# Drugs and Biologicals Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who administer drugs and biologicals to members of the CarePartners of Connecticut plans selected above.

**Note:** Audit and disclaimer information is located at the end of this document.

## Policy

CarePartners of Connecticut covers medically necessary, practitioner-administered, FDA-approved drugs and biologicals and the associated administration services, in accordance with the member's benefits.

Drugs and biologicals policies are derived from the following specific resources: manufacturer's prescribing information, Elsevier Gold Standard's Clinical Pharmacology, Thomson MICROMEDEX® (DRUGDEX®, DrugPoints®), American Hospital Formulary System, National Comprehensive Cancer Network (NCCN) Drugs and Biologicals Compendium, and Regional Local Coverage Determinations (LCDs). The policies support appropriate indications, dosages and frequency based on these resources. In some instances where there is evidence of efficacy, off-label indications will also be allowed.

## Drug Waste

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, CarePartners of Connecticut 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 Pharmaceutical waste and unused portions of pharmaceutical vials are not compensated if the pharmaceutical is withdrawn from a multidose vial.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.

**Note:** Effective for DOS beginning Nov. 1, 2024, providers must append modifier JZ on claim lines for drugs when there is no discarded amount from single-dose containers or single-use packages.

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.

CarePartners of Connecticut does not compensate for discarded amounts of drug or biologicals of multiuse vials, discarded drugs when none of the drug is administered to the patient and 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 will not be compensated.

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

## General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

CarePartners of Connecticut follows the Medicare Part B definition for drugs covered under the medical benefit.

**Note:** Refer to the Pharmacy section of the CarePartners of Connecticut website for information on medications covered under the member's pharmacy benefit.

## Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

No referrals are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

Refer to the online drug search for a list of drugs that are subject to CarePartners of Connecticut prior authorization program.

Refer to the Resource Center for more information for CarePartners of Connecticut.

If a medication requires prior authorization, complete the Request for Medicare Prescription Drug Coverage Determination (Part D drugs) or the Request for Medicare Part B Prescription Drug Organization Determination Form (Part B drugs) and fax it to the Pharmacy Utilization Management Department at 617-673-0956.

## Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Use of labs not participating in the member's applicable network(s) may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

- Submit modifier JW on a separate line to identify unused drug or biologicals from SUVs or single-use packages, appropriately discarded.
- Effective for DOS beginning Nov. 1, 2024, submit modifier JZ on claim lines for drugs when there is no discarded amount from single-dose containers or single-use packages

Per CMS, preadministrative-related services for IV infusion of immunoglobulin must be reported with the appropriate immunoglobulin injection code for the same encounter.

## Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

### Administration Denials for Drugs and Biologicals

CarePartners of Connecticut does not compensate for chemotherapy drug administration codes (96401-96450, 96542-96549, Q0083-Q0085) if billed with a drug that is administered using non-chemotherapy administration codes and a drug that is administered using chemotherapy codes has not been billed for the same date of service.

### Autologous Cultured Chondrocytes, Implant

CarePartners of Connecticut does not routinely compensate for the following:

- 27412 (autologous chondrocyte implantation, knee) if billed and J7330 (autologous cultured chondrocytes, implant) has not been billed for the same DOS by any provider.
- J7330 if billed and 27412 has not been billed for the same DOS by any provider.
- J7330 if billed and arthroscopy of knee has not been billed by any provider within the previous month
- J7330 if billed and autologous chondrocyte implantation of knee has not been billed for the same DOS by any provider.

### CMS Coverage Rules

CarePartners of Connecticut does not compensate for certain services when billed prior to the effective date of FDA approval. Refer to the CMS Outpatient Prospective Payment System for additional information.

### Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions

- J0881 or J0885 will not be compensated if billed without modifiers EA or EC

- J0881, J0885 or Q5106 will not be compensated when billed with modifier EC and the diagnosis associated with the claim line is not approved for ESA treatment
- J0881, J0885 or Q5106 will not be compensated if billed for non-end-stage renal disease (ESRD) ESA treatments if billed with modifier EB

### Modifier JW

- Modifier JW is not compensated unless it is appended to a drug code packaged for single doses.
- CarePartners of Connecticut does not compensate any drug billed with modifier JW unless another claim line for the same drug is billed on the claim.

