

**WEST VIRGINIA MEDICAID  
BUREAU FOR MEDICAL SERVICES  
NDC AND HCPCS  
FREQUENTLY ASKED QUESTIONS  
(Revised July 10, 2019)**

**1. Why do I have to start billing with National Drug Codes (NDCs) in addition to HCPCS codes?**

The Deficit Reduction Act of 2005 (DRA) includes new provisions regarding State collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for physician-administered drugs. Section 6002 of the DRA adds section 1927(a)(7) to the Social Security Act to *require* States to collect rebates on physician-administered drugs. In order for Federal Financial Participation (FFP) to be available for these drugs, the State must provide collection and submission of utilization data in order to secure rebates. Since there are often several NDCs linked to a single Healthcare Common Procedure Coding System (HCPCS) code, the Centers for Medicare and Medicaid Services (CMS) deem that the use of NDC numbers is critical to correctly identify the drug and manufacturer in order to invoice and collect the rebates.

**2. What is the Drug Rebate Program?**

The Medicaid Drug Rebate Program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) which added Section 1927 to the Social Security Act and became effective on January 1, 1991. The law requires that drug manufacturers enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to provide rebates for their drug products that are paid for by Medicaid. Manufacturers that do not sign an agreement with CMS are not eligible for federal Medicaid coverage of their products. Since 1991, it has been required that outpatient Medicaid pharmacy providers dispense only rebateable drugs and bill with the NDCs. Now, with the Deficit Reduction Act of 2005, this requirement is being expanded to include physician-administered drugs.

**3. What is an NDC?**

The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer. Some packages will display less than 11 digits, but leading "0's" can be assumed and need to be used when billing. For example:

XXXX-XXXX-XX = 0XXXX-XXXX-XX  
XXXXX-XXX-XX = XXXXX-0XXX-XX  
XXXXX-XXXX-X = XXXXX-XXXX-0X

The NDC is found on the drug container, i.e. vial, bottle, tube. The NDC submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered. Do not bill for one manufacturer's product and dispense another. The benefits of accurate billing include reduced audits, telephone calls, and manufacturers' disputes of their rebate invoices. It is considered a fraudulent billing practice to bill using an NDC other than the one administered.

**4. Does the drug administered by the physician and billed to Medicaid with an NDC have to be a "rebateable" drug?**

Yes. Manufacturers who wish their products to be eligible for coverage by Medicaid must first sign a rebate agreement with CMS.

**5. How do I know if a drug is rebateable?**

You may refer to the CMS website at [www.cms.gov](http://www.cms.gov) to determine if an NDC is manufactured by a company that participates in the Federal Drug Rebate Program or consult your wholesaler for assistance. (Revised 4/23/08)

**6. Will my claim be denied or rejected if the drug is non-rebateable?**

A warning message will be given on the remittance voucher if a drug is not rebateable until January 1, 2008, when the claim lines will begin to deny and not pay. This is based on the date of service, not the submission date.

**7. Will my claim be denied or rejected if I don't include the NDC and NDC units?**

Claim lines without the proper NDC qualifier, an NDC, and units of measurement associated with the NDC will deny. Claims with a date of service prior to January 1, 2008 will display a warning message on the remittance voucher. (Revised 4/23/08)

**8. Do I need to include units for both the HCPCS code and the NDC?**

Yes.

**9. Are the HCPCS code units different from the NDC units?**

Yes. Use the HCPCS code and service units as you have in the past. NDC units are based upon the numeric quantity administered to the patient and the unit of measurement. The actual metric decimal quantity administered and the unit of measurement are required for billing the NDC units. If reporting a fraction, use a decimal point. The unit of measurement codes are listed below. The appropriate NDC unit of measurement codes have been added to the Drug Code List found on the BMS website. (Revised 4/23/08)

F2 = International Unit  
GR = Gram  
ML = Milliliter  
UN = Unit (Each)

**10. If the physician administered a vial of medication to a patient, do I bill the NDC units in grams, milliliters, or units?**

It depends on how the manufacturer and CMS have determined the rebate unit amount. The rule of thumb is:

If a drug comes in a vial in powder form and has to be reconstituted before administration, then bill each vial (unit/each) used. If a drug comes in a vial in a liquid form, bill in milliliters. Grams are usually used when an ointment, cream, inhaler, or a bulk powder in a jar are dispensed. This unit of measure will primarily be used in the retail pharmacy setting and not for physician-administered drug billing. International Units (F2) will mainly be used when billing for Factor VIII-Antihemophilic Factors.

