Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health

Payment Policy:
Drugs and Biologicals

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Tufts Health Plan covers medically necessary medically necessary, practitioner-administered, FDA-approved drugs and biologicals and the associated administration services, in accordance with the member's benefits.

Note: Drugs and biologicals outlined in this policy are covered under the member's medical benefit. Refer to the Pharmacy section of the Tufts Health Plan website for information on medications covered under the pharmacy benefit.

Drugs and biologicals policies are derived from the following specific resources: manufacturer's prescribing information, Elsevier Gold Standard's Clinical Pharmacology, Thomson MICROMEDEX® (DRUGDEX®, DrugPoints®), American Hospital Formulary System, National Comprehensive Cancer Network (NCCN) Drugs and Biologicals Compendium, and Regional Local Coverage Determinations (LCDs). The policies support appropriate indications, dosages and frequency based on these resources. In some instances where there is evidence of efficacy, off-label indications will also be allowed.

Drug Wastage

Practitioners, hospitals, and other providers are encouraged to care for and administer to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner. Providers should administer medications in the most cost-effective manner, utilizing the most cost-effective vial and/or combination of vial sizes to minimize waste.

When a practitioner, hospital or other provider must discard the remainder of a single-use vial (SUV) or other single-use package after administering a dose/quantity of the drug or biological for the last dose of the day for that drug or biological, Tufts Health Plan compensates for the amount of drug or biological discarded, as well as the dose administered, up to the next incremental J-code of administered medication. Pharmaceutical waste and unused portions of pharmaceutical vials are not compensated if the pharmaceutical is withdrawn from a multidose vial.

Providers must submit modifier JW to identify unused drug or biologicals from SUVs or single-use packages for the last dose of the day for that drug or biological that is appropriately discarded.

Pharmaceutical waste and unused portions of any SUV will be considered for compensation, at the current fee schedule, if the wasted medication is documented within the patient's medical record file. Medical record documentation of waste should include the name of the clinician wasting the pharmaceutical, date/time, amount of wasted pharmaceutical and national drug code (NDC) number. Payment for wasted medication will not be considered if supporting documentation is not present within the medical record.

Tufts Health Plan does not compensate for discarded amounts of drug or biologicals of multiuse vials, discarded drugs when none of the drug is administered to the patient and drug waste when the provider has not billed with the most appropriate size vial, or combination of vials, to deliver the administered dose. Contaminated pharmaceuticals will not be reimbursed.

This policy applies to professional as well as outpatient and inpatient facility claims.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

Drugs and Biologicals Covered under the Medical Benefit

Tufts Health Plan covers medically necessary drugs and biologicals under the medical benefit, as outlined below. Refer to the Pharmacy section of the Tufts Health Plan website for information on drugs covered under the pharmacy benefit.

Note: Tufts Health Plan follows the Medicare Part B definition for drugs covered under the medical benefit for Senior Products and Tufts Health Unify.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization, and Notification Policy.

Prior Authorization Form Requirements

Refer to the list of medical necessity guidelines for clinical coverage criteria and to determine which drugs require prior authorization. Refer to the Utilization Management Prior Authorization Requirements for a list of product-specific prior authorization forms and submission channels.

Billing Instructions

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Per CMS, pre-administrative-related services for IV infusion of immunoglobulins need to be reported with the appropriate immunoglobulin injection code for the same encounter.

Drug Wastage

If the drug Unit of Service (UOS) is less than the drug quantity contained in the SUV or single dose package, submit the administered drug quantity on one claim line and the discarded quantity on a separate claim line with the JW modifier.

- Modifier JW must be appended to a drug code packaged for single doses[1]
- Effective for DOS on or after July 1, 2023, providers must append modifiers JW (drug wastage) or JZ (no drug wastage) to single-dose vial/package claim lines for Senior Products members, in accordance with CMS.

Tufts Health Together

In accordance with MassHealth Acute Outpatient Hospital Bulletin 34, Tufts Health Plan requires all clinician-administered outpatient drugs (including 340B drugs) to include the 11-digit National Drug Code (NDC). Refer to Bulletin 34 for any limited exceptions.

Submit modifier UD with the 11-digit NDC code when filing a claim for administering single-source drugs purchased under the 340B drug discount program.

