PAYMENT AND REIMBURSEMENT POLICY

Title: PRP-20 340B Drug and Biological Discount Program (Modifiers JG and TB)

Category: Compliance

Effective Date: 06/22/2021

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy applies to all network and non-network providers, including but not limited to percent of charge contract providers. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Health Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but which are covered by the Health Plan to support covered benefits available through one of the Health Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

The Federal 340B Drug Pricing Program allows qualifying participants such as hospitals, specialty clinics and associated outpatient facilities that serve uninsured and low-income patients the option to purchase outpatient drugs from manufacturers at discounted rates. Eligible participants must obtain approval through the Office of Pharmacy Affairs (OPA) located within the Health Resources and Services Administration (HRSA). These qualified participants are also known in the program as, Covered Entities (CEs). Health Plan does not determine status of covered entities.

3.0 Coding and Billing:

The Health Plan follows Center for Medicare and Medicaid Services (CMS) 340B reporting requirements and expects CEs to bill related services accordingly. CEs are responsible for program participation status, knowing whether a 340B eligible drug was obtained under the 340B program, and for maintaining documentation.

1. Type of Bill.

   When billing for outpatient facility services the following type of bill should be selected with appropriate frequency (X):

   - 013X Hospital Outpatient.

2. National Drug Code (NDC):

   - NDC Codes must be reported with exact NDC from medication packaging.
   - NDC units must be reported.

3. Modifiers.

Must be applied to each line of a 340B acquired drug/biological. The application of 340B related modifier is also dependent on the provider/facility type, drug or biological CMS status indicator, and:

- JG Drug or biological acquired with 340B drug pricing program discount.
- TB Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes.

4. Drug Waste.

   Discarded drug amount must be billed on a separate claim line with JW modifier and the appropriate 340B modifier as well as any other applicable modifiers.

4.0 Documentation Requirements:

The medical record must reflect a complete and accurate summary of the services performed and billed. When submitting for reimbursement of procedures billed with other payment modifiers, documentation must support the application of those modifiers as well.

5.0 Verification of Compliance

Claims are subject to audit, prepayment and post payment, to validate compliance with the terms and conditions of this policy.

6.0 Terms & Definitions:

Covered Entity. A 340B covered entity is an entity described in section 340B(a) (4) of the "Public Health Service Act," 42 U.S.C. 256B (a) (4) and includes any pharmacy under contract with the entity to dispense drugs on behalf of the entity.

Medical Coding Modifier. Two characters (letter or number) appended to a CPT® or HCPCS Level II code. The modifier provides additional information about the medial procedure, service, or supply involved without changing the meaning of the code.

National Drug Code (NDC). Unique three segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug and Cosmetic Act. Generally located on the drug label or outer packaging.

CMS Status Indicator. Payment status indicator assigned to each HCPCS/CPT® service billed under OPPS. Indicates whether service is eligible for reimbursement and if packaging and discounting may apply. Status indicators for OPPS services are located on Addendum B. There are updated quarterly by CMS and applicable in accordance with date of service billed.

Type of Bill. Identifies the type of bill being submitted to a payer. Four-digit alphanumeric codes that specify different pieces of information on claim form UB-04 or form CMS -1450 and it reported in box 4 on line 1. First Digit = Leading zero. Second Digit = Type of facility. Third Digit = Type of care. Fourth Digit = Sequence of this bill in this episode of care, also referred to as a "frequency" code.

7.0 References, Citations & Resources:

Current edition of the American Medical Association (AMA) CPT®

Medicare- FFS Program Billing 340B Modifiers under the Hospital Outpatient Prospective Payment System (OPPS) FAQ

Health Plan PRP-11 Drugs and Biologicals

8.0 Revision History:

Original Effective Date: 06/22/2021

Next Review Date: 06/22/2022

Revision Date	Reason for Revision