For example:

- A patient received 4 mg Zofran IV in the physician's office. The NDC you used was 00173-0442-02, which is Zofran 2 mg/ml in solution form. There are 2 milliliters per vial. You would bill J-2405 (ondansetron hydrochloride, per 1 mg) with 4 HCPCS units, and since this drug comes in a liquid form, you would bill the NDC units as 2 milliliters.
- A patient received 1 gm Rocephin IM in the physician's office. The NDC of the product used was 00004-1963-02, which is Rocephin 500 mg vial in a powder form that you needed to reconstitute before the injection. You would bill J-0696 (ceftriaxone sodium, per 250 mg) with 4 HCPCS units, and since this drug comes in powder form, you would bill the NDC units as 2 Units (also called 2 Each). (Revised 4/23/08)

**11. How will NDC information be billed on electronic and paper claims forms?**

See billing instructions for the UB-04 and CMS-1500 paper claim forms at the DXC WVMMIS website at:

<http://www.wvmmis.com/contentDelivery/manuals.screen>

From the "Choose a Topic" dropdown menu, pick "2007" and click on "Submit". Then, you may choose the instructions you need.

You may bill claims electronically through your clearinghouse using your Companion Guide as a reference.

You cannot bill these claims through the Web Portal via Direct Data Entry (DDE) at this time. The Web Portal is currently being configured to accommodate this process. A message will be posted to the Web Portal when it is ready for use.

*The NDC number being submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.*

**12. If the NDC is not rebateable or I am not sure which NDC was used, can I pick another NDC under the J-Code and bill with it?**

**No.** *The NDC submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.* It is considered a fraudulent billing practice to bill using an NDC other than the one administered.

**13. Do radiopharmaceuticals or contrast media require an NDC?**

No. BMS has revised its original plans to require NDCs for radiopharmaceuticals because the NDCs were not found in the drug database. BMS has requested assistance from CMS and will not require NDCs for these agents until clarification is made by CMS. (Revised 01/10/08)

**14. Do vaccines/immunizations require an NDC?**

No. Vaccines are not included in the rebate requirements.

**15. Who do I contact if I have questions about billing with an NDC?**

Call DXC Provider Relations at 1-888-483-0793 or 304-348-3360.

**16. Are Medicare primary claims excluded from the NDC requirement?**

No. Medicare primary claims will require NDCs with the HCPCS codes. These claims will deny. Claims with dates of service prior to January 1, 2008, will display a warning message on the remittance advice. (Revised 4/23/08)

**17. Do dentists need to bill with both HCPCS codes and NDC numbers?**

No. Use of NDCs with HCPCS codes is not applicable to dentists. Dentists have a different process for billing Medicaid claims. For questions, call DXC Provider Relations at 1-888-483-0793 or 304-348-3360.

**18. Do anesthesia drugs require NDCs?**

No. Drugs used for local anesthesia, general anesthesia, or conscious sedation are bundled together under other codes.

**19. Do I bill the HCPCS code and NDC of a drug if I just administer the drug?**

No. For example, if the patient has a prescription filled and brings the drug into the facility to have the physician administer it, the drug may not be billed by the physician. The physician should only bill for the administration of the drug. The retail pharmacy would have already billed for the drug.

**20. How do I bill for a drug when only a partial vial was administered?**

If the drug is packaged in a multi-dose vial (can be used for more than one patient), then only the units administered should be billed to Medicaid.

If the drug is packaged in a single-dose vial that cannot be used for multiple injections, then the whole vial may be billed to Medicaid. (Revised 4/23/08)

**21. What happens if I enter incorrect NDC units?**

Claims continue to process using the procedure code units and no untoward effects should be noticed by the provider. Rebates will be billed to manufacturers by cross walking the procedure code units. However, in the future, BMS will begin processing claims for physician administered drugs and providers will be required to bill accurate units in order to be correctly reimbursed. BMS will use the NDC units being billed to determine the level of training needed to transition to NDC units for reimbursement. (Revised 11/29/07)

**22. Will BMS post a procedure code/NDC code crosswalk?**

No. Although providers have requested that BMS post the NDC/J code crosswalk, BMS will not be doing this because rebates are dependent upon correct NDCs being used. The actual NDC on the container that is administered is the one to be billed. (Revised 11/29/07)

**23. I am a 340b participating hospital. Do I need to submit NDC codes for drug claims?**

Yes. Although 340b purchased claims are not eligible for drug rebates, BMS will require the submission of this data.

**24. What if I submit an NDC on a claim prior to the 7/1/2007 effective date – will my claim be denied?**

The claim will not be denied if an NDC is submitted prior to 7/1/2007. The claim will be processed based upon the procedure code that was submitted.

**25. For services billed to the Medicaid HMO plans for assigned members, is the NDC required in billing?**

Yes. HMOs are now included in the CMS requirements. Because of the changes in the law under section 2501(c) of the Patient Protection and Affordable Care Act (PPACA), states must collect manufacturers' rebates for drugs dispensed to individuals (including provider administered drugs) enrolled with a Medicaid MCO, effective March 23, 2010. In order to facilitate the collection of these rebates, states must include utilization data, which includes the NDC, reported by each Medicaid MCO. (Added 01/27/11)

**26. Do CAHs have to bill NDCs for drug codes?**

CAHs must bill a HCPCS or CPT code when billing for a drug that is on the Drug Code List on the BMS web page if the NDC code is listed as required. (Added 01/14/08)

**27. What do I do when I receive a denial for an invalid NDC, but the NDC is actually valid (remit Reason Code 16, Claim/service lacks information which is needed for adjudication and Remark Code M119, Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC)).**

