PAYMENT POLICY		
National Drug Code		
Original Date Approved	**Effective Date**	**Revision Date**
10/26/2017	1/1/2026	11/13/2025
Applies to Products:		
☒ Senior Care Options (FIDE-SNP)	☒ One Care (FIDE-SNP)	

PAYMENT POLICY STATEMENT:

This payment policy outlines the national drug code requirements utilized for all CCA products in accordance with state and federal guidelines.

DEFINITIONS:

National Drug Code (NDC): A universal product identifier that consists of 11 digits made up of three segments in a 5-4-2 format that is found on the package or vial of the medication. 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.

Physician Administered Drugs: Covered outpatient drugs other than vaccines that are administered outside of the pharmacy setting by a healthcare professional in an office, clinic, or hospital setting. These drugs are considered a medical benefit and are not self-administered by a member or caregiver.

340B Drugs: A prescription drug purchased by certain eligible healthcare organizations, known as "covered entities," at a discounted price through the 340B Drug Pricing Program.

Medicaid Drug Rebate Program: A program that includes CMS, state Medicaid agencies, and participating drug manufacturers that helps to offset the Federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients.

Qualifier: A code that provides additional information about a claim or a specific element within the claim. A qualifier can provide important details that may not be captured by other codes billed on a claim.

Centers for Medicare & Medicaid (CMS): A federal agency that is part of the U.S. Department of Health and Human Services responsible for administering and managing the Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA, and the Clinical Laboratory Improvement Amendments (CLIA) programs.

MassHealth: The medical assistance and benefit programs administered by the Massachusetts Executive Office of Health and Human Services pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c.118E, and other applicable laws and waivers to provider and pay for medical services to eligible members.

Healthcare Common Procedure Coding System (HCPCS): (Also known as HCPCS Level II) An alphanumeric code starting with an alphabetical letter followed by 4 numeric digits; it is used to identify medical related products, supplies, and services not included in the CPTS codes for billing purposes.

Revenue Codes: A 4-digit number that is used on facility claims to tell where the patient was when they received treatment, or what type of item a patient may have received.

CMS-1500: (also known as HCFA) Claim form used for professional services.

CMS-1450: (also known as UB-04) Claim form used for institutional (facility) services.

AUTHORIZATION REQUIREMENTS (If applicable):

N/A

REIMBURSEMENT GUIDELINES:

CCA follows CMS and MassHealth guidelines for NDC code requirements. NDC codes are required for drugs/biologicals dispensed by pharmacies/medical suppliers, and for physician administered drugs provided in an office or facility setting. The NDC must be the actual NDC number located on the package or container of the administered medication.

When submitting an NDC on the claim, the following are required:

- Qualifier N4 preceding a valid 11-digit NDC number without the hyphens or spaces.
    - **NOTE**: If the NDC is less than 11 digits, a zero must be added to the beginning of the appropriate segment.

NDC Package Display	11-Digit NDC Format
XXXX-XXXX-XX	0XXXX-XXXX-XX
XXXXX-XXX-XX	XXXXX-0XXX-XX
XXXXX-XXXX-X	XXXXX-XXXX-0X

- An appropriate HCPCS code for the administered drug/biological.
- The correct NDC unit of measure qualifier.
    - UN – Unit
    - F2-International Unit

- GR- Gram
- ME – Milligram
- ML – Milliliter

- The correct NDC units dispensed.
- The correct HCPCS units for the drug/biological.

Claims reimbursement for drugs and biologicals is based on the valid NDC code, correct NDC unit of measure, correct HCPCS code and modifier if applicable, and correct HCPCS units. Even though the NDC quantity is a requirement, it is not utilized for reimbursement. If a specific drug or biological does not have an HCPCS, please use the appropriate miscellaneous/unlisted drug code along with the correct NDC for the drug. Any claims submitted without an NDC, submitted with an invalid NDC, or which are not billed according to CMS or MassHealth requirements will be denied.

If a drug has more than one ingredient and requires multiple NDCs, submit each applicable NDC and HCPCS code on a separate claim line. If the units exceed the size of the field and more space is required, repeat the NDC and HCPCS codes on multiple lines until all units have been reported.

NOTE: All NDC units submitted for drugs/biologicals should align with the standard number of units and increments outlined on the drug package. When the units submitted exceed the maximum units allowed per package or are not in increments of the package, the units over the maximum unit will be denied.

For NDC requirements information, please refer to CMS Medicare Claims Processing Manual Chapter 17 – Drugs and Biological and MassHealth All Provider Bulletin 397. For information regarding billing NDC codes on the CMS-1500 claims form, please refer to CMS Medicare Claims Processing Manual Chapter 26 (Section 10.4, Item 24) and MassHealth Billing Guide for the CMS-1500 (Field No. 24). For more information regarding billing NDC codes on the CMS-1450 (UB-04) claim form, please refer to CMS Medicare Claims Processing Manual Chapter 25 (Section 75 and 75.5) and MassHealth Billing Guide for the UB-04 (Field No. 43).

RELATED SERVICE POLICIES:

All provider bulletin 397

AUDIT and DISCLAIMER:

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 accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CCA has the right to expect the

provider/facility to refund all payments related to non-compliance. CCA reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

REFERENCES:

CMS Medicare Claims Processing Manual, Chapter 17 - Drugs and Biologicals
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c17.pdf

MassHealth All Provider Bulletin 397: Requirements for Completion of Data Fields on Claims for Clinician-Administered Drugs
https://www.mass.gov/doc/all-provider-bulletin-397-requirements-for-completion-of-data-fields-on-claims-for-clinician-administered-drugs-0/download
MassHealth Learn about National Drug Code (NDC) requirements
https://www.mass.gov/info-details/learn-about-national-drug-code-ndc-requirements

CMS Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c25.pdf

CMS Medicare Claims Processing Manual Chapter 26 - Completing and Processing Form CMS-1500 Data Set
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf

POLICY TIMELINE DETAILS:

1. Effective: October 26, 2017
2. Revision: June 2022, updated formatting
3. Revision: November 2025, updated template, added definitions, modified language, updated requirements, updated references