would accommodate the NDCs. In Figure 2,

**Detail 1** for RCC code 636 is being submitted with 2 sequences, which indicates it is comprised of 2 NDCs.
- Field 43 indicated the qualifier N4, NDC, units of measure, and the NDC quantity.
- Field 44 indicated the HCPCS
- Field 46 indicates the HCPCS quantity for all associated sequences – Note sequence 2 does not show a value. The total units should be included on sequence 1. In this example 2 units.
- Field 47 indicates the total cost for all associated sequences - Note sequence 2 shows a value of Zero. The total charges must be included on sequence 1. In this example 125.00.

**Detail 2** for RCC 305 is not for a physician administered drug, therefore, no sequence or NDC is needed

**Detail 3** for RCC 636 is displaying 1 sequence to indicate the 1 NDC administered

Please contact your vendor to make the necessary software changes.
Editing/Explanation of Benefits if submitted incorrectly
Claims with Dates of Service 07/01/08 forward, that do not comply with the mandate will deny. The following explanation of benefits will be received for claims not meeting the new billing requirements:
EOB 0840 - RCC requires a HCPCS. This EOB will be received and the claim will deny when the RCC is 250-253, 258-260, 273, 634-637 and the associated HCPC is missing or invalid.
EOB 0861 - RCC requires an NDC. This EOB will be received and the claim will deny when the RCC is 250-253, 258-260, 273, 634-637 and the NDC is missing, invalid terminated, not rebateable, *DESI, institutional, repackage, inner package, or the NDC qualifier is missing or invalid.
EOB 0841 - Unit of measure qualifier is required for NDC. This EOB will be received and the claim will deny when an inappropriate unit of measure is submitted with an NDC.
EOB 0842 - NDC units missing or invalid. This EOB will be received and the claim will deny when the NDC units is missing or invalid.

* A list of DESI drugs is maintained on the CT Medicaid Web site at www.ctdssmap.com → Pharmacy Information → Pharmacy Program Publications → DESI List

Electronic claim submission

Provider Electronic Solution Software submitters filing 837I Outpatient and Outpatient Medicare Crossover claims will enter the NDC, Units, Basis of Measurement, and Unit Price for each NDC on the Service tab. Note: Multiple NDCs per RCC/HCPC are not supported via Provider Electronic Solution Software at this time. For additional information, please refer to the PES handbook on the web site at www.ctdssmap.com → Trading Partner → EDI → PES Handbook

Vendor software submitters, check with your vendor to ensure your software will be able to capture the criteria necessary to submit these 837 Institutional Outpatient claims and Institutional Outpatient Medicare Crossover formats have designated fields for the HCPCS, HCPCS units, NDC qualifier, NDC, NDC units of measure qualifier and NDC quantity.

Please refer to the Companion Guide for additional information:

This bulletin and other program information can be found at www.ctdssmap.com.
Questions regarding this bulletin may be directed to the EDS Provider Assistance Center - Monday through Friday from 8:00 a.m. to 5:00 p.m. at:
In-state toll free ....................... 800-842-8440 or EDS
Out-of-state or in the PO Box 2991
Local Farmington, CT area ....... 860-269-2028 Hartford, CT 06104