North Carolina
Medicaid Special Bulletin

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Attention: Physicians, Nurse Practitioners, Nurse Midwives, Federally Qualified Health Centers, Rural Health Centers, Local Health Departments, Outpatient Hospital and Certified Dialysis Providers

National Drug Code Implementation, December 28, 2007 and July 1, 2008: Billing for Drugs Through the Physician's Drug Program

Effective with dates of service on and after **December 28, 2007,** the North Carolina Division of Medical Assistance (DMA) will require all physician-administered drugs in an office/clinic, outpatient hospital (effective with date of processing on or after July 1, 2008) including 340B providers or certified facility (non-hospital based dialysis treatment centers; dialysis center hospitals, satellites; and out-of-state dialysis centers) to include the National Drug Code (NDC) for each drug administered on the submitted claim.

When billed on CMS-1500 or UB claim forms, the Healthcare Common Procedure Coding System (HCPCS) drug code that is billed to N.C. Medicaid must include the following data elements:

- **N4 Qualifier** (paper submissions only)
- **NDC** - Each drug or biologic product approved by the Food and Drug Administration (FDA) is given a unique NDC number. The NDC is found on the package and/or vial of medication.
- **Quantity** of each submitted NDC

This change is in compliance with the Centers for Medicare and Medicaid Services (CMS) requirements related to the Deficit Reduction Act of 2005. Please access http://www.cms.hhs.gov/MedicaidGenInfo/08_DRASection.asp for details on the Deficit Reduction Act.

Billing software programs and office procedures need to be modified to include the required NDC-related data.

All 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. Please note that the billed HCPCS code must also be valid and covered by N.C. Medicaid. If the HCPCS code is not accompanied by the NDC, the detail will be denied.

Currently, N.C. Medicaid requires claims with HCPCS codes J2353, J3490, J3590, and J9999 to be submitted on paper with an invoice. Upon the implementation of the NDC project, invoices will no longer be 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 for compound drugs, which continue to require an invoice. These invoices must show the individual break down of each NDC purchase for rebate purposes and for proper pricing to occur.

Upon the implementation of the NDC project, any claim that processes by Medicaid as a Medicare crossover will not require an NDC on the claim. CMS-1500 claims that do not process as crossovers will require an NDC. The UB claims requiring an NDC are those billed by dialysis providers and outpatient hospital providers. These UB claims require an NDC regardless of whether the payment is made by Medicare or a third party insurance.

New Criteria

Example label image: NDC is located here (10-digit format)

NDC Conversion

NDCs are sometimes displayed on drug packaging in a 10-digit format (see above example). Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10-digit to 11-digit format requires a strategically placed zero. The following table shows common 10-digit NDC formats indicated on packaging and the associated conversion to an 11-digit format. The asterisk (*) sign represents the proper placement of the additional zero.

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
5-4-1	99999-9999-9	5-4-2	99999-9999-*9	60574-4112-1 Synagis 50-mg vial	60574-4112-01

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.

Claim Processing/Drug Rebate

Claims will continue to be priced based on the HCPCS code, with the NDC and corresponding units being used for drug rebate processing. During claims processing, the NDC will be edited for validity. If the NDC is invalid or terminated, the detail will be denied. The detail will also be denied if a HCPCS 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 and/or terminated NDCs.**

The prescribed drug must have FDA-approved indications. 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 participates with labelers who offer rebates to state Medicaid programs. The N.C. Medicaid Pharmacy program has operated under the Drug Rebate Program since 1991.

The NDC number being submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered. Sometimes the package will contain multiple vials or units. There have been a few instances noted where the NDC on the vial was not rebatable but the NDC from the outer package was rebatable. Therefore, if the two NDCs differ, it may be more prudent to report the NDC from the outer package.

The first 5 digits of the NDC represent the manufacturer (labeler), use this information to determine if the NDC is rebatable. **Ensure that the 11-digit NDC is covered by N.C. Medicaid prior to billing.**

The following chart contains a list of manufacturers (labelers) that supply rebatable drugs. **This list changes quarterly** (the version in this bulletin is from November 2007) and can be found on DMA's Web site (http://www.ncdhhs.gov/dma/pharmacy.htm). You may also refer to page 11 for AVRS instructions to validate coverage of 11-digit NDCs.

