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Provider Notice – Requirement to Bill for Physician-Administered Drugs

This notice is in follow up to the article in the summer 2010 edition of the Delaware Physicians Care provider newsletter addressing billing requirements of physician-administered drugs. We want to notify providers of our requirements to submit the National Drug Code (NDC) for physician-administered drugs effective January 1, 2011 for all claims submitted to Delaware Physicians Care.

This requirement is due to the implementation of the Patient Protection and Affordable Care Act of 2010 (PPACA) (Health Care Reform Law) which requires all state Medicaid agencies to collect rebates from drug manufacturers for physician-administered or dispensed drugs provided through Medicaid health plans. A physician-administered drug includes any covered outpatient drug provided or administered to a recipient, which is billed by a provider other than a pharmacy. Such providers would include, but not be limited to, physician offices, clinics, home health agencies, skilled nursing homes and hospitals.

Delaware Physicians Care Billing Requirements

Providers need to include the following data on claims forms/EDI claims submission to Delaware Physicians Care:

- *CMS1500 forms – Box 24*
 - The top area of the six service lines is shaded and is the location for reporting supplemental information, such as NDCs for drugs. The shaded areas of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.
 - When entering supplemental information for NDC, add in the following order: NDC qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number do not use a decimal. Do not use commas.
 - The, Qualifier N4 11 digit valid NDC code, HCPCS (J) Code, quantity and amount billed. Only one NDC code can be reported per line (for each HCPCS (J)) Code in box 24.
- *UB04 – Box 43, Line 1*
 - 11-digit valid NDC code, HCPCS Code, quantity and amount billed
- *Electronic Claim Form 837 Professional or Institutional – Loop 2410, LIN03=NDC code, 11 digit valid NDC, HCPCS codes, CTP04 =Quantity and CPT05=Unit of Measure, amount billed.*

The State of Delaware's Medicaid Physician Billing Manual instructs providers that reporting of the NDC/quantity is required when billing for drugs using A-J-Q-codes and certain CPT codes. The reporting requirement also extends to claims where there is other primary coverage. The NDC number reported must be the actual NDC number on the package or container from which the medication was administered. It may be necessary to pad NDC numbers with left-digit zeros in order to report eleven digits.

Please be aware that claims with dates of service on or after January 1, 2011 that do not meet the NDC reporting requirements to include a valid NDC paired with a valid HCPCS code will result in a communication on your remittance advice that states *Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC)*. Your claim will be paid during this 90-day notice period.

Effective April 25, 2011, claims with dates of service on or after January 1, 2011 that do not meet the NDC reporting requirements to include a valid NDC paired with a valid HCPCS code will result in claims being **denied** by Delaware Physicians Care and will require resubmission for payment.

For more information please call your Provider Relations representative at 1-800-287-9860.

Sincerely,

Provider Relations
Delaware Physicians Care, an Aetna Medicaid Plan