healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	National Drug Code (NDC) Billing Requirements		
Policy Number:	PO-RE-088v1		
Effective Date:	01/01/2024	**Last Approval Date:**	11/20/2023

I. Policy Description

This policy describes the National Drug Code (NDC) information that is required on professional and outpatient facility drug claims that are reported for reimbursement. National Drug Code (NDC) numbers are the industry standard identifier for drugs and provide full transparency to the medication administered.

The NDC number identifies the manufacturer, drug name, dosage, strength, package size and quantity. For purposes of this policy, a valid NDC number, NDC unit of measure and NDC units dispensed for the drug administered will be required for reimbursement of professional drug claims on a 1500 Health Insurance Claim Form (CMS-1500), the 837-professional transaction, a UB-04 Claim Form or the 837i facility transaction.

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 and a UD modifier.
- Outpatient drug claims billed by providers who are not 340B qualified must contain the NDC number.
- 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 Billing Requirements

- The NDC must be submitted along with the applicable HCPCS/CPT code(s) and the number of HCPCS/CPT units.
- The NDC must follow the 5digit4digit2digit format (11-digit billing format, with no spaces, hyphens or special characters). If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 5-4-2 configuration.
- The NDC must be active for the date of service.

NDC Unit of Measure (UOM):

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
GR	Gram	Ointments, creams, inhalers, or bulk powder in a jar
F2	International Unit	Products described as IU/vial, or micrograms

Adjudication and Appeal Process

1. For institutional and professional claims:
    a. Failure to bill with the NDC number will result in denial of all claim lines.
    b. For 340B qualified providers, must contain both NDC number and UD modifier.
    c. All outpatient drugs with an unlisted or miscellaneous HCPCS/CPT code for both 340B and Non-340 B qualified providers must contain the NDC number.

2. If the NDC information is missing, invalid, incomplete, or does not match the HCPCS or CPT submitted, the claim may be denied. If the claim is denied, it can be resubmitted with the appropriate NDC information for reconsideration of reimbursement.

3. Corrected claim submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual.

In Scope Lines of Business:

Medicare, Medicaid, HARP, Child Health Plus, Essential Plan, Qualified Health Plan, Commercial

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 on 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

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

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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 amounts that Healthfirst or the member owes the provider.