PREMERA BLUE CROSS
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Payment Policy

cmi_171641

Title	**National Drug Code (NDC) Billing Guidelines-Outpatient Facility Claims**		
Number	**CP.PP.405.v1.5**		
Last Approval Date	01/08/25	**Original Effective Date**	01/01/18
Replaces			
Cross Reference	*Modifier JW – Drug amount discarded/not administered to any patient and Modifier JZ – Zero drug amount discarded/not administered to any patient*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To provide clarity that a National Drug Code (NDC) number is required to be included for any drug, radiopharmaceutical, supply or device which has an assigned NDC number, when administered or supplied by an **outpatient facility** and which is submitted on a facility claim form (either a UB-04/CMS-1450 paper claim or ANSI 837I electronic claim) along with an appropriate drug HCPCS procedure code.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Definitions	**National Drug Code (NDC)** – An 11-digit number in a 5-4-2-digit format that is assigned to each medication approved by the Food and Drug Administration (FDA). The three segments in the number, NNNNN-NNNN-NN, indicate the following: • First segment – Identifies the company that manufactures or distributes the drug (assigned by the FDA) • Second segment – Identifies the product, its specific strength, dosage form and formulation of a drug (assigned by the Drug Manufacturer) • Third segment – Identifies the package size and type (assigned by the Drug Manufacturer) **Compound Drug** – An administered drug composed of more than one drug ingredient.
Policy	For any drug, radiopharmaceutical, supply or device which has an assigned NDC number, that is administered or supplied in an Outpatient hospital or facility setting and is submitted on an electronic claim (ANSI 837I) or a paper claim (UB-04/CMS-1450), an active/valid NDC number, an NDC unit/basis of measure and NDC units are **required** to be submitted along with an appropriate HCPCS drug procedure code on the same claim line. The appropriate NDC number is found on the drug label or outer packaging. The number on the package may be less than 11 digits or an asterisk (*) may appear as a placeholder for any leading zeros in the segments of the NDC number. The missing digits or the asterisk are required to be filled in with zero(s) on the submitted claim form in order to complete the 11-digit number. In addition, the label will also display information about the NDC unit/basis of measurement for the drug. Listed below are the preferred units/basis of measurement to use for the drug and their respective descriptions:

- **UN (Units)** – powder for injection (needs to be reconstituted), pellet, kit, patch, tablet, device
- **ML (Milliliter)** – liquid, solution, or suspension
- **GR (Gram)** – ointments, creams, inhalers, or bulk powder in a jar
- **F2 (International Units)** – Products described as IU/vial or micrograms

How to Submit an NDC on a Claim Form

Some general guidelines to help with the submission of an NDC number include:

- Submit an NDC number along with the appropriate HCPCS drug procedure code and the number of HCPCS drug code units
- NDC number must follow the 11-digit billing format (5-4-2) with no spaces, hyphens, or special characters
- If the NDC number on the package label is less than 11-digits or includes asterisk(s), leading zero(s) must be added to the appropriate segment(s) to create the 5-4-2-digit configuration
- **The NDC number must be active/valid for the date of service submitted**;
- The NDC number must include the Product ID Qualifier, the NDC unit/basis of measurement, and the number of NDC units

Electronic Claim Guidelines (ANSI 837I)

Field Name	Field Description	Loop ID	Segment/ Element
Product or Service ID Qualifier	Enter **N4** in this field	2410	LIN02
National Drug Code number	Enter the 11-digit NDC billing format assigned to the drug administered; No dashes should be in the NDC number	2410	LIN03
National Drug Unit Count	Enter the quantity for the NDC billed (number of NDC Units)	2410	CPT04
Unit/basis of measurement	Enter the NDC unit/basis of measurement for the prescription drug given • **UN - Unit** • **ML - Milliliter** • **GR - Gram** • **F2 – International Unit**	2410	CPT05

Paper Claim Guidelines (UB-04/CMS-1450)

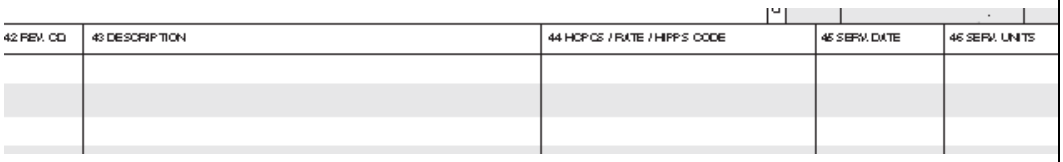
On the UB-04/CMS-1450 claim form, each drug, radiopharmaceutical, or vaccine administered in the hospital/facility setting is **required to be submitted on an individual line with an appropriate Revenue Code (Field 42).**

Each drug code line must include:

- An **active/valid** NDC number (Field 43, left justified),
- the applicable HCPCS drug procedure code (Field 44),
- date of service (Field 45),
- HCPCS drug procedure code units (Field 46) and
- a charge for the drug supplied/administered (Field 47).

Submit multiple lines to bill for multiple individual drugs administered.

UB-04/CMS-1450 Paper Claim Example:



42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS

Field 42: REVENUE CODE – insert the appropriate revenue code
Field 43: DESCRIPTION - Insert the active/valid NDC number along with the following information:

- First 2 digits: NDC qualifier = (EX: N4)
- Next 11 digits: NDC number (EX: 12345678901)
- Next 2 digits: unit of measurement qualifier
    - F2-International Units;
    - GR-Gram;
    - ML-Milliliter;
    - UN-Units)
- Final digits: unit quantity **for the NDC drug**, **not the HCPCS drug procedure code units** (maximum of 7 digits before decimal and maximum of 3 digits after decimal)
- If entering a "whole" number, do not include a decimal point or comma and do not zero fill. Leave the remaining positions blank

Field 44: HCPCS/RATE/HIPPS CODE - HCPCS drug procedure code (from the HCPCS J, C, Q or S series of codes)
Field 45: SERV DATE - Date of service
Field 46: SERV UNITS - HCPCS drug procedure code units (**not the units for the NDC** but units associated with the dosage for the HCPCS code)
Field 47: TOTAL CHARGES - Billed amount

When billing for a compound drug, **each specific drug** in the compound must be billed on a separate line with the appropriate HCPCS drug procedure code, the corresponding product ID qualifier, the NDC number, unit/basis of measurement, and NDC units.

