

North Carolina Medicaid Special Bulletin



An Information Service of the
Division of Medical Assistance

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Published by EDS, fiscal agent for the North Carolina Medicaid Program

Number V

October 2008

Attention:
Professional Claim (CMS-1500/837P) Billers
Certified Dialysis Providers
Outpatient Hospital Services

National Drug Code Implementation, Phase III

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PROGRAM BACKGROUND

The Deficit Reduction Act of 2005 (DRA) requires all state Medicaid Agencies to collect rebates from drug manufacturers for all outpatient drugs. Only those products manufactured by companies participating in the federal Medicaid rebate program are reimbursable under Medicaid. A list of manufacturers participating in the rebate program, which changes periodically, is available on the DMA pharmacy website (<http://www.ncdhhs.gov/dma/pharmacy.htm>).

A sample of manufacturer's labeler codes are listed in the chart below. A full list of codes is available on the DMA pharmacy website.

Manufacturer's Labeler Codes (First 5 Digits of National Drug Code)

00002	00003	00004	00005	00006	00007	00008	00009	00013	00015	00023
00024	00025	00026	00028	00029	00031	00032	00034	00037	00039	00045
00046	00049	00051	00052	00053	00054	00056	00062	00064	00065	00066
00067	00068	00069	00071	00072	00074	00075	00076	00078	00083	00085
00086	00087	00088	00089	00091	00093	00095	00096	00108	00113	00115
00116	00121	00126	00131	00132	00135	00143	00145	00149	00165	00168
00169	00172	00173	00178	00182	00185	00186	00187	00205	00206	00224
00225	00228	00245	00254	00256	00258	00206	00259	00264	00276	00277
00281	00288	00299	00300	00310	00327	00338	00364	00378	00406	00409
00414	00421	00430	00456	00462	00469	00472	00482	00485	00486	00487
00496	00501	00517	00525	00527	00535	00536	00548	00555	00573	00574
00575	00590	00591	00597	00603	00615	00640	00641	00642	00677	00682
00703	00713	00777	00781	00785	00813	00832	00884	00904	00944	00955
00998	05940	08004	08880	10019	10122	10144	10147	10148	10158	10235
10267	10337	10454	10542	10572	10631	10702	10768	10892	10914	10922
10956	11042	11098	11399	11523	11528	11530	11701	11980	12496	12593
12830	12939	12948	13107	13279	13310	13453	13478	13533	13548	13551
13632	13811	13913	14168	14290	14508	14629	15054	15127	15210	15330
15370	15456	15584	15686	15821	16103					

For details on the DRA, please access http://www.cms.hhs.gov/MedicaidGenInfo/08_DRASection.asp.

The prescribed drug must have indications approved by the Food and Drug Administration (FDA). The prescribed drug must bear the federal legend statement and must be manufactured by a company that has signed a National Medicaid Drug Rebate Agreement with CMS. **N.C. Medicaid will not reimburse for non-rebatable, invalid and/or terminated National Drug Codes (NDCs).**

Beginning with dates of service on or after December 28, 2007, claims submitted for payment that do not meet the NDC reporting requirements – to include a valid NDC with a HCPCS Level II code and quantity – will result in line item denial.

The following table illustrates the NDC billing requirements by provider group and effective date:

National Drug Code Phases			
	Phase I	Phase II Added	Phase III Added
Effective Date	December 28, 2007 Date of service on or after December 28, 2007	July 1, 2008 Date of processing on or after July 1, 2008, for dates of service on or after December 28, 2007	November 21, 2008 Date of processing on or after November 21, 2008, for dates of service on or after December 28, 2007
Providers	All physician-administered drugs in an office/clinic (including 340B drugs); certified dialysis treatment centers	Outpatient hospital claims and institutional outpatient crossovers (including 340B drugs)	Professional crossover claims; addition of UD modifier for 340B drugs applies to all providers