Acute Hospital Carve-Out Drugs

Tufts Health Together

High-cost drugs identified on the MassHealth Acute Hospital Carve-Out Drugs List must be submitted separately from facility claims to provide appropriate compensation. Providers must include the NDC, corresponding HCPCS code(s) and number of units administered to the member on the claim. Providers must also include the following supporting documentation, in

[1] Claim lines submitted with modifier JW on Tufts Health Together claims will deny, in accordance with MassHealth.

accordance with MassHealth MCE Bulletin 42:

- The hospital's actual acquisition cost of the drug
- Copy of the invoice(s) for the drug from the drug manufacturer, supplier, distributor, or other similar party or agent
- Any additional supporting documentation, as necessary

Claims with supporting documentation cannot be submitted electronically and must be submitted on paper, in accordance with Tufts Health Plan's claim submission requirements. Refer to the Claim Requirements, Coordination of Benefits and Dispute Guidelines chapter of the Tufts Health Public Plans Provider Manual for more information on claim submission requirements.

Non-Hepatitis C Virus (HCV) High-Cost Drugs

Tufts Health Together

All claims for non-HCV high-cost drugs that have a typical treatment cost greater than $200,000 per patient per year, an FDA orphan designation, and treat an applicable condition that affects fewer than 20,000 individuals nationwide must be billed with the HCPCS Level II code and 11-digit National Drug Code (NDC), including units and unit descriptors.

As a reminder, submit modifier UD with the 11-digit NDC code when filing a claim for administering single-source drugs purchased under the 340B drug discount program.

Tufts Health Direct, Tufts Health RITogether and Tufts Health One Care

Claims for single-source drugs administered by providers in a health care setting must include both the HCPCS Level II code and 11-digit NDC number, including units and descriptors, with the following exceptions:

- Inpatient claims
- Outpatient claims included in a bundled rate or global fee
- Claims for drugs purchased under the 340B drug discount program as designated by the Office of PharmacyAffairs
- Claims for radiopharmaceuticals, contrast media, vaccines, or devices

Submit modifier UD with the 11-digit NDC code when filing a claim for administering single-source drugs purchased under the 340B drug discount program.

Unlisted Drug Codes

Providers submitting unlisted drug codes not currently covered by a HCPCS code must submit the appropriate 11-digit NDC number.

Compensation/Reimbursement Information

Providers are compensated according to the applicable network contracted rates and applicable fee schedules.

Refer to the Drugs and Biologicals Claim Edits Grid for individual claim edits.

Administration Denials

Tufts Health Plan does not compensate for chemotherapy drug administration codes (96401–96450, 96542–96549 and Q0083–Q0085) if billed with a drug that is administered using non-chemotherapy administration codes and a drug that is administered using chemotherapy codes has not been billed for the same date of service (DOS).

Autologous Cultured Chondrocytes, Implant

- 27412 (autologous chondrocyte implantation, knee) and J7330 (autologous cultured chondrocytes, implant) must be billed for the same DOS by any provider.
- J7330 will not be reimbursed if billed and a knee arthroscopy code has not been billed by any provider within the previous month.

Refer to the Spinal Conditions Management and Joint Surgery Program Prior Authorization Code Matrix code list for more information on autologous chondrocyte implantation codes.

CMS Coverage Rules

Tufts Health Plan does not compensate certain services billed prior to the effective date of FDA approval. Refer to the CMS Outpatient Prospective Payment System for additional information.

Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions

Tufts Health Plan does not routinely compensate J0881 or J0885 when billed without modifier EA or EC.

Tufts Health Plan does not routinely compensate J0881, J0885 or Q5106 for non-end-stage renal disease (ESRD) ESA treatments when billed with modifier EB.

Tufts Health Plan does not routinely compensate J0881, J0885 or Q5106 when billed with modifier EC and the diagnosis

associated to the claim line is not approved for ESA treatment.

Self-Administered Drugs

Senior Products

Self-administered drugs are not compensated if billed with place of service codes 01, 03, 04, 09, 11-16, 20, 25, 32, 33, 49, 50, 54, 55, 71, 72 or 81.

