TUFTS Health Plan

Drugs and Biologicals Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]

☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers who administer drugs and biologicals.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

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

POLICY

Tufts Health Plan covers medically necessary 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 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.

Refer to the Radiation Oncology Payment Policy for information regarding oncology services.

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 Pharmaceutical waste and unused portions of pharmaceutical vials are not compensated if the pharmaceutical is withdrawn from a multidose vial.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

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.

Tufts Health Plan 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

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

has not billed with the most appropriate size vial, or combination of vials, to deliver the administered dose. Contaminated pharmaceuticals will not be reimbursed.

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 website or by contacting Commercial Provider Services or Senior Products Provider Relations.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

Drugs Covered under the Medical Benefit

Drugs that require skilled administration by providers (e.g., injected, infused or inhaled drugs) are covered under the member's medical benefit instead of the pharmacy benefit. Medical benefit drugs should be procured by the provider and billed with the applicable administration code (i.e., "buy and bill"). Medical benefit drugs are not available through retail pharmacies or CVS Specialty, except for select drugs that are available to be shipped by CVS Specialty to the provider's office for administration to the member (referred to as "white bag"). Refer to the Office-Administered Medical Drugs Available through CVS Specialty list for a list of these drugs.

AUTHORIZATION REQUIREMENTS

Refer to the online drug search for a list of drugs that are subject to Tufts Health Plan's prior authorization program.

For additional information for Commercial members, refer to the Pharmacy Medical Necessity Guidelines in the Resource Center. Refer to the Medicare section of the Pharmacy page for additional information for Tufts Medicare Preferred HMO and Tufts Health Plan SCO members.

If a medication requires prior authorization, complete the Universal Pharmacy Programs Request Form and fax it to the Precertification Operations Department at 617.972.9409. Refer to the Pharmacy section of our website for additional information.

BILLING INSTRUCTIONS

Submit modifier JW on a separate line to identify unused drug or biologicals from SUVs or single-use packages, appropriately discarded.

Note: This does not apply to drugs provided under the Competitive Acquisition Program for Part B drugs and biologicals (CAP).

CMS Coverage Rules

Preadministrative-related services for IV infusion of immunoglobulins need to be reported with the appropriate immunoglobulin injection code for the same encounter. Refer to CMS for additional information.

COMPENSATION/REIMBURSEMENT INFORMATION

Administration Denials for Drugs and Biologicals

Tufts Health Plan does not compensate for chemotherapy drug administration codes (96401–96450, 96542–96549 and 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

Tufts Health Plan 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 date of service by any provider.
- J7330 if billed and 27412 has not been billed for the same date of service by any provider.
- Tufts Health Plan does not routinely compensate J7330 if billed and arthroscopy of knee has not been billed by any provider within the previous month.
- Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7330 when billed and autologous chondrocyte implantation of knee has not been billed for the same date of service by any provider.

CMS Coverage Rules
Tufts Health Plan 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
Tufts Health Plan does not routinely compensate J0881, J0885 or J0888 for non-ESRD treatments if billed without modifier EA, EB or EC.

Tufts Health Plan does not routinely compensate J0881, J0885 or J0888 for non-ESRD treatments if billed with the following:

- Modifier EB
- Modifier EC and the diagnosis associated to the claim line is not approved for ESA treatment.

Modifier JW
Tufts Health Plan does not compensate for modifier JW unless it is appended to a drug code packaged for single doses.

Tufts Health Plan does not compensate for any drug billed with modifier JW unless another claim line for the same drug is billed on the claim.

Self-Administered Drugs (Senior Products only)
Effective for dates of service on or after January 1, 2019, Tufts Health Plan will not routinely compensate any self-administered drug when billed with place of service codes 01, 03, 04, 09, 11-16, 20, 25, 32, 33, 49, 50, 54, 55, 71, 72 or 81.

Subcutaneous or Intramuscular Injection
Tufts Health Plan does not compensate for the subcutaneous or intramuscular injection code when billed with the administration of vaccines and toxoids, as the subcutaneous or intramuscular injection code is inappropriate to use for the administration of vaccines and toxoids. Refer to the AMA CPT Manual for additional information.

Unlisted Drug Codes (Commercial only)
Providers submitting unlisted drug codes not currently covered by a HCPCS code are required to submit the appropriate NDC number.

The NDC is a code set that identifies the manufacturer, product and package size of all drugs and biologicals recognized by the FDA. For more information, refer to the FDA National Drug Code Directory.

Drug and Biological Edits[2]

Policy	Description
Abatacept (Orencia®)	Tufts Health Plan limits J0129 to the following when billed by any provider: • 100 combined units per date of service if the diagnosis is juvenile idiopathic arthritis, psoriatic arthritis, or rheumatoid arthritis • 13 combined units per date of service by any provider if billed with subcutaneous administration codes (96372, 96377) and no other drug administered by non-chemotherapy subcutaneous technique has been billed for the same date of service
	Tufts Health Plan does not routinely compensate J0129 when billed by any provider in the following circumstances: • More than one unique visit per week if the diagnosis is juvenile idiopathic arthritis, psoriatic arthritis, or rheumatoid arthritis, except when the IV loading dose of J0129 is administered the previous day • 96374-96376 (non-chemotherapy IV administration) if billed with J0129 and no other drug administered by non-chemotherapy IV push technique has been billed for the same date of service.
Ado-Trastuzumab Emtansine	Tufts Health Plan does not routinely compensate for J9354 unless HER2 testing has been billed within the past 18 months by any provider.

[2] Policies apply to Tufts Medicare Preferred HMO and Tufts Health Plan SCO for professional claims only, when applicable.

Policy	Description
(Kadcyla)®	Tufts Health Plan does not routinely compensate for IV push chemotherapy administration if billed with J9354 unless another drug administered by intravenous push chemotherapy administration has been billed for the same date of service.
	Tufts Health Plan limits coverage of J9354 to 411 combined units per date of service and/**or** once every 19 days by any provider.
Aflibercept (Eylea®)	Tufts Health Plan does not routinely compensate for J0178 if modifier LT (left side) or RT (right side) is not also present on the claim.
	Tufts Health Plan does not routinely compensate for J0178 if a diagnosis of central retinal vein occlusion is billed and a diagnosis of retinal edema is not also present on the claim.
	Tufts Health Plan does not routinely compensate for J0178 unless billed with intravitreal injection of a pharmacologic agent (67028).
	Tufts Health Plan limits coverage of J0178 to four units per date of service when billed by any provider.
	Tufts Health Plan does not routinely compensate for J0178 if a diagnosis of diabetic macular edema is billed but a diagnosis of diabetes mellitus with ophthalmic manifestations is not also present on the claim.
	Tufts Health Plan does not routinely compensate for J0178 when a diagnosis of diabetic macular edema is billed and a diagnosis of diabetic retinopathy is not also present on the claim.
	Tufts Health Plan does not routinely compensate for the intravitreal injection of a pharmacologic agent, separate procedure (67028) when billed with J0178 if modifier LT, RT or 50 (bilateral procedure) is not appended to the procedure code.
	Tufts Health Plan will not routinely compensate for J0178 when billed by any provider more than two visits per 28 days.
Agalsidase beta (Fabrazyme®)	Tufts Health Plan limits coverage of J0180 to once every 12 days when billed by any provider.
	Tufts Health Plan does not routinely compensate J0180 if billed and the member is less than eight years of age on the date of service.
Alglucosidase alfa (Myozyme®, Lumizyme®)	Tufts Health Plan does not routinely compensate for J0220, J0221 unless billed with a diagnosis of Pompe disease.
	Tufts Health Plan limits J0220 or J0221 to 228 combined units per date of service by any provider.
Alemtuzumab	Tufts Health Plan limits J0202 to 12 combined units per date of service by any provider.
Alpha-1 proteinase inhibitors (Aralast®, Glassia®, Prolastin®, Zemaira®)	Tufts Health Plan does not routinely compensate for alpha-1 proteinase inhibitors and their administration when a diagnosis for alpha-1-antitrypsin deficiency is not also present on the claim.
	Tufts Health Plan does not routinely compensate for alpha-1 proteinase inhibitors and their administration when billed with a diagnosis for alpha-1-antitrypsin deficiency and a diagnosis for panacinar emphysema is not also present on the claim.
	Tufts Health Plan limits coverage of J0256 or J0257 to once every 6 days when billed by any provider.
Amphotericin B liposome (AmBisome®)	Tufts Health Plan will not routinely compensate for amphotericin B liposome (J0289) if an approved indication or approved off-label indication is not also billed on the same claim.