All affected providers must implement a process to record and maintain the NDC(s) of the actual drug(s) administered to the recipient as well as the quantity of the drug(s) given. **Billing software programs and office procedures need to be modified to include the required NDC-related data.**

Please note that the billed Revenue Code and/or HCPCS Level II code must also be valid and covered by N.C. Medicaid. The drug class of the submitted HCPCS Level II code must match the drug class of the submitted NDC. If the Revenue Code or HCPCS Level II code is not accompanied by the matching NDC, the detail will be denied. The NDC submitted to N.C. Medicaid must be the actual NDC number on the package or container from which the medication was administered. Billing using an NDC other than the one administered is considered fraud.

NATIONAL DRUG CODE DESCRIPTION

The NDC, a number that identifies a specific drug, is found on the drug container (vial, box, bottle or tube). The NDC number consists of 11 digits in a 5-4-2 format, and all digits must be present and in the prescribed format for the number to be considered complete. The first 5 digits of an NDC identify the manufacturer of the drug and are assigned by the FDA. The remaining digits are assigned by the manufacturer and identify the specific product and package size. A complete 11-digit number must have 5 digits in the first segment, 4 digits in the second segment, and 2 digits in the last segment.

There have been a few instances in which where the NDC on the vial was not rebatable but the NDC from the outer package was rebatable. Therefore, if the two NDCs differ, report the NDC from the outer package.

Example of Label Image

NDC is located here (10-digit format)



In some instances, NDCs are displayed in a 10-digit format. Add a leading zero to the NDC if a conversion to 11 digits is necessary. The asterisks are shown in the examples below to indicate placement of the leading zeros. Refer to conversion examples in the table below for instructions on completing a segment with the correct number of digits.

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example	Actual 10-Digit NDC Example	11-Digit Conversion of Example
4-4-2	9999-9999-99	5-4-2	*9999-9999-99	0002-7597-01 Zyprexa 10-mg vial	00002-7597-01
5-3-2	99999-999-99	5-4-2	99999-*999-99	50242-040-62 Xolair 150-mg vial	50242-0040-62

Note: Hyphens indicated in the chart are used solely to illustrate the various formatting examples for NDCs. Do **not** use hyphens when entering the actual data.

CLAIMS PROCESSING

Claims will continue to be priced based on the Revenue Code/HCPSC code, with the NDC and corresponding units being used for drug rebate processing. Medicare and third-party liability primary claims also require NDCs with HCPSC codes. During claims processing, the NDC is edited for validity. If the NDC is invalid or terminated, the detail will be denied. The detail will also be denied if a HCPSC drug code is billed without an NDC or if the NDC is for a non-rebatable drug. **N.C. Medicaid will not reimburse for non-rebatable, invalid or terminated NDCs.**

In compliance with HIPAA standards, the NDC price must be provided; however, N.C. Medicaid will not use the NDC price during claim processing.

Data Elements Used by N.C. Medicaid for National Drug Code Claims Processing

- **N4 Qualifier** – paper submissions only.
- **NDC** – All-numeric, 11-digit code (no hyphens or spaces).
- **NDC Quantity** – Submitted units for the billed HCPCS code must be billed with the accurate NDC quantity. If claims are submitted with an invalid quantity, the claim will be denied for invalid units. It is important that all information submitted on the claim be accurate.

N.C. Medicaid claim processing guidelines for reporting NDC quantity when more than one NDC is billed for a single HCPCS code:

- Must be a numeric value greater than zero
Example: 1234567.123
- Maximum length of 11 characters (including the decimal)
- Include the decimal point
- The whole-number portion has a maximum length of 7 characters
- The decimal portion has a maximum length of 3 characters
- No decimal is required with the use of a whole-number value

Unit of Measurement (UOM) for each submitted NDC – The unit of measure quantity code is a required data element for processing the NDC code. There are 4 unit of measure quantity codes:

- F2 (international unit)
- GR (gram)
- ML (milliliter)
- UN (unit)

Note: For purposes of billing N.C. Medicaid, it is considered acceptable to always use the unit of measure quantity code UN (unit).

