Policy Title:	Medically Administered Medications Payment Policy		
Policy Number:	000642	**Department:**	PHA
Effective Date:	11/01/2019		
Review Date:	1/16/2020, 1/11/2021, 1/28/2021, 1/6/2022		
Revision Date:	1/16/2020, 1/11/2021, 1/28/2021, 1/6/2022		

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.

For Medicaid, 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 NDC's that are included in the Medicaid Prescription Drug Rebate program are eligible for payment consideration.

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 (Medication 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 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. For Medicaid, 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 that do not have a specified HCPCS code and are covered under the pharmacy benefit, 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. Medical and Pharmacy Benefit Billing
    a. If it is determined that Medical Benefit Pharmacy HCPCS codes were submitted for reimbursement for the same time period as the referenced medication being dispensed on the Pharmacy Benefit, Neighborhood will request the provider/facility retract the claim or Neighborhood will retract the claim after confirming with the provider/facility that the claim was billed inappropriately on the Medical Benefit.