Payment Policy: Drugs & Biologicals		
Original Date Approved: 09/15/2020	**Effective Date** 12/01/2020	**Date Revised:** N/A
Scope: Commonwealth Care Alliance (CCA) Product Lines: ☒ Senior Care Options ☒ One Care		

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance (CCA) covers medically necessary drugs and biologicals and the associated administration services, in accordance with medical necessity guideline (MNG) policies and member benefits.

REIMBURSEMENT REQUIREMENTS:

Drugs covered under the medical benefit (vs. pharmacy benefit) are drugs that require skilled administration by providers (e.g. infused or injected). Medical benefit drugs should be procured by the provider and billed to CCA with the applicable administration code(s).

In addition to the required drug HCPCS or CPT code(s) and the number of HCPCS and/or CPT units, the NDC number, unit(s) of measure, and quantity must be submitted for reimbursement. Claims are priced based on HCPCS or CPT codes and associated units of service. If the NDC does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous drug code.

Providers are responsible for the submission of accurate claims.

DRUG WASTAGE:

Physicians, hospitals, and other providers are expected to care for patients in such a way that they can use/administer drugs or biologicals in the most effective and 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 drug waste.

If a physician, hospital, or other provider must discard the remainder of a single-use vial 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, CCA will compensate for drug or biological discarded, as well as the dose administered, up to the next incremental J-code of administered medication. Medical record documentation must clearly indicate the amount of drug administered and the amount wasted.

CCA will not compensate for pharmaceutical waste and/or unused portions of pharmaceutical vials withdrawn from a multi-dose vial.

REFERRAL/NOTIFICATION/PRIOR AUTHORIZATION REQUIREMENTS:

For more information on covered services and prior authorizations, please see the Provider Manual:
Section 4: Covered Services & Prior Authorization Requirements

Please see the Pharmacy Program section of the Commonwealth Care Alliance © website for more information on drug coverage.

BILLING AND CODING GUIDELINES:

For Drugs/Biologicals without a corresponding HCPCS code, follow the guidance in the current year HCPCS manual:

HCPCS for Unlisted Code	Unlisted Code Description
A9699	Radiopharmaceutical, therapeutic, not otherwise classified
J3490	Unclassified Drugs
J3590	Unclassified Biologics
J7599	Immunosuppressive drug, not otherwise classified
J7699	NOC drugs, inhalation solution administered through DME
J7799	NOC drugs, other than inhalation drugs, administered through DME
J7999	Compounded drug, not otherwise classified
J8498	Antiemetic drug, rectal/suppository, not otherwise specified
J8499	Prescription drug, oral, nonchemotherapeutic, NOS
J8597	Antiemetic drug, oral, not otherwise specified
J8999	Prescription drug, oral, chemotherapeutic, NOS
J9999	Not otherwise classified, antineoplastic drugs
C9399	Unclassified drugs or biologicals

*NOS- Not otherwise specified **NOC- Not otherwise classified

Modifier	Description
JW	Drug amount discarded/not administered to any patient
UD	340B Drugs

NOTE:

All unlisted NOC, NOS, or Unclassified Drugs/Biologicals require the unit of measure, NDC number, and quantity present on the claim.

Any applicable modifiers should be utilized to indicate drug waste on single unit vials,

As of 12/01/2020, CCA will be implementing a new policy for the list of drugs below regarding brand name drugs and Biosimilars affecting the following drugs below. Please reference the Medical Necessity Guidelines for more information.

<table>
<tr><th>Drug</th><th>Policy Description</th></tr>
<tr><td>Bevacizumab</td><td>
Code(s) J9035, Q5107, Q5118

CCA does not usually compensate for bevacizumab when it is billed less than one month following a major surgery.
CCA limits coverage to the following when billed by any provider:

Once every 6 days
Once every 20 days if the diagnosis is non-small cell lung cancer
Once every 13 days if the diagnosis is breast cancer, colorectal cancer, glioblastoma, pancreatic cancer, renal cell carcinoma, or soft tissue sarcoma
Two units per date of service if the diagnosis is for ophthalmic indications

CCA does not usually compensate without an FDA-approved or an off-label recommended indication.

Code: C9257

CCA does not compensate unless the diagnosis on the claim is for ophthalmic indications.
CCA limits coverage to 20 units.
CCA does not compensate when billed by any provider more than twice within a four-week period.
CCA does not compensate unless the diagnosis on the claim is for ophthalmic indications.
CCA will limit 10 combined units per date of service by any provider when the diagnosis is angioid streaks of the choroid, branch retinal vein occlusion with macular edema, central retinal vein occlusion with macular edema, choroidal retinal neovascularization associated with age-related macular degeneration, choroidal retinal neovascularization associated with angioid streaks, cystoid macular degeneration, degenerative myopia, diabetic macular edema, histoplasmosis retinitis, neovascular glaucoma, nondiabetic proliferative retinopathy, proliferative diabetic retinopathy, retinal edema, retinal ischemia, retinal neovascularization, retinal telangiectasia, or rubeosis iridis.

