

## Informational Notice

**Date:**

**To: All Medical Assistance Providers**

**Re: Requirements for Reporting of the National Drug Code (NDC) on Professional Claims**

---

This notice is an important reminder of the requirements for reporting of the NDC code on all professional claims for physician-administered or dispensed drugs. The NDC reporting requirement will be implemented effective with dates of service on and after January 1, 2008, when billing on the 837P, HFS 2360, HFS 1443 or the HFS 3797. **Professional claims that do not meet the NDC reporting requirements will reject beginning with dates of service January 1, 2008.** This notice supercedes the previous notices on the NDC requirement issued on October 19, 2007, March 29, 2007, and June 16, 2005. Providers are encouraged to read this notice thoroughly and contact the department with any questions. The previous notices are available on the department's Web site at: <http://www.hfs.illinois.gov/physicians/>

As you are aware, the federal Deficit Reduction Act of 2005 requires all state Medicaid Agencies to collect rebates from drug manufacturers for physician-administered or dispensed drugs. This includes physician-administered or dispensed drugs given in a physician's office or a hospital outpatient department. This requirement also applies to Medicare crossover claims.

Only those products manufactured by companies participating in the federal Medicaid rebate program are reimbursable under Medicaid. Claims for drugs manufactured by companies that do not participate in the federal rebate program will be rejected. A list of manufacturers participating in the rebate program is available at <http://www.hfs.illinois.gov/pharmacy/labelers.html>

The department will continue to reimburse providers based on the Health Care Procedure Coding System [HCPCS] procedure code and HCPCS procedure code units billed. **However, effective with dates of service January 1, 2008, the NDC must be reported in conjunction with the HCPCS. If the NDC is not reported, the claim will reject. The following error codes will be reported on the remittance advice:**

**Error Codes**

H16  
R77  
C01  
R86  
D82  
D83  
D88  
D90  
F68  
R78  
U65

**Messages**

Missing/Invalid NDC  
NDC Not Covered on Date of Service  
NDC/Item Number Not on File  
NDC is Terminated  
NDC Not Covered/MFGR Not on File for Rebate  
NDC Not Covered/MFGR Not on File for Rebate on Date of Service  
NDC/Item Number Not Approved on File  
Manufacturer Not on File For Rebate Quarter  
NDC Obsolete/Check Obsolete Date  
DESI Drug Not Allowed for Payment  
NDC Not Valid for Date of Service

## **HIPAA 837P Transactions and Direct Data Entry through the MEDI System**

For HIPAA 837P electronic claim transactions, the HCPCS code is reported in Loop ID 2400 and the NDC is reported in Loop ID 2410. For more detailed information please refer to the billing instructions for electronic claim transactions found in Chapter 300, Topic 302, located on the department's Web site at: <http://www.hfs.illinois.gov/handbooks/>

For paper claims, the HCPCS code is reported on one service line, and the NDC is reported in the service line immediately following the service line on which the HCPCS code was reported.

Providers registered to bill through the Direct Data Entry MEDI System can access instructions for the specific claim format [HFS 2360, HFS 1443, HFS 3797] by going to <http://www.myhfs.illinois.gov/>

### **Reporting Quantities**

These instructions apply to both paper claims and electronic transactions.

At this time, the department will use only the HCPCS quantities/units for payment and rebate purposes.

When a provider uses more than one NDC of a drug, the provider must include all NDCs on the claim. The quantity for **each** NDC must be reported separately by repeating the HCPCS code. Please refer to the **Reporting of Multiple NDCs** section.

### **Reporting Charges**

These instructions apply to both paper claims and electronic transactions.

The provider's charge must be reported for each HCPCS Code. A charge of zero should be reported for each NDC.

### **Paper Transactions**

The HCPCS code with the charge and the appropriate quantity based on the HCPCS definition should be billed on one service line. The corresponding NDC must always be reported on the service line directly after the drug HCPCS code service line. The NDC service line(s) must include the date of service, place of service, NDC Code, and NDC charge amount of zero.

### **Reporting of Multiple NDCs**

These instructions apply to both paper claims and electronic transactions.

At times, it may be necessary for providers to bill multiple NDCs for a single procedure code. This may happen when two different strengths of the same drug are needed in order to administer the appropriate dose. This will also be necessary when multiple vials of the same drug are used to administer the appropriate dose, and the vials are manufactured by different manufacturers. Billing examples of these situations are provided below. The examples apply to both paper claims and electronic transactions.

Procedure for billing one HCPCS and multiple NDCs:

Service Line 1 or Loop 2400: HCPCS Code  
Report HCPCS quantity associated with NDC in Service Line 2

Service Line 2 or Loop 2410: NDC associated with Service Line 1

Service Line 3 or Loop 2400: HCPCS Code (same as Service Line 1) - Modifier 76 (Repeat Procedure)  
Report HCPCS quantity associated with NDC in Service Line 4

Service Line 4 or Loop 2410: NDC associated with Service Line 3

Service Line 5 or Loop 2400: HCPCS Code (same as Service Line 1 & 3) - Modifier 51 (Multiple Procedures)  
Report HCPCS quantity associated with NDC in Service Line 6

Service Line 6 or Loop 2410: NDC associated with Service Line 5

**Example 1:** Procedure for billing **three (3)** 250 mg vials of ceftriaxone manufactured by two different manufacturers.

