

Subject:	National Drug Code (NDC) Billing Requirements		
Policy Number:	PO-RE-088v2		
Effective Date:	01/01/2024	Last Approval Date:	06/15/2026

I. Policy Description

This policy describes the National Drug Code (NDC) information required on professional and outpatient facility drug claims submitted for reimbursement. NDC numbers are the industry standard identifier for drugs and provide transparency regarding the medication administered, including manufacturer, drug name, strength, dosage form, and package size.

In alignment with CMS guidance and industry-standard billing practices, Healthfirst requires that all applicable claims include complete and accurate NDC information, including **NDC number, unit of measure (UOM) qualifier, and NDC quantity**.

The information below applies to the following lines of business:

<ul style="list-style-type: none"> Child Health Plus (CHP) 	<ul style="list-style-type: none"> Essential Plan (EP)
<ul style="list-style-type: none"> Integrated Benefit Dual Plan (IB-Dual) 	<ul style="list-style-type: none"> Managed Long Term Care Plan (MLTCP – Senior Health Partners)
<ul style="list-style-type: none"> Medicaid Managed Care (MMC) 	<ul style="list-style-type: none"> Medicaid Advantage Plus/MAP (CompleteCare)
<ul style="list-style-type: none"> Medicare Advantage HMO 	<ul style="list-style-type: none"> Qualified Health Plan (QHP)
<ul style="list-style-type: none"> Medicare PPO 	<ul style="list-style-type: none"> Personal Wellness Plan (HARP)

Reimbursement Guidelines:

340B Program:

Providers enrolled in the 340B program must adhere to the following billing requirements:

- Outpatient drug claims billed by 340B qualified providers must contain the NDC number, NDC unit of measure (UOM) qualifier, NDC quantity and a UD modifier.
- Outpatient drug claims billed by providers who are **not** 340B qualified must contain the NDC number, NDC unit of measure (UOM) qualifier, and NDC quantity.

- All outpatient drug claims with an unlisted or miscellaneous HCPC/CPT code for both 340B and non-340B qualified providers must contain the NDC number, NDC unit of measure (UOM) qualifier, and NDC quantity.

NDC Billing Requirements

- The NDC must be submitted along with the applicable HCPCS/CPT code(s) and the number of HCPCS/CPT units, NDC unit of measure (UOM) qualifier, and NDC quantity.
- The NDC must follow the 5-4-2 format (11-digit billing format, no spaces or hyphens). If fewer than 11 digits, a leading zero must be added.
- The NDC must be active for the date of service.
- Both NDC quantity and UOM qualifiers are required for all claims billed with NDCs.
- The NDC must accurately correspond to the drug administered and align with the HCPCS/CPT code billed.

NDC Quantity Reporting Requirements

- The NDC quantity represents the actual amount of drug administered to the patient.
- Quantity must be reported using standard decimal format when applicable (e.g., 1, 0.5, 0.25).
- Quantity must reflect the administered dose, not the total vial size (unless the entire vial is used).
- Partial vial usage must be accurately reported.
- Quantity must align with the HCPCS/CPT units billed.
- Inconsistent or mismatched quantity reporting may result in claim denial or reprocessing.

NDC Unit of Measure (UOM):

The UOM qualifier identifies the type of measurement used to report the NDC quantity and is required for all NDC submissions.

Unit of Measure	Description:	Guidelines:
UN	Unit	Powder-filled vials for injection (needs to be reconstituted), pellet, kit, patch, tablet, device
ML	Milliliter	Liquid, solution, or suspension
ME	Milligrams	Drugs measured and administered in milligram units
GR	Gram	Ointments, creams, inhalers, or bulk powder in a jar
F2	International Unit	Products described as IU/vial, or micrograms

- The UOM must correspond to the NDC description and packaging.
- Use of an incorrect qualifier may result in claim denial.