National Drug Code Unit of Measure Conversion Examples

1. Two (2) ceftriaxone 500-mg vials (NDC: 00409733801) are used to administer a 1,000-mg dose to a patient. The definition of HCPCS code J0696 is 250 mg. Bill four (4) units of J0696. In this case, do not convert milligrams (mg) to grams (GR). GR is only used when the product is weight based, like creams or ointments. Each vial is reported as a “unit.” Report the NDC units as “UN2.”
2. Three (3) Epogen 4,000 units/ml vials (NDC: 55513014801) are used to administer 12,000 units to a patient. The definition of HCPCS code J0885 is 1000 units. Bill twelve (12) units of J0885. The NDC quantity and unit of measure could be reported as “UN3” OR “ML3,” for the number of milliliters.

Miscellaneous Codes

For Professional claims, invoices are no longer required when billing J2353, J3490, J3590, or J9999 if only one NDC is submitted per detail. Therefore, these claims can be billed electronically. The exception to this rule occurs when billing J3490 on a CMS-1500 claim form for compound drugs, which continues to require submission of a paper claim with the invoice attached. The invoices must show the individual breakdown of each NDC purchased for rebate purposes and for proper pricing to occur.

For Institutional claims, an invoice is not required when billing J3490 for a single NDC. When reporting compounds on a UB-04 claim form, report NDCs separately, one per detail. Include the Revenue Code and HCPCS Level II code. Price separately.

If the HCPCS code is not accompanied by the corresponding NDC, the detail will be denied. Therefore, bill miscellaneous codes only when there is no specific HCPCS code for the NDC submitted on the claim.

Adjustments

To correct and resubmit NDC-related denials or to correct previously paid claims, submit an electronic replacement claim. If a vendor cannot process replacement claims, the NCECSWeb tool is available through N.C. Medicaid. More information is available in the June 2007 Special Bulletin, *NCECSWeb Instruction Guide*, at <http://www.ncdhhs.gov/dma/bulletinspecial.htm>.

340B Drugs

The 340B Drug Pricing Program resulted from the enactment of the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act. Providers are able to acquire drugs through that program at significantly discounted rates. Because of the discounted acquisition cost, these drugs are not eligible for the Medicaid Drug Rebate Program. State Medicaid programs are obligated to ensure that rebates are not claimed on 340B drugs. The DRA 2005 does not exclude 340B drugs; therefore, all providers must also meet these requirements.

In order for providers to identify 340B drugs dispensed in an outpatient or clinic setting, the National Medicaid Electronic Data Interchange HIPAA workgroup has recommended use of the “UD” modifier. This will allow Medicaid to identify details on primary and secondary claims that have 340B drugs and exclude them from the rebate collection process. The UD modifier should be billed on the CMS-1500/837 Professional and the UB04/837 Institutional claims forms, associated with the applicable HCPCS code and NDC to properly identify 340B drugs. The UD modifier is to be used only in this circumstance. All non-340B drugs are billed using the applicable HCPCS and NDC pair without a modifier.

Submitting National Drug Code-related Data on Electronic Claims

Billing software programs need to be modified to include the required NDC-related fields. The complete 837 instructions are available in the *HIPAA Implementation Guide*, on the Washington Publishing website at <http://www.wpc-edi.com/>. The N.C. Medicaid *HIPAA Companion Guide* is available on the DMA website at <http://www.ncdhhs.gov/dma/hipaa/compguides.htm>.

Note: N.C. Medicaid accepts up to 10 NDC codes and units per HCPCS code when claims are submitted electronically.

Submitting National Drug Code-Related Data on the NCECSWeb Tool

The data elements and claims processing guidelines are the same as those described above, with the exception of the UOM. The NCECSWeb tool will accept only a numeric value for NDC units and will not require the UOM. The required NDC fields are located within "Add/Edit Details" in the detail line entry screen. Please refer to the NCECSWeb claims submission tool at <https://webclaims.ncmedicaid.com/ncecs>.

Example 1: NCECSWeb Screen Shot – CMS-1500 Claim Form

Detail Service Information							
From Date of Service MM/DD/YYYY		Through Date Of Service MM/DD/YYYY		Place of Service 99	HCPCS/CPT XXXXXX	Mod	
Other Insurer Information							
Insurer Detail Allowed Amt 9		Insurer Detail Paid Amt 9		Insurer Detail de 9			
NDC Information							
NDC	NDC Units	NDC	NDC Units	NDC	NDC Units	NDC	
999999999999	9999999.999	999999999999	9999999.999	999999999999	9999999.999	999999	
999999999999	9999999.999	999999999999	9999999.999	999999999999	9999999.999	999999	

Detail Service Information							
From Date of Service 06012008		Through Date Of Service 06012008		Place of Service [Dropdown]	HCPCS/CPT J1055	Mod FP	
Insured Information							
Insurer Detail Allowed Amt [Text Box]		Insurer Detail Paid Amt [Text Box]		Insurer Detail de [Text Box]			
NDC Information							
NDC	NDC Units	NDC	NDC Units	NDC	NDC Units	NDC	NI
00009737604	1	[Text Box]	[Text Box]	[Text Box]	[Text Box]	[Text Box]	[Text Box]
[Text Box]	[Text Box]	[Text Box]	[Text Box]	[Text Box]	[Text Box]	[Text Box]	[Text Box]

Example 2: NCECSWeb Screen Shot – UB Claim Form

Claim Type:	UB-Data	Claim ID:	905020061923294835	Save	Cancel
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Recipient Information

Last Name: Test new Medicaid ID: 123456789X

UB-Data Detail

#	Rev Code	HCPCS/CPT	Modifier	Service Date	Accom Rate	Accom Days	Ancil Units	D	Ch
1	999	XXXXX	XX	MM/DD/YYYY			5		
	NDC	NDC Units	NDC	NDC Units	NDC	NDC Units	NDC	NDC Units	N
	9999999999	999999.99	9999999999	999999.99	9999999999	999999.99	9999999999	999999.99	99999
	9999999999	999999.99	9999999999	999999.99	9999999999	999999.99	9999999999	999999.99	99999

#	Rev Code	HCPCS/CPT	Modifier	Service Date	Accom Rate	Accom Days	Ancil Units	D	Ch
	250	J1270	...	UD	01052008				
	NDC	NDC Units	NDC	NDC Units	NDC	NDC Units	NDC	NDC Units	N
58468012201	10								

Submitting National Drug Code-related Data on Paper Claims

Professional Paper Claims

When a HCPCS Level II drug code covered under the Physicians Drug Program (PDP) is entered in block 24D, a corresponding **11-digit NDC number** must also be indicated on the claim in the upper shaded area of the corresponding detail. The six service lines in block 24 have been divided horizontally to accommodate additional information. See the CMS-1500 manual (<http://www.nucc.org>) for additional information.

Note: If more than three NDCs are submitted for one procedure code, then the claim must be submitted electronically. If more than one NDC is associated with one HCPCS Level II code, the entire shaded area of blocks 24A through 24H will be used for reporting NDC information.

Complete the upper shaded portion of block 24 as described below when billing for drug-related codes on the CMS-1500 claim form.

These instructions apply when a single NDC is associated with a single HCPCS Level II code. Failure to include all components on the claim form will result in a denial.

- Begin by left-justifying the N4 qualifier
- Immediately follow it with the 11-digit NDC
- Insert three (3) spaces
- Enter one of the four (4) UOMs (F2, GR, ML, UN)
- Follow it immediately with the quantity

CMS-1500 Claim Examples

Example 1: Single NDC, With and Without UD Modifier

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From MM DD YY	MM	DD	YY	To MM DD YY	YY			CPT/HCPCS	MODIFIER								
1	N400075800120	UN4							J9170	UD				3584.00	8		1D	1234567
	07	23	08	07	23	08	11										NPI	0123456789
2	N455513092401	UN0.5							J1440					300.00	1		1D	1234567
	07	23	08	07	23	08	11										NPI	0123456789

When billing for more than one NDC per HCPCS code, continue by adding three (3) additional spaces before starting the second NDC.

Example 2: Compound Billed With J3490 Miscellaneous Code

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From	To	From	To	From	To			CPT/HCPCS	MODIFIER								
1	N400409113405	UN25	N438779052404	UN5	N451927200700	UN1			J3490					248.00	1	N	1D	890XXXX
2	08	01	08	08	01	08	11										NPI	0123456789
																	NPI	

Additional Information When Billing Compounds

When billing for compounds with more than three NDCs on a CMS-1500 paper claim, include the three NDCs that are the main ingredients for the HCPCS Level II code submitted. Wrapping to the next detail line is not an accepted method for reporting more than three NDCs on a paper CMS-1500 claim form for a single HCPCS Level II code.

Providers must document all ingredients used for compounds in corresponding medical records; however, because of space restrictions, only the three main ingredients for the compound may be reported per detail line. All NDCs reported per single HCPCS Level II code must be rebatable for the detail to process for payment.

Note: If no NDC is required for the HCPCS Level II code submitted, and an NDC is entered in the detail, the claims may be denied.

Institutional Paper Claims

The UB-04 claim form does not contain specific fields designated for NDC codes and/or NDC units. DMA, along with other state Medicaid programs, utilizes FL43 for the submission of the NDC codes and NDC units. The UB-04 manual can be found at <http://www.nubc.org>.

The following institutional providers billing on UB-04 claim forms are affected by this change as of date of service December 28, 2007, and date of processing July 1, 2008:

- Dialysis treatment center, non-hospital-based
- Dialysis center hospital, satellites
- Out-of-state dialysis center
- Outpatient hospital services

The following fields are required when reporting NDCs:

- **FL42:** Revenue code
- **FL43:** Enter the NDC qualifier of N4, followed by the 11-digit NDC number, the unit of measure, and the metric decimal quantity.
 - o Do not enter spaces between the NDC data elements.
 - o Do not enter hyphens within the NDC number.
 - o Enter one of the four (4) UOMs (F2, GR, ML, UN).
 - o Enter the actual metric decimal quantity (units) administered to the patient.
 - o If reporting a fraction of a unit, use the decimal point.
- **FL44:** Enter the appropriate CPT or HCPCS procedure code.
 - o **340B drugs:** When reporting 340B-qualified NDCs skip one space and follow the HCPCS Level II code with the UD modifier.

- **FL45:** Enter the line item service date. This field is used only for outpatient claims.
- **FL46:** Enter the HCPCS units.
- **FL47:** Enter the total charges.

UB Claim Examples

Example 1: Single Rev Code, NDC, HCPCS - Epogen

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48
635	N455513028310UN1.4	Q4081	042808	140	1391.00	

Example 2: Compound – Miscellaneous HCPCS J3490

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48
250	N400409113405UN25	J3490	021608	25	24000.00	
250	N438779052404UN5	J3490	021608	5	560.00	
250	N451927200700UN1	J3490	021608	1	32.00	

Example 3: UD Modifier

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48
258	N400338004904UN1000	J7030	070708	1	124.00	
636	N400641012125UN4	J1170 UD	070708	2	50.00	

Duplicate Revenue Codes on the same claim should be rolled into one detail reporting multiple units unless billing for a different HCPCS Level II code. Duplication of Revenue Codes on different detail lines will be denied as a duplicate with EOB 21 or 22 if billed on the same date of service, same admit hour, same or different provider, and same NDC.