Policy	Description
Antihemophilic Factor IX (IDELVION®)	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J7202 to 10,462 units per date of service by any provider when billed and the diagnosis is congenital Factor IX deficiency.
Antihemophilic Factor VIII (XYNTHA®)	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J7185 to 20,400 units per date of service by any provider and the diagnosis is hemophilia A.
Antihemophilic Factor VIII (Advate, Helixate FS, Kogenate FS, Recombinate)	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J7192 to 27,200 units per date of service by any provider and the diagnosis is hemophilia A.
Aprepitant	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0185 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0185 when billed and a highly or moderately emetogenic chemotherapy agent has not been billed for the same date of service by any provider.
Arformoterol (Brovana®)	Tufts Health Plan does not routinely compensate for J7605 if the member's age is 17 years or younger on the date of service.
Arsenic Trioxide	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9017 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9017 to 21 units per date of service by any provider and the diagnosis is acute promyelocytic leukemia (APL).
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9017 when billed by any provider more than 60 visits in 12 weeks and the diagnosis is acute promyelocytic leukemia (APL) or multiple myeloma.
Asparaginase Erwinaze®	Tufts Health Plan does not compensate for J9019 unless a diagnosis of acute lymphoblastic leukemia is also present on the claim.
Atezolizumab	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9022 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9022 when billed by any provider more than once every two weeks and the diagnosis is non-small cell lung cancer or urothelial carcinoma.
Azacitidine	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9025 to 260 combined units per date of service by any provider when the diagnosis is myelofibrosis.
Basiliximab Simulect®	Tufts Health Plan does not compensate for J0480 unless a kidney or liver transplantation has been billed and paid for on the same date of service or in the previous 5 days by any provider.
BCG (Intravesical)	Tufts Health Plan limits J9031 to 1 unit per date of service or one visit per week by any provider if the diagnosis is urothelial carcinoma.
	Tufts Health Plan does not routinely compensate J9031 if billed and 50391 or 51720 (bladder installation administration) has not been billed for the same date of service.

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<tr><th>Policy</th><th>Description</th></tr>
<tr><td rowspan="2">Belatacept (Nulojix)</td><td>Tufts Health Plan does not routinely compensate for J0485 if billed without a diagnosis of kidney transplant rejection prophylaxis.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J0485 to 1,360 combined units per date of service by any provider and the diagnosis is kidney transplant rejection prophylaxis.</td></tr>
<tr><td>Belimumab (Benlysta®)</td><td>Tufts Health Plan limits coverage of J0490 to the following when billed by any provider:
• 1 visit within 12 days
• 114 combined units per date of service
• Members aged 18 years or older on the date of service</td></tr>
<tr><td rowspan="7">Bendamustine HCl (Treanda®)</td><td>Tufts Health Plan does not compensate for J9033 if an approved indication or approved off-label indication is not also billed.</td></tr>
<tr><td>Tufts Health Plan limits coverage of J9033 to 221 combined units per date of service by any provider if billed with a diagnosis of Waldenström's macroglobulinemia or lymphoplasmacytic lymphoma.</td></tr>
<tr><td>Tufts Health Plan limits coverage of J9033 to 1,326 combined units within a 12-week period by any provider if the diagnosis is Waldenstrom's macroglobulinemia or lymphoplasmacytic lymphoma.</td></tr>
<tr><td>Tufts Health Plan limits coverage of J9033 to 245 combined units per date of service when billed with a diagnosis of chronic lymphocytic leukemia.</td></tr>
<tr><td>Tufts Health Plan limits coverage of J9033 to 2,952 combined units in a 24-week period by any provider when the diagnosis is chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL).</td></tr>
<tr><td>Tufts Health Plan limits coverage of J9033 to 296 combined units per date of service by any provider when the diagnosis is any of the following:
• Adult T-cell leukemia/lymphoma
• AIDS-related B-cell lymphoma
• Hodgkin's lymphoma
• Non-Hodgkin's lymphoma.</td></tr>
<tr><td>Tufts Health Plan will limit J9033 to 2,336 combined units within a 12-week period by any provider if the diagnosis is any of the following:
• Adult T-cell leukemia/lymphoma
• AIDS-related B-cell lymphoma
• Breast cancer
• Hodgkin's lymphoma (classical)
• Mantle cell lymphoma
• Non-Hodgkin's lymphoma (except mantle cell lymphoma)</td></tr>
<tr><td rowspan="3">Bevacizumab (Avastin®)</td><td>Tufts Health Plan does not compensate for IV push chemotherapy administration codes (96409, 96411, Q0083, Q0085) for J9035.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate for bevacizumab when it is billed less than one month following a major surgery.</td></tr>
<tr><td>Tufts Health Plan limits coverage of J9035 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</td></tr>
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Policy	Description
	Tufts Health Plan does not routinely compensate for J9035 without an FDA-approved or an off-label recommended indication.
	Tufts Health Plan does not compensate for C9257 unless the diagnosis on the claim is for ophthalmic indications.
	Tufts Health Plan limits coverage of C9257 to 20 units.
	Tufts Health Plan does not compensate for C9257 when billed by any provider more than twice within a four-week period.
	Tufts Health Plan does not compensate for J9035 or C9257 for members age 17 years or younger unless a diagnosis of retinopathy of prematurity (stage 3+) is on the claim.
	Tufts Health Plan limits J9035 to 171 combined units per date of service when billed by any provider.
	Tufts Health Plan does not compensate for J9035 if billed by any provider less than three weeks before a major surgery.
	Tufts Health Plan does not compensate for J9035 if billed more than twice per month by any provider and the diagnosis on the claim is an ophthalmologic indication.
	Tufts Health Plan does not compensate for intravitreal injections (67028) if billed with bevacizumab (C9257, J9035) and modifier LT (left side), RT (right side) or 50 (bilateral) has not also been billed.
Bevacizumab (Avastin®)	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit C9257 to 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.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9035 or Q5107 to 68 combined units per date of service by any provider when the diagnosis is hereditary hemorrhagic telangiectasia.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9035 or Q5107 to 408 combined units within a 26-week period by any provider when the diagnosis is hereditary hemorrhagic telangiectasia.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9035 or Q5107 when billed by any provider more than twice per month and the diagnosis is hereditary hemorrhagic telangiectasia.
	Tufts Health Plan limits coverage of J9041 to 35 units if the diagnosis on the claim is multiple myeloma.
Bortezomib (Velcade®)	[3]Tufts Health Plan does not compensate for J9041 if a diagnosis of amyloidosis, myelomatous pleural effusion, multiple myeloma, mantle cell lymphoma, non-Hodgkin's lymphoma (excluding mantle cell lymphoma), or Waldenström macroglobulinemia is not also present on the claim.
	Tufts Health Plan does not compensate for chemotherapy administration by other than subcutaneous or intravenous push technique when billed with bortezomib (J9041) if no other drug administered via chemotherapy administration is billed for the same date of service.