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Infliximab	**Code(s) J1745, Q5103, Q5104, and Q5121**
	
	• CCA does not usually compensate for the chemotherapy administration, IV infusion technique, for the first hour unless the chemotherapy administration, IV infusion technique, each additional hour has been billed for the same date of service
	• CCA limits to the following when billed by a provider:
	  ○ Once every 6 days
	  ○ Once every 12 days with the diagnosis of an FDA-approved or an off-label recommended indication
	• CCA limits to 80 units per date of service if the diagnosis on the claim is Crohn's disease, rheumatoid arthritis or ulcerative colitis, and infliximab has not been billed in the past year
	• CCA limits units per date of service if the diagnosis on the claim is ankylosing spondylitis, Behcet's syndrome, hidradenitis suppurativa, plaque psoriasis, psoriatic arthritis, pyoderma gangrenosum with inflammatory bowel disease, reactive arthritis, SAPHO syndrome, sarcoidosis, or Takayasu's disease.
	• CCA limits to 570 combined units within a 26-week period when billed by any provider and the diagnosis is any of the following:
	  ○ Early synovitis in rheumatoid arthritis
	  ○ Plaque psoriasis
	  ○ Psoriatic arthritis
	  ○ Pyoderma gangrenosum with inflammatory bowel disease
	• CCA will not usually compensate if billed more than five times every 26 weeks by any provider and the diagnosis is any of the following:
	  ○ Adult regional enteritis (Crohn's disease)
	  ○ Adult ulcerative colitis
	  ○ Early synovitis in rheumatoid arthritis
	  ○ Plaque psoriasis
	  ○ Psoriatic arthritis

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Filgrastim
 	
Pegfilgrastim
	Code(s) J2505, J1442, J1447, Q5018, Q5101, Q5110, Q5111, Q5120
	
	• CCA does not usually compensate if billed by any provider within 11 days prior to the administration of a cytotoxic chemotherapy drug.
	• CCA does not usually compensate when billed without an FDA-approved or an off-label recommended indication.
	• CCA limits coverage to one unit per date of service unless the diagnosis is mobilization of peripheral blood progenitor cells prior to autologous stem cell transplantation when billed by any provider
	• CCA limits coverage to two units when billed by any provider.
	• CCA will not usually compensate when billed more than once every 12 days by any provider and the diagnosis is any of the following:
	    ○ Chemotherapy-induced neutropenia
	    ○ Mobilization of peripheral blood progenitor cells prior to autologous stem cell transplantation
	    ○ Post-peripheral blood progenitor cell transplant supportive care.
	• CCA will not usually compensate when billed and the diagnosis on the claim is chemotherapy-induced neutropenia, and a diagnosis of a neoplasm is not also present

Rituximab	Code(s) J9312, Q5115, Q5119
	
	• CCA does not usually compensate for intravenous push chemotherapy administration when billed with rituximab unless another drug administered by chemotherapy administration has been billed for the same date of service.
	• CCA does not usually compensate for chemotherapy administration, IV infusion technique, for the first hour when billed with rituximab unless chemotherapy administration, IV infusion technique, each additional hour has been billed for the same date of service
	• CCA does not usually compensate for rituximab when billed with a diagnosis of chronic graft-versus-host disease and a diagnosis of complications of transplanted stem cells is not also present.
	• CCA does not usually compensate for rituximab when billed by any provider more than once per six days unless the diagnosis is:
	    ○ AIDS-related B-cell lymphoma
	    ○ Chronic lymphocytic leukemia
	    ○ Non-Hodgkin's lymphoma
	    ○ Evan's syndrome
	    ○ Malignant ascites in advanced low-grade non-Hodgkin's lymphoma Waldenström's macroglobulinemia
	    ○ Burkitt-type acute lymphoblastic leukemia (ALL)Lymphoma
	• CCA does not usually compensate for rituximab when billed more than one visits every two weeks by any provider for a diagnosis of:
	    ○ Primary Sjögren's syndrome
	    ○ Relapsing-remitting multiple sclerosis
	    ○ Rheumatoid arthritis
	• CCA will not usually compensate for rituximab when billed by any provider more than 12 times in a patient lifetime and the diagnosis is chronic lymphocytic leukemia, hairy cell leukemia, large B-cell lymphoma, or mantle cell lymphoma

Trastuzumab	**Code(s) J9355, Q5112, Q5113, Q5114, Q5116, Q5117**
	
	• CCA does not usually compensate if billed without an FDA-approved indication or an approved off-labeled indication.
	• CCA does not usually compensate for intravenous push chemotherapy administration when billed unless another drug administered by chemotherapy administration has been billed for the same date of service
	• CCA limits coverage if billed more than once every 12 days by any provider and the diagnosis is esophageal and gastroesophageal junction adenocarcinoma or gastric cancer.
	• CCA limits to the following when billed by any provider:
	    o 91 combined units per date of service
	    o One unit if billed and no other drug administered by chemotherapy administration has been billed
	• CCA will limit to 762 combined units every 26 weeks by any provider and the diagnosis is esophageal cancer, esophagogastric junction cancer, gastric cancer, or HER2-positive breast cancer.
	• CCA will not usually compensate when billed by any provider more than once per week and the diagnosis is HER2-positive breast cancer or leptomeningeal metastases in HER2-positive breast cancer.

RELATED SERVICE POLICIES:

National Drug Code

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to patient eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable and adherence to CCA policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

CMS Billing Guide https://www.mass.gov/files/documents/2017/11/06/bg-cms-1500-paperclaims-draft.pdf

Commonwealth Care Alliance https://www.commonwealthcare.org

Mass Health Provider Regulations https://www.mass.gov/service-details/masshealth-provider-regulations

Medicare Claims Processing Manual 100-04 Ch 17 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf

POLICY TIMELINE DETAILS

1. Drafted July 2020
2. Effective 12/01/2020