Payment Policy: National Drug Code (NDC) Requirements for Physician-Administered Medications

Purpose: The Deficit Reduction Act of 2005 (DRA) includes provisions about the state collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for physician-administered drugs. 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) deems that the use of NDC numbers is critical to correctly identify the drug and manufacturer in order to invoice and collect the rebates.

Original Date Approved: 10/26/17  Effective Date: 1/1/18  Date Revised: N/A

Scope: Commonwealth Care Alliance (CCA) Product Lines:
X All product lines
☐ Senior Care Options
☐ One Care

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PAYMENT POLICY SUMMARY
The Medicaid Drug Rebate Program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA’90) and became effective January 1, 1991. The law requires drug manufacturers to enter into an agreement with CMS to provide rebates for their drug products that are paid for by Medicaid. Outpatient Medicaid pharmacy providers have billed with NDCs and requested rebates since 1991. The DRA expanded the rebate requirements to physician-administered drugs.

The NDC is a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format (i.e., xxxxx-xxxx-xx). The first five digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The remaining digits are assigned by the manufacturer and identify the specific product and package size. The NDC is found on the drug container (i.e., vial, bottle, or tube). The NDC submitted to MassHealth must be the actual NDC number on the package or container from which the medication was administered (with any necessary leading zeros applied).

REQUIRED NDC INFORMATION
The following information will be required when submitting an NDC:
1. Valid 11-digit NDC number
2. NDC unit of measure (F2, GR, ML, UN)
• F2: International unit – International units will mainly be used when billing for Factor VIII, Antihemophilic Factors
• GR: Gram – Grams are usually used when an ointment, cream, inhaler, or bulk powder in a jar are dispensed. This unit of measure will primarily be used in the retail pharmacy setting and not for physician-administered drug billing.
• ML: Milliliter – If a drug is supplied in vial in liquid form, bill in milliliters.
• UN: Unit – If a drug is supplied in vial in powder form and must be reconstituted before administration, bill each vial (unit/each) used.

3. NDC units dispensed (must be greater than 0)

NDC INFORMATION TO BE SUBMITTED
The NDC number, NDC units of measure and NDC quantity must be submitted in addition to the applicable HCPCS or CPT code(s) and the number of HCPCS/CPT units. A valid HCPCS or CPT code with units of service must continue to be entered on the claim form on the basis for reimbursement. Claims are priced based on HCPCS or CPT codes and the units of service. If the NDC does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code.

The NDC is found on the prescription drug label of the drug container (e.g. vial, bottle or tube). The NDC is a universal number that identifies a drug or a related drug item. The NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2 format. The NDC submitted must be the actual valid NDC number on the container from which the medication was administered.

Physician Administered Medications – NDC: CMS – 1500 Billing Instructions:

If there is more than one NDC utilized within the HCPCS code (i.e., when multiple drug strengths are used), submit each applicable NDC as a separate claim line. Each drug code submitted must have a corresponding NDC on each claim line.

REIMBURSEMENT GUIDELINES
Claims will be initially denied for failure to bill with an NDC. All charges for HCPCS drug codes that require NDCs can be resubmitted with NDCs. Timely filing and claim reconsideration requirements will need to be followed when resubmitting denied claims.
AUDIT AND DISCLAIMER INFORMATION
As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES AND RESOURCES
CMS Website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-MedicaidCoordination.html
CCA Website: http://www.commonwealthcarealliance.org/
FDA U.S. Food and Drug Administration:
https://www.fda.gov/drugs/informationondrugs/ucm142438.htm