Priority Health	BILLING POLICY No. 175
340B Drug Payment Policy	
Date of origin: December 2025	**Review dates: NA**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

The 340B Drug Pricing Program is a federal initiative that reduces the cost of outpatient prescription drugs for eligible health care organizations and covered entities.

Definitions

340B Covered Entity (CE) – A facility listed in the HRSA Office of Pharmacy Affairs Information System (OPAIS) that qualifies to purchase drugs through the 340B Program.

340B Drug Discount Program (340B)- Section 340B of the Public Health Service (PHS) Act, enacted in 1992, requires drug manufacturers that participate in the Medicaid Drug Rebate Program to enter into a Pharmaceutical Pricing Agreement (PPA) with the Secretary of Health and Human Services.

Actual Acquisition Cost – The actual purchase prices for drug products from a specific manufacturer.

Care Management Organization (CMO)- Organizations, such as HAP CareSource, that are contracted by the Michigan Department of Health and Human Services to manage and coordinate services for Medicaid members.

Contract Pharmacy- A pharmacy contracted by a Covered Entity to dispense 340B medications purchased by that entity.

Current Procedural Terminology (CPT)- A medical code set developed and maintained by the American Medical Association for describing and billing medical, surgical, and diagnostic services.

Fee-for-Service (FFS)- Claims submitted directly to Michigan Medicaid for prescriptions and physician-administered drugs provided to fee-for-service (FFS) members.

Healthcare Common Procedure Coding System (HCPCS) – A standardized set of medical codes, maintained by the Centers for Medicare & Medicaid Services, used to identify and describe healthcare services, items, and procedures.

Health Resources and Services Administration (HRSA) – The primary federal agency that oversees and administers the 340B program.

National Council for Prescription Drug Programs (NCPDP)- The standards organization that establishes the format used to submit pharmacy claims to Pharmacy Benefit Managers (PBMs).

National Drug Code (NDC) – A drug product identified and reported using a unique three-segment number that serves as a universal identifier for that specific drug.

Pharmacy Benefit Manager (PBM) – The entity responsible for processing retail pharmacy and PBM benefit claims on behalf of HAP CareSource.

Provider Administered Drugs – Drugs administered directly to a patient by a healthcare provider.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Pharmacies Allowed to Bill 340B Claims:

A. Only Covered Entities listed on the HRSA Medicaid Exclusion File that have chosen to dispense 340B medications to Medicaid members are permitted to bill 340B claims.
B. Contract pharmacies within the HAP CareSource pharmacy network are authorized to bill for drugs purchased under the 340B program.

Retail Pharmacy (Point-of-Sale) 340B Claims:

A. Along with the NDC and other fields typically submitted to the PBM for payment, all 340B Covered Entities must identify 340B claims by entering Submission Clarification Code (SCC) 20 in field 420-DK of the NCPDP Telecommunication Standard D.0.
B. When submitting 340B claims, providers may choose—but are not required—to include Basis of Cost Determination Code 08. If providers elect to use this field, they must also enter their 340B acquisition cost in the Submitted Ingredient Cost field (409-D9).
C. For drugs not purchased at 340B rates, do not include any of the 340B identifiers mentioned above.

Provider Administered 340B Drug Claims:

A. In addition to the HCPCS/CPT code, NDC, and other fields consistently submitted for claims payment, 340B Covered Entities should submit the claim on a CMS 1500 or in the appropriate field in the electronic format using the Michigan Department of Health and Human Services modifier U6 and CMS modifiers for Outpatient Prospective Payment System (OPPS) drugs acquired under the 340B program. In addition, providers must report the actual acquisition cost (price paid) for 340B-purchased stock.

Auditing and Monitoring:

To ensure compliance with 340B billing requirements, HAP CareSource will monitor both 340B and non-340B claim submissions to identify potential 340B claims. If a claim appears to be 340B, we will notify the provider of the possible billing error and request validation and correction.

Place of service
This applies to outpatient places of service only.

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Coding specifics
Reimbursement depends on, but is not limited to, submitting the correct and applicable drug-related codes (HCPCS, CPT, NDC) along with the appropriate 340B claim fields, when applicable.

Resources
https://www.caresource.com/documents/medicaid-mi-policy-pharmacy-340b-drug-pricing-20250801.pdf

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to

these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
12/17/2025	Policy created