First 5 Digits of NDC (Manufacturers' Labeler Codes)

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
16252	16477	16571	16781	16837	16881	16887	17205	17270	17314	17433	17478
17714	18011	18754	18860	19810	20091	23155	23589	23635	24108	24162	24208
24385	24430	24839	25010	25382	25682	27437	28105	29033	31722	37000	37205
38245	39506	39822	44087	44206	45802	45809	45985	46287	46678	48878	49158
49230	49281	49348	49483	49502	49614	49669	49730	49884	49938	50111	50201
50242	50383	50419	50458	50474	50484	50580	50844	50907	50991	51079	51248
51284	51285	51479	51552	51645	51660	51672	51674	51801	51817	51991	52152
52268	52544	52555	52569	52604	52735	52747	52769	53014	53062	53303	53329
53489	53706	53746	53905	54092	54391	54396	54482	54569	54643	54746	54799
54838	54859	55111	55253	55390	55513	55515	55566	55654	56091	57664	57665
57782	57844	57894	58063	58177	58178	58211	58223	58281	58291	58394	58406
58407	58468	58605	58768	58790	58809	58826	58869	58914	58980	59011	59060
58075	59148	59196	59243	59310	59366	59390	59528	59572	59627	59630	59640

59676	59702	59730	59743	59746	59762	59767	59772	59911	59930	60242	60258
60267	60432	60492	60505	60553	60574	60575	60598	60758	60793	60951	60976
60977	61073	61314	61379	61451	61480	61570	61598	61703	61748	61787	61924
61953	61958	62022	62037	62053	62103	62107	62161	62175	62341	62436	62541
62559	62584	62592	62756	62794	62856	63004	63010	63020	63032	63044	63162
63304	63323	63395	63402	63459	63481	63653	63672	63717	63739	63801	63824
63857	63868	63921	64011	64019	64029	64108	64116	64125	64193	64365	64376
64406	64455	64543	64597	64661	64679	64682	64720	64731	64764	64875	64894
64980	65086	65162	65199	65224	65234	65473	65483	65580	65597	65649	65726
65847	65862	65880	66203	66213	66215	66220	66302	66346	66378	66424	66435
66440	66479	66490	66500	66530	66582	66591	66593	66594	66607	66621	66657
66663	66685	66689	66733	66758	66780	66794	66813	66860	66869	66870	66887
66934	66977	66992	66993	67108	67112	67159	67204	67211	67253	67286	67336
67386	67402	67425	67537	67546	67618	67707	67767	67781	67817	67857	67870
67871	67887	67919	68012	68013	68025	68032	68040	68047	68084	68094	68134
68135	68180	68188	68220	68249	68308	68322	68330	68382	68453	68462	68516
68546	68669	68712	68716	68727	68734	68774	68782	68817	68820	68850	68968
99207											

Data elements used by N.C. Medicaid for NDC claims processing

NDC – All-numeric 11-digit code (no hyphens or spaces)

NDC Units Value (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 units when more than one NDC is billed for a single HCPCS code:

- 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
- Must be a numeric value greater than zero

  Example: 1234567.123

Unit of Measurement (UOM) for each submitted NDC – Valid quantity codes include

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

Note: The above applies only to the capturing of NDC information.

Regarding the billing of the NDC price, the HIPAA standard requires the NDC price to be provided; however, NC Medicaid will not be using the NDC price during claim processing.

Submitting NDC-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 Web site at http://www.wpc-edi.com/. The NC Medicaid *HIPAA Companion Guide* is available on the DMA Web site at http://www.ncdhhs.gov/dma/hipaa/compguides.htm. The *HIPAA Companion Guide* will be updated prior to implementation.

