PROVIDER REIMBURSEMENT GUIDANCE			
National Drug Code (NDC) Requirements for Physician-Administered Medications			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
10/26/2017	03/01/2022	03/01/2022	02/01/2022

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

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 National Drug Codes ("NDCs") and requested rebates since 1991. The Medicaid Drug Rebate Program 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). Any NDC submitted to MassHealth for reimbursement of medication administration 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:

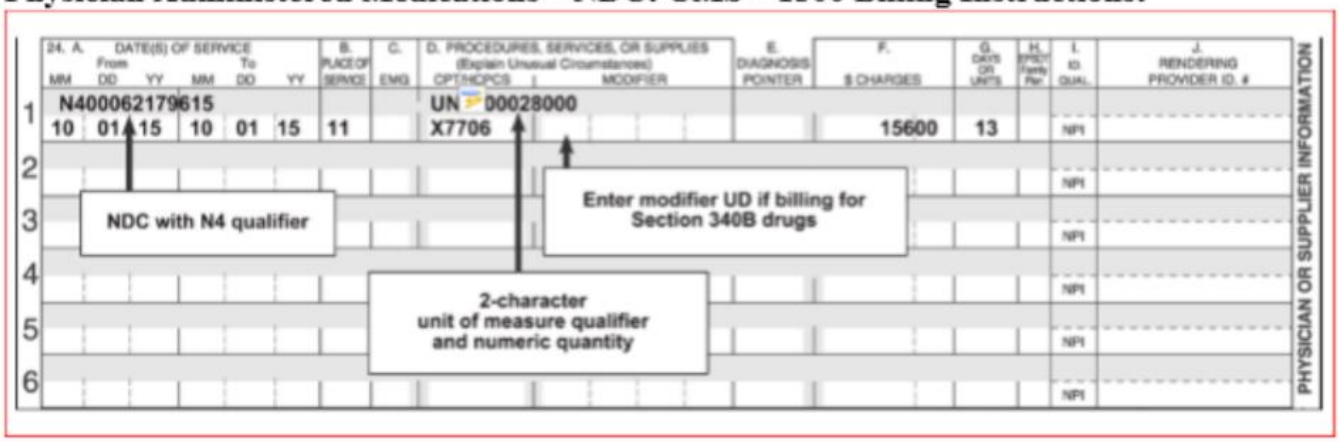
The following information will be required when submitting an NDC to CCA:

- Valid 11-digit NDC number
- 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 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 millimeters.
- UN: Unit – If a drug is supplied in vial in powder form and must be reconstituted before administration, bill each vial (unit/each) used.
- NDC units dispensed (must be greater than zero)

NDC Information to be Submitted:

The NDC number, NDC units of measure, and NDC quantity must be submitted in addition to the applicable valid HCPCS or CPT code(s) and the number of HCPCS and/or CPT units. Claims are priced based on HCPCS or CPT codes and associated units of service. If the NDC does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous drug code.

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 line on each claim.

Reimbursement Guidelines:

Claims will initially deny, all charges for the HCPCS drug codes that require NDCs. Claims must be resubmitted with NDCs in order to be reimbursed. Timely filing and claim reconsideration requirements will need to be followed when resubmitting denied claims.

Units submitted for a drug should not exceed the package maximum units available based on the NDC number or increments associated with the drug package. Maximum units will be applied for specific drugs where a specific and standard number of units should be submitted per the NDC of the package. When units submitted exceed, the maximum units allowed per package or when units submitted are not in increments of the package, the units over the maximum unit will be denied.

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, 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

CCA Website

CMS Website

FDA U.S. Food and Drug Administration

Current Year HCPCS Manual

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island

Policy Timeline Details

1. Drafted: October 2017
2. Edited: November 2021
3. Approved:
4. Implemented: