WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

518A PHYSICIAN ADMINISTERED DRUGS

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BACKGROUND

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) mandated major change in coverage and reimbursement for Medicaid-covered outpatient drugs. West Virginia Medicaid reimbursement is limited to drugs whose manufacturers have entered into and have in effect a rebate agreement with the Secretary, US Department of Health and Human Services.

POLICY

West Virginia Medicaid offers a comprehensive scope of drug coverage to Medicaid members, subject to medical necessity and appropriateness criteria, such as but not limited to the U.S. Foods and Drug Administration (FDA)-approved indication, dose limitations, and age restrictions; and prior authorization requirements, if applicable.

Medications that are not self-administered, i.e., physician- and facility-administered, are reimbursed utilizing the assigned Healthcare Common Procedure Coding System (HCPCS) code(s).

Per Federal Medicaid rules and regulations, only drugs produced by pharmaceutical manufacturers participating in the Federal drug rebate program are covered. In order to collect drug rebates as required by Federal Law, the National Drug Code (NDC) must be submitted when billing for covered medications. Claims submitted without the appropriate NDC will be denied. Providers are required to bill for the actual NDC that is administered. For drug codes requiring an NDC, coverage depends on the drug NDC status (rebate eligible, Non-DESI, non-termed, etc.) on the date of service. Refer to the HCPCS/Drug Code List on the BMS webpage for coverage and other information regarding physician and facility-administered drugs.

Administration for drugs billed with an HCPCS code is not reimbursed when administered as a result of an evaluation and management (E&M) service.

Physician-and facility-administered medications are reimbursed using the Centers for Medicare and Medicaid Services' (CMS) pricing file found at Medicare Part B Drug Average Sales Price. In the absence of a fee, pricing will reflect the methodology used for retail pharmacies.

Refer to *Chapter 518, Pharmacy Services*, for coverage, limitations, and policy information pertaining to self-administered drugs dispensed by participating pharmacies.

518A.1 INJECTIONS

Appropriate HCPCS codes are used to bill for the reimbursement of the medication injected or infused.

If there is not a specific HCPCS code for the medication, West Virginia Medicaid reimburses claims billed with J3490 only. These claims must be billed on a paper claim.

When billing with J3490, the following information may be required:

- Name of the drug
- The NDC

- Exact dosage administered
- Strength of the drug administered
- A cost invoice for the drug

518A.2 CHEMOTHERAPY

West Virginia Medicaid covers chemotherapy administration. This service includes refilling and maintenance of a portable or implantable pump, chemotherapy injection/infusion, and provision of the chemotherapy agent. The preparation of the chemotherapy agent is included in the payment for administration of the agent and, therefore, is not separately reimbursable. Chemotherapy drugs administered in the office are reimbursed using the appropriate HCPCS code. An office visit on the same date of service as the chemotherapy administration may be covered if it is for a separately identifiable service documented in the member's medical record. Refer to the HCPCS /Drug Code List on the BMS webpage for coverage and other information.

518A.3 PALIVIZUMAB/SYNAGIS®

Prior authorization through the Rational Drug Therapy Program (RDTP) is required for all orders for Palivizumab (Synagis®). The RDTP may be reached at 1-800-847-3859 or faxed at 1-800-531-7787. The mailing address is:

Rational Drug Therapy Program
West Virginia University, School of Pharmacy
Robert C. Byrd Health Sciences Center
PO Box 9511
Morgantown, West Virginia 26506-9511

Refer to the BMS website for Synagis® coverage criteria.

518A.4 BOTULINUM TOXIN

West Virginia Medicaid reimburses for botulinum toxin using the applicable HCPCS code when used for approved indications, and requires prior authorization. Refer to the BMS website for Botulinum Toxin coverage criteria.

518A.5 PHYSICIAN ADMINISTERED DRUGS

In cases where a Physician Administered Drug (PAD) becomes available in a self-administered form, the **prescriber** must select the site of administration and dosage form of the drug to be used. Any prescriber who believes he/she has been directed or coerced by an MCO in determining site of administration and dosage form must report the issue to the BMS Director of Pharmacy Services. Please note that this policy does not alter any existing prior authorization criteria or quantity limits.

518A.6 ACQUISITION AND BILLING OF 340B DRUGS

Section 340B of the Public Health Services Act of 1992 provides access to deeply discounted drugs for certain provider entities who meet the qualifications for participation in the 340B Program, as established

by the Health Resources and Services Administration (HRSA). This program allows participating providers, including eligible hospitals, to offer medications to their patients at deeply discounted prices.

Per Federal law, drugs with discounts generated from participation in the 340B Program are not eligible for Medicaid Federal drug rebates and drug claims from these provider entities must be exempted from Medicaid drug rebate invoicing. All provider entities must submit their **Actual Acquisition Costs (AAC)** when billing for drugs purchased under the 340B Program when billing claims to the West Virginia Medicaid Program. Submission of drug purchase invoices may be required for audit purposes.

All claims billed to West Virginia Medicaid for drugs purchased at the 340B price must be identified with the **modifier UD.** This modifier identifies claims to be removed from the rebate file which avoids billing manufacturers for duplicate discounts. As per 42 USC 256b(a)(5), a manufacturer may audit and seek recoupment of the duplicate discount from covered entities found to be non-compliant with 340B requirements. In these instances, the rebate is due to the State and the duplicate discount will be recouped from the non-compliant covered entities.

All covered entities must ensure that the drugs purchased through this program are used for **outpatients only**. This program does not apply to drugs supplied to inpatients. Covered entities are prohibited from transferring or reselling 340B purchased drugs to individuals who are not patients of the facility. The entity is responsible for implementing systems to ensure compliance and maintain documentation of these practices.

All entities must apply to HRSA for participation in the 340B program. At the time of application, providers must determine whether they will use 340B drugs for their Medicaid patients (carve-in) or whether they will purchase drugs for their Medicaid patients through other sources (carve-out).

Entities that carve-in are required to inform HRSA of their decision that they will purchase and dispense 340B drugs for their Medicaid patients by providing their Medicaid provider number/National Provider Identifier (NPI) at the time they enroll in the 340B program.

The HRSA maintains a current listing of eligible providers on the HRSA website. It is the providers' responsibility to verify that the HRSA listing of their participation is current and accurate.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter.

REFERENCES

West Virginia State Plan references reimbursement for physician and facility-administered drugs at 4.19-B(12)(b).

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	518.1 Physician Administered Drugs	October 1, 2018
Entire Chapter	518A Physician Administered Drugs	July 20, 2018
Entire Chapter	Changes were made to: 518A.5 Physician Administered Drugs 518A.6 Acquisition and Billing of 340B Drugs	TBD