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October 19, 2007

MEMORANDUM ACS M07-19

TO: Medicaid Participating Hospitals Emergency Rooms, Dialysis Centers, Home Health Agencies and Institutional Providers that Submit UB92/04 Forms

FROM: Lois Lee, Acting Med-QUEST Division Administrator

SUBJECT: FEE-FOR-SERVICE (FFS) PROGRAM ONLY

NATIONAL DRUG CODE (NDC) REQUIREMENTS ON UB92/04 OUTPATIENT DRUG CLAIMS, EFFECTIVE JANUARY 1, 2008

Effective January 1, 2008[1], Medicaid participating providers billing for drugs to the Medicaid Fee-For-Service (FFS) Fiscal Agent (FA) are required to submit National Drug Code (NDC) information in addition to revenue codes and/or Healthcare Common Procedure Coding System (HCPCS) codes as required by Medicare. The Med-QUEST Division (MQD) has not changed when drugs should be billed to the FA. The only change is the additional information that must be included on the claim when drugs are billed. Drugs can continue to be billed along with other items.

Hospital emergency rooms, dialysis centers, home health agencies, and other institutions submitting paper claims on the UB92/04 or electronic claims using the 837I X12 transaction for outpatient services must include NDC information for the following situations:

- When Medicaid is the **primary** insurance;

Note: Drugs bundled together with other services are not impacted by this change so drugs are not to be billed separately from the inclusive bundled rate.

Dialysis centers are currently only allowed to bill revenue codes 0634 and 0635. Drugs falling under revenue code 0636 are still required to be submitted to Hawaii Medicaid's pharmacy benefit manager (PBM) by NDC number.

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- When Medicaid is the **secondary** insurance [i.e., for Medicare A/B (manual or electronic) crossover claims]; or
- When Medicaid is the **tertiary** insurance.

The following revenue codes are impacted: 0250–0259, 0262, 0263, 028X, 0630–0635 and 0637. If claims meet the above criteria then providers must submit:

- The "N4" NDC qualifier;
- The NDC number;
- The NDC quantity[2]; and
- The appropriate unit qualifier[2] (milliliter, gram, or each).

Effective January 1, 2008, any drug claims submitted without the required NDC information listed above will be denied for payment regardless of the date of service on the claim.

See the attached UB04 sample claim with the NDC number, quantity[2] and billing units.

If you have any questions regarding claims issues, please contact Affiliated Computer Services (ACS) FA at (808) 952-5570 or from the neighbor islands at (800) 235-4378 for assistance.

Attachment

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[1]The Deficit Reduction Act (DRA) of 2005 requires Medicaid agencies to submit all outpatient drugs paid by Medicaid FFS to the Centers for Medicare and Medicaid Services (CMS) for the purpose of collecting Federal drug rebates, no later than January 1, 2008. In order for Medicaid to report and collect these rebates, the NDC number, the quantity and corresponding billing unit must be submitted on claims from institutional providers that bill services on UB92/04 forms.

Fortunately, since the 1990s, Hawaii Medicaid has required institutional providers to submit outpatient non-emergency drug claims by NDC number and quantity to Hawaii Medicaid's PBM. Also, drugs provided by nursing facilities and by hospitals for patients at nursing facility level of care have been treated as outpatient drugs. Thus, we believe that the only outpatient drugs that have not been submitted for rebates are those drugs submitted on claims for emergency room services, for dialysis centers, and home health agencies.

[2]The NDC billing quantity and unit are also known as the National Council for Prescription Drug Programs (NCPDP) billing quantity and unit.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	N400002750201 1EA	J9201	010108	5	3 00		
0250	N400045025414 1ML	J1631	010108	2	3 00		
0250	N400004197101 1EA	J0696	010108	40	3 00		
0250	N455513092401 0.5ML	J1440	010108	1	3 00		
025X	N4 NDC & NDC(NCPDP)units	HCPCS	MMDDYY	HCPCS Units	$$ CC		

PAGE ____ OF ____ CREATION DATE TOTALS

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME | 9 PATIENT ADDRESS

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31–34 OCCURRENCE CODE DATE | 35–36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39–41 VALUE CODES CODE AMOUNT

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P.REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | 75

76 ATTENDING NPI QUAL LAST FIRST | 77 OPERATING NPI QUAL LAST FIRST | 78 OTHER NPI QUAL LAST FIRST | 79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81CC