Minnesota Department of Health (MDH) Rule

Minnesota Uniform Companion Guide (MUCG) Version 18.0 for the Implementation of the X12/005010X223A2 Health Care Claim: Institutional (837)

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Contents

Minnesota Uniform Companion Guide (MUCG) Version 18.0 for the Implementation of the X12/005010X223A2 Health Care Claim: Institutional (837)

1 Introduction and Overview

This is version 18.0 of the Minnesota Uniform Companion Guide (MUCG) for the Implementation of the X12/005010X223A2 Health Care Claim: Institutional (837). It was adopted as a rule pursuant to Minnesota Statutes, section 62J.61 (https://www.revisor.mn.gov/statutes/cite/62J.61).

1.1 How to obtain a copy of this document

This document is available at no charge on the Minnesota Department of Health Minnesota Uniform Companion Guides webpage (https://www.health.state.mn.us/facilities/ehealth/auc/guides/index.html).

1.2 Applicable statutes and requirements

Minnesota Statutes, section 62J.536 (https://www.revisor.mn.gov/statutes/cite/62J.536) requires health care providers (https://www.revisor.mn.gov/statutes/cite/62J.03), group purchasers (payers) (https://www.revisor.mn.gov/statutes/cite/62J.03), and health care clearinghouses (https://www.revisor.mn.gov/statutes/cite/62J.51) to exchange certain health care business (administrative) transactions electronically. These exchanges must comply with the specifications of a single uniform "companion guide" adopted into rule by the Commissioner of Health in consultation with a large, voluntary external stakeholder advisory organization, the Minnesota Administrative Uniformity Committee (AUC) (https://www.health.state.mn.us/facilities/ehealth/auc/index.html). The state's companion guide rules are adopted pursuant to the process described in Minnesota Statutes, section 62J.61 (https://www.revisor.mn.gov/statutes/cite/62J.61). Other state statutes also reference MS §62J.536.

Note: Compliance with a companion guide rule adopted pursuant to MS §62J.536 does not mean that a health care claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

Additional information regarding Minnesota's requirements for the standard, electronic exchange of health care administrative transactions, including relevant rules, examples of entities that are subject to MS §62J.536, Frequently Asked Questions (FAQs) and other

information, is available on the MDH Administrative Simplification Act webpage (https://www.health.state.mn.us/facilities/ehealth/asa/index.html).

1.3 Further description and use of this document

This document:

- Describes the proposed data content and other transaction specific information to be used with the X12/005010X223A2 Health Care Claim: Institutional (837), hereinafter referred to as 005010X223A2, by entities subject to Minnesota Statutes, section 62J.536.
- Supplements, but does not otherwise modify the 005010X223A2 in a manner that will make its implementation by users to be out of compliance.
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related X12N and retail pharmacy specifications (X12 and NCPDP implementation specifications).
- Was prepared by the Minnesota Department of Health (MDH) (https://www.health.state.mn.us) with the assistance of the Minnesota Administrative Uniformity Committee (AUC) (https://www.health.state.mn.us/facilities/ehealth/auc/index.html).

1.4 Reference for this document

The X12 reference [(the X12 "Implementation Guide - Type 3 (TR3)" technical report] for this document is the X12/005010X223A2 Health Care Claim: Institutional (837) (Copyright © 2008, Data Interchange Standards Association on behalf of X12. Format © 2008, X12. All Rights Reserved), hereinafter described below as 005010X223A2. Learn more about licensing X12's work at https://x12.org/licensing.

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1.5 Best practices for the implementation of electronic health care transactions

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. While use of the best practices is not required per statute, their use is strongly encouraged to aid in meeting the state's health care administrative data exchange requirements, and to provide the greatest benefits of health care administrative simplification. Please visit the AUC best practices webpage (https://www.health.state.mn.us/facilities/ehealth/auc/bestpractices/index.html) for more information about best practices for implementing electronic health care administrative transactions in Minnesota.

1.6 Contact for further information

Minnesota Department of Health
Division of Health Policy
Center for Health Information Policy and Transformation
Email: health.ASAguides@state.mn.us

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2 Transaction specific instructions and information to be used with the 005010X223A2

The remainder of this document, including Appendices A-D, provides transaction-specific information to be used in conjunction with the 005010X223A2.

2.1 Business terminology and related instructions

For purposes of this document, the following terms have the meaning given to them in this section.

