

# PROVIDER BULLETIN

No. 10-59

Date: November 17, 2010

TO: Medicaid Providers

FROM: Vivianne M. Chaumont, Director   
Division of Medicaid & Long-Term Care

BY: Margaret Booth  
Division of Medicaid & Long-Term Care

RE: **National Drug Code (NDC) Requirements for Physician Administered Medication**

**Please share this information with administrative, clinical, and billing staff.**

Nebraska DHHS Division of Medicaid and Long-Term Care is federally mandated to collect rebates from drug manufacturers for drugs that are administered to Medicaid clients and Medicare crossover claims for Medicare Part B drugs. Medicaid requires that providers report accurate National Drug Codes (NDCs) and associated units on submitted claims. Multiple Provider Bulletins (08-02, 08-03, 08-16, 08-28, and 10-31) have been posted regarding this requirement.

Currently, we are finding significant errors that are negatively impacting Nebraska's rebate process which results in the state being unable to properly collect the rebates.

To correct these deficiencies, Nebraska Medicaid will be recouping payments for those claims where NDCs or related information were determined to be in error. If sufficient funds are available for an auto recoupment the Department will follow standard recoupment procedures. If the full amount is not available, the provider will need to issue a manual payment to the department or make the appropriate adjustments as soon as possible.

When a provider receives a refund request, the provider can request an adjustment by supplying the missing NDC data or correcting the original data. Do not submit a new claim as the claim will be deleted as a duplicate. A copy of your report or claim with the missing or corrected information requesting the adjustment will suffice. To facilitate the processing of these specific NDC Adjustment requests, please include the following statement as part of the mail-in address when sending your documentation: **Attention: Roxie G/Screening Desk Personal & Confidential.**

Please keep in mind that providers are restricted to a maximum time limitation of 90 days to request an adjustment to a claim that has been paid with a portion reduced or disallowed, or a

claim that has been disallowed in total. The 90-day limitation begins with the payment date of the paper remittance advice (Form MCP-248) or with the payment date of the electronic remittance advice (ASC X12N835).

If you have any questions regarding this bulletin, please contact Margaret Brockman at 402-471-9368 for physician claims and Margaret Booth for hospital claims at 402-471-9380.