Please contact Molina Provider Relations so that the NDC can be researched. If our research shows that the NDC is valid and missing from the Unisys database, then the NDC will be added and DXC will reprocess the denied claims. (Added 4/23/08)

**28. What do I do if my whole claim rejects because the J-code line I am billing is incorrect/invalid?**

Providers should consider submitting J-code claims separately if they are having problems with rejections because of J-code issues. This way, the provider can be paid for most of their services and then resubmit the J-code claims when the errors are determined and corrected. (Added 5/19/2008)

Please note: For UB04 or 837I format, only revenue codes are used in duplicate check edits. The same revenue code may not be billed on two separate claims with the same date of service because the second claim will deny as a duplicate. (Added 6/9/2008)

**29. Do all J-code claims (or other drug codes) require an NDC, NDC units, and NDC unit of measure?**

No. Not all J-codes require the submission of an NDC, NDC units, and NDC unit of measure. The BMS website Drug Code List informs the provider of which codes require an NDC and the appropriate unit of measure. If the provider adds the NDC information to a claim for a J-code (or other code) even if an NDC is NOT required for the code, the claim will be rejected if the information is incorrect or invalid. (Added 6/9/2008). It is better to leave fields that are not required blank. (Revised 6/9/2008) Providers should

refer to the BMS website at [www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms) to access the Drug Code List.  
 (Added 5/19/2008)

**30. How do I convert the HCPCS units to NDC units?**

Providers continue to ask this question. Below is a conversion chart that may be helpful in converting units. (Added 6/9/2008)

The following general advice may help in determining which NDC unit of measurement code is applicable for a given claim:

<b>NDC UNIT OF MEASURE DESCRIPTION</b>	<b>DOSAGE ADMINISTERED TO PATIENT</b>	<b>NDC INFORMATION ON VIAL/BOX</b>	<b>NDC BILLING UNIT</b>	<b>HCPCS CODE DESCRIPTION</b>	<b>HCPCS CODE BILLING UNIT</b>
ML= (Milliliters): Any liquid form of anything (syrups, IV solutions, injectable in liquid form etc)	4 mg	2 mg/ml	2 ml	1 mg	4
UN= (Units): Any single unit (for single dosage units like capsules, tablets, kits, vials with powder that has to be reconstituted, etc.).	5 gm	500 mg	10 un	250 mg	20
GR= (Grams): Powders, ointments, creams, etc.	3 gm	1 gm	3 gm	500 mg	6
F2= (International Units): International units pertaining to a product's strength and not volume	6192 IU	516 U/VL	12 IU	Per IU	6192

Please note that all claims with an NDC requires one of the above named NDC units of measurement codes or the claim line will deny and Claim Adjustment Reason Code 125 (Payment adjusted due to a submission/billing error(s))

and Remittance Advice Remark Code M53 (Missing/incomplete/invalid days or units of service) will appear on the paper remittance advice or the 835 transaction.

### **31. How is a J code reimbursed?**

Physician/Facility-administered medications billed with a HCPCS code are priced using the Medicare Part B Drug Average Sales Price (ASP). This fee schedule can be found at the website of the Centers for Medicare and Medicaid Services (CMS)—[www.cms.gov](http://www.cms.gov). For those medications not issued a fee by CMS, pricing will reflect the methodology used for retail pharmacies. Please refer to Chapter 518 of the West Virginia Medicaid Provider Manual for information on reimbursement.

(Added 8/6/08)

### **32. How does a provider bill multiple NDCs for the same service code?**

Standard HCPCS billing accepts the use of modifiers to determine when more than one NDC is billed for a service code.

- To bill the same procedure code with different NDCs for multiple drug unit dose formulations use:
  - KP-first drug of a multiple drug unit dose formulation
  - KQ-second or subsequent drug of a multiple drug unit dose formulation
- To bill concurrently administered infusion therapies with multiple procedure codes:
  - first administered infusion with no modifier
  - SH-second or concurrently administered infusion therapy
  - SJ-third or more concurrently administered infusion

(Added 5/7/09) (Revised 8/25/17)

### **33. How do I determine if an NDC can be reimbursed by West Virginia Medicaid?**

You may go to [data.medicaid.gov](http://data.medicaid.gov) to search a database of NDCs participating in the federal drug rebate program, which is a requirement for Medicaid to reimburse any drug product. Click on [Drug Pricing & Payment](#) upon accessing the site.

(Added 7/10/19)



**34. How can I ask for a review of my drug claim line(s) denying for missing/invalid/incomplete NDCs?**

Drug claim lines denying for “invalid” NDCs (a typical claim edit for this problem would be edit 753/M119) can be reviewed by calling the Medicaid claims processor, DXC Provider Relations at 1-888-483-0793 or 304-348-3360, or by inquiring with your DXC field representative.

Because the Medicaid MCOs use the same reference file of NDCs in drug claim’s processing, DXC can still be contacted to review HCPCS/NDC combinations.

(Added 7/10/19)