If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of IL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. Blue Cross and Blue Shield of IL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Revenue Codes Requiring Supporting CPT, HCPCS and/or NDC Codes - Outpatient Facility Claims

Policy Number: CPCP018

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: October 2, 2024

Plan Effective Date: April 14, 2025

Description

This policy does not apply to Inpatient claims.

The Plan requires outpatient facility providers to indicate the most appropriate Healthcare Common Procedure Coding System/HCPCS, Current Procedural Terminology/CPT code(s), and National Drug Codes/NDC in addition to the revenue code for all electronic outpatient facility claims.

Reimbursement Information

The plan reserves the right to request supporting documentation. Claim submissions that do not adhere to coding and billing policies may delay or impact claims processing and reimbursement.

All claims submitted by an outpatient facility provider must include a supporting HCPCS, CPT or NDC code with a revenue code when applicable. Revenue codes and procedure code combinations that are submitted on outpatient claims should reflect the services that were provided to the member on that date of service. These codes should be submitted on the same line for accurate claims processing. If more than one HCPCS, CPT or NDC code is needed for a revenue code, the revenue code should also appear on a separate line.

Billing and Coding

Revenue code(s) and corresponding procedure code(s) must be compatible.

The plan may deny an outpatient facility claim if a revenue code is submitted without the appropriate procedure code(s). when submitted on the following bill types:

- Bill Types: 12x 13x, 14x, 74x, 75x, 76x, 83x, 84x, 85x, and 89x

The Centers for Medicare and Medicaid Services Outpatient Prospective Payment System, OPPS, Integrated Outpatient Code Editor, I/OCE, maintains a current list of codes that require HCPCS. For the most up-to-date list, providers should refer to the CMS website.

National Drug Codes (NDC)

For voluntary reporting and clinical encounter purposes, NDC information may be submitted with the related revenue or CPT/HCPCS codes as additional information when NDC information is not contractually required.

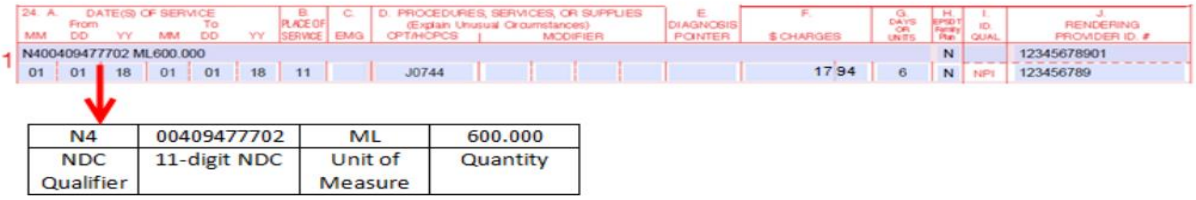
Electronic claim transactions for NDC data (ANSI 837I)

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter **N4** in this field	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure for the prescription drug given (**UN**, **ML**, **GR**, or **F2**)	2410	CTP05

Paper claim transactions for NDC data (CMS-1500 or UB-04)

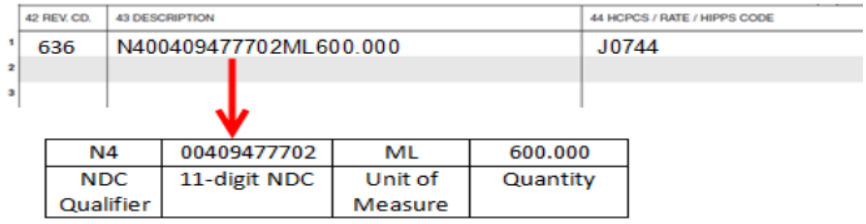
- **Professional Paper Claims CMS-1500:** In the shaded portion of line-item field 24A-24G, enter NDC qualifier N4 (left-justified), immediately followed by the NDC. Enter one space for separation. Next enter the appropriate qualifier for the correct dispensing NDC unit of measure (UN, ML GR or F2). Following this, enter the quantity (number of NDC units up to three decimal places).

  See example below:



- **Institutional Paper Claims UB-04:** In line-item field 42-46, enter the appropriate drug-related revenue code in field 42, report the NDC qualifier N4 (left-justified), immediately followed by the 11-character NDC in the 5-4-2 format (no hyphens). Immediately after the last digit of the NDC, enter the appropriate qualifier for the correct package size, NDC unit of measure (UN, ML, GR or F2). Following this, enter the quantity (number of NDC units up to three decimal places).

See example below:



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE
636	N400409477702ML600.000	J0744

N4	00409477702	ML	600.000
NDC Qualifier	11-digit NDC	Unit of Measure	Quantity

Additional Resources

Clinical Payment and Coding Policy

CPCP025 Corrected Claim Submissions

References

Centers for Medicare and Medicaid Services (CMS), Outpatient Code Editor (OCE)

https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit

National Council for Prescription Drug Programs (NCPDP) Standards

https://standards.ncpdp.org/Access-to-Standards.aspx

Policy Update History

Approval Date	Description
07/12/2018	New policy
06/24/2019	Annual Review
06/16/2020	Annual Review, Disclaimer update
10/30/2020	Added revenue code 078x
12/01/2021	Annual Review
10/27/2022	Annual Review
10/30/2023	Annual Review
10/02/2024	Annual Review