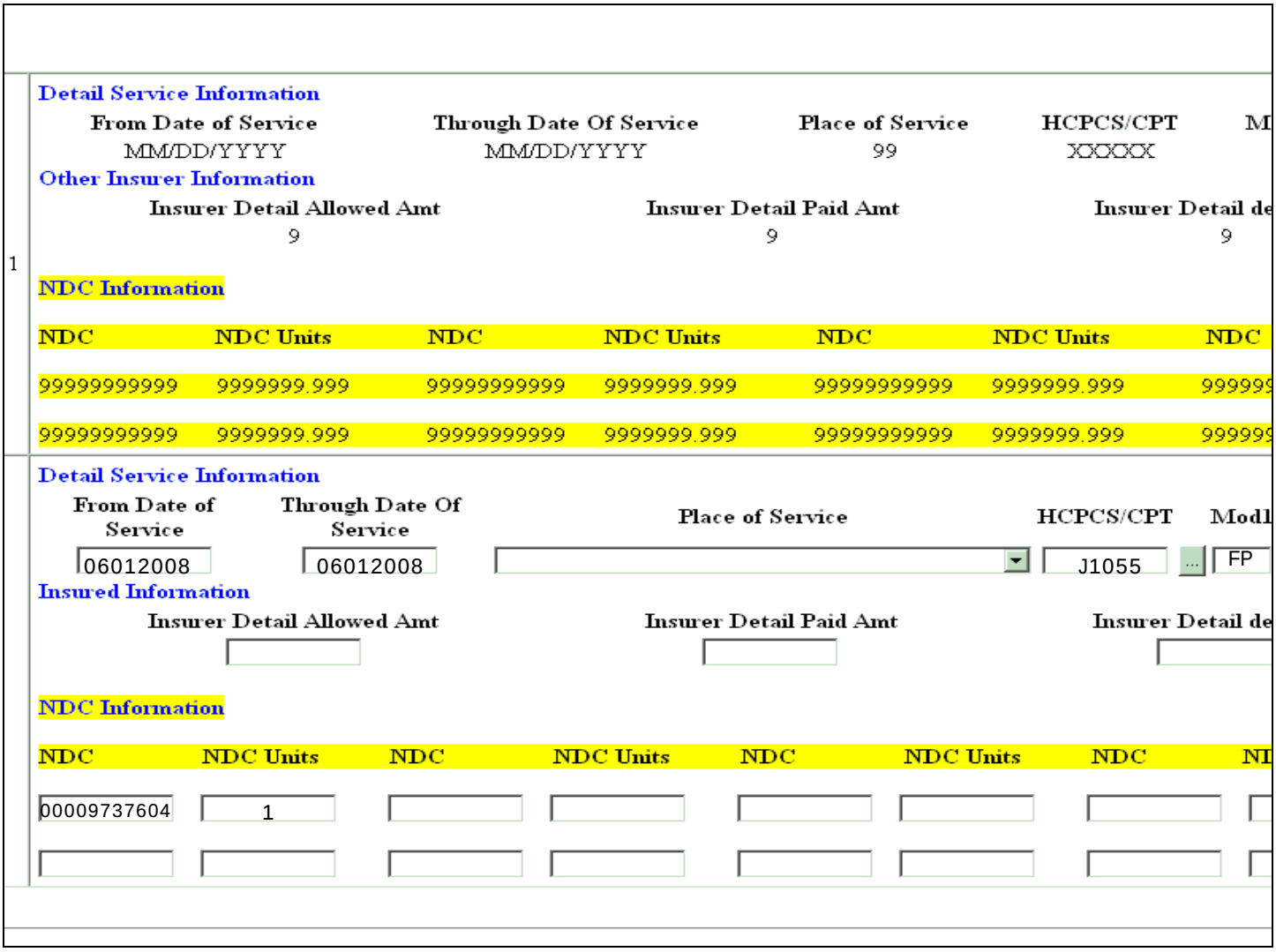
Note: N.C. Medicaid accepts up to 10 NDC codes and units per HCPCS code when submitted electronically.

Submitting NDC-Related Data on the North Carolina Electronic Claims Submission (NCECS) Web Tool

The data elements and claims processing guidelines are the same as those described above, with the exception of Unit of Measurement (UOM). The NCECS Web Tool will only accept a numeric value for NDC units and will not require the UOM. The required NDC fields will be updated on the detail line entry screen prior to NDC implementation. Please refer to the NCECS Web-based Claims Submission Tool at https://webclaims.ncmedicaid.com/ncecs.

Example NCECS screen shots upon NDC implementation:

CMS-1500



Detail Service Information

From Date of Service	Through Date Of Service	Place of Service	HCPCS/CPT	M
MM/DD/YYYY	MM/DD/YYYY	99	XXXXX	

Other Insurer Information

Insurer Detail Allowed Amt	Insurer Detail Paid Amt	Insurer Detail de
9	9	9

1

NDC Information

NDC	NDC Units	NDC	NDC Units	NDC	NDC Units	NDC
99999999999	9999999.999	99999999999	9999999.999	99999999999	9999999.999	999999
99999999999	9999999.999	99999999999	9999999.999	99999999999	9999999.999	999999

Detail Service Information

From Date of Service	Through Date Of Service	Place of Service	HCPCS/CPT	Modl
06012008	06012008		J1055	FP