Detail line 23 on a paper claim may be used to continue to a second page by entering Page _ of _ . However, the limit of 28 detail lines per paper claim still applies.

Note: The Physician Drug Program Fee Schedule should not be used by outpatient hospital services to determine HCPCS and NDC requirements.

The tables below can be used as a reference for outpatient hospital services when determining HCPCS Level II code and NDC claim requirements.

Outpatient Hospital Pharmaceutical Billing Guidelines

Table 1: Outpatient Hospital Pharmacy Claims Billing Guidelines

Revenue Code	Revenue Code Description	Covered Service	Require HCPCS Code?	Require NDC and NDC Units?
250	Pharmacy – General Classification	Yes	Yes	Yes
251	Pharmacy – Generic Drugs	Yes	Yes	Yes
252	Pharmacy – Non-Generic Drugs	Yes	Yes	Yes
253	Pharmacy – Take Home Drugs	No	No	No
254	Pharmacy – Drugs Incident to other Diagnostic Services	Yes **	Yes	Yes
255	Pharmacy – Drugs Incident to Radiology	Yes	Yes *	Yes *
256	Pharmacy – Experimental Drugs	No	No	No
257	Pharmacy – Non-Prescription	No	Yes	Yes
258	Pharmacy – IV Solutions	Yes	Yes	Yes
259	Pharmacy – Other Pharmacy	Yes	Yes	Yes
630	Pharmacy Extension of 25X – Reserved	No	No	No
631	Pharmacy Extension of 25X – Single Source Drug	No	No	No
632	Pharmacy Extension of 25X – Multiple Source Drugs	No	No	No
633	Pharmacy Extension of 25X – Restrictive Prescription	No	No	No
634	Pharmacy Extension of 25X – Erythropoietin (EPO) < 10,000 Units	Yes	Yes	Yes
635	Pharmacy Extension of 25X – Erythropoietin (EPO) ≥ 10,000 Units	Yes	Yes	Yes
636	Pharmacy Extension of 25X – Drugs Requiring Detailed Coding	Yes	Yes	Yes
637	Pharmacy Extension of 25X – Self-Administratable	No	No	No
638	Pharmacy Extension of 25X – Reserved	No	No	No
639	Pharmacy Extension of 25X – Reserved	No	No	No

* See Table 2 for list of HCPCS Level II codes that will require NDC and NDC units for payment.

** This revenue code was previously not covered. N.C. Medicaid covers items billed under this revenue code as of date of service July 1, 2008.

Table 2: HCPCS Level II Codes That Require NDC and NDC Units When Billed Under RC 255

A9542	A9543	A9544
A9545	A9556	A9579

To determine drug coverage under N.C. Medicaid, refer to Clinical Coverage Policy #9, *Outpatient Pharmacy Program*, and General Policy #A-2, *Over-the-Counter Medications*, (<http://www.ncdhhs.gov/dma/pharmacy.htm>). If the drug is covered, it can be billed using Revenue Code 25X with a HCPCS code and NDC information.

Non-covered over-the-counter drugs can be billed using Revenue Code 637. Billing of Revenue Code 637 (Pharmacy self-administered drugs per *UB-04 Manual*) will be allowed effective with date of processing July 1, 2008, for any outpatient hospital claims submitted with dates of service on or after December 28, 2007. Charges should be listed as non-covered when using Revenue Code 637. Revenue Code 637 does not require HCPCS Level II codes or NDC information to be included on the detail. Charges billed with Revenue Code 637 will not be considered when calculating hospital cost payments, cost settlements, or Disproportionate Share Hospital payments. Charges billed with Revenue Code 637 can be listed as patient liability using Value Code 31. Self-administered drugs may be billed under 25X with a HCPCS code and NDC information or under RC 637 as non-covered charges. For example, Xanax or a generic tablet that is not an over-the-counter medication may be reported with RC 637.

