PARTNERSHIP HEALTHPLAN of CALIFORNIA

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Date: 9/18/19

Medi-Cal

Important Provider Notice: # 364

Subject: Important changes to the NDCs and Claims Submission Requirements

Currently, providers are required to bill with National Drug Codes (NDCs) in conjunction with the customary Healthcare Common Procedure Coding System (HCPCS) or CPT (Current Procedural Terminology) codes for submission of physician administered drug claims. Effective for claims received on or after November 1, 2019, PHC will also require NDC number's for encounter data and claims with other coverage primary.

NEW NATIONAL DRUG CODE (NDC) FREQUENTLY ASKED QUESTIONS

1. **Why is NDC information required on Partnership HealthPlan claims?**

   The Department of Health Care Services requires all providers of physician-administered drugs to accurately document and submit claims for all physician-administered drugs covered by the Medi-Cal Program. Effective for claims received on or after November 1, 2019, PHC will also require providers to use NDC number's in conjunction with the customary Healthcare Common Procedure Coding System (HCPCS) or CPT (Current Procedural Terminology) codes for submission of encounter data and claims with other primary health coverage.

2. **When should providers start billing with NDCs on Medi-Cal claims?**

   Effective for claims received on or after November 1, 2019, providers are also required to start submitting NDC number's in conjunction with the customary Healthcare Common Procedure Coding System (HCPCS) or CPT (Current Procedural Terminology) codes for submission of encounter data and claims with other primary health coverage.

3. **What is the final implementation date when providers must be able to bill the NDC on encounter data and claims with other coverage primary?**

   Providers are already required to submit an NDC number on physician administered drug claims, however effective for services received on or after November 1, 2019, claims for encounter data and claims that have other coverage primary that are not billed with a valid NDC and appropriate Healthcare Common Procedure Coding System (HCPCS) or CPT (Current Procedural Terminology) code will be denied.

4. **Is NDC information required on all PHC Medi-Cal claims and encounters?**

   Yes, when the drug is billed independent of the service. See chart below:

Type of Claim	NDC information
Fee for Service where PHC is the primary payer	Required
Medicare/Medi-Cal crossover claims	Required
Fee for Service where PHC is the secondary payer (other health coverage)	Required
California Children's Services (CCS) claims	Required
Capitated claims billed to PHC	Required
Encounter claim submissions for PHC members	Required
COBA claims	Required
Corrected claims	Required
Claims Inquiry Forms (CIFs) and Appeals	Required
Inpatient Facility claims	Not required

5. **Are the NDC and unit of measurement (UOM) required on claims when billing with either the UB-04 or CMS-1500 claim forms? Are the NDC and unit of measurement (UOM) required on a crossover claims also?**

   Yes, both the NDC and UOM is required when billing for physician administered drugs, regardless of submission method or form. Crossover claims require NDC and UOM information effective for claims received on or after November 1, 2019. Corrected claims, CIFs and appeals require NDC and UOM information if received on or after November 1, 2019.

6. **Are compound drugs exempt from NDC reporting requirements in the hospital outpatient environment?**

   No. Each drug dispensed should be entered on separate lines of the *CMS-1500* or *UB-04* claim forms using the appropriate Healthcare Common Procedure Coding System (HCPCS) or CPT (Current Procedural Terminology) code, NDC, UOM and units.

7. **Is the NDC required on an outpatient claim if a drug is not covered by PHC?**

   PHC providers should submit an NDC for <u>every</u> claim billed for a drug. If a claim is denied, then providers will receive the correct reason code for the denial. If the drug is billed with the NDC and it is not covered by PHC, the denial reason code will indicate that the drug was not covered. Any claim line billed **without** the NDC will be denied because the NDC was not submitted. It will appear as if the provider made a mistake so the denial code may not be accurate.

8. **If the required NDC information is missing, will the entire claim or CIF be denied or just the claim line for the physician-administered drug?**

   Only the claim/CIF line for the physician administered drug will be denied if the NDC information is missing or invalid. Other claim lines will not be impacted.

9. **If a provider enters the Healthcare Common Procedure Coding System (HCPCS) or CPT (Current Procedural Terminology) code, count and/or NDC correctly, but does not enter the unit of measurement correctly, will that line item be denied?**

   Yes, the claim line will be denied. A valid unit of measure must be billed with the NDC information for all claims and CIFs.

10. **Do NDCs eliminate the need for providers to describe the drugs used with a Healthcare Common Procedure Coding System (HCPCS) code such as Z7610 (miscellaneous drugs) or a CPT (Current Procedural Terminology) code such as J3490 (unclassified drugs) in the *Additional Claim Information* field (Box 19) on the CMS-1500 claim form?**

    No. Any drugs administered or dispensed for codes such as these still require a description in the *Additional Claim Information* field (Box 19) on the *CMS-1500* claim form or the *Remarks* field (Box 80) on the *UB-04* claim form.

11. **How do providers bill for two medications when HCPCS Level III code Z7610 (miscellaneous supplies) is used for both medications administered or dispensed on the same day?**

    PHC allows HCPCS Level III code Z7610 to be used more than once for the same date of service. Providers should bill this code twice as separate line items along with the appropriate NDCs.

12. **Can providers/hospitals choose to not report NDC information and allow the claim line to deny, rather than going to the expense of changing procedures, policies and systems to capture NDC information?**

    No. The Department of Health Care Services requires all providers of physician-administered drugs to accurately document and submit claims for all physician-administered drugs covered by the Medi-Cal Program.

