Pharmaceutical Supplies Payment Policy

Policy Statement

This policy documents Neighborhood Health Plan of Rhode Island's (Neighborhood) coverage requirements for pharmaceutical Supplies.

Scope

This policy applies to **Medicaid, INTEGRITY,** and **Health Benefits Exchange (HBE)** lines of business.

Prerequisites

All services must be medically necessary to qualify for reimbursement.

Service-specific criteria benefit limitations and prior authorization requirements may apply. Prior authorization requirements vary by line of business and services provided. It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies. In the absence of a clinical medical policy, Neighborhood utilizes industry standard evidenced-based clinical review criteria.

Please contact Neighborhood Member Services at 1-800-459-6019 for additional details.

Reimbursement Requirements

For Medicaid, INTEGRITY, and HBE

This policy applies to professional services billed on a CMS-1500 claim form and facility services billed on a UB-04 claim form.

- All medical benefit drugs, including provider-administered, injected or infused medications, billed on a UB-04 should be billed with a cross-walked revenue code (e.g. 636, 250) for the service, the appropriate CPT or HCPCS code and a valid corresponding NDC number.
- All medical benefit drugs, including provider-administered, injected or infused medications, billed on a CMS-1500 should be billed with the appropriate CPT or HCPCS code and a valid corresponding NDC number.
- If the medical benefit drug is considered a miscellaneous, not otherwise classified, unlisted or unclassified medication and does not have an assigned temporary or permanent HCPCS code, the claim must be billed with the appropriate unclassified HCPCS code, valid NDC number and an invoice attached for review.

- Any medical benefit drug for outpatient services that crosses over more than one calendar day must be itemized by individual service date and corresponding units per day.

For Medicaid and HBE

- Neighborhood reserves the right to cover medications in the most administratively cost effective way that does not interfere with positive clinical outcomes.
- For medications that are on the formulary under the pharmacy benefit and do not have a specified HCPCS code under the medical benefit, these medications are not covered under the medical benefit with an unclassified code.

Payment Methodology

Medical benefit drugs are reimbursable when they meet the following conditions:

- They are FDA approved;
- Have supported off-label use from one of the following standard reference compendia:
    - American Hospital Formulary Service Drug information (AHFS-DI);
    - Thomson Micromedex DrugDex;
    - Clinical Pharmacology;
    - Wolters Kluwer Lexi-Drugs; or
    - Have peer-reviewed published medical literature indicating that sufficient evidence exists to support requested use.

The Neighborhood standard fee schedule contains the following methodology for provider-administered, injected or infused medications:

- New-to-market medications, without a classified HCPCS code, that are billed with an unclassified code will be reimbursed at average wholesale price (AWP) minus sixteen (16) percent (%).
- Medical benefit drugs that have classified HCPCS codes without an established average sales price (ASP) will be reimbursed at AWP minus sixteen (16) percent (%).
- Medical benefit drugs that have classified HCPCS codes with an established average sales price (ASP) will be reimbursed at the CMS Payment Limit, which is also ASP + six (6) percent (%).
- For next generation biotherapeutics, providers will be reimbursed between wholesale acquisition cost (WAC) and WAC plus three (3) percent (%).
- For select classified drugs that are covered under both the medical and pharmacy benefits, medical drug reimbursement will be aligned to match the pharmacy benefit reimbursement.
- Neighborhood reserves the right to evaluate and amend its pharmaceutical supplies billing and reimbursement guideline and apply maximum allowable cost pricing at its sole discretion.

340B Drug Pricing Program

- Medical benefit drug claims submitted by 340B Covered Entities for drugs or biologics purchased through the 340B Drug Pricing Program must be submitted with the appropriate HCPCS modifier code, UD, during initial claim submission.
- This requirement applies to all Neighborhood lines of business, Medicaid, Exchange and Medicare-Medicaid Plan (MMP).

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within 90 days of the date services are provided to members.

Adjustments, corrections, and reconsiderations must include the required forms. All submissions must be in compliance with National Claims Standards.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Member Responsibility

HBE plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
09/01/2013	Format change, minor edits, added language of applicability to professional and facility services, deleted modifier language, added outpatient case rate exclusion.
04/01/2020	Added requirements for medically administered medications, standard fee schedules and reimbursement rates for medical benefit drugs