Provider will bill **a total quantity of** three (3) HCPCS procedure code units, but will divide those units between two service lines, as follows:

Service Line 1 or Loop 2400: J0696 billed with a quantity of 2

Service Line 2 or Loop 2410: 00781320695

Service Line 3 or Loop 2400: J0696 billed with a quantity of 1

Service Line 4 or Loop 2410: 00409733701

Reporting Multiple NDCs – Example 1				
HCPCS Code	HCPCS Code Description and HCPCS Quantity	Drug Administered	HCPCS Quantity Billed	NDCs Used
J0696	Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	Two (2) 250 mg vials	2	00781320695 ceftriaxone 250 mg vial manufactured by Sandoz
J0696	Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	One (1) 250 mg vials	1	00409733701 ceftriaxone 250 mg vial manufactured by Hospira

**Example 2:** Procedure for billing 125 mcg of Aranesp (darbepoetin alfa) using two different vials/strengths of the drug: one (1) 25 mcg syringe and one (1) 100 mcg syringe.

Provider will bill **a total quantity of** 125 HCPCS procedure code units, but will divide those units between two service lines, as follows:

Service Line 1 or Loop 2400: J0881 billed with a quantity of 25

Service Line 2 or Loop 2410: 55513005704

Service Line 3 or Loop 2400: J0881 billed with a quantity of 100

Service Line 4 or Loop 2410: 55513002504

<b>Reporting Multiple NDCs - Example 2</b>				
<b>HCPCS Code</b>	<b>HCPCS Code Description and HCPCS Quantity</b>	<b>Drug Administered</b>	<b>HCPCS Quantity Billed</b>	<b>NDCs Used</b>
J0881	Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 25 mcg/ 0.42 ml syringe	25	55513005704 Aranesp 25 mcg/0.42 ml syringe
J0881	Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 100 mcg/ 0.5 ml syringe	100	55513002504 Aranesp 100 mcg/0.5 ml syringe

### **Hand Priced Drug Procedure Codes**

These instructions apply to both paper claims and electronic transactions.

Providers must report both the HCPCS code and NDC for drugs requiring hand pricing. These procedure codes are identified on the physician's fee schedule on the department's Web site at <<http://www.hfs.illinois.gov/feeschedule/>>. Providers must report the HCPCS code in the procedure field, and the product name, strength and the dosage administered or dispensed in the description field. The description field is Box 24C on paper claims, the "procedure literal description" field for DDE claims, or the NTE segment of Loop 2400 for electronic transactions. On paper claims only, the quantity in the units field must be 1. In the service line immediately following, providers must report the NDC as the procedure code.

The department will not require providers to report the NDC quantity, as indicated in previous notices regarding the NDC requirements

### **Medicare Crossover Claims**

The NDC requirements apply to Medicare crossover claims.

### **Conversion of NDC Code to Eleven-Digit Code**

These instructions apply to both paper claims and electronic transactions.

Each drug product listed under Section 510 of the Federal Food, Drug, and Cosmetic Act is assigned a unique 10-digit, 3-segment number. This number, known as the NDC, identifies the labeler/vendor, product, and trade package size. The first segment, the labeler code, is assigned by the Food and Drug Administration (FDA). A labeler is any firm that manufactures, repacks or distributes a drug product. The second segment, the product code, identifies a specific strength, dosage form, and formulation. The third segment, the package code, identifies package sizes. The labeler assigns both the product and package codes.

The Health Insurance Portability and Accountability Act (HIPAA) standard code set for NDCs is eleven digits. The first segment must include five digits, the second segment must include four digits, and the third segment must include two digits (5-4-2 configuration). For example, 12345-

1234-12 is a correctly configured NDC. However, the NDC on the product label might not contain 11 digits. The labeler may have dropped leading zeros in a segment. In this situation, the appropriate number of leading zeros must be added at the beginning of each segment to ensure that the NDC is shown in the 5-4-2 format. Where the zero is added depends upon the configuration of the NDC.

See the examples below:

An NDC in the 5-3-2 configuration would require a leading zero in the second segment in order to have a 5-4-2 configuration. The following table provides examples of incorrectly configured NDCs and the corresponding correctly configured NDC. The segment that is missing the leading zero is bolded in each example.

<b>NDC on Label</b>	<b>Configuration on Label</b>	<b>NDC in Required 5-4-2 Format</b>
05678- <b>123</b> -01	5-3-2	05678-0123-01
<b>5678</b> -0123-01	4-4-2	05678-0123-01
05678-0123- <b>1</b>	5-4-1	05678-0123-01

If you have questions regarding this notice, please contact the Bureau of Comprehensive Health Services at 1-877-782-5565.

Theresa A. Eagleson, Administrator  
Division of Medical Programs