HOW TO SUBMIT NATIONAL DRUG CODE (NDC) INFORMATION TO PHC

13. **What is an NDC?**

    The NDC is a universal number that identifies a drug. The NDC consists of 11 digits in a 5-4-2 format. Proper billing of claims submitted for HCPCS drug codes requires 11-digit all-numeric NDC codes.

14. **Are the HCPCS/CPT/revenue code units different from the NDC units?**

    Yes, they are different. Use the HCPCS/CPT/revenue code and service units as you have in the past. NDC units are based on the numeric quantities administered to the patient and the unit of measure (UOM). The UOM codes are the following:

    - F2: international unit

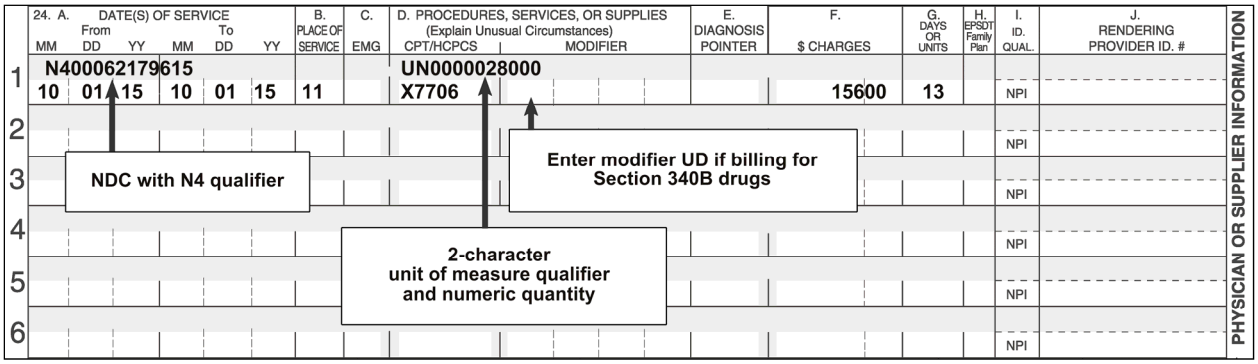
- GR: gram
- ML: milliliter
- UN: unit (each)

15. How should an NDC be billed on the *CMS-1500* claim form?

When billing a claim that requires an NDC Code on the *CMS-1500* claim form, please use the following format:

- **Box 24A (shaded area)** – Enter"N4" Qualifier and 11-digit National Drug Code (NDC).
- **Box 24D (white Area)** – HCPCS Code
- **Box 24F (white Area)** – Billed Charges
- **Box 24G (white Area)** – Units of Service
- **Box 24D (shaded area)** – NDC unit of measure (two positions). Enter the NDC Unit of Measure (two positions) immediately followed by the numeric quantity administered, which is a full 10-digit number. The 10 digits consist of seven digits for the whole number, followed by the three-digit decimal portion of the number. The quantity field should be entered from left to right, without a decimal.

***CMS-1500* form example:** 'N4' is used as the Product ID Qualifier, followed by the 11-digit NDC '00062179615'. 'UN' is used as the Unit of Measure and the units administered are '28'.

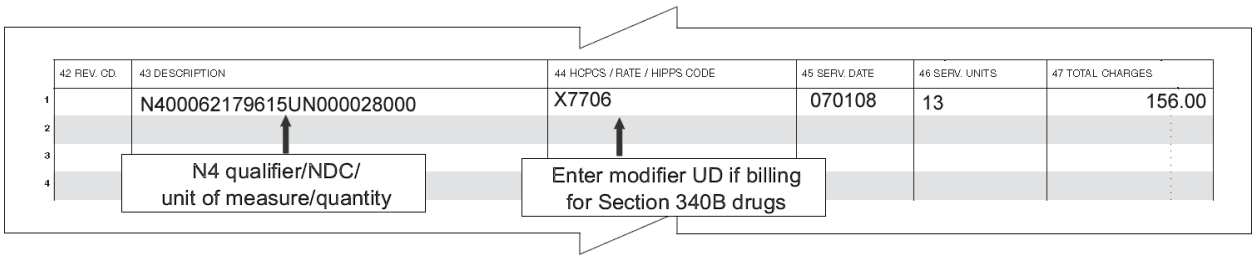


16. How should an NDC be billed on the *UB-04* claim form?

For the *UB-04* claim form, the NDC is reported in the following format:

- **Box 43 (Description Field)** – "N4" Qualifier and 11-digit National Drug Code (NDC). Enter first two positions as the Product ID Qualifier of 'N4' followed by the 11-digit NDC (no hyphens). Directly following the last digit of the NDC (no delimiter), enter the two-digit Unit of Measurement Qualifier as noted below followed by the nine-digit quantity. The nine digits consist of six digits for the whole number, followed by the three-digit decimal portion of the number.
- **Box 44** – Using the HCPCS/RATE/HIPPS Code field, enter the five-character HCPCS code.
- **Box 46** – Using the 'Serv Units' field, enter the corresponding service units for the HCPCS reported

***UB-04* form example:** 'N4' is used as the Product ID Qualifier with an NDC code of '00062179615'. Code 'UN' is used to identify the unit quantity of '28' reported as '000028000' (Nine-digit quantity).



17. Where do I enter NDC data on electronic claim (ANSI 5010 837P or ANSI 5010 837I) transactions?

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter **N4** in this field	2410	LIN02
National Drug Code assigned to the drug administered	Enter the 11-digit NDC billing format	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure for the prescription drug given (UN, ML, GR, or F2)	2410	CTP05

Note: The total charge amount for each line of service also must be included for the Monetary Amount in Loop ID, Segment SV102 for 839P and Segment SV203 for 837I.

18. Providers that have additional questions about determining NDCs for Medi-Cal claims are advised to consult with their pharmacists.