Medically Administered Medications Payment Policy

Policy Statement

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

Scope

This policy applies to:

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**Commercial**
☒**Dual CONNECT (Coordination only D-SNP)**
☒**INTEGRITY for Duals (Fully Integrated D-SNP)**

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).

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as InterQual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

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 Pharmacy Prior Authorization Criteria and Clinical Medical Policies

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Reimbursement Requirements

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, JG or TB, 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.

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 ONLY**
    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 Medicare.
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.)
10. Rhode Island Medicaid High-Cost Drug List Administrative Services Model
    a. Effective July 1st, 2026 designated high-cost drugs will be reimbursed at Fee for Service (FFS) rates through a state-defined pass-through mechanism. Neighborhood will continue to administer the prior authorization (criteria sent to and approved by EOHHS), care coordination, reporting, and claim adjudication for these products.
    b. The designated high-cost drug list is maintained by Rhode Island Medicaid and may be periodically modified as deemed necessary by the State. Below is the list of in scope drugs as of July 1st, 2026 and subject to change based on EOHHS guidance:
        i. Abecma (idecabtagene vicleucel)
        ii. Amtagvi (lifileucel)
        iii. Aucatzyl (obecabtagene autoleucel)
        iv. Breyanzi (lisocabtagene maraleucel)
        v. Carvykti (ciltacabtagene autoleucel)
        vi. Casgevy (exagamglogene autotemcel)
        vii. Elevidys (delandistrogene moxeparvovec-rokl)
        viii. Encelto (revakinagene taroretcel-lwey)

ix. Hemgenix (etranacogene dezaparvovec-drlb)
x. Imlygic (talimogene laherparepvec)
xi. Itvisma (onasemnogene abeparvovec-brve)
xii. Kebilidi (eladocagene exuparvovec-tneq)
xiii. Kymriah (tisagenlecleucel)
xiv. Lantidra (donislecel-jujn)
xv. Lenmeldy (atidarsagene autotemcel)
xvi. Luxturna (voretigene neparvovec-rzyl)
xvii. Lyfgenia (lovotibeglogene autotemcel)
xviii. Omisirge (omidubicel-onlv)
xix. Papzimeos (zopapogene imadenovec-drba)
xx. Ryoncil (remestemcel-L-rknd)
xxi. Skysona (elivaldogene autotemcel)
xxii. Tecartus (brexucabtagene autoleucel)
xxiii. Tecelra (afamitresgene autoleucel)
xxiv. Vyjuvek (beremagene geperpavec)
xxv. Waskyra (etuvetidigene autotemcel)
xxvi. Yescarta (axicabtagene ciloleucel)
xxvii. Zevaskyn (prademagene zamikeracel)
xxviii. Zynteglo (betibeglogene autotemcel)
xxix. Zolgensma (onasemnogene abeparvovec-xioi)

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

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.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial 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.

For Dual CONNECT (Coordination only D-SNP plan), providers must submit claims to Neighborhood and any remaining copays/coinsurance amounts and Medicaid covered benefits to EOHHS for reimbursement.

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.

Neighborhood processes Dual CONNECT in accordance with CMS Medicare guidelines. Neighborhood processes INTEGRITY for Duals in accordance with CMS Medicare and Rhode Island Executive Office of Health and Human Services (RI EOHHS) guidelines. Refer to CMS Medicare guidance and RI EOHHS Provider Manuals & Guidelines for rules and claims processing policies.

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
09/01/2026	Policy Review Date. Updated policy template to include new lines of business. Updated Member Responsibility and Disclaimer language. Added section on State's High-Cost Drug List Administrative Services Model.
12/11/2024	Policy Review Date. Updated statement under bullet 5 to state Medicaid ONLY.
09/05/2023	Policy Review Date. Format changes. Added language to Drug Wastage.
11/01/2019	Policy Effective Date