

NDC Drug Code Billing Requirement for Outpatient Drugs Delayed Effective Date



Effective September 1, 2017 all claims for outpatient, drug-related HCPCS codes and CPT codes must also include the following information:

- NDC code of the product that was administered
- Unit of measure
- Quantity

Claims submitted without a valid NDC will reject.

This information is required for CMS-1500 and UB-04 claim forms and Electronic Data Interface transactions. This applies to all HAP products, excluding Medicare crossover claims and claims where HAP is **not** the primary payer. Please see attached list of affected codes. In the future, you can find this list when you log in at hap.org. Select *Procedure Reference Lists* under *Quick Links* and look for:

- *Codes that require an NDC*
- *Services that Require Prior Authorization List* or the *DME Services that Require Authorization List* (NDC will be indicated in the Key column if it is required)

Format

NDCs must contain a valid 11-digit number (no spaces, hyphens or extra characters) in a 5-4-2 format. The first five digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The other digits, which are assigned by the manufacturer of the drug, identify the specific product and package size. If an NDC is less than 11 digits, add leading zeros to the appropriate segment to create the 5-4-2 configuration. Please see table below for format details.

NDC format on label	Convert to 5-4-2 format
4-4-2: xxxx-xxxx-xx	0xxxxxxxxxx
5-3-2: xxxxx-xxx-xx	Xxxxx0xxxxx
5-4-1: xxxxx-xxxx-x	Xxxxxxxxx0x

Submitting the NDC

Claim	How to Submit																																													
Electronic claims	Follow the 5010 837 X12 standard																																													
CMS-1500 claim form	<div>box 24A-24G – in the shaded portion</div> <div><div><div>• Enter the NDC qualifier of N4</div><div>• Followed by the NDC number (see format above)</div><div>• Enter one space for separation</div><div>• Enter appropriate unit of measure (F2, GR, ML or UN)</div><div>• Enter the quantity</div></div><div><div><div>→</div><table><tr><td>24. A. DATE(S) OF SERVICE</td><td>B. PLACE OF SERVICE</td><td>C. EMG</td><td>D. PROCEDURES, SERVICES, OR SUPPLIES</td><td>E. DIAGNOSIS</td><td>F. \$ CHARGES</td><td>G. DAYS OF UNITS</td><td>H. ID. QUAL</td><td>J. RENDERING PROVIDER ID. #</td></tr><tr><td>From To</td><td></td><td></td><td>(Explain Unusual Circumstances)</td><td>POINTER</td><td></td><td></td><td></td><td></td></tr><tr><td>MM DD YY MM DD YY</td><td>SERVICE</td><td></td><td>CPT/HCPCS MODIFIER</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>N400409476586 ML120</td><td></td><td></td><td></td><td></td><td></td><td></td><td>N</td><td>12345678901</td></tr><tr><td>01 01 13 01 01 13 11</td><td></td><td></td><td>J0744</td><td>1</td><td>17.94</td><td>6</td><td>N NPI</td><td>123456789</td></tr></table></div></div></div>	24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. \$ CHARGES	G. DAYS OF UNITS	H. ID. QUAL	J. RENDERING PROVIDER ID. #	From To			(Explain Unusual Circumstances)	POINTER					MM DD YY MM DD YY	SERVICE		CPT/HCPCS MODIFIER						N400409476586 ML120							N	12345678901	01 01 13 01 01 13 11			J0744	1	17.94	6	N NPI	123456789
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UB-04 claim form	<div>In box 43</div> <div><table><tr><td>43 DESCRIPTION</td></tr><tr><td>N412345678901UN1234.567</td></tr></table></div>	43 DESCRIPTION	N412345678901UN1234.567																																											
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If you have questions, please contact Provider Inquiry at (866) 766-4661.