Examples of Correct NDC Billing

Scenario	HCPCS Code	NDC	UOM	Quantity	Notes
Injectable drug (partial vial)	J1234	12345-6789-10	ML	0.5	Reflects administered dose
Tablet	J5678	98765-4321-10	UN	1	One unit administered
Cream	J9012	55555-1111-22	GR	2	Two grams applied

- Providers must ensure alignment between HCPCS units and NDC quantity.

CMS-1500 paper claims (professional services)

Where to report:

- Line 24A (shaded area): Enter the NDC information.
- Line 24D: Enter the HCPCS code for the drug-related service.

Format example — N412345678901 UN1:

- N4 is the NDC qualifier.
- 12345678901 (11 digits) is the NDC without hyphens.
- UN is the unit-of-measure code.
- 1 is the quantity administered.

24. A	DATE(S) OF SERVICE						B	C	D. PROCEDURES, SERVICES, OR SUPPLIES		E	F	G	H	I	J	
From	To	PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	UNIT	IO	RENDERING						
MM	DD	YY	MM	DD	YY	SERVICE	MODIFIER	PORTER			QUAL	PROVIDER ID, #					
N98765432110UN1																	
10	01	20	10	01	20	11	J5678			156.00	13		NPI				
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> NDC with N4 Qualifier, 2-character unit of measure and numeric quantity </div>							<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Enter modifier UD if billing for Section 340 B drugs </div>										
NPI																	

UB-04 paper claims (institutional services)

Where to report:

- Form Locator 43 (*Revenue Description* field)

Format example — N412345678901UN1:

- Run the NDC, unit of measure, and quantity together, no spaces

42	43	44	45	46	47
REV. CD.	DESCRIPTION	HCPCS / RATE / HPPS CODE	SERV. DATE	SERV. UNITS	TOTAL CHARGES
1	N400062179615UN000028000	X7706	070108	13	156.00
2					
3					
4					

N4 qualifier/NDC/
unit of measure/quantity

Enter modifier UD if billing
for Section 340B drugs

Electronic claims, ANSI X12 5010 format

837P (professional):

- Loop 2410 — LIN segment:
 - LIN02: N4 (qualifier)
 - LIN03: 12345678901 (11-digit NDC)
- CTP segment:
 - CTP04: quantity
 - CTP05-1: unit (UN, ML, and so on)

837I (Institutional):

- Loop 2400 — service line
- Nested loop 2410 — drug identification:
 - Same as 837P LIN and CTP segment structure

Adjudication and Appeal Process

1. Claims may be denied if:
 - NDC number is missing, invalid, or inactive
 - NDC quantity is missing, invalid, or inconsistent with HCPCS units
 - UOM qualifier is missing or incorrect
 - NDC information does not match the drug bill
2. Claims denied for incomplete or inaccurate NDC information may be resubmitted with corrections.
3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.
4. This policy is a provider resource for understanding Healthfirst’s reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.
5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. Refer to: Healthfirst Provider Manual Subsection 17, “Billing & Claims Processing”.

II. Applicable Codes

Code	Description	Comment
UD Modifier	The UD modifier is a procedure code modifier nationally designated as applicable only to Medicaid billing. In NYS, the UD modifier is included in claims to designate a drug purchased at a discounted rate (340B pricing).	

III. Definitions

Term	Meaning
NDC	National Drug Code
UOM	Unit of Measure

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

New York State Medicaid Update - July 2022 Volume 38 - Number 8
NYS MEDICAID BILLING INSTRUCTIONS FOR 340B DRUG CLAIMS
Billing 340B Modifiers under the Hospital Outpatient Prospective Payment System (OPPS)

VI. Revision History

Revision Date	Summary of Changes
06/15/2026	Expanded NDC requirements to include quantity and UOM qualifiers

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Disclaimer

Healthfirst’s claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst’s coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor’s revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider’s participation agreement. This includes the determination of any amount that Healthfirst or the member owes the provider.