

Self-Administered Drugs

Policy Numbers:

UM25P0041A1

SC25P0077A1

Effective Date: July 1, 2025

Last Update: May 6, 2025

PAYMENT POLICY HISTORY

DATE	SUMMARY OF CHANGES
May 6, 2025	UCare established the Self-Administered Drugs Payment Policy.

APPLICABLE PRODUCTS

This policy applies to the products checked below:

UCARE PRODUCT	PRODUCT TYPE	APPLIES TO
UCare Connect + Medicare	Dually Integrated	✓
UCare Minnesota Senior Health Options (MSHO)	Dually Integrated	✓
UCare Individual & Family Plans	IFP	✓
UCare Individual & Family Plans M Health Fairview	IFP	✓
UCare EssentiaCare Plans	Medicare	✓
UCare Medicare – ISNP	Medicare	✓
UCare Medicare Plans	Medicare	✓
UCare Your Choice Plans	Medicare	✓
UCare Connect	Minnesota Health Care Programs (MHCP)	✓
UCare Minnesota Senior Care Plus (MSC+)	Minnesota Health Care Programs (MHCP)	✓
UCare MinnesotaCare	Minnesota Health Care Programs (MHCP)	✓
UCare Prepaid Medical Assistance (PMAP)	Minnesota Health Care Programs (MHCP)	✓

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PAYMENT POLICY INSTRUCTIONS

A payment policy assists in determining provider reimbursement for specific covered services. To receive payment, the provider must be in a contractual relationship with UCare and provide services to a member enrolled in one of UCare's products. This payment policy is intended to provide a foundation for system configuration, work instructions, call scripts, and provider communications. A payment policy describes the rules for payment, which include applicable fee schedules, additional payment rules by regulatory bodies, and contractual terms. This policy is a general guideline and may be superseded by specific provider contract language.

PAYMENT POLICY OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) covers drugs that are furnished incident to a physician's service provided that the drugs are not usually self-administered by the member(s). Medicare Part B does not generally cover drugs that can be self-administered, such as those in pill form or are used for self-injection.

UCare follows CMS guidance as it relates to reimbursement of self-administered drugs for all products. As such, self-administered drugs are not reimbursed under the UCare medical benefit and should be billed under the pharmacy benefit.

POLICY DEFINITIONS

TERM	NARRATIVE DESCRIPTION
Acute	An acute condition represents a condition that begins over a short period, is likely to be of short duration and/or the expected course of treatment is for a finite interval. Generally, a course of treatment lasting less than two weeks is considered acute.
Administered	Refers only to the physical process by which the drug enters the patient's body.
Apparent on its face	For certain injectable drugs, the classification will be apparent due to the nature of the conditions for which the drug is administered or the usual course of treatment for those conditions, the drug is or is not self-administered.
By the patient	For the purposes of this policy, 'by the patient' represents beneficiaries as a collective whole. The determination of this status is based on:

TERM	NARRATIVE DESCRIPTION
	<ul style="list-style-type: none"> whether the drug is self-administered by the patient the majority of the time (see term: usually). drug by drug basis, not beneficiary by beneficiary basis.
Usually	<p>For the purposes of applying the self-administered drugs list to this policy, 'usually' represents more than 50% of the time for all beneficiaries who use the drug.</p> <p>In instances of multiple indications, for example, when a drug has three indications and is not self-administered for the first indication (40% of total usage), but the subsequent two indications are self-administered (60% of total usage), the drug is considered 'usually' self-administered.</p>

ENROLLEE ELIGIBILITY CRITERIA

THIS SECTION OF THE POLICY PROVIDES INFORMATION THAT IS SPECIFIC TO THE UCARE MEMBER, INCLUDING INFORMATION ABOUT THE CRITERIA THE MEMBER MUST MEET IN ORDER FOR THE SERVICE(S) IN THE POLICY TO BE ELIGIBLE FOR PAYMENT.

The Self-Administered Drugs Payment Policy applies to all enrolled UCare members.

ELIGIBLE PROVIDERS OR FACILITIES

OUTLINED BELOW IS THE SPECIFIC CRITERIA A PROVIDER MUST MEET IN ORDER FOR THE SERVICE(S) IN THIS POLICY TO BE ELIGIBLE FOR PAYMENT.

Provider

Not applicable.

Facility

Not applicable.

Other and/or Additional Information

Not applicable.

EXCLUDED PROVIDER TYPES**OUTLINED BELOW IS INFORMATION REGARDING PROVIDERS WHO ARE NOT ELIGIBLE TO FURNISH THE SERVICE(S) LISTED IN THIS POLICY.**

Not applicable.

MODIFIERS, CPT, HCPCS, AND REVENUE CODES**General Information**

The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and Revenue codes listed in this policy are for reference purposes only. Including information in this policy does not imply that the service described by a code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee of claim payment.

Modifiers

The modifiers listed below are not intended to be a comprehensive list of all modifiers. Instead, the modifiers that are listed are those that must be appended to the CPT® / HCPCS codes listed below. Based on the service(s) provided, and the circumstances surrounding those services it may, based on correct coding, be appropriate to append an additional modifier(s) to the CPT® / HCPCS code.

When a service requires multiple modifiers, the modifiers must be submitted in the order listed below. If it is necessary to add additional modifiers, they should be added after the modifiers listed below.

Route of administration modifiers

The use of the JA and JB modifiers is required for drugs which have one HCPCS Level II (J or Q) code but multiple routes of administration. Drugs that fall under this category will be marked with an asterisk (*) and must be billed with a JA modifier for intravenous infusion of the drug or billed with the JB modifier for the subcutaneous injection form of administration. Subcutaneously administered drugs listed on the CMS Self-Administered Drug Exclusion List (A53022) will be denied as a medical benefit exclusion. Claims for drugs marked with an asterisk (*) billed without either a JA or JB modifier will also be denied.

The drugs represented by HCPCS codes J0801 and J0802 are administered by intramuscular or subcutaneous injection, therefore they will require the JB modifier for subcutaneous injection and should not have any modifier reported for the intramuscular injection.

MODIFIER(S)	NARRATIVE DESCRIPTION
JA	Intravenous infusion
JB	Subcutaneous injection

CPT and/or HCPCS Code(s)

[CMS Self-Administered Drug Exclusion List \(A53022\)](#)

Services listed on the CMS Self-Administered Drug Exclusion List (A53022) billed with miscellaneous HCPCS codes (ex: J3490, J3590, & C9399) to UCare medical benefit plans will be denied.

Revenue Codes

Not applicable.

PAYMENT INFORMATION

General Guidance

Drugs on the CMS Self-Administered Drug Exclusion List (A53022) have been determined to be excluded from medical plan payment.

CMS Self-Administered Drug Exclusion List (A53022) is reviewed periodically and updated as needed. Therefore, the absence of a drug on the list does not preclude the drug from being deemed excluded later.

Considerations Used to Classify Self-Administered Drug Status

The term 'administered' refers only to the physical process by which the drug enters the patient's body. It does not refer to whether the process is supervised by a medical professional.

Injectable drugs, including intravenously and intramuscularly administered drugs, are typically eligible for reimbursement under the medical plan ('incident to') benefit.

With limited exceptions, other routes of administration including, but not limited to, oral drugs, suppositories, topical medications, and drugs delivered subcutaneously are 'usually' self-administered by the patient and are therefore not reimbursable under the medical plan benefit.

For the purposes of this policy, 'usually' means more than 50% of the time for all beneficiaries who use the drug.

For the purposes of this policy, 'by the patient' refers to beneficiaries as a collective whole, on a drug-by-drug basis, not a beneficiary-by-beneficiary basis.

Below are the potential classifications given to drugs on the CMS Self-Administered Drug Exclusion List (A53022):

- Apparent on its face.
 - For certain injectable drugs, the classification will be apparent due to the nature of the conditions for which the drug is administered or the usual course of treatment for those conditions, the drug is or is not self-administered.
- Presumption of long-term (non-acute) administration.
 - An acute condition represents a condition that begins over a short period, is likely to be of short duration, and/or the expected course of treatment is for a finite interval.
 - A course of treatment consisting of scheduled injections lasting less than two weeks, regardless of frequency or route of administration is considered acute.
 - If the condition being treated is for a longer term (more than two weeks), the drug for this indication is considered "usually self-administered by the patient."
- Acceptable evidentiary criteria available:
 - Peer reviewed medical literature
 - Standards of medical practice
 - Evidence-based practice guidelines
 - FDA approved labels
 - FDA approved package inserts
 - Drug compendia references
 - Self-administered drug utilization statistics

BILLING REQUIREMENTS AND DIRECTIONS

Drugs on the CMS Self-Administered Drug Exclusion List (A53022) should not be billed to the medical benefit and should be billed under the pharmacy benefit.

PRIOR AUTHORIZATION, NOTIFICATION, AND THRESHOLD INFORMATION

[Prior Authorization, Notification, and Threshold Requirements](#)

UCare does update authorization, notification, and threshold requirements from time-to-time. The most current prior authorization requirements can be found [here](#).

RELATED PAYMENT POLICY INFORMATION

OUTLINED BELOW ARE OTHER POLICIES THAT MAY RELATE TO THIS POLICY AND/OR MAY HAVE AN IMPACT ON THIS POLICY.

POLICY NUMBER	POLICY TITLE

SOURCE DOCUMENTS AND REGULATORY REFERENCES

LISTED BELOW ARE LINKS TO CMS, MHCP, AND STATUTORY AND REGULATORY REFERENCES USED TO CREATE THIS POLICY.

CMS Benefit Policy Manual

[Medicare Benefit Policy Manual, Chapter 15, Section 50.2](#)

CMS Medicare Coverage Database

[Article - Self-Administered Drug Exclusion List: Medical Policy Article \(A53022\)](#)

[Article - Self-Administered Drug Exclusion List: \(SAD List\) \(A53020\)](#)

UCare's Contracts with DHS

[MHCP contracts with managed care plans / Minnesota Department of Human Services](#)

DISCLAIMER

"Payment Policies assist in administering payment for UCare benefits under UCare's health benefit Plans. Payment Policies are intended to serve only as a general reference resource regarding UCare's administration of health benefits and are not intended to address all issues related to payment for health care services provided to UCare members. When submitting claims, all providers must first identify member eligibility, federal and state legislation, or regulatory guidance regarding claims submission, UCare provider participation agreement contract terms, and the member-specific Evidence

of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, UCare also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®*), InterQual guidelines, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT® or other sources in UCare Payment Policies are for definitional purposes only and do not imply any right to payment. Other UCare Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other than as described by UCare Payment Policies when necessitated by operational considerations.”