Failure to include an NDC number in the format described above along with the billed HCPCS drug procedure code will result in a denial of reimbursement of the claim.

<u>Administered and Non-Administered/Wasted Drugs</u>

Reimbursement for discarded, non-administered or wasted drugs applies only to **single-use vials or packages**. Multi-use vials are not reimbursed for the discarded or wasted amounts of the drug.

	Non-administered/wasted drug amounts from single use vials must be identified by appending modifier JW-*Drug amount discarded/not administered to any patient* to the HCPCS drug procedure code. If no amount of a single use vial was discarded or wasted and **ALL** of the drug was administered, modifier JZ-*Zero drug amount discarded/not administered to any patient* must be appended to the HCPCS drug procedure code. To submit a claim for wasted drugs, submit two separate claim lines: Claim line #1 - the administered portion of the drug: • an appropriate Revenue Code (Field 42), • an NDC number (Field 43), • a HCPCS drug procedure code (Field 44) with **NO** modifier and • the units administered (Field 46). Claim line #2 – the wasted portion of the drug: • an appropriate Revenue Code (Field 42), • the same NDC number (Field 43), • the same HCPCS drug procedure code (Field 44) but appended **with** modifier JW and • the units wasted (Field 46). To submit a claim for a totally administer drug with **NO** wastage, submit a single claim line for each drug administered: • an appropriate Revenue Code (Field 42), • an NDC number (Field 43), • a HCPCS drug procedure code (Field 44) appended **with** modifier JZ, and • the administered units (Field 46).

Codes/Coding Guidelines	For Washington state facilities: **<u>WA SB 6127 – Human Immunodeficiency Virus Post Exposure Prophylaxis (HIV/PEP) Drugs and Therapies</u>** Effective with dates of service on and after January 1, 2025, HIV PEP drugs, when supplied in the Emergency Room should be billed as follows: • On a separate line with Revenue Code *0253 – Take Home Drugs* • With an appropriate diagnosis code indicating possible exposure to HIV • With a HCPCS drug procedure code for the HIV drugs supplied or an unlisted HCPCS drug procedure code specific to an oral specific drug • With a valid/active NDC number for the drugs **<u>WA SB 6228: Substance Use Disorder Treatment</u>** Effective with dates of service on and after January 1, 2025, opioid overdose reversal medications and long-acting injectable buprenorphine dispensed or distributed to a patient at certain outpatient facilities, should be billed as follows: • On a separate line with either Revenue Code *0636-Drugs requiring detailed coding* or Revenue Code *0253 – Take Home Drugs* for each drug administered • With an appropriate diagnosis related to mental and behavioral disorders due to psychoactive substance use (diagnosis code range F10-F16, F18-F19) • With a HCPCS drug procedure code for the drug(s) administered • With a valid/active NDC number for the drug(s) administered • Appropriate units administered
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	This policy does not apply to Freestanding Rural Health Clinics billing commercial secondary services for Medicare crossover claims or Inpatient hospital/facility claims
Laws, Regulations & Standards	• WA SB 6127 – Human Immunodeficiency Virus Post Exposure Prophylaxis (HIV/PEP) Drugs and Therapies • WA SB 6228: Substance Use Disorder Treatment
References	• ASC X12 837 Institutional Claim Format • CMS Publication 100-04 Medicare Claims Processing Manual, Ch.17, Section 70 • Official UB-04 Data Specifications Manual, American Hospital Associations • U.S. Food and Drug Administration (FDA)

Policy Owner Review	Payment Integrity Oversight Committee
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.
Annual Review Dates	01/08/25; 02/05/24; 03/13/23; 05/12/22; 05/27/21; 06/15/20; 07/30/19; 08/09/18; 11/07/17; 09/11/17

Version History	08/09/18	Clarified that any drug, radiopharmaceutical, supply, or device that has an assigned NDC number must be submitted with that NDC number along with appropriate units, basis of measurement and an appropriate HCPCS code
	07/30/19	Annual review; no changes
	06/15/20	Annual review; no changes
	05/27/21	Annual review; no changes
	05/12/22	Annual review; no changes
	03/13/23	In the Policy section, created a new section in the policy Discarded, Wasted and Non-Administered Drugs and added instructions on how to correctly bill/code for single use vial/package drug wastage by billing on two separate lines with modifier JW appended to the code line representing the wasted portion of the drug.
	02/05/24	The following updates and clarifications were made to sections of the Policy statement: • Removed the "ME-Milligrams" unit of measurement from the entire policy • In the subsection "How to Submit an NDC on a Claim Form" added the third bullet • In the subsection "2) Paper Claim Guidelines (UB-04/CMS-1450), added bullet five under Field 43-Descriptions • Expanded the last subsection in the Policy to include "Administered" drugs and added clarification on how to bill for administered drugs (modifier JZ) and wasted drugs (modifier JW) on the facility claim form
	01/08/25	• Added a new section "Codes/Coding Guidelines" and listed two mandates for Washington providers and their respective billing guidelines • In the Laws, Regulations and Standards section, listed the two Washington Senate Bills referenced in the Codes/Coding Guidelines section of the policy