Policy	Description
	Tufts Health Plan does not routinely compensate J9041 if billed by any provider more than twice per week.
Botulinum Toxin A and B (Botox®, Dysport™ Myobloc®)	Tufts Health Plan limits coverage of J0585 to the following: • 195 units for the diagnosis of chronic migraine headache • 300 units if the diagnosis on the claim is cervical dystonia, neurogenic bladder, or oromandibular dystonia • 30 combined units per date of service for the diagnosis of hemifacial spasm or pelvic floor dyssynergia (anismus) • 400 units within three months • 400 combined units per date of service3 • 360 combined units within a three-month period for the diagnoses other than spasticity (post-stroke hemiplegia, upper and lower limb spasticity, cerebral palsy) when billed by any provider
	Tufts Health Plan limits coverage of J0585 to 100 combined units per date of service by any provider when: The diagnosis is anal fissure (chronic) A diagnosis of tension-type headache and a diagnosis of chronic migraine headache is not also present on the claim
	Tufts Health Plan limits J0585 to 200 combined units per month by any provider when billed with a diagnosis of backache, blepharospasm, chronic migraine headache prophylaxis, detrusor overactivity associated with neurologic conditions, oromandibular dystonia or overactive bladder
	Tufts Health Plan limits coverage of J0587 to the following: • 100 units within 3 months if billed with a diagnosis of cervical dystonia • 100 combined units per date of service if billed with a diagnosis of cervical dystonia (spasmodic torticollis) or migraine headache prophylaxis
	Tufts Health Plan limits coverage of J0585 to the following: • 80 combined units per date of service when the diagnosis is tardive dyskinesia • 150 combined units per date of service when the diagnosis is axillary hyperhidrosis[3]
	Tufts Health Plan limits J0585 to 20 combined units per date of service if the diagnosis is oculomotor injury (acute) or vocal cord granuloma.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J0586 to 44 combined units per date of service by any provider and the diagnosis on the claim is hemifacial spasm.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J0586 to 300 combined units in three months by any provider.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J0587 to 20 combined units per date of service when billed by any provider and the diagnosis on the claim is sialorrhea associated with neurological conditions.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J0588 to 120 combined units per date of service by any provider and the diagnosis is cervical dystonia [spasmodic torticollis].

[3] Applies to Tufts Medicare Preferred HMO and Tufts Health Plan SCO products only.

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<tr><th>Policy</th><th>Description</th></tr>
<tr><td></td><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0588 when billed and J0585, J0586, or J0587 (Botulinum toxin) has been billed in the previous three months by any provider.</td></tr>
<tr><td rowspan="3">Brentuximab Vedotin (Adcetris®)</td><td>Tufts Health Plan compensates J9042 if billed with a diagnosis of Hodgkin lymphoma or systemic anaplastic large cell lymphoma (sALCL).</td></tr>
<tr><td>Tufts Health Plan limits coverage of J9042 to 180 combined units per date of service and/or once every 19 days when billed by any provider.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9042 when billed and the patient is less than 18 years of age and an FDA approved or an approved off-labeled indication is present.</td></tr>
<tr><td>Canakinumab Ilaris®</td><td>Tufts Health Plan limits coverage of J0638 when billed by any provider:
• 300 combined units per date of service and/or once every 26 days
• 150 combined units per date of service if billed with a diagnosis of acute gouty arthritis or cryopyrin-associated periodic syndrome (CAPS)</td></tr>
<tr><td rowspan="3">Carfilzomib (Kyprolis®)</td><td>Tufts Health Plan limits coverage of J9047 to 124 combined units per date of service and/or 6 visits per 26 days when billed by any provider.</td></tr>
<tr><td>Tufts Health Plan does not compensate for chemotherapy administration by other than IV push when billed with J9047 and no other drug administered via chemotherapy administration is billed for the same date of service.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate for J9047 if billed without a diagnosis for an FDA-approved indication or an off-labeled indication.</td></tr>
<tr><td>Certolizumab pegol (Cimzia®)</td><td>[3]Tufts Health Plan limits coverage of J0717 to 400 units per date of service when billed by any provider.</td></tr>
<tr><td rowspan="3">Cetuximab (Erbitux®)</td><td>Coverage of J9055 is limited to 62 units when units greater than 62 units have been billed in the previous 14 days.</td></tr>
<tr><td>Tufts Health Plan does not compensate for J9055 if billed more than once a week by any provider.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate 96409, 96411 (IV push chemotherapy administration) if billed with J9055 and no other drug administered by chemotherapy administration has been billed for the same date of service.</td></tr>
<tr><td>Cinacalcet</td><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0604 when billed and the diagnosis is secondary hyperparathyroidism in adult patients with chronic kidney disease on hemodialysis and serum calcium testing has not been billed by any provider in the previous month.</td></tr>
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<tr><th>Policy</th><th>Description</th></tr>
<tr><td>Collagenase clostridium histolyticum (Xiaflex®)</td><td>Tufts Health Plan does not routinely compensate J0775 if billed under the following circumstances:
If billed with a diagnosis of Peyronie's disease and 54200 (administration) has not been billed for the same date of service
If billed with a diagnosis of Peyronie's disease and 54235 (corpora cavernosa injection) has not been billed for the same date of service or in the previous three days
If billed without 20527 (injection, enzyme, palmar fascial cord) and the diagnosis is Dupuytren's contracture
If 26341 (manipulation, palmar fascial cord, post enzyme injection, single cord) is billed with a diagnosis of Dupuytren's contracture, and administration code 20527 or J0775 has not been billed for the same date of service or in the previous three days.</td></tr>
<tr><td>Corticotropin</td><td>Tufts Health Plan does not routinely compensate IV infusion (96365-96371, 96373-96379) if billed with J0800 and no other drug administered by nonchemotherapy IV administration has been billed for the same date of service by any provider.</td></tr>
<tr><td>Cosyntropin (Cortrosyn™)</td><td>Tufts Health Plan does not compensate for J0833 or J0834 unless a diagnosis of screening for adrenocortical insufficiency or a diagnosis of infantile spasms is also present on the claim.</td></tr>
<tr><td>C1 esterase Inhibitor (Berinert®, Cinryze®)</td><td>Tufts Health Plan does not compensate for J0597 or J0598 unless a diagnosis of hereditary angioedema or acute myocardial infarction is not also present on the claim.</td></tr>
<tr><td>Daratumumab (Darzalex®)</td><td>Tufts Health Plan does not routinely compensate J9145 under any of the following circumstances:
If billed more than once per week with a diagnosis of multiple myeloma
If billed with modifier JW and the units equal or exceed 10</td></tr>
<tr><td rowspan="5">Darbepoetin alfa (Aranesp®)</td><td>Tufts Health Plan does not compensate for J0881 if ferritin, iron or iron binding capacity has not been billed within the past three months prior to administering darbepoetin.</td></tr>
<tr><td>Tufts Health Plan does not compensate for J0881 if a diagnosis of chronic renal failure is billed on the claim but a diagnosis for anemia in chronic kidney disease is not also present on the claim.</td></tr>
<tr><td>Tufts Health Plan limits coverage of the initial dose of J0881 to 86 units for the diagnosis of chronic renal failure if darbepoetin alfa or epoetin alfa has not been billed by any provider in the previous 35 days.</td></tr>
<tr><td>Tufts Health Plan limits coverage of J0881 or J0882 to one administration every 6 days when billed by any provider.</td></tr>
<tr><td>Tufts Health Plan does not compensate for J0881 or J0882 if any of the following have not been billed on the same day or within the last 7 days by any provider:
80050 (general health panel)
80055 (obstetrical panel)
85025 (CBC, automated with WBC)
85027 (CBC, automated)
85013 (hematocrit, spun)
85014 (hematocrit)
85018 (hemoglobin)
G0306 (CBC, automated with WBC)
G0307 (CBC, automated)</td></tr>
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Policy	Description
	Tufts Health Plan will not routinely compensate for J0881 if billed without the following diagnoses combinations: • Nonmyeloid malignant neoplasm and anemia • Hepatitis C treatment with ribavirin and anemia of other chronic disease
	Tufts Health Plan limits coverage of coverage of J0882 to 52 combined units if: • J0882 has not been billed in the previous 28 days or • Q4081 (epoetin alfa, 100 units for ESRD use) has not been billed in the previous two weeks
	Tufts Health Plan does not routinely compensate J0882 unless 82728 (ferritin), 83540 (iron), 83550 (iron binding capacity), or 84466 (transferrin) have also been billed for the same date of service or within the past three months.3
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0881 when billed and a diagnosis for anemia in neoplastic disease is present and a diagnosis of neoplasm is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0881 when billed and hemoglobin studies (80050, 80055, 80081, 85013, 85014, 85018, 85025, 85027, G0306, or G0307) has not been billed by any provider on the same day, or within the past month.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0882 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Darbepoetin alfa (Aranesp®)	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0882 when billed and the diagnosis is end stage renal disease, and a diagnosis for anemia in chronic kidney disease is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0882 when billed and the diagnosis is end stage renal disease, and a diagnosis of dependence on renal dialysis is not also present.
Decitabine	Tufts Health Plan limits J0894 to 49 units per date of service if billed with a diagnosis of myelofibrosis.
Denosumab (Prolia®, Xgeva®)	Tufts Health Plan limits coverage of J0897 to the following: • 60 combined units per date of service if billed by any provider unless the diagnosis is adults and skeletally mature adolescents with giant cell tumor of bone, hypercalcemia of malignancy refractory to bisphosphonate therapy, or prevention of skeletal-related events in members with bone metastases from solid tumors. • once per 26 days and the diagnosis is prevention of skeletal-related events in members with bone metastases from solid tumors
	Tufts Health Plan will not compensate for J0897 when billed without a diagnosis for an FDA-approved indication or an off-labeled indication.

