PHYSICIAN ADMINISTERED DRUGS

PURPOSE

North Dakota Medicaid covers most drugs and biologics administered in a physician's office or other licensed practitioner's (OLP) office or outpatient setting that cannot be self-administered. Physicians and other licensed practitioners are responsible for ensuring that the treatment is appropriate based on FDA-approved indications, compendia-supported indications, and standards of practice. To be covered, drugs and biologics must represent an expense to the physician, OLP, or legal entity billing Medicaid. Injections by a physician or OLP of medications that can be self-administered are not covered unless justified by the member's condition.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as locum tenens providers must enroll in ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

Physician administered drug services can be ordered and provided by the following enrolled providers as allowed by the scope of their licensure:

- Physicians
- Physician Assistants
- Advanced Practice Registered Nurses;
    - Nurse Practitioner
    - Clinical Nurse Specialist
    - Certified Nurse Midwife
    - Certified registered nurse anesthetists

ELIGIBILE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the Automated Voice Response System by dialing 1.877.328.7098.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies detail basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

ONCOLOGY DRUG TRIALS

ND Medicaid will pay for chemotherapy when administered via a protocol that is registered with one of the main regional oncology research organizations provided the FDA has approved each medication in the regimen. FDA approval can be for any indication.

If the member has a primary payer, the primary payer must be billed before requesting payment from ND Medicaid. If the primary payer denies coverage of the product because they consider the use "experimental", ND Medicaid will also deny the claim.

SERVICE AUTHORIZATION REQUIREMENTS

Please use the Procedure Look-up Tool to identify physician administered drugs that require service authorization.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

Drugs that are not included in the Medicaid Drug Rebate Program are non-covered.

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for

at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

CLAIM FORM

Physician administered drugs can be billed using the CMS 1500 / 887P for drugs administered in the clinic setting or the UB04/ 837I for drugs administered in a facility setting. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

CLAIM REQUIREMENTS

For physician administered drugs, in addition to the HCPCS drug code, providers may separately bill the applicable administration procedures, including intramuscular or subcutaneous injections and intravenous or subcutaneous infusion.

Providers must ensure that the units of drugs or biologics administered to patients are accurately reported regarding the dosage/units specified in the complete HCPCS code descriptor. Before submitting claims, providers should review the HCPCS code long descriptor. The provider should not bill units based on how the drug is packaged, priced, stored, or stocked. The following are examples of how to bill units:

- HCPCS drug descriptor is 10 mg. 700mg of the drug is administered to the member. The units billed are 70.
- HCPCS drug descriptor is 5 mcg. 5 mcg of the drug is administered to the member. The units billed are 1.
- HCPCS drug descriptor is 25 mg. 250 mg of the drug is administered to the member. The units billed are 10.

PHARMACY ACQUIRED DRUGS

Drugs acquired directly from the pharmacy for administration in the clinic should be reported on the claim at zero dollars or a nominal amount of $0.01 if required by the provider's billing system.

DISCARDED PORTION OF ADMINISTERED DRUGS

When a provider must discard the remainder of a single-use vial or other single-use package after administering a dose or quantity of the drug or biological, the provider must bill the amount of the unused and discarded drug on a separate claim line using the JW modifier. Providers are expected to use the package size that minimizes the amount of waste billed to North Dakota Medicaid. For example, if a patient needs 50 mg of a drug and the product comes in 50 and 100 mg vials, providers should use the 50 mg vial. Reimbursement will be made for the discarded amount of a single-use dosage drug or biological product that is discarded and the amount administered to the member up to the amount indicated on the vial or package label that is necessary for the member's condition. The discarded drugs or biologics are not administered to another patient.

NATIONAL DRUG CODE (NDC)

Physician administered drugs must be billed with a HCPCS code and an 11-character NDC with no hyphens or spaces. The Federal Deficit Reduction Act of 2005 (DRA) requires Medicaid state agencies to collect rebates from participating drug manufacturers for physician-administered or dispensed drugs. An NDC is required as it allows the state to identify which manufacturer should be billed for rebates. The NDC is found on the drug container, such as a vial, bottle, or tube. The NDC submitted on the claim must be the actual NDC number on the package or container from which the medication was administered. The NDC must be entered in Field 24D of the CMS 1500 or the 2410 Loop, LIN 03 field/element of the HIPAA 837 Professional Electronic form.

340B DRUGS

The 340B Program requires drug manufacturers participating in Medicaid to provide outpatient drugs to covered entities at significantly reduced prices. To participate in the 340B Program, covered entities must register and be enrolled with the 340B program and comply with all 340B Program requirements administered by HRSA. Any drugs billed to ND Medicaid that were or acquired through a 340B contract or agreement must be excluded from the Medicaid drug rebate invoicing process to avoid duplicative discounts. Therefore, any drug acquired through a 340B contract or agreement must be identified on the claim line with one of the following modifiers:

- **UD** Medicaid level of care 13, as defined by each state - 340B acquired drug
- **JG** Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes
- **TB** Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes for select entities

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

RELATED POLICIES

- Physician Services
- Provider Requirements
- Pharmacy Medical Billing Provider Manual

CONTACT

Medical Services
600 East Boulevard Ave
Bismarck, ND 58505-0250
Phone: (701) 328-2310
Email: dhsmedicalservices@nd.gov
-OR-
Jennifer Sanders, CPC, Business Analyst, jasanders@nd.gov

POLICY UPDATES

April 2025

Section	Summary
	Format changes and clarifications added throughout

May 2025

Section	Summary
Covered Services	Oncology drug trials section added

June 2025

Section	Summary
340B	Language was added to clarify that drugs acquired through 340B must be excluded from the Medicaid drug rebate invoicing process to avoid duplicate discounts.