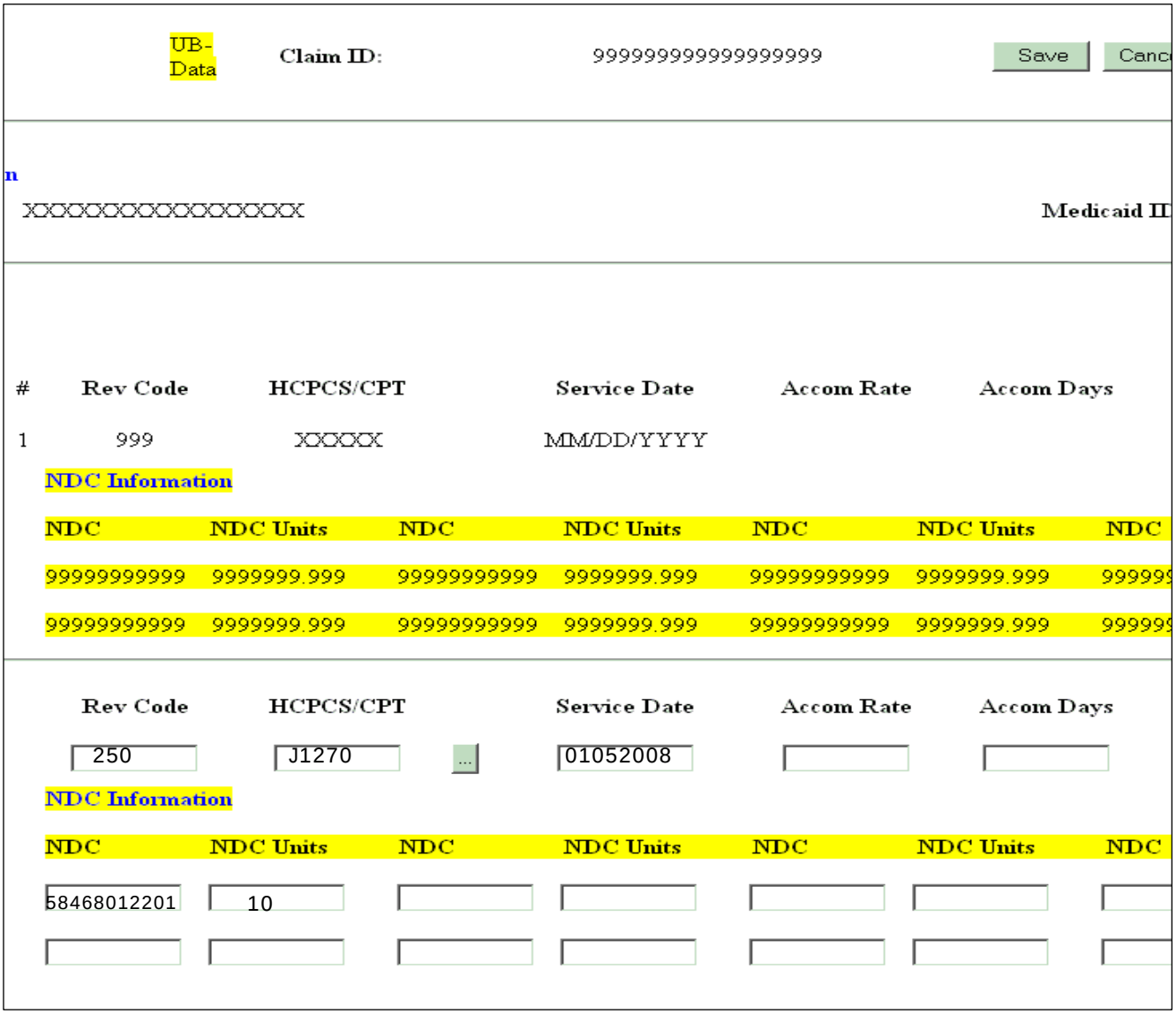
Insured Information

Insurer Detail Allowed Amt	Insurer Detail Paid Amt	Insurer Detail de

NDC Information

NDC	NDC Units	NDC	NDC Units	NDC	NDC Units	NDC	NI
00009737604	1						

UB Claim Form



Submitting NDC-Related Data on Paper Claims

CMS-1500 Paper Claims

When a HCPCS drug code covered under the Physicians Drug Program (PDP) is entered in box 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 section 24 have been divided horizontally to accommodate additional information. See the CMS-1500 manual for additional information at www.nucc.org.