Policy	Description
	Tufts Health Plan does not compensate for J0897 when billed more than two times every 46 weeks by any provider for a diagnosis of: • Intolerance to other osteoporosis therapy • Men receiving androgen deprivation therapy for prostate cancer • Men with osteoporosis at high risk for fracture • Postmenopausal women with osteoporosis at high risk for fracture • Prevention of postmenopausal osteoporosis • Women receiving aromatase inhibitor therapy for breast cancer.
	Tufts Health Plan limits J0897 to 120 combined units per date of service by any provider if the diagnosis is bone metastases, giant cell tumor of bone, hypercalcemia of malignancy or multiple myeloma.
Docetaxel (Taxotere®)	Tufts Health Plan does not compensate for J9171 for the diagnosis of occult primary unless carboplatin, cisplatin, fluorouracil or gemcitabine have been billed for the same date of service.
	Tufts Health Plan does not routinely compensate for J9171 if billed without an FDA-approved indication or an off-labeled indication on the claim.
	Tufts Health Plan limits coverage of J9171 to 185 units per date of service and the diagnosis is esophageal cancer, Ewing's sarcoma, occult primary, or osteosarcoma.
	Tufts Health Plan limits J9171 to 147 units per date of service if billed by any provider with a diagnosis of thyroid carcinoma.
Doxorubicin HCl liposome (Doxil®)	Tufts Health Plan does not routinely compensate J9002, Q2049 or Q2050 if billed without an FDA-approved indication or an off-label indication.
	Tufts Health Plan limits coverage of J9002, Q2049 or Q2050 to one time every 20 days if billed by any provider and the diagnosis on the claim is bladder cancer, endometrial carcinoma, endometrial sarcoma, mycosis fungoides, ovarian cancer/primary peritoneal cancer, or soft tissue sarcoma.
	Tufts Health Plan will not routinely compensate for 96401-96411, 96420-96450, 96542, or Q0083 if billed with Q2049 or Q2050 and another drug administered by chemotherapy administration has not been billed for the same date of service by any provider.
	Tufts Health Plan does not routinely compensate Q2049 or Q2050 if billed with a diagnosis of Kaposi's sarcoma unless a diagnosis of human immunodeficiency virus (HIV) disease is present.
	Tufts Health Plan limits Q2049 or Q2050 to the following: • 5 units per date of service if the diagnosis is AIDS-related Kaposi's sarcoma or Castleman's disease • 13 units per date of service if billed with a diagnosis of breast cancer, dermatofibrosarcoma protuberans, endometrial carcinoma, ovarian cancer/primary peritoneal cancer, soft tissue sarcoma or uterine sarcoma
Durvalumab	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9173 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9173 to 136 units per date of service by any provider when billed and the diagnosis is non-small cell lung cancer or urothelial carcinoma.

Policy	Description
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9173 when billed by any provider more than one visit every two weeks and the diagnosis is non-small cell lung cancer or urothelial carcinoma.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9173 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 12.
Eculizumab (Soliris®)	Tufts Health Plan limits J1300 to 90 combined units per date of service or 600 combined units in 10 weeks if a diagnosis of paroxysmal nocturnal hemoglobinuria is billed.
Epoetin alfa (Procrit®, Epogen®)	Tufts Health Plan limits coverage of J0885 to 60 combined units per date of service when the member is more than 17 years of age, J0885 or Q4081 has been billed in the previous week by any provider, and the diagnosis on the claim is any of the following: • End-stage renal disease (ESRD) • Chronic kidney disease • Non-myeloid malignancy • Personal history of antineoplastic chemotherapy
	Tufts Health Plan does not routinely compensate for J0885 when billed with a non-myeloid malignancy diagnosis if a diagnosis for anemia is not also present on the claim.
	Tufts Health Plan does not routinely compensate for J0886 or Q4081 when a diagnosis of ESRD, renal dialysis status, or encounter for dialysis is present on the claim AND anemia for chronic kidney disease or anemia, unspecified is not also present on the claim.
	Tufts Health Plan limits coverage of J0885 for nonESRD use to 40 units per day if the diagnosis on the claim is myelodysplastic syndrome and the member's age is 17 years of age or older.
	Tufts Health Plan does not routinely compensate for J0885 for nonESRD use when a diagnosis for chronic renal failure is billed and the diagnosis of anemia is not also present on the claim.
	Tufts Health Plan limits coverage of J0885 to 40 units if the diagnosis is nonmyeloid malignancy and the member's age is 17 years or greater when billed within 42 days by any provider.
	Tufts Health Plan does not routinely compensate for J0885 if ferritin, iron or iron binding capacity has not been billed within the past three months prior to administering epoetin alfa.
	Tufts Health Plan does not routinely compensate for J0885, J0886 or Q4081 if the diagnosis on the claim is chronic renal failure and the following have not been billed by any provider within the past year: • 80047 (Basic metabolic panel) • 80048 (basic metabolic panel) • 80050 (general health panel) • 80053 (comprehensive metabolic panel) • 84520 (BUN) • 84525 (BUN) • 82565 (creatinine, blood) • 82570 (creatine, other source) • 82575 (creatinine, clearance) • 82610 (Cystatin C)

Policy	Description
	Tufts Health Plan does not routinely compensate for J0885, J0886, Q4081) if any of the following have not been billed within the previous two weeks by any provider: • 80050 (general health panel) • 80055 (obstetrical panel) • 80081 (obstetric panel, includes HIV testing) • 85025 (CBC, automated with WBC) • 85027 (CBC, automated) • 85013 (Hematocrit, spun) • 85014 (Hematocrit) • 85018 (Hemoglobin) • G0306 (CBC, automated with WBC) • G0307 (CBC, automated)
	Tufts Health Plan does not routinely compensate J0885 if billed with a diagnosis of anemia due to neoplastic disease or anemia in members receiving immunosuppressive chemotherapy with at least two additional months of planned chemotherapy, unless a laboratory service that includes hemoglobin testing has been billed for the same date of service or in the previous two weeks by any provider.
	Tufts Health Plan does not routinely compensate J0885 if billed with a diagnosis of anemia in members with chronic kidney disease not on dialysis unless an iron status study (82728, 83540, 83550) has been billed on the same date of service or within the previous 12 weeks
	Tufts Health Plan limits J0885 to the following when billed by any provider: • 12 combined units per date of service if the diagnosis is anemia in patients with chronic kidney disease not on dialysis and the member is 17 years of age or older on the date of service, and J0885 has not been billed in the previous week by any provider. • 6 combined units per date of service if the diagnosis is anemia in members with congestive heart failure
	Tufts Health Plan does not routinely compensate subcutaneous or intramuscular injection (96372) if billed with J0885 and all of the following are met: • The diagnosis is anemia in members receiving myelosuppressive chemotherapy with at least two additional months of planned chemotherapy • The member is less than 18 years of age • No other nonchemotherapy subcutaneous or intramuscular drug has been billed for the same date of service by any provider
Eribulin Mesylate (Halaven®)	Tufts Health Plan does not routinely compensate for J9179 unless the diagnosis on the claim is malignant neoplasm of the breast.
	Tufts Health Plan will not routinely compensate for 96401-96406, 96413-96450,96542 or 96549 (chemotherapy administration by other than intravenous push technique code) if billed with J9179 and no other drug administered via chemotherapy administration is billed for the same date of service by any provider.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1439 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.

Policy	Description
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1439 when billed with a diagnosis of anemia in chronic kidney disease and a diagnosis of chronic kidney disease is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1439 when billed with a diagnosis of anemia complicating pregnancy and a diagnosis of iron deficiency anemia is not also present.
Etelcalcetide	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0606 when billed with a diagnosis of ESRD and a diagnosis of dependence on renal dialysis is not also present on the claim.
Ferric Carboxymaltose	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1439 when billed with a diagnosis of encounter for antineoplastic chemotherapy or encounter for other specified aftercare, and a diagnosis of anemia due to antineoplastic chemotherapy is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1439 when billed with a diagnosis of encounter for antineoplastic chemotherapy or encounter for other specified aftercare, and a diagnosis of anemia due to antineoplastic chemotherapy is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1439 when billed and the patient is less than 18 years of age and the diagnosis is cancer-induced anemia, chemotherapy-induced anemia, iron deficiency anemia, iron deficiency anemia in chronic kidney disease, iron deficiency anemia in end-stage renal disease on dialysis, iron deficiency anemia associated with heart failure, iron deficiency of pregnancy, or restless legs syndrome [Willis-Ekbom disease].
Ferumoxytol (Feraheme®)	Tufts Health Plan does not routinely compensate for Q0139 unless billed with a diagnosis of ESRD.
	Tufts Health Plan does not routinely compensate for Q0138 unless billed with a diagnosis of cancer-induced anemia, chemotherapy-induced anemia, chronic kidney disease, intolerance to oral iron supplementation, iron deficiency anemia, iron deficiency anemia of pregnancy, or malabsorption disorders.
	Tufts Health Plan does not routinely compensate for Q0138 if the billed diagnosis is either encounter for antineoplastic chemotherapy and immunotherapy or convalescence and palliative care following chemotherapy and a diagnosis of anemia in neoplastic disease is not also present on the claim
	Tufts Health Plan does not routinely compensate for Q0138 if the diagnosis on the claim is nonmyeloid malignancy and a diagnosis of antineoplastic chemotherapy induced anemia is not also present on the claim.
	Tufts Health Plan limits coverage of Q0138 or Q0139 to 510 combined units per date of service when billed by any provider.
	Tufts Health Plan does not routinely compensate for Q0138 for non-ESRD use when a diagnosis of chronic kidney disease is billed and a diagnosis of iron deficiency or anemia of chronic kidney disease is not also present on the claim.

Policy	Description
	Tufts Health Plan does not routinely compensate for Q0138 for the diagnosis of intestinal malabsorption unless a diagnosis of iron deficiency anemia is not also present on the claim.
	Tufts Health Plan does not routinely compensate Q0139 if billed with a diagnosis of anemia in chronic kidney disease and a diagnosis of ESRD is not present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate Q0138 when billed with a diagnosis of intolerance to oral iron, unsatisfactory or impossible oral administration, or malabsorption disorders, and a diagnosis of anemia in other chronic disease classified elsewhere is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit Q0138 to 1020 combined units per week by any provider and the diagnosis is iron deficiency anemia in patients with chronic kidney disease, iron deficiency anemia in patients with intolerance to oral iron, or iron deficiency anemia of pregnancy.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate Q0139 when billed with a diagnosis of end stage renal disease and a diagnosis of dialysis status is not also present on the claim.
Filgrastim (Neupogen®)	Tufts Health Plan does not routinely compensate for J1442 if billed with a neoplasm diagnosis and a claim for either a chemotherapy administration or a chemotherapy drug has not been billed in the previous two weeks by any provider.
	Tufts Health Plan does not routinely compensate for J1442 if billed by any provider on the same date of service as a cytotoxic chemotherapy drug.
	Coverage for J1442 is limited to two units when billed with a diagnosis of myelodysplastic syndrome or acute lymphoid leukemia.
	Tufts Health Plan does not routinely compensate for filgrastim when billed with a chemotherapy administration code and a CBC with differential (80050, 80055, 80081, 85004–85009, 85025–85032, 85048, 85060, G0306, G0307) has not been billed by any provider for the same date of service or within the 10 days prior to the administration.
	Tufts Health Plan limits coverage of filgrastim (J1442) to 1136 combined units per date of service when billed with a diagnosis of the following by any provider: • Aplastic anemia • Cancer patients receiving bone marrow transplant • Chemotherapy-induced neutropenia • Infectious disease prophylaxis in members with esophageal cancer • Decreasing the period of neutropenia following reinfusion of peripheral blood stem cells • Febrile neutropenia • Ganciclovir-induced neutropenia • HIV-induced neutropenia • Prophylaxis for members with acute lymphoid leukemia

Policy	Description
	Tufts Health Plan does not routinely compensate for filgrastim (J1442, Q5101) when billed with the following diagnoses unless a diagnosis for neutropenia is also on the claim: • Pre-eclampsia • Human immunodeficiency virus [HIV] disease • Fever presenting with conditions classified elsewhere
	Tufts Health Plan does not routinely compensate for filgrastim (J1442, Q5101) when billed with a bone marrow transplant diagnosis unless a claim for a bone marrow transplant (38204-38242) has been billed in the previous three weeks by any provider.
	Tufts Health Plan does not routinely compensate for filgrastim (J1442, J1447, Q5101) if billed on the same date of service or within the previous 13 days as J2505 (pegfilgrastim).
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1442, Q5101, or Q5110 when billed and the diagnosis on the claim is encounter for other specified aftercare, and a diagnosis describing the condition that is requiring care is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1442, Q5101, or Q5110 when billed and the diagnosis on the claim is encounter for antineoplastic chemotherapy and immunotherapy and a white blood cell (WBC) count with differential has not been billed for the same date of service or in the previous week by any provider.
Fluocinolone Acetonide, Intravitreal Implant (Iluvien)	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7313 when billed without intravitreal injection of a pharmacologic agent (67028).
Fosaprepitant (Emend®)	Tufts Health Plan does not routinely compensate for fosaprepitant (J1453) unless a highly or moderately emetogenic chemotherapy agent is not also present on the claim for the same date of service.
	Tufts Health Plan does not routinely compensate for intravenous infusion, for therapy, prophylaxis, or diagnosis; each additional hour or for non-intravenous administration codes when billed with J1453 if no other drug administered using one of these techniques has been billed for the same date of service.
	Tufts Health Plan does not routinely compensate for J1453 if the member's age is 17 years or younger on the date of service.
	Tufts Health Plan limits coverage of J1453 to 150 combined units per date of service when billed by any provider.
Fulvestrant (Faslodex®)	Tufts Health Plan does not routinely compensate for J9395 unless a diagnosis of metastatic breast cancer is present on the claim.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9395 to 10 combined units per date of service by any provider and the diagnosis is endometrial carcinoma.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9395 when billed by any provider more than once every two weeks and the diagnosis is breast cancer.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9395 when billed by any provider more than once per month and the diagnosis is endometrial carcinoma.
Gemcitabine HCl (Gemzar®)	Tufts Health Plan does not routinely compensate for J9201 when billed without an FDA approved indication or an approved off-labeled indication on the claim.