2.1.1 Factoring Agent

Business models exist in the healthcare industry where services are performed by a provider, which are billed to an entity acting as a receivables Factoring Agent. The entity pays the provider directly. The Factoring Agent then bills the insurance company. In this case both the name/address of Pay-To are different than Billing Provider. In order to use the 005010X223A2 for this business situation, the Standards Development Organization X12 recommends that the Factoring Agent entity name, address, and identification be submitted as the Pay-To Plan in loop 2010AC. The notes and guidelines should be followed as if the Pay-To Plan entity was performing post payment recovery as described.

2.2 Provider Identifiers and National Provider Identifier (NPI) Assignments

If the provider is a health care provider as defined under federal standards, then the only identifier that is valid is the NPI with the exception of the billing loop. For the billing provider, a secondary identifier-- the Taxpayer Identification Number (TIN) -- is also required.

If the provider is not a health care provider as defined under federal standards the provider is known as an "atypical provider." Atypical providers do meet the Minnesota statutory definition of health care provider and therefore are subject to the requirements of Minnesota statutes, section 62J.536 and related rules. For atypical providers, the primary identifier is the TIN and a secondary identifier is allowable. The qualifier for the secondary identifier is "G2." The identifier associated with this qualifier is the specific payer assigned/required identifier. For related additional information, please see Table 3.1 in section "3 -- ASC X12N/005010X222A1 Health Care Claim: Professional (837) -- Transaction Specific Information" below.

2.3 Adjustments and Appeals

2.3.1 Definitions

- **Adjustment**

  Adjustment – Provider has additional data that should have been submitted on the original claim or has a need to correct data that was sent incorrectly on the original claim.

- **Appeal**

  Appeal – Provider is requesting a reconsideration of a previously adjudicated claim for which there is no additional data or corrected data to be submitted. Providers should contact the payer or the payer's website for further instructions regarding reconsiderations or appeals.

Examples of appeals include:

- Timely filing denial;
- Payer allowance;
- Incorrect benefit applied;
- Eligibility issues;
- Benefit Accumulation Errors; and
- Medical Policy/Medical Necessity

2.3.2 Process for submission of adjustments and appeals

2.3.2.1 Adjustment

Adjustment – Provider should submit an adjustment electronically using the appropriate value in CLM05-3 to indicate that this is a replacement claim. If the payer has assigned a payer number to the claim, it must be submitted in loop 2300, REF02, using qualifier F8 in REF01 (Note: the original payer-assigned claim number is not the property and casualty number). If additional information is required to support the adjustment based on payer business rules, the SV202-7, NTE segment, PWK segment, or Condition Codes should be used. See section 2.5 below regarding these segments for appropriate instructions.

2.3.2.2 Appeal

Appeal – Follow payer standard processes for requesting an appeal to a previously adjudicated claim. If a paper appeal process is utilized, then a standard, Best Practice Minnesota appeal form is available at the AUC Forms webpage (https://www.health.state.mn.us/facilities/ehealth/auc/forms/index.html). Additional documentation should be sent as required by the payer to support the appeal consideration; this documentation does not include resubmission of the claim.

2.4 Claim Frequency Type Code (CFTC) Values

Claim/Bill submissions are often original, first-time submissions with no follow-up submissions. In some cases, subsequent submissions directly related to a prior submission will be necessary. When subsequent submissions occur for legitimate business purposes, the normal processing flow may change.

Since a relationship between an original submission and subsequent submissions are necessary, the data requirements both for original and subsequent submissions must be specified.

For example, when a Replacement bill is submitted (CFTC 7), in order to meet the processing requirement to void the original and replace it with the re-submitted bill, common consistent data elements are required. To qualify as a Replacement, some data need to be different than the original.

If the bill is re-submitted with no changes from the original, and the claim was accepted by the payer, it would be considered a Duplicate instead of a Replacement.

If the bill is resubmitted with no changes from the original and the original was not accepted by the payer, the resubmitted bill will be considered an original claim. These distinctions are important to allow for proper handling of the submission.

Refer to the current National Uniform Billing Committee (NUBC) code list for allowed values and usage descriptions. Late charge billings (xx5) are not considered for processing in Minnesota; replacement (xx7) must be utilized. Should a covered provider submit a late charge bill using (xx5), the adjudication rules of the payer may result in denial of the claim as it should not have been sent. Both the sender and receiver must understand how each code value should be interpreted and what processing requirements need to be applied.