ADDITIONAL INFORMATION

Prior Approval

Medicaid prior approval requirements remain consistent with current guidelines. All drugs that require prior approval will continue to do so.

Copayments

Medicaid copayment criteria remain consistent with current guidelines. For detailed copayment information, please see the *Basic Medicaid Billing Guide*, Section 2 (<http://www.ncdhhs.gov/dma/medbillcaguide.htm>).

Billing the Recipient

When a non-covered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to rendering the service.

A provider may refuse to accept a Medicaid recipient and bill the recipient as private pay only if the provider informs the recipient prior to rendering the service, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for payment.

Automated Voice Response System

The Automated Voice Response (AVR) System is the most up-to-date method for checking the status of an NDC. Providers are able to verify an NDC as covered or non-covered using the AVR System (1-800-723-4337, option 3). The required information is a valid provider number, the NDC in an 11-digit format, and the date of service. For detailed instructions on the AVR System, refer to the July 2001

Special Bulletin, *Automated Voice Response (AVR) System Provider Inquiry Instructions*. It is on the DMA website at <http://www.ncdhhs.gov/dma/bulletinspecial.htm>.

There are three possible responses given by the AVRS:

- If the AVR System states this drug is covered, then it is also rebatable.
- If the NDC is non-rebatable, the AVR System states this drug is not covered under rebate agreement.
- If the AVR System states the drug is not allowed, the NDC may not be part of the Pharmacy program, but could be included by the PDP. Further research may be required to determine if the NDC is covered. Please call EDS Provider Services (1-800-688-6696, option 3) for assistance.

Reminder: N.C. Medicaid will not reimburse for non-rebatable NDCs.

Note: The HCPCS code must also be valid and covered by N.C. Medicaid.

Carolina ACCESS Referrals

Carolina ACCESS referral requirements remain consistent with current guidelines.

Remittance and Status Report

There will be no changes to the current components of the N.C. Medicaid Remittance and Status Report (RA).

EOBs Related to the National Drug Code Program

EOBs 8989 through 8999 – NDC invalid.

EOBs 9011 through 9021 – NDC was terminated for the detail date of service billed.

EOB 9992 – NDC missing.

EOB 9904 – CMS 1500 claim with more than three NDCs per procedure code must be billed electronically.

EOB 9198 – All NDC units must be greater than zero.

EOBs 9496 through 9506 – NDC is non-rebatable.

Note: If the detail is denied stating an NDC is non-rebatable, an adjustment may be submitted to request further medical review if the non-rebatable drug is the only option to treat a particular diagnosis. If a rebatable NDC is not effective in treatment, an adjustment request for further medical review can be submitted.

All supporting documentation must be included in the adjustment request in order for the case to have proper review. Adjustments are reviewed on a case-by-case basis.

EOB 9300 – This revenue code must be billed with a valid HCPCS code. Correct denied detail and refile as a new day claim.

EOB 1720 – NDC validity cannot be confirmed.

EOB 1998 – Duplicate claim. Same DOS, admit hour and NDC number.

EOB 6337 – Procedure code missing or invalid.

Additional Resource

Noridian has replaced Palmetto as a secondary resource for HCPCS codes and billing:

<https://www.dmepdac.com/>

https://www.dmepdac.com/crosswalk/index.html

NORIDIAN
Administrative Services LLC

PDAC
Medicare Pricing, Data Analysis and Coding

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DMECS HCPCS Review **NDC/HCPCS Crosswalk** OACD Assignment Reports Resources

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NDC/HCPCS CROSSWALK

The NDC/HCPCS crosswalk provides a listing of each National Drug Code that is assigned to a HCPCS. The crosswalk is updated monthly, but contains all prior updates, along with providing details on what changes occurred that month.

August 2008

- NDC to HCPCS Crosswalk [XLS]
- NDC to HCPCS Crosswalk [PDF]
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- Date Changes [PDF]
- Coding Changes [PDF]
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- Records and NDCs Removed [PDF]
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July 2008

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