Policy	Description
	Tufts Health Plan limits coverage of J9201 to the following when billed by any provider: • Once every 6 days • 10 combined units per date of service when billed with 50391 or 51720 (intravesical therapy) and a diagnosis of bladder cancer • 16 units per date of service if billed with a diagnosis of bladder cancer, cutaneous T-cell lymphoma, or germ cell tumor of the prostate cancer
	Tufts Health Plan limits J9201 to 13 units per date of service by any provider if the diagnosis is Ewing's sarcoma, mantle cell lymphoma, occult primary, osteosarcoma, thymoma and thymic carcinoma, or urothelial carcinoma of the prostate.
	Tufts Health Plan limits J9201 to 16 units per date of service by any provider if the diagnosis is AIDS-related B-cell lymphoma, cervical cancer, head and neck cancer, kidney cancer, non-Hodgkin's lymphoma (excluding cutaneous T-cell lymphoma and mantle cell lymphoma), non-small cell lung cancer, small cell lung cancer, or uterine sarcoma.
	Tufts Health Plan limits J9201 to 27 units per date of service.
Goserelin Acetate Implant (Zoladex®)	Tufts Health Plan limits coverage of J9202 to 3 units within 80 days when billed by any provider.
	Tufts Health Plan limits coverage of J9202 to 1 unit per date of service if the diagnosis on the claim is benign prostatic hyperplasia, breast cancer, dysfunctional uterine bleeding, endometriosis, invitro fertilization, ovarian carcinoma, or uterine leiomyomata.
	Tufts Health Plan does not routinely compensate for J9202 if billed without an FDA-approved indication or an off-label recommended indication.
	Tufts Health Plan limits coverage of J9202 to 3 combined units per date of service by any provider.
	Tufts Health Plan does not routinely compensate J9202 if billed more than once within a month.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9202 when billed by any provider more than three units within a three month period.
Golimumab (Simponi Aria®)	Tufts Health Plan limits coverage of J1602 to 228 combined units per date of service or once every 26 days when billed by any provider.
Histrelin Implant (Supprelin LA®, Vantas®)	Tufts Health Plan does not routinely compensate for J9225 or J9226 if 11981 (insertion, non-biodegradable drug delivery implant) or 11983 (removal and reinsertion of nonbiodegradable drug delivery implant) has not been billed on the same date of service or in the previous two weeks by any provider.
	Tufts Health Plan does not routinely compensate for J9226 if billed without a diagnosis of central precocious puberty (CPP) or if billed for members who are over the age of 12 on the date of service.
Human Antithrombin III	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7197 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Hydroxyprogesterone caproate (Makena)	Tufts Health Plan does not routinely compensate J1726 if billed more than one unique visit per week and the diagnosis is singleton pregnancy with history of singleton spontaneous preterm birth.

Policy	Description
Immune Globulins, IM (BayGam® GamaStan® S/D)	Tufts Health Plan does not routinely compensate for immune globulins, IM (90281, J1460, J1560) unless the diagnosis is hepatitis A prophylaxis, IgA nephropathy, immunoglobulin deficiency, measles prophylaxis, post-exposure prophylaxis for rubella during pregnancy, rubella during pregnancy (definitive diagnosis) or varicella prophylaxis.
Infliximab (Remicade®)	Tufts Health Plan does not routinely compensate for the chemotherapy administration, IV infusion technique, first hour of J1745 unless the chemotherapy administration, IV infusion technique, each additional hour has been billed for the same date of service.
	Tufts Health Plan limits J1745 to the following when billed by any provider: • Once every 6 days • Once every 12 days with the diagnosis of an FDA-approved or an off-label recommended indication • 57 units per date of service if billed with a diagnosis of pediatric regional enteritis (Crohn's disease) or pediatric ulcerative colitis and the member's age is less than 18 years • 69 combined units per date of service for the diagnosis is juvenile idiopathic arthritis • 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 • 114 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.
	Tufts health Plan limits J1745 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.
	Tufts Health Plan does not routinely compensate for J1745 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 • Pediatric regional enteritis (Crohn's disease) • Pediatric ulcerative colitis • Plaque psoriasis • Psoriatic arthritis • Pyoderma gangrenosum with inflammatory bowel disease
	Tufts Health Plan will not routinely compensate for J1745 or Q5102 to 342 combined units within a 26-week period by any provider and the diagnosis is any of the following: • Acute graft-versus-host disease following peripheral blood stem cell transplant • Adult ankylosing spondylitis • Adult-onset Still's disease • SAPHO syndrome • Sarcoidosis

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<tr><th>Policy</th><th>Description</th></tr>
<tr><td rowspan="2"></td><td>Tufts Health Plan limits J1745 or Q5102 to 342 combined units within a 26-week period if:
The diagnosis is acute graft-versus-host disease following peripheral blood stem cell transplant, adult ankylosing spondylitis, adult-onset Still's disease, SAPHO syndrome, or sarcoidosis
The member is less than 18 years of age on the date of service, and the diagnosis is pediatric regional enteritis (Crohn's disease) or pediatric ulcerative colitis
The member is greater than 18 years of age on the date of service and the diagnosis is adult regional enteritis (Crohn's disease) or adult ulcerative colitis</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J1745, Q5103, Q5104, or Q5109 to 114 combined units per date of service by any provider.</td></tr>
<tr><td rowspan="6">Intrauterine Contraceptive Systems and Contraceptive Implants</td><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7296, J7297 or J7301 when billed and the diagnosis is not prevention of pregnancy, endometrial hyperplasia, endometriosis or menopausal symptoms.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7298 when billed and the diagnosis is not endometriosis, menopausal symptoms, menorrhagia, endometrial hyperplasia or prevention of pregnancy.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7300 when billed and the diagnosis is not prevention of pregnancy.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7307 when billed and the diagnosis is not endometriosis, chronic pelvic pain of female, associated with pelvic congestion syndrome or prevention of pregnancy.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7296, J7297, J7298, J7300, or J7301 when billed by any provider more than one visit every three years, and intrauterine device removal (58301) has not been billed for the same date of service, or within the previous three years.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7307 when billed by any provider and drug delivery implant insertion code 11981 or 11983 has not been billed for the same date of service.</td></tr>
<tr><td rowspan="4">Ipilimumab (Yervoy™)</td><td>Tufts Health Plan limits coverage of J9228 to once every 19 days or 1136 combined units per date of service when billed by any provider.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate J9228 if billed more than seven times per year when the diagnosis is central nervous system metastases (melanoma), melanoma, or small cell lung cancer.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9228 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9228 to 136 combined units per date of service by any provider and the diagnosis on the claim is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer.</td></tr>
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<tr><th>Policy</th><th>Description</th></tr>
<tr><td rowspan="5">Irinotecan (Camptosar®)</td><td>Tufts Health Plan does not routinely compensate for J9206 without an FDA-approved or an off-label recommended indication.</td></tr>
<tr><td>Tufts Health Plan limits coverage of J9206 to 3 combined units per date of service by any provider when the diagnosis is Ewing's sarcoma.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate J9206 if billed and the member is less than 18 years of age on the date of service and the diagnosis is any of the following:
Acute lymphoblastic leukemia
Acute myeloid leukemia
Anaplastic glioma
Breast cancer
Cervical cancer
Colorectal cancer
Esophageal cancer
Esophagogastric junction cancer
Gastric cancer
Glioblastoma multiforme
Non-Hodgkin's lymphoma
Non-small cell lung cancer
Occult primary
Ovarian cancer
Pancreatic adenocarcinoma
Small cell lung cancer
Vaginal cancer</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate J9205 if billed by any provider more than once every two weeks with a diagnosis of pancreatic adenocarcinoma.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate J9206 if billed and one of the following laboratory services has not been billed for the same date of service or in the previous 7 days by any provider:
80050 (general health panel)
80055, 80081 (obstetrical panel)
85004-85007 (differential WBC count)
85009 (manual differential WBC count, buffy coat)
85025-85027 (complete CBC)
85032 (manual cell count)
G0306-G0307 (complete CBC)</td></tr>
<tr><td rowspan="4">Iron dextran
(INFed®)</td><td>Tufts Health Plan limits coverage of J1750 to 20 units when billed for any diagnosis other than antepartum anemia or chronic kidney disease diagnoses.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate J1750 when billed without a diagnosis cancer-induced anemia, chemotherapy-induced anemia, chronic kidney disease, epidermolysis bullosa, intolerance to oral iron supplementation, iron deficiency anemia, iron deficiency anemia of pregnancy, malabsorption disorders, or preterm infant with neonatal anemia.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate J1750 if diagnosis of encounter for antineoplastic chemotherapy and immunotherapy or convalescence and palliative care following chemotherapy is billed and diagnosis of anemia in neoplastic disease is not also present on the claim.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate J1750 if a diagnosis of non-myeloid malignancy is billed and a diagnosis of antineoplastic chemotherapy induced anemia is not also present on the claim.</td></tr>
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Policy	Description
	Tufts Health Plan does not routinely compensate J1750 if billed with any of the following diagnoses unless a diagnosis of iron deficiency anemia is also billed: • Epidermolysis bullosa • Intolerance to oral iron supplementation • Iron deficiency anemia of pregnancy • Malabsorption disorders
	Tufts Health Plan does not routinely compensate J1750 if billed with a diagnosis of anemia complicating pregnancy and a diagnosis of iron deficiency anemia is not also present.
	Tufts Health Plan does not routinely compensate J1750 if billed with a diagnosis of encounter for antineoplastic chemotherapy and a diagnosis of nonmyeloid malignancy is not also present.
Iron Sucrose (Venofer®)	Tufts Health Plan limits coverage of J1756 to the following when billed by any provider: • 200 units unless the diagnosis on the claim is chronic kidney disease • 500 combined units per date of service
	Tufts Health Plan does not routinely compensate J1756 if billed with a diagnosis of encounter for antineoplastic chemotherapy and immunotherapy, or convalescence and palliative care following chemotherapy if a diagnosis of anemia of chronic disease is not also present on the claim.
	Tufts Health Plan does not routinely compensate for J1756 if billed with a diagnosis of nonmyeloid malignancy if a diagnosis of antineoplastic chemotherapy induced anemia is not also present on the claim.
	Tufts Health Plan does not routinely compensate for J1756 unless billed with a diagnosis of cancer-induced anemia, chemotherapy-induced anemia, chronic kidney disease, intolerance to oral iron supplementation, iron deficiency anemia, iron deficiency anemia of pregnancy, malabsorption disorders, or preterm infant with neonatal anemia.
	Tufts Health Plan does not routinely compensate for J1756 when billed with a diagnosis of chronic kidney disease only if a diagnosis of iron deficiency or anemia of chronic disease is also present on the claim.
	Tufts Health Plan does not routinely compensate for J1756 when a diagnosis of intestinal malabsorption intolerance to oral iron supplementation, iron deficiency anemia of pregnancy or malabsorption disorders is billed and a diagnosis of iron deficiency anemia is not also present on the claim.
	Tufts Health Plan does not routinely compensate J1756 if billed with a diagnosis of ESRD unless a diagnosis of dialysis status is also present.
	Tufts Health Plan limits J1756 to 300 combined units per date of service by any provider when the diagnosis is cancer-induced anemia or chemotherapy-induced anemia.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1756 when billed with a diagnosis of anemia in neoplastic disease and a diagnosis of non-myeloid malignancy is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1756 when billed with a diagnosis of encounter for antineoplastic chemotherapy and a diagnosis of non-myeloid malignancy is not also present.

