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 that are contracted by the Michigan Department of Health and Human Services to coordinate and manage 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 sent directly to Michigan Medicaid for prescriptions and physician-administered medications supplied to fee-for-service (FFS) members.

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

Health Resources and Services Administration (HRSA) – The lead federal agency responsible for overseeing and administering the 340B program.

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

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

Pharmacy Benefit Manager (PBM) – The entity responsible for processing retail pharmacy and PBM benefit claims.

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

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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 pharmacy network are authorized to bill for drugs purchased under the 340B program.

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

A. In addition to the NDC and other standard fields submitted to the PBM for payment, all 340B Covered Entities are required to flag 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 opt—but are not obligated—to include Basis of Cost Determination Code 08. If they choose to use this field, they must also report their 340B acquisition cost in the Submitted Ingredient Cost field (409-D9).
C. For medications not acquired at 340B pricing, exclude all 340B-related identifiers described above.

Provider Administered 340B Drug Claims:

Along with the HCPCS/CPT code, NDC, and other standard claim-payment fields, 340B Covered Entities should submit the claim on a CMS-1500—or in the appropriate electronic field—using the Michigan Department of Health and Human Services modifier U6 and the applicable CMS modifiers for OPPS drugs acquired under the 340B program. Providers must also report the actual acquisition cost (price paid) for any 340B-purchased stock.

Auditing and Monitoring:

To support compliance with 340B billing requirements, Priority Health will review both 340B and non-340B claim submissions to identify claims that may qualify as 340B. If a claim appears to be 340B, we will alert the provider of the potential billing error and request verification 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