Payment Policy: Injectable Drugs in an Outpatient setting

Reference Number:
Product Types: Medicaid
Effective Date: January 1, 2018
Last Review Date: January 1, 2018

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
NH Healthy Families covers medically necessary drugs and biologicals, such as outpatient injectable drugs, and associated administration services.

Application
The policy applies to NH Healthy Families participating providers who administer drugs and biologicals. This policy applies only applies to the New Hampshire Medicaid network.

Policy Description
RX outpatient injectable drugs must be reasonable and necessary for the diagnosis and/or treatment of the condition in which they are administered according to acceptable standards of medical practice.

NH Healthy Families requires prior authorization for certain outpatient injectable drugs. Please utilize the Pre-Auth Check Tool for details.

Drug Wastage
Physicians, hospitals and other providers are encouraged to care for and administer to patients in such a way that they can use drugs or biologicals most efficiently, in a 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 in order to minimize waste.

When a physician, hospital or other 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 for the last dose of the day for that drug or biological, NH Healthy Families compensates for the amount of drug or biological discarded, as well as the dose administered, up to the next incremental J-code of administered medication. Pharmaceutical waste and unused portions of pharmaceutical vials are not compensated if the pharmaceutical is withdrawn from a multi dose vial.

Providers must submit modifier JW to identify unused drug or biologicals from SUVs or single-use packages for the last dose of the day for that drug or biological that is appropriately discarded. Pharmaceutical waste and unused portions of any SUV will be considered for compensation, at the current fee schedule, if the wasted medication is documented within the patient's medical record file. Medical record documentation of waste should include the name of the clinician wasting the pharmaceutical, date/time, amount of wasted pharmaceutical and national drug code (NDC) number. Payment for wasted medication will not be considered if supporting documentation is not present within the medical record.

NH Healthy Families Does Not Reimburse:

- Discarded amounts of drug or biologicals of multiuse vials
- Discarded drugs when none of the drug is administered to the patient
- Drug waste when the provider has not billed with the most appropriate size vial, or combination of vials, to deliver the administered dose
- Contaminated pharmaceuticals

This policy applies to professional as well as outpatient and inpatient facility claims.

Billing Instructions

- RX outpatient injectable drugs should be billed with the appropriate count per HCPCS description requirements.
  Example:
  J1745 - Injection, infliximab, excludes biosimilar, 10 mg
  - If the patient requires 30 milligrams of infliximab per session, the claim must be billed with 3 units.
- Submit modifier JW on a separate line to identify unused drugs or biologicals

Revision History	
01/01/2018	Original Effective Date

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.