### Self-Administered Drugs

Self-administered drugs are not compensated if billed with place of service (POS) codes 01, 03, 04, 09, 11-16, 20, 25, 32, 33, 49, 50, 54, 55, 71, 72 or 81.

### Subcutaneous or Intramuscular Injection

Subcutaneous or intramuscular injection codes are not separately compensated if billed with the administration of vaccines and toxoids, as the injection code is inappropriate to use for the administration of vaccines and toxoids. Refer to the AMA CPT Manual for more information.

## Document History

- September 2024: Added billing requirements for modifier JZ, effective for DOS beginning Nov. 1, 2024
- November 2023: Annual policy review; removed claim edits as they enforce industry standars; administrative updates
- November 2022: Annual policy review; administrative updates
- August 2021: Updated previously communicated claim edit for durvalumab
- May 2021: Added claim edits for hydration therapy and intrauterine contraceptive systems and contraceptive implants, effective for dates of service on or after July 1, 2021; reviewed and updated claim edits grid
- January 2021: Added edit for sodium hyaluronan or derivative (J7318, J7320-J7329, J7331, J7332), effective for dates of service on or after April 1, 2021
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- November 2020: Added edits for aflibercept, aripiprazole extended release, aripiprazole lauroxil, atezolizumab, avelumab, BCG, belimumab, bendamustine HCl, bevacizumab, biosimilar drugs, botulinum toxin A, cemiplimab, daratumumab, darbepoetin alfa [Non-ESRD], epoetin alfa, eribulin mesylate, goserelin acetate implant, immune globulins (IM, SQ), infliximab, iron sucrose, natalizumab, nivolumab, nusinersen, obinutuzumab, paliperidone palmitate, palonosetron HCl, panitumumab, patisiran, pegfilgrastim, pertuzumab, plerixafor, radium Ra-223 dichloride, ramucirumab, ranibizumab, reslizumab, risperidone, rituximab, rituximab and hyaluronidase, sodium hyaluronan or derivative, TBO-filgrastim, tocilizumab, trabectedin, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, ustekinumab, ziv-aflibercept, effective for dates of service on or after January 1, 2021
- February 2020: Added edits for Autologous Cultured Chondrocytes, Antihemophilic Factor IX (Idelvion), Antihemophilic Factor VIII (XYNTHA®), Antihemophilic Factor VIII (Advate, Helixate FS, Kogenate FS, Recombinate), Aprepitant, Arsenic Trioxide, Atezolizumab, Azacitidine, Belatacept (Nulojix), Bevacizumab (Avastin®), Bezlotoxumab, Botulinum Toxin A and B (Botox®, Dysport™, Myobloc®), Brentuximab Vedotin (Adcetris®), Cinacalcet, Darbepoetin alfa (Aranesp®), Durvalumab, Etelcalcetide, Ferumoxytol (Feraheme®), Ferric Carboxymaltose, Filgrastim (Neupogen®), Fluocinolone Acetonide, Intravitreal Implant (Iluvien), Fulvestrant (Faslodex®), Goserelin Acetate Implant (Zoladex®), Human Antithrombin III, Intrauterine Contraceptive Systems and Contraceptive Implants, Ipilimumab, Iron Sucrose (Venofer®), Leuprolide acetate depot, 3.75 mg, Leuprolide Acetate depot, 7.5 mg, Mepolizumab, Oxaliplatin (Eloxatin®), Pegfilgrastim (Neulasta®), Pegloticase, Pertuzumab (Perjeta®), Ramucirumab, Rituximab (Rituxan®), Rituximab and Hyaluronidase, Romiplostim (Nplate®), TBO-filgrastim (GRANIXTM), Trastuzumab (Herceptin®), Treprostinil, Triamcinolone acetonide effective for dates of service on or after April 1, 2020
- January 2019: Policy created

## Audit and Disclaimer Information

CarePartners of Connecticut reserves 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 a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.