Policy Title:	Medically Administered Medications Payment Policy		
Policy Number:	000642	**Department:**	PHA
Effective Date:	11/01/2019		
Review Date:	3/30/2023		
Revision Date:	3/30/2023		

Purpose:

To ensure Neighborhood Health Plan of Rhode Island (Neighborhood) covers medically administered medications that are clinically appropriate and cost effective.

Scope:

Medicaid, Commercial, INTEGRITY (MMP)

Medications administered in either an outpatient or inpatient setting where medications are billed separately. (Medically administered medications started in an inpatient setting must meet clinical criteria to be continued through an outpatient benefit).

Policy Statement:

Neighborhood Health Plan of Rhode Island will cover medically administered medications following a review by the Neighborhood P&T committee.

Options for coverage of medications are:

- Covered without Authorization
- Covered without Authorization, following medical policy
- Covered with Authorization
- Drug Exclusions, Investigational, or Experimental Services
- Not covered

  * Medically administered drugs covered under Medicare Part B may follow specific Medicare requirements.

All unclassified codes over $50 require authorization for reimbursement. If a medically administered drug has its own HCPCS code, the plan will not reimburse claims billed with an unclassified code.

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.

All claims must be submitted with both the appropriate HCPCS code and NDC, in compliance with Neighborhood's Pharmaceuticals NDC Billing Requirements Policy.

Only claims with valid NDCs that are included in the Medicaid Prescription Drug Rebate program are eligible for payment consideration for Medicaid Members.

Procedure:

1. Medically administered medications must be billed with the correct HCPCS code. For medically administered medications that require an authorization, additional documents will be submitted to the pharmacy department for review prior to administration. Failure to submit accurate HCPCS codes or additional clinical documentation may result in non-payment.
2. Medically administered medications will fall under one of the following categories:
    a. Covered without Authorization (provider must submit an accurate HCPCS code).
    b. Covered without Authorization, following medical policy
    c. Covered with Authorization (must meet clinical medical policy criteria or medical necessity criteria. Some drugs may require authorization for specific diagnoses only, as referenced in the Medical Pharmacy Benefit Searchable HCPCS Listing.)
    d. Drug Exclusions (example: cosmetic treatment or treatment of sexual/erectile dysfunction), Investigational, or Experimental Services:
        i. Drug or device that lacks FDA approval.
        ii. Requested treatment is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials. (Phase II and Phase III clinical trials can be used to support off-label use in oncology.)
        iii. Services, which are delivered in connection with, or required by, an item or service, not covered.
    e. Non-covered mediations: Drug or device (that includes a drug) that the Pharmacy and Therapeutics (P&T) Committee and the Plan have determined should not be covered because such drug at the time of review lacked demonstrated effectiveness. This policy will coincide with the New to Market policy where if the P&T Committee has not reviewed the medication, the medication will not be a covered benefit unless a request is made to the Chief Medical Officer (CMO) and approved by the CMO or his/her representative.
3. Unclassified Codes**:** An unclassified code provides the means of reporting procedures or services that do not have an established CPT/HCPCS code, which adequately describes the service performed. Unclassified codes do not include descriptor language that specifies the components of a particular service, therefore one unclassified code can represent numerous procedures or services that may or may not be covered.
    a. In order to be considered for payment, unclassified codes will require an Authorization for payment, if the amount exceeds $50.
    b. For Authorization, the request must include the specific NDC, NDC units, and supporting clinical documentation showing the necessity of the medication.

4. All claims must be submitted with both the appropriate HCPCS code and NDC, in compliance with Neighborhood's *Pharmaceuticals NDC Billing Requirements Policy.*
5. For Medicaid and Commercial
    a. Neighborhood reserves the right to cover medications in the most administratively cost effective way that does not interfere with positive clinical outcomes. This includes, but is not limited to initiatives such as Site of Care (receiving infusion medications at the most cost effective site when clinically appropriate), White Bagging (specialty pharmacy ships the medication directly to the provider's office), Brown Bagging (patient receives the medication from the specialty pharmacy and takes it to their provider for administration), etc.
    b. For medications covered under the pharmacy benefit that do not have a specified HCPCS code, these medications are not covered under the medical benefit with an unclassified code.
6. 340B Drug Pricing Program
    a. 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.
    b. This requirement applies to all Neighborhood lines of business- Medicaid, Commercial and INTEGRITY (MMP).
7. Drug Wastage
    a. Providers are encouraged to care for and treat patients in such a way that they can use medically administered drugs most efficiently, in a clinically appropriate manner. Providers should administer medications in the most cost-effective manner, utilizing the most efficient vial and/or combination of vial sizes to minimize waste.
    b. When a 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, Neighborhood Health Plan compensates for the amount of drug or biological discarded, as well as the dose administered. Pharmaceutical waste and unused portions of pharmaceutical vials are not compensated if the pharmaceutical is withdrawn from a multi-dose vial.
    c. Providers must submit modifier JW to identify unused drug or biologicals from SUVs or single-use packages for medically administered drugs that are appropriately discarded. The JW modifier is only applied to the amount of the drug or biological that is discarded.
    d. Providers must submit modifier JZ on all claims for single dose containers where there are no discarded amounts for medically administered drugs.
8. Clinical Trials
    a. Please see Neighborhood Health Plan of Rhode Island's Clinical Trials policy.
9. Infusion Services
    a. The following services and supplies are included in the product (HCPCS) codes and administration (CPT) codes and are not billed separately:
        i. Use of local anesthetic
        ii. IV access
        iii. Access to an indwelling IV, subcutaneous catheter or port
        iv. Flush at the conclusion of infusion

v. Standard tubing, syringes, and supplies
vi. Payment for hydration therapy is bundled into the payment for chemotherapy drugs administration when the infusions are administered at the same time.
vii. Preparation of the chemotherapy agents
viii. Fluids used to administer or prepare the chemotherapy drugs are considered incidental hydration and are not separately reportable.

b. Hydration is only payable when sequential or as a separate and medically necessary service.
c. Prophylactic and diagnostic injections and infusions exclude the administration of chemotherapy agents.
d. Evaluation and management services provided on the same day as chemotherapy or non-chemotherapy injections and infusions are covered if medically necessary and separately identifiable from the other services. (Exception: 99211 should not be billed with a diagnostic or therapeutic injection or infusion.)