Additional Resources

- Home Infusion Payment Policy
- Chemotherapy Oncology Payment Policy
- Vaccines and Immunizations Payment Policy

Document History

- August 2023: Added modifier JW and JZ billing requirements for Senior Products, effective for DOS on or after July 1, 2023
- October 2022: Added compensation information for modifier JW for Tufts Health Together claims, effective for dates of service on or after December 1, 2022
- May 2021: Added claim edits to appropriate grids for hydration therapy and intrauterine contraceptive systems and contraceptive implants effective for dates of service on or after July 1, 2021
- April 2021: Policy reviewed for clarity; added content for Tufts Health Public Plans; created separate claim edits documents for Commercial/Senior Products and Tufts Heath Public Plans and added links to combined policy
- February 2021: Clarified existing billing requirements for clinician-administered outpatient drugs in accordance with MassHealth requirements for Tufts Health Together members
- January 2021: Added edit for sodium hyaluronan or derivative (J7318, J7320-J7329, J7331, J7332) for Senior Products, effective for dates of service on or after April 1, 2021
- December 2020: Added Acute Hospital Carve-Out Drugs billing requirements for Tufts Health Together members, in accordance with MassHealth MCE Bulletin 42
- November 2020: Added edits for aflibercept, aripiprazole extended release, aripiprazole lauroxil, atezolizumab, avelumab, BCG, belimumab, bendamustine HCl, bevacizumab, biosimilar drugs, botulinum toxin A, cemiplimab, daratumumab, darbepoetin alfa [Non-ESRD], epoetin alfa, eribulin mesylate, goserelin acetate implant, immune globulins (IM, SQ), infliximab, iron sucrose, natalizumab, nivolumab, nusinersen, obinutuzumab, paliperidone palmitate, palonosetron HCl, panitumumab, patisiran, pegfilgrastim, pertuzumab, plerixafor, radium Ra-223 dichloride, ramucirumab, ranibizumab, reslizumab, risperidone, rituximab, rituximab and hyaluronidase, sodium hyaluronan or derivative, TBO-filgrastim, tocilizumab, trabectedin, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, ustekinumab, ziv-aflibercept, effective for dates of service on or after January 1, 2021
- October 2020: Updated code J9145
- February 2020: Corrected claim edit for Epoetin alfa to 40 units covered for myelodysplastic syndrome
- January 2020: Added edits for antihemophilic factor IX, antihemophilic factor VIII, aprepitant, arsenic trioxide, atezolizumab, autologous cultured chondrocytes implant, azacytidine, belatacept, bevacizumab, bezlotoxumab, botulinum toxin A and B, brentuximab vedotin, cinacalcet, darbepoetin alfa, durvalumab, eribulin mesylate, etelcalcetide, ferric carboxymaltose, ferumoxytol, filgrastim, fluocinolone acetonide intravitreal implant, fulvestrant, goserelin acetate implant, human antithrombin III, infliximab, intrauterine contraceptive systems and contraceptive implants, ipilimumab, iron sucrose, lanreotide, leuprolide acetate depot, 3.75 mg, leuprolide acetate depot, 7.5 mg, mepolizumab, oxaliplatin, pegfilgrastim, pegloticase, pertuzumab, ramucirumab, rituximab and hyaluronidase, romiplostim, TBO-filgrastim, trastuzumab, treprostinil, triamcinolone acetonide preservative-free extended-release microsphere formulation, effective for dates of service on or after April 1, 2020.
- July 2019: Removed female breast cancer as an indication for leuprolide acetate depot, 7.5 mg (J9217)
- November 2018: Added claim edits for self-administered drugs, effective for dates of service on or after January 1, 2019
- August 2018: Added edits for abatacept, agalsidase beta, alemtuzumab, alglucosidase alfa, BCG (Intravesical), bendamustine HCl, bortezomib, botulinum toxin A, cetuximab, collagenase clostridium histolyticum, corticotropin, daratumumab, darbepoetin alfa, decitabine, denosumab, docetaxel, doxorubicin HCL liposome, eculizumab, epoetin alfa, ferumoxytol, gemcitabine HCl, goserelin acetate implant, hydroxyprogesterone caproate, ipilimumab, irinotecan, iron dextran, iron sucrose, nivolumab, ocriplasmin, paclitaxel protein-bound particles, panitumumab, pegfilgrastim, pembrolizumab, pemetrexed, pertuzumab, ramucirumab, regadenoson, romiplostim, sipuleucel-T, tocilizumab, trastuzumab, and vedolizumab, effective for dates of service on or after October 1, 2018; removed edit for J9355 for units representing a multiple of an entire vial, as it is no longer active as of August 1, 2018
- June 2018: Template updates

- May 2018: Added claim edit for paclitaxel (J9267), effective for dates of service on or after July 1, 2018
- February 2018: Added claim edits for autologous cultured chondrocytes, ESAs in cancer and related neoplastic conditions, effective for dates of service on or after April 1, 2018
- September 2017: Added language regarding drugs covered under the member's medical benefit

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to Plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.