In conjunction with the CFTC code values, Condition Codes may be submitted that will impact processing and handling requirements.

2.5 Claim Attachments and Notes

2.5.1 NTE segment

- Use the NTE segment at the claim or line level to provide free-form text with additional information.
  - The NTE segment must not be used to report data elements that are codified or may be codified within this transaction.
  - If reporting a simple description of the service is required, such as when a non-specific code is being reported, the SV202-7 in the 2400 loop must be used.
- Do not exceed the usage available in the 005010X223A2.
- Be succinct and abbreviate when possible. Do not repeat code descriptions or unnecessary information.

2.5.2 PWK segment

If the number of characters for the NTE or SV202-7 will exceed available characters, or a hard copy document is sent, use only the PWK segment at the claim level.

When populating the PWK segment, the following guidelines must be followed:

- PWK01 - The qualifier value of 'OZ' should only be used if none of the other values apply. The most specific qualifier value must be utilized.
- PWK06 - Billing providers must use a unique number for this field for each individual attachment on the claim, as well as a unique number across all claims requiring attachments. This unique number identifies a specific attachment within the billing provider's system. This unique number is the key that associates the attachment to the claim. The number must be sent in PWK06 of the claim and with the attachment. The provider must not use the same number on any other claim in their system to identify different attachments.

2.5.3 Claim attachments for workers' compensation medical claims

NOTE: Regarding claim attachments for workers' compensation medical claims only -- Minnesota Statutes, section 176.135, Subd. 7a (https://www.revisor.mn.gov/statutes/cite/176.135) requires that:

- "health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the ASC X12N 5010 version of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter")," …; and
- "workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the ASC X12N 5010 version of the ASC X12 electronic acknowledgment for the attachment transaction."

3 ASC X12N/005010X223A2 Health Care Claim: Institutional (837) -- Transaction Specific Information

The table below summarizes transaction-specific information to be used in conjunction with the 005010X223A2 and any other applicable information and specifications noted in section 1.3. It includes a row for each segment for which there is additional information over and above the information in the 005010X223A2 and shows the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

Note: The designation "N/A" in the table below means that the "Value Definition and Notes" applies to the segment rather than a particular data element. Please also see section 1.3 above.

Table 3.1 TRANSACTION-SPECIFIC INFORMATION TO BE USED IN CONJUNCTION WITH THE 005010X223A2

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2000B SUBSCRIBER HIERARCHICAL EVEL	SBR Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2010BA SUBSCRIBER NAME	NM1 Subscriber Name	NM103 Name Last or Organization Name	For Workers' Compensation this is the employer name. For Property & Casualty this may be a non-person.
2010BA SUBSCRIBER NAME	DMG Subscriber Demographic Information	DMG02 Date Time Period	Services to unborn children should be billed under the mother as the patient
2010BB PAYER NAME	REF Billing Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2010CA PATIENT NAME	DMG Patient Demographic Information	DMG02 Date Time Period	Services to unborn children should be billed under the mother as the patient.
2300 CLAIM INFORMATION	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 2.4 of this document for definition.
2300 CLAIM INFORMATION	CLM Claim Information	CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
2300 CLAIM INFORMATION	PWK Claim Supplemental Information	N/A	See front matter section 2.5 of this document for definition.
2300 CLAIM INFORMATION	PWK Claim Supplemental Information	PWK02 Attachment Transmission Code	Use of AA value may result in a delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
2300 CLAIM INFORMATION	REF Payer Claim Control Number	N/A	If the original payer assigned claim number is obtained from the 835, it corresponds to CLP07.
2300 CLAIM INFORMATION	NTE Claim Note	N/A	See front matter section 2.5 of this document for definition.
2300 CLAIM INFORMATION	NTE Billing Note	N/A	See front matter section 2.5 of this document for definition.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2300 CLAIM INFORMATION	CRC EPSDT Referral	N/A	Required for Medicaid Programs when service is rendered under the Minnesota Child and Teen Checkup Programs.
2310D RENDERING PROVIDER NAME	REF Rendering Provider Secondary Identification	N/A	See front matter section 2.2 of this document for usage
2310D RENDERING PROVIDER NAME	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310E SERVICE FACILITY LOCATION NAME	REF Service Facility Location Secondary Identification	N/A	See front matter section 2.2 of this document for usage
2310E SERVICE FACILITY LOCATION NAME	REF Service Facility Location Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310F REFERRING PROVIDER NAME	REF Referring Provider Secondary Identification	N/A	See front matter section 2.2 of this document for usage
2310F	REF Referring Provider	REF01 Reference Identification Qualifier	Use G2 for atypical provider.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
REFERRING PROVIDER NAME	Secondary Identification		
2320 OTHER SUBSCRIBER INFORMATION	SBR Other Subscriber Information	N/A	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2330B OTHER PAYER NAME	NM1 Other Payer Name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2330B loop must be unique within the claim.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV202-7 Description	See front matter section 2.5 of this document for additional instructions.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV204 Unit or Basis for Measurement Code	See Appendix A for coding measurements.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV205 Quantity	Zero “0" is an acceptable value only if defined as appropriate pursuant to NUBC rules.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV207 Monetary Amount	This amount cannot exceed the service line charge amount.
2400 SERVICE LINE NUMBER	DTP Date – Service Date	DTP03 Date Time Period	Must be greater than or equal to patient's date of birth. If DTP02 is RD8, then the 'to' date must be equal to or greater than the 'from' date.
2400 SERVICE LINE NUMBER	AMT Facility Tax Amount	N/A	See Appendix C for details on reporting MNCare Tax.