Policy	Description
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1756 when billed with a diagnosis of chronic heart failure and a diagnosis of iron deficiency anemia is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1756 when billed with a diagnosis of anemia complicating pregnancy and a diagnosis of iron deficiency anemia is not also present.
Ixabepilone (Ixempra®)	Tufts Health Plan will not routinely compensate for 96413 (chemotherapy administration, IV infusion technique, first hour) when billed with ixabepilone (J9307) and 96415 (chemotherapy administration, IV infusion technique, each additional hour) has not been billed for the same date of service.
	Tufts Health Plan does not routinely compensate J9207 if billed without an FDA-approved indication or an approved off-labeled indication.
Lanreotide (Somatuline Depot®)	Tufts Health Plan does not routinely compensate for J1930 when billed without an FDA-approved indication or an approved off-labeled indication.
	Tufts Health Plan will not routinely compensate for J1930 when billed by any provider more than once every 26 days and the diagnosis is acromegaly or gastroenteropancreatic neuroendocrine tumors.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1930 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Leuprolide acetate, 1 mg	Tufts Health Plan does not routinely compensate for J9218 without an FDA approved indication or an off-label recommended indication.
	Tufts Health Plan will not routinely compensate for Leuprolide acetate (J9218) when billed and the member's age is less than 18 years and the diagnosis is other than central precocious puberty.
Leuprolide acetate depot, 3.75 mg (Lupron Depot®)	Tufts Health Plan does not routinely compensate for leuprolide acetate depot, 3.75 mg (J1950) for female members unless the diagnosis on the claim is any of the following: • Amenorrhea induction prior to bone marrow transplant • Breast cancer (female) • Central precocious puberty • Endometriosis • Infertility • Irritable bowel syndrome • Catamenial pneumothorax • Ovarian cancer • Premenstrual syndrome • Uterine leiomyomata
	Tufts Health Plan does not routinely compensate for J1950 without an FDA-approved indication or an off-label recommended indication.
	Tufts Health Plan will not routinely compensate for J1950 if billed by any provider more than once per month.
	Tufts Health Plan will not routinely compensate for J1950 if the member's age is less than 18 years on the date of service and the diagnosis is anything other than central precocious puberty.

Policy	Description
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J1950 to three combined units in 10 weeks by any provider when the diagnosis on the claim is benign prostatic hyperplasia, breast cancer, endometriosis, premenstrual syndrome, or uterine leiomyomata.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1950 when billed and the diagnosis is prostate cancer.
Leuprolide Acetate depot, 7.5 mg (Lupron Depot®)	Tufts Health Plan does not routinely compensate for leuprolide acetate depot, 7.5 mg (J9217) for male members unless the diagnosis on the claim is benign prostatic hyperplasia, central precocious puberty, prostate cancer, or stuttering priapism.
	Tufts Health Plan limits coverage of leuprolide acetate depot, 7.5 mg (J9217) to 12 in a 48-week period for the diagnosis of prostate cancer.
	Tufts Health Plan limits coverage of leuprolide acetate depot, 7.5 mg (J9217) to once in 30 days when billed by any provider.
	Tufts Health Plan does not routinely compensate for leuprolide acetate depot, 7.5 mg (J9217) for female members unless the diagnosis on the claim is amenorrhea induction prior to bone marrow transplant, central precocious puberty, irritable bowel syndrome, catamenial pneumothorax, or ovarian cancer.
	Tufts Health Plan will not routinely compensate for Leuprolide acetate (J9217) when billed and the member is less than 18 years of age and the diagnosis is other than central precocious puberty.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9217 when billed more than once per month by any provider and the diagnosis on the claim is amenorrhea induction prior to bone marrow transplant, central precocious puberty, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, prostate cancer, salivary gland tumor, or stuttering priapism.
Mepolizumab	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J2182 to 100 combined units per date of service by any provider when billed and the diagnosis is severe asthma of eosinophilic phenotype.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J2182 when billed by any provider more than once per month and the diagnosis is eosinophilic granulomatosis with polyangiitis or severe asthma of eosinophilic phenotype.
Natalizumab (Tysabri®)	Tufts Health Plan limits coverage of natalizumab (J2323) to 341 combined units per date of service when billed by any provider.
Nivolumab (Opdivo®)	Tufts Health Plan will not routinely compensate for J9299 if billed without an FDA-approved indication.
	Tufts Health Plan will not routinely compensate for nivolumab (J9299) when billed with a diagnosis of unresectable or metastatic malignant melanoma, and BRAF V600 mutation testing has not been previously billed by any provider in the member's lifetime.
	Tufts Health Plan limits coverage of nivolumab (J9299) to 342 combined units per date of service by any provider with a diagnosis of Hodgkin's lymphoma (classical).
	Tufts Health Plan will not routinely compensate for nivolumab (J9299) when billed with modifier JW and the units equal or exceed 40.
	Tufts Health Plan limits J9299 to 114 combined units per date of service when billed with J9228 by any provider and the diagnosis is melanoma.