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 code, the entire shaded area of boxes 24A through 24H will be used for reporting NDC information.

Complete the upper gray portion of section 24 as described below when billing for drug-related codes on the CMS-1500.

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

- Begin by left justifying the N4 qualifier
- Immediately followed by the 11-digit NDC
- Three (3) spaces
- One of the four (4) Units of Measurement (F2, GR, ML, UN)
- Followed immediately by the quantity

CMS-1500 Claim Examples

Single NDC Example:

NDC – 00009737604 - DEPO-PROVERA 150 MG/ML SYRN

If 1 HCPCS unit is billed, it should be converted to 1 ml for the NDC(s) units.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N400009737604 ML1														ZZ	123456789XX
	06	01	08	06	01	08	11		J1055	FP		50.00	1		NPI	0123456789
2																
															NPI	

NPI Implementation example with taxonomy

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

Two NDCs billed for a single HCPCS code example:

NDC – 00703301812 – ADRUCIL 50 MG/ML VIAL

NDC – 00703301513 – ADRUCIL 50 MG/ML VIAL

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N400703301812 ML50 N400703301513 ML10														1D	890XXXX
	01	01	08	01	01	08	11		J9190			50.00	6	N	NPI	0123456789
2																
															NPI	

Prior to NPI Implementation with Medicaid provider number

Additional Information when Billing Compounds

When billing for compounds with more than three (3) NDCs on a CMS-1500 paper claim, include the three NDCs which are the main ingredients for the HCPCS 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 code.

Providers must document all ingredients used for compounds in corresponding medical records, however due to space restrictions, only the three main ingredients for the compound may be reported per detail line. All NDCs reported per single HCPCS code must be rebatable for the detail to process for payment. Please refer to pg. 15 and 16 for guidelines on non-rebatable NDCs and the adjustment process.

UB Paper Claims

The National Uniform Billing Committee (NUBC) released a new UB claim form for use by institutional providers. The UB04 manual can be found at www.nubc.org. The UB form does not contain specific fields designated for NDC codes and/or NDC units. DMA, along with other state Medicaid programs, will utilize FL43 for the submission of the NDC codes and NDC units.

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

- Dialysis Treatment Center, non-hospital-based
- Dialysis Center Hospital, satellites
- Out-of-State Dialysis Center
- Outpatient Hospitals

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.

  The units of measure are as follows:

  F2 – International Unit

  GR – Gram

  ML – Milliliter

  UN – Unit

  - Do not enter spaces between the NDC data elements.
  - Do not enter hyphens within the NDC number.
  - Enter the NDC unit of measure code and numeric quantity administered to the patient.
  - Enter the actual metric decimal quantity administered to the patient.
  - Enter the actual metric decimal quantity (units) administered to the patient.
  - If reporting a fraction of a unit, use the decimal point.
- **FL44:** Enter the appropriate CPT or HCPCS procedure code.
- **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: J1270 – Doxercalciferol, 1 mcg

NDC – 58468012201 - HECTOROL 4 MCG/2 ML AMPUL (or 2 mcg/ml)

If 20 J-code units are billed, they should be converted to 10 ml for the NDC units.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48
250	N458468012201ML10	J1270	010508	20	311.80	

Example: J1756 – Iron Sucrose, 1 mg

NDC – 00517234010 – VENOFER 20MG/ML (or 100 mg/5 ml)

If 1 J-code unit is billed, it should be converted to 0.05 ml for the NDC units.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48
250	N400517234010ML0.05	J1756	021608	1	6.88	

Example: J0881 – Darbepoetin alfa, 1 mcg

NDC – 55513000201 – ARANESP 25 mcg/ml

If 5 J-code units are billed, they should be converted to 0.20 ml for the NDC units. (There are many strengths available for this product and the conversion will be different for other NDC's.)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48
250	N455513000201ML0.20	J0881	011508	5	723.15	

If additional NDCs are associated with one HCPCS code, the additional NDCs and units should be placed in the following detail lines. Up to 10 detail lines are allowed per procedure.

Detail line 23 may be used to continue to a second page by entering Page _ of _. However, the limit of 28 detail lines per claim still applies (North Carolina general Medicaid bulletin, January 2005, p. 27).

Additional Information

Eligible Providers

Any CMS-1500 biller, outpatient hospital, and certified dialysis providers billing on the UB for drugs through the PDP.