List of Appendices

- **Appendix A: Medical Code Set -- Supplemental Information for Minnesota Uniform Companion Guides**

  Appendix A lists instructions and related information for the selection and use of medical codes from HIPAA code sets.

- **Appendix B: K3 Segment Usage Instructions**

  Appendix B provides instructions for the use of the K3 segment for reporting state of jurisdiction.

- **Appendix C: Reporting MNCare Tax**

  Appendix C provides brief instructions for reporting the MinnesotaCare (MNCare) Tax

- **Appendix D: Required Reporting of National Drug Codes (NDC)**

  Appendix D provides instructions and examples for reporting National Drug Codes (NDC)

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Appendix A: Code Set Supplemental Information for Minnesota Uniform Companion Guides

A.1 Purpose and Scope

This Appendix provides coding information and instructions that must be followed to meet requirements for efficient, effective exchanges of the 837I transaction pursuant to Minnesota Statutes, Section 62J.536 (https://www.revisor.mn.gov/statutes/cite/62J.536) and this Minnesota Uniform Companion Guide (MUCG).

The appendix was developed in consultation with the Minnesota Administrative Uniformity Committee (AUC) (https://www.health.state.mn.us/facilities/ehealth/auc/index.html) and its Medical Code Technical Advisory Group (TAG) (https://www.health.state.mn.us/facilities/ehealth/auc/tags/mct/index.html) to address needs, priorities, and improvement opportunities identified by the AUC and the broader health care community.

A.1.1 Limits to scope

This appendix does not address or govern:

- the services or benefits that are eligible for payment under a contract, insurance policy, or law; and
- payment for health care services under a contract, insurance policy, or law.

A.2 Relationship to state and federal requirements

MS §62J.536 requires that the MUCG must specify "uniform billing and coding standards." The statute cites federal law, 45 CFR 162[1] (federal HIPAA Administrative Data Standards and Related Requirements), as well as the Medicare program as the sources for uniform billing and coding, and provides that the Commissioner of Health may adopt modifications from Medicare after consultation with the AUC.

[1] As noted in the body of this document, this MUCG (including all appendices) "*Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162 ….*"

As a result, it is important to note that "*Covered entities that create and process administrative transactions must implement the standard codes according to the implementation specifications adopted for each coding system and each transaction. Those that receive standard electronic administrative transactions must be able to receive and process all standard codes irrespective of local policies regarding reimbursement for certain conditions or procedures, coverage policies, or need for certain types of information that are part of a standard transaction*." (Health Insurance Reform: Standards for Electronic Transactions. Affected Entities. HHS/ASPE 2000. https://aspe.hhs.gov/reports/health-insurance-reform-standards-electronic-transactions.)

Consistent with the 45 CFR 162 HIPAA Requirements, all covered entities are required to submit or receive codes that are:

- valid on the date of service for medical code sets; and
- valid at the time the transaction was created and submitted for non-medical code sets.