<table>
<tr><th>Policy</th><th>Description</th></tr>
<tr><td></td><td>Tufts Health Plan does not routinely compensate J9299 if billed with a diagnosis of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer, unless 81301, 81479, 88341, 88342, or 0037U (MSI-H or dMMR testing) or J9299 has not been previously billed by any provider in the member's lifetime.</td></tr>
<tr><td>Ocriplasmin</td><td>Tufts Health Plan limits J7316 to 3 combined units per date of service by any provider.</td></tr>
<tr><td rowspan="3">Octreotide acetate (Sandostatin LAR Depot®)</td><td>Tufts Health Plan does not routinely compensate for J2353 without an FDA-approved indication or an off-label recommended indication.</td></tr>
<tr><td>Tufts Health Plan limits coverage of J2353 to the following when billed by any provider:
40 combined units per date of service
20 combined units per date of service for the diagnosis of angiodysplasia of the intestine with hemorrhage, postgastrectomy dumping syndrome, or thymoma and thymic cancer
30 combined units per date of service for the diagnosis of carcinoid/neuroendocrine tumors, chemotherapy-induced diarrhea, or vasoactive intestinal peptide tumor (VIPoma) service
One visit every 12 days
Once every 26 days for the diagnosis of acromegaly, AIDS-related diarrhea, angiodysplasia of the intestine with hemorrhage, chemotherapy-induced diarrhea, enterocolic fistula, gastroesophageal varices, postgastrectomy dumping syndrome, meningioma, or vasoactive intestinal peptide tumor (VIPoma) service</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate for intravenous infusion other than intramuscular technique for J2353 unless another drug has been billed for the same date of service.</td></tr>
<tr><td>Ofatumumab (ARZERRA™)</td><td>Tufts Health Plan will not routinely compensate ofatumumab (J9302) when billed by any provider more than 15 unique visits in two years and the diagnosis on the claim is chronic lymphocytic leukemia/small cell lymphoma (CLL/SLL).</td></tr>
<tr><td>Olaratumab</td><td>Tufts Health Plan does not routinely compensate J9285 if billed by any provider more than 2 visits every 3 weeks and the diagnosis is soft tissue sarcoma.</td></tr>
<tr><td>Omalizumab (Xolair®)</td><td>Tufts Health Plan limits coverage of omalizumab (J2357) to the following:
75 combined units per date of service for the diagnosis of moderate to severe persistent asthma when billed by any provider
60 combined units every three weeks by any provider when billed with a diagnosis of seasonal allergic rhinitis or adjunct to subcutaneous immunotherapy (unless a diagnosis of moderate to severe persistent asthma is also billed on the claim)
150 combined units every 26 days when billed by any provider
Once every 12 days when billed by any provider
once every 26 days for the diagnosis of chronic idiopathic urticaria or latex allergy when billed by any provider
150 combined units per date of service by any provider when the diagnosis is latex allergy</td></tr>
</table>

Policy	Description
	Tufts Health Plan does not compensate drug administration services (Other than for subcutaneous technique) when billed with omalizumab (J2357) and no other drug has been billed for the same date of service by any provider.
Oxaliplatin (Eloxatin®)	Tufts Health Plan limits coverage of oxailplatin (J9263) to the following: • 640 combined units per date of service when billed by any provider • 450 units per date of service for the diagnosis of esophageal or head and neck cancer when billed by any provider
	Tufts Health Plan does not routinely compensate for oxaliplatin (J9263) when billed more than once every three weeks by any provider if the diagnosis on the claim is breast cancer or ovarian cancer.
	Tufts Health Plan does not routinely compensate for oxaliplatin (J9263) when billed by any provider more than once every 12 days and the diagnosis on the claim is colorectal cancer, esophageal cancer, head and neck cancer, non-Hodgkin's lymphoma, occult primary, pancreatic cancer or small intestine cancer.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9263 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 100.
Paclitaxel (Taxol®)	Tufts Health Plan does not routinely compensate for paclitaxel (J9265, J9267) when one of the following laboratory codes is not billed for the same date of service or in the previous 20 days by any provider: • 80050 (general health panel) • 80055 (obstetrical panel) • 85004–85007 (differential WBC count) • 85009 (manual differential WBC count, buffy coat) • 85018 (hemoglobin) • 85025–85027 (complete CBC) • 85032 (manual cell count) • 85049 (platelet count) • G0306-G0307 (complete CBC)
	Coverage for paclitaxel (J9265) is limited to the following: • Once every six days; or • Once in 13 days when billed by any provider if the diagnosis on the claim is Kaposi's sarcoma
	Tufts Health Plan does not routinely compensate J9267 if billed without an FDA-approved indication or an approved off-labeled indication.
Paclitaxel protein-bound particles (Abraxane®)	Tufts Health Plan does not routinely compensate for J9264 if billed without an FDA-approved or an off-label recommended indication.
	Tufts Health Plan limits 96413, 96417 (chemotherapy administration, intravenous infusion) to one unit when billed with J9264, the diagnosis is breast cancer, non-small cell lung cancer, ovarian cancer/primary peritoneal cancer, or pancreatic cancer, and no other drug administered via chemotherapy administration is billed for the same date of service.
	Tufts Health Plan limits coverage of J9264 to 637 combined units per date of service for the diagnosis of ovarian cancer when billed by any provider.

Policy	Description
	Tufts Health Plan does not routinely compensate J9264 if billed more than the following: • Once within a week with a diagnosis of breast cancer, hypersensitivity to docetaxel or paclitaxel, melanoma, non-small cell lung cancer, ovarian cancer, or pancreatic adenocarcinoma • Once within three weeks and the diagnosis is endometrial carcinoma, head and neck cancer, or urothelial carcinoma
	Tufts Health Plan does not routinely compensate J9264 if billed with a diagnosis of pancreatic adenocarcinoma unless J9201 (gemcitabine HCL) has been billed for the same date of service.
Palonosetron (Aloxi®)	Tufts Health Plan does not routinely compensate for administration codes 96365-96372 and 96379 when billed with J2469 unless another drug administered by non-chemotherapy administration services has been billed for the same date of service.
	Tufts Health Plan limits coverage of J2469 to the following: • 3 combined units per date of service when billed by any provider for diagnoses related to prevention of postoperative nausea and vomiting • 10 combined units per date of service when billed by any provider and the diagnosis is other than vomiting following gastrointestinal surgery, nausea with vomiting, or need for other prophylactic measure
	Tufts Health Plan does not routinely compensate for J2469 without an FDA approved indication or an off-label recommended indication.
Panitumumab	Tufts Health Plan does not routinely compensate for panitumumab (J9303) unless billed with a diagnosis of colorectal cancer or non-small cell lung cancer.
	Tufts Health Plan limits J9303 to the following when billed: • 69 combined units per date of service • One unit of 96415 (IV chemotherapy administration) if billed with J9303 and no other drug administered by IV chemotherapy administration has been billed for the same date of service
Pegfilgrastim (Neulasta®)	Tufts Health Plan does not routinely compensate for J2505 if billed by any provider within 11 days prior to the administration of a cytotoxic chemotherapy drug.
	Tufts Health Plan does not routinely compensate for J2505 when billed without an FDA-approved or an off-label recommended indication.
	Tufts Health Plan limits coverage of J2505 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.
	Tufts Health Plan limits coverage of J2505 to two units when billed by any provider.
	Tufts Health Plan will not routinely compensate for J2505 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.

Policy	Description
	Tufts Health Plan does not routinely compensate J2505 if the member is less than 18 years of age on the date of service and the diagnosis is mobilization of peripheral blood progenitor cells prior to autologous stem cell transplantation, or post-peripheral blood peripheral blood progenitor cell transplant supportive care.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J2505, Q5108, or Q5111 when billed and the diagnosis on the claim is chemotherapy-induced neutropenia, and a diagnosis of neoplasm is not also present.
Pegloticase	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J2507 when billed and laboratory service for uric acid testing (84550) has not been billed for the same date of service or in the previous two weeks by any provider.
Pembrolizumab (Keytruda®)	Tufts Health Plan will not routinely compensate for pembrolizumab HCl (J9271) if an approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan will not routinely compensate for pembrolizumab (J9271) when billed by any provider more than once every 19 days and the diagnosis is head and neck carcinoma, melanoma, merkel cell carcinoma or non-small cell lung cancer.
	Tufts Health Plan limits J9271 to 200 combined units per date of service when the diagnosis is esophagogastric junction cancer, gastric cancer, head and neck cancer, Hodgkin's lymphoma (classical), melanoma, microsatellite instability-high cancer, non-small cell lung cancer, or urothelial carcinoma.
	Tufts Health Plan does not routinely compensate J9271 if: • Billed with modifier JW and the units equal or exceed 50 • Billed with a diagnosis of MSI-H or dMMR cancer, and MSI-H or dMMR testing (81301, 81479, 88341, 88342, or 0037U), or J9271 has not been previously billed by any provider in the member's lifetime
Pemetrexed (Alimta®)	Tufts Health Plan