RB.042.A NDC Billing Requirements for Medical Drugs

Original Implementation Date : 01/01/2026
Version [A] Date : 01/01/2026
Last Reviewed Date: 12/19/2025

PRODUCT VARIATIONS

This policy applies to Health Partners Plans Medicaid and Health Partners Plans CHIP product lines of business only.

Application of Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may vary based on individual contract.

POLICY STATEMENT

In accordance with Department of Human Services (DHS) directives and the CMS Medicaid Drug Rebate Program, Health Partners Plans requires the following for timely accurate payment and drug rebate eligibility:

1. Claims must be submitted using 837 Professional or 837 Institutional formats.

2. Drugs billed via HCPCS codes (e.g., J-codes or Q-codes) must also adhere to the following requirements:

    - Accurate National Drug Codes (NDCs) and corresponding HCPCS codes are included.
        - Drug quantity must be billed.
            - NDC quantity must be included on claims.
    - Appropriate 837 form unit of measurements (ML, UN, GR, F2, or ME).
    - The drug appears on a single claim line, with no other services.
    - Drug administration is billed separately.

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- Does not exceed the maximum daily dosage limits based on clinical guidelines, FDA, and Off-Label Compendia.
    - The plan will consider daily dosages over the maximum in very limited clinical scenarios.
- 340B-purchased drugs must include the UD modifier.
    - Exception: Any provider identified by the Department as a **340B-covered entity** must **dispense or administer non-340B purchased gene therapy products** unless otherwise approved to Medicaid beneficiaries.

DHS Special Guidance: CMS Cell and Gene Therapy (CGT) Access Model for Sickle Cell Disease

For applicable CGT therapies (e.g., **Lyfgenia**, **Casgevy**), the following conditions apply:

- Providers must be registered with the Center for International Blood & Marrow Transplant Research (CIBMTR) and engaged in a CMS-specified research study.
- These therapies are excluded from 340B purchasing under the model.

Health Partners Plans Medicaid and Health Partners Plans CHIP members receiving SCD gene therapies included in the model must continue to have access to their same SCD gene therapy providers until at least one year after receiving their gene therapy infusion.

POLICY GUIDELINES

Drugs must comply with Medicaid drug rebate eligibility requirements. Claims should accurately report NDC and J-codes and be properly structured to prevent delays or denials. Accurate claim submission is essential for timely payment and adherence to federal rebate program requirements.

Physicians and hospitals are required by CMS to use the JW modifier to identify discarded drugs and biologicals. The JW modifier is used to report a discarded/unused portion of a drug.

The JW modifier is reported on drug claims to report the amount of drug or biological that is discarded and eligible for payment. The JW modifier requirement applies to all separately payable drugs assigned status indicators G or K under CMS OPPS for which there is an unused or discarded amount. Eligible and participating 340B providers are not exempt from reporting the JW modifier. The JW modifier is not intended for use on claims for hospital inpatient admissions.

When a provider must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological, payment is made for the amount of drug or biological discarded as well as the dose administered, up to amount of the drug or biological as indicated on the vial or package label. The discarded drug amount should be billed on a separate line on the claim with the JW modifier. The administered amount should be billed on a separate line without the modifier.

Note: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

If a National Drug Code (NDC) is no longer in production, the plan will evaluate the drug for payment eligibility for up to 30 months following the product's discontinuation date.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

CPT Code	Description
N/A	

HCPCS Code	Description
N/A	

ICD-10 Codes	Description
N/A	

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DESCRIPTION OF SERVICES

N/A

DEFINITIONS

A **340B purchased drug** is an outpatient medication acquired by a covered entity through the federal **340B Drug Pricing Program** at the program's discounted 340B ceiling price. A 340B purchased drug must be dispensed or administered to an **eligible patient** of the covered entity and must comply with all 340B requirements, including prevention of diversion and duplicate discounts under Medicaid.

The **UD modifier** is a **HCPCS Level II modifier** used primarily by state Medicaid programs and certain payers to indicate medically necessary drug or item supplied under Medicaid rebate or state-specific coverage requirements.

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

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Summary	Version	Version Date
New policy.	A	01/01/2026

REFERENCES

1. MAB 202212201: 340B Drug Pricing Program – Dispensing 340B Purchased Drugs : https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2022122201.pdf

2. Health Resources & Services Administration (HRSA): https://www.hrsa.gov/opa

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