A.3 General coding instructions and information

A.3.1 Selection of codes

Select codes that most accurately identify the procedure/service/product provided.

A.3.2 Units

The number of units is the number of services performed and reported per service line item as defined in the code description unless instructed differently in this appendix.

The following are unit clarifications/exceptions:

- Report one unit for all services without a measure in the description.
- Report the number of units as the number of services performed for services with a measure in the description. For example, one unit equals:
  - "per vertebral body;"
  - "each 30 minutes;"
  - "each specimen;"
  - "15 or more lesions;"
  - "initial."
- Follow all related American Medical Association (AMA) guidelines in Current Procedural Terminology (CPT).[2]
  - For example, "unit of service is the specimen" for pathology codes.
  - Definition of "specimen": "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."
- In the case of time as part of the code definition, follow HCPCS/CPT guidelines to determine the appropriate unit(s) of time to report. Per the guidelines, more than half the time of a time-based code must be spent performing the service in order to report the code. If the time spent results in more than one- and one-half times the defined value of the code, and no additional time increment code exists, round up to the next whole number.

[2] Current Procedural Terminology (CPT®), copyright 2020 American Medical Association

- For physical, occupational, and speech language pathology services (PT/OT/SLP) follow HCPCS/CPT guidelines for determining rounding time.
- Anesthesia codes 00100-01999: 1 unit = 1 minute.
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

A.4 Specific coding instructions

This section provides instructions to be followed regarding particular priority coding topics and questions that have been reviewed and addressed by the AUC.

A.4.1 Selected topics identified by the Minnesota Administrative Uniformity Committee for which coding instructions differ from Medicare coding instructions

Topic/Issue	Setting/situation/ scenario	Instructions
Rounding rules	Outpatient Rehabilitation and CORF/OPT Services	Follow HCPCS/CPT rounding guidelines
Oxygen codes		Oxygen codes are used as defined. When appropriate to report contents, Minnesota providers may report E or S oxygen content codes as definition allows.
Licensed birth centers		• "Birth center" is defined in state law and means a facility licensed for the primary purpose of performing low-risk deliveries that is not a hospital or licensed as part of a hospital and where births are planned to occur away from the mother's usual residence following a low-risk pregnancy. See Minnesota Statutes, Sections 144.615 and 144.651 for more information. • Birth centers provide outpatient services. (cont.)

Topic/Issue	Setting/situation/ scenario	Instructions
		Low-risk deliveries, and services related to the delivery, performed in a free-standing birth center should be reported on an 837I transaction including the following data: • *Type of Bill*: 084x – Special Facility – Freestanding Birthing Center (NOTE: TOB 084x is designated as "outpatient"by the National Uniform Billing Committee. HCPCS codes are required with submitted revenue codes.) • *Revenue Code*: 0724 – Birthing Center • *HCPCS Code*: ○ Use appropriate HCPCS code for delivery: ○ Use S4005 when labor does not result in delivery. • Professional services related to the mother's and newborn's cares are reported on the 837P only.

Note:

The AUC Medical Code Technical Advisory Group (TAG) provides a variety of information and resources not incorporated as part of this rule, but which are valuable and should be used for efficient, accurate medical coding and in meeting a broader statewide goal of greater health care administrative uniformity and consistency to reduce health care administrative costs and burdens. This additional information is available on the on the AUC Coding Recommendations webpage (https://www.health.state.mn.us/facilities/ehealth/auc/coding/index.html).

Appendix B: K3 Segment Usage Instructions

The K3 segment in the 2300 and 2400 Loops is used to meet regulatory requirements when the X12N Committee has determined that there is no alternative solution within the current structure of the 005010X223A2. The situations noted here have been approved by the X12N Committee and will be considered as a business need in development of future versions of this transaction.

If multiple K3 needs exist on a single claim at the same loop level, it is recommended that separate K3 segments be sent.

B.1 State of Jurisdiction

In workers' compensation, insurance carriers have indicated a need to determine jurisdiction in certain situations. For this workers' compensation implementation, providers may populate this field with the appropriate state code.

LU is the qualifier to indicate this value and should be followed by the two-character state code.

Report at 2300 Loop only.

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Appendix C: Reporting MNCare Tax

NOTE: Instructions for MNCare Tax billing only apply if the provider bills the group purchaser for MNCare Tax. Some providers do not bill the group purchaser for MNCare Tax. This document DOES NOT require them to do so but if they do identify the tax it must be done as follows. Some group purchasers may not reimburse MNCare Tax unless it is identified in the AMT.

- MNCare Tax must be reported as part of the line-item charge and reported in the corresponding AMT tax segment on the lines.

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Appendix D: Required Reporting of National Drug Codes (NDC)

- Bill physician-administered drugs to a patient as part of a clinic or other outpatient visit using the appropriate Healthcare Common Procedure Coding System (HCPCS) code(s). If the HCPCS code is associated with a physician-administered drug for which there is a National Drug Code (NDC), the NDC must be reported on the claim. **Note: This NDC reporting requirement does not apply to inpatient claims**.
- For injections that involve multiple national drug codes (NDCs), bill the initial line with the HCPC code, units and NDC with modifier KP (first drug of a multiple drug unit dose formulation). Bill the second, and any subsequent line item(s) of the same HCPC code with modifier KQ (second or subsequent drug of a multiple drug unit dose formulation). If billing the same HCPC code on more than two lines, the KQ modifier and an additional modifier are needed on each subsequent line.
- Multiple service lines are necessary to report a compound drug. One NDC is allowed per line. Report the HCPC code as a separate line for each associated NDC.

D.1 Additional Information and Examples

The following information and examples below are excerpted from the Workgroup for Electronic Data Interchange (WEDI) "NDC Reporting White Paper" (https://www.wedi.org/2014/10/28/ndc-reporting-requirements-in-health-care-claims/).

D.1.1 NDC Format

NDCs must be reported using the "5-4-2 format" shown below. If a drug's NDC does not follow this format, then a zero must be inserted at the beginning of the appropriate section of the number, as shown in the table below, in order to create the 5-4-2 format. The following table shows where to insert the zeros. Note: NDCs are reported in the 837 transaction without the hyphens shown below.

NDC	11 digits ("5-4-2" format)	Examples
4-4-2 XXXX-XXXX-XX	**0**XXXX-XXXX-XX	1234-5678-91 = **0**1234-5678-91
5-3-2 XXXXX-XXX-XX	XXXXX-**0**XXX-XX	12345-678-91 = 12345-**0**678-91
5-4-1 XXXXX-XXXX-X	XXXXX-XXXX-**0**X	12345-6789-1 = 12345-6789-**0**1

D.1.2 Reporting NDC in Institutional Claims (Outpatient claims)

D.1.2.1 Data Requirements

SV2 is where the drug procedure code is reported. Qualifier "HC" in SV202-1 indicates that the procedure code is a HCPCS or Current Procedural Terminology (CPT®) code. The actual procedure code is reported in SV202-2. SV204 is the qualifier for the procedure units and SV205 is where the procedure units are reported. All of the SV2 data elements for reporting drug procedure code information are required.

The Drug Information (LIN) segment is situational and is required to be reported when federal or state regulations mandate that the drugs or biologics be reported with NDC. Providers or submitters may also report NDC when it is known to support the claim and facilitate the adjudication. LIN02 is the qualifier for reporting the NDC number, which is code value N4. LIN03 is where the NDC number is reported. Both of these data elements are required when reporting the segment.

The CTP segment is required to be reported when reporting the NDC in the LIN segment. Both CTP04 (NDC unit count) and CTP05 (unit of measure) are required.

D.1.2.2 Example 1

A patient is given an injection in the physician's office of 500 mg Ampicillin sodium, which is reconstituted from a 500 mg vial of powder.

Therefore:

- HCPCS: J0290 (Injection, Ampicillin sodium, 500 mg)
- NDC: 00781-9407-78
- HCPCS unit: 1
- NDC quantity: 1
- Unit of measure: UN

See additional detail in the following table.

Loop	Segment	Data Element	Data Reported
2400	SV2	SV202-1	HC
2400	SV2	SV202-2	J0290
2400	SV2	SV204	UN
2400	SV2	SV205	1
2410	LIN	LIN02	N4
2410	LIN	LIN03	00781940778
2410	CTP	CTP04	1
2410	CTP	CTP05-1	UN

See WEDI "NDC Reporting White Paper" (https://www.wedi.org/2014/10/28/ndc-reporting-requirements-in-health-care-claims/) for more examples.