340-B Providers

340-B providers are not addressed by the DRA, nor has CMS or HRSA made a ruling regarding the exclusion of 340-B providers from this program. Until a ruling is issued on a federal level, 340-B providers are not excluded from this program.

The Office of Pharmacy Affairs maintains a Web site where all 340-B entities can be identified. If a Medicaid provider is participating, their Medicaid provider number should be listed on the Web site. EDS will review this each quarter for updates prior to running the drug rebate cycle. If the provider number is listed and EDS has confirmed they are participating in 340-B, their claims will be excluded from the rebate process.

Note: The 340-B provider's "usual and customary charge" should be reflective of their acquisition cost.

Prior Approval

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

Co-payments

Medicaid co-payment criteria remain consistent with current guidelines. For detailed co-payment information, please see the *Basic Medicaid Billing Guide*, Section 2.

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 (AVRS)

The automated Voice Response System (AVRS) is the most up to date method for checking the status of an NDC. Providers are able to verify a NDC as covered or not allowed on the AVRS (800-723-4337, option 3). The required information is a valid provider number, NDC in an 11-digit format, and the date of service. For detailed instructions on the AVRS, refer to the July 2001 special bulletin, *Automated Voice Response (AVR) System Provider Inquiry Instructions.* It is on the DMA Web site at www.ncdhhs.gov/dma/bulletin.htm#special.

There are three (3) possible responses given by the AVRS:

- If the AVRS states this drug is covered, then it is also rebatable.
- If the NDC is non-rebatable, the AVRS states this drug is not covered under rebate agreement..

- If the AVRS 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 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. Refer to the fee schedule list of covered PDP drugs, on DMA's Web site at http://www.ncdhhs.gov/dma/fee/fee.htm

Prior to the implementation of the NDC project, the PDP fee schedule will identify the drugs that require an NDC on the submitted claim.

Carolina Access Referrals

Carolina Access referral requirements remain consistent with current guidelines.

Remittance and Status Report (RA)

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

New EOBs related to the National Drug Code (NDC) Program

EOBs 8989 – 8999

When submitting a single NDC on one detail (per HCPCS)

8989 NDC INVALID.

When submitting multiple NDCs on one detail (per HCPCS)

8990 FIRST NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM
8991 SECOND NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM
8992 THIRD NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM
8993 FOURTH NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM
8994 FIFTH NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM
8995 SIXTH NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM
8996 SEVENTH NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM
8997 EIGHTH NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM
8998 NINTH NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM
8999 TENTH NDC INVALID. VERIFY AND ENTER THE CORRECT NDC AND SUBMIT AS A NEW CLAIM

EOBs 9011 - 9021

9011 NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED

First through the tenth NDC with deny with corresponding **EOBs 9012 – 9021** as follows:

9012 FIRST NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED
9013 SECOND NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED
9014 THIRD NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED
9015 FOURTH NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED
9016 FIFTH NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED
9017 SIXTH NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED
9018 SEVENTH NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED
9019 EIGHTH NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED
9020 NINTH NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED
9021 TENTH NDC WAS TERMINATED FOR THE DETAIL DATE OF SERVICE BILLED

EOB 9992

9992 NDC MISSING.

EOB 9904

9904 CMS 1500 CLAIM WITH MORE THAN 3 NDC'S PER PROCEDURE CODE MUST BE BILLED ELECTRONICALLY

EOBs 9496 - 9506

9496 NDC IS NON-REBATABLE

First through the tenth NDC with deny with corresponding **EOBs 9497 – 9506** as follows:

9497 FIRST NDC IS NON-REBATABLE
9498 SECOND NDC IS NON-REBATABLE
9499 THIRD NDC IS NON-REBATABLE
9500 FOURTH NDC IS NON-REBATABLE
9501 FIFTH NDC IS NON-REBATABLE
9502 SIXTH NDC IS NON-REBATABLE
9503 SEVENTH NDC IS NON-REBATABLE
9504 EIGHTH NDC IS NON-REBATABLE
9505 NINTH NDC IS NON-REBATABLE
9506 TENTH NDC IS NON-REBATABLE

If the detail denies 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.

Please note that 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.

Seminar Information

The slides from the November 2007 NDC workshops are posted on the DMA website at www.ncdhhs.gov/dma/pharmacy/ndc_seminar_presentation_1107.pdf.