REIMBURSEMENT POLICY STATEMENT
NEVADA MEDICAID

Policy Name		Policy Number	Effective Date
340B Drug Pricing		PY-PHARM-16972	01/01/2026
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding, and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification, and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. Subject

340B Drug Pricing

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility. It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS/ICD-10 code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

The 340B Drug Pricing Program is a federal program, which limits the cost of covered outpatient drugs to eligible health care organizations and covered entities. The purpose of the program was to enable covered entities "to stretch scarce federal resources as far as possible, reach more eligible patients and provide more comprehensive services." This policy describes the claim submission requirements for outpatient pharmacy and provider administered drugs.

C. Definitions

- **340B Covered Entity (CE)** – A facility that is eligible to purchase drugs through the 340B Program and appears on the HRSA Office of Pharmacy Affairs Information System (OPAIS).
- **340B Drug Discount Program (340B)** – Section 340B of the Public Health Service (PHS) Act (1992) that requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services.
- **Actual Acquisition Cost (AAC)** – The actual prices paid to acquire drug products sold by a specific manufacturer.
- **Managed Care Organization (MCO)** – Organizations, such as CareSource, contracted by the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) to coordinate services for Nevada Medicaid members.
- **Contract Pharmacy** – A pharmacy contracted with a Covered Entity to dispense medications purchased by the Covered Entity.
- **Current Procedural Terminology (CPT)** – A medical code set maintained by the American Medical Association to describe and bill for medical, surgical, and diagnostic services.
- **Fee-for-Service (FFS)** – Claims billed directly to Nevada Medicaid for prescriptions and physician administered drugs provided to FFS members.

- **Healthcare Common Procedure Coding System (HCPCS)** – A standardized set of medical codes maintained by the Centers for Medicare and Medicaid Services (CMS) used to describe healthcare services, items, and procedures.

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

- **National Council for Prescription Drug Programs (NCPDP)** – The standards organization that creates the standard format through which pharmacy claims are submitted to a Pharmacy Benefit Manager (PBM).

- **National Drug Code (NDC)** – A drug product that is identified and reported using a unique, three-segment number, which serves as a universal product identifier for the specific drug.

- **Pharmacy Benefit Manager (PBM)** – The entity that processes retail pharmacy or PBM benefit claims for CareSource.

- **Provider Administered Drugs (PAD)** – Drugs administered directly by a health care provider to a patient.

D. Policy

I. Pharmacies Allowed to Bill 340B Claims

A. Only Covered Entities that elected to dispense 340B medications to Medicaid members on the HRSA Medicaid Exclusion File may bill 340B claims.

B. Contract pharmacies are **not** permitted to bill for 340B purchased drugs.

II. Retail Pharmacy (Point-of-Sale) 340B Claims

A. In addition to the NDC and other fields consistently submitted to the PBM for payment, all 340B Covered Entities must identify 340B claims by entering **both** of the following codes in the NCPDP Telecommunication Standard D.0 fields as listed below:

- Field 420-DK: Submission Clarification Code (SCC): a value of 20, **AND**

- Field 423-DN: Basis of Cost Determination: a value of 08

B. Providers electing to identify 340B claims using these field can also submit their ingredient cost in Field 409-D9: Submitted Ingredient Cost. The submitted ingredient costs entered in the claim must be the 340B AAC.

C. For drugs not purchased at 340B rates, do not include any of the 340B identifiers noted above.

III. Provider Administered 340B Drug Claims

A. In addition to the HCPCS/CPT code, NDC, and other fields consistently submitted for claims payment, 340B Covered Entities should submit the claim on a CMS 1500 or UB-04 claim form, or in the appropriate field in the electronic format using one of the CMS procedure modifiers, TB or UD, for 340B acquired drugs or biologicals.

B. Additionally, providers are required to submit a valid NDC number on all PAD claims and encounters.

IV. Auditing and Monitoring

A. To ensure compliance with 340B billing requirements, CareSource will monitor both 340B and non-340B claim submissions to identify potential 340B claims. Should we identify a claim we believe is 340B, we will inform the provider of the potential billing error and ask for validation, as well as correction.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting the appropriate and applicable drug-related codes (HCPCS, CPT, NDC) along with appropriate 340B claim fields.

F. Related Policies/Rules

Nevada Revised Statutes (NRS) 687B.805 requires the following regarding health carrier contracts related to the 340B Program.

1. A health carrier shall not:

(a) Discriminate against a covered entity, a contract pharmacy or a 340B drug in the amount of reimbursement for any item or service or the procedures for obtaining such reimbursement;

(b) Assess any fee, chargeback, clawback or adjustment against a covered entity or contract pharmacy on the basis that the covered entity or contract pharmacy dispenses a 340B drug or otherwise limit the ability of a covered entity or contract pharmacy to receive the full benefit of purchasing the 340B drug at or below the ceiling price, as calculated pursuant to 42 U.S.C. § 256b(a)(1);

(c) Exclude a covered entity or contract pharmacy from any network because the covered entity or contract pharmacy dispenses a 340B drug;

(d) Restrict the ability of a person to receive a 340B drug, including, without limitation, by imposing a copayment, coinsurance, deductible or other cost-sharing obligation on the drug that is different from a similar drug on the basis that the drug is a 340B drug;

(e) Restrict the methods by which a covered entity or contract pharmacy may dispense or deliver a 340B drug or the entity through which a covered entity may dispense or deliver such a drug in a manner that does not apply to drugs that are not 340B drugs; or

(f) Prohibit a covered entity or contract pharmacy from purchasing a 340B drug or interfere with the ability of a covered entity or contract pharmacy to purchase a 340B drug.

2. This section does not prohibit the Department of Health and Human Services, the Division of Health Care Financing and Policy of the Department of Health and Human Services or a Medicaid managed care organization from taking such actions as are necessary to:

(a) Prevent duplicate discounts or rebates where prohibited by 42 U.S.C. § 256b(a)(5)(A); or

(b) Ensure the financial stability of the Medicaid program, including, without limitation, by including or enforcing provisions in any relevant contract.

G. Review/Revision History

Date Issued	10/01/2025	
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

1. Appendix A – 340B Drug Pricing Program. Nevada Medicaid and Nevada Check Up Pharmacy Manual. https://nv.primetherapeutics.com/cms/nvm/static-assets/documents2/document/NV_Pharmacy_Manual.pdf
2. Nevada Medicaid Web Announcement 3374. Nevada Department of Health and Human Services. Issued June 12, 2024. https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3374_20240612.pdf
3. Nevada Medicaid 837 Health Care Claim/Encounter: Institutional Encounter (837I). https://www.medicaid.nv.gov/Downloads/provider/Encounter-Professional_837P_MCO_Companion_Guide_-_Mod.pdf.
4. Nevada Medicaid 837 Health Care Claim/Encounter: Professional Encounter (837P). https://www.medicaid.nv.gov/Downloads/provider/Encounter-Institutional_837I_MCO_Companion_Guide_-_Mod.pdf.
5. NRS 687B.805 – “Prohibited acts by health carrier relating to 340B Program”. 2024 Nevada Revised Statutes (NRS) Chapter 687B – Contracts of Insurance. Approved June 12, 2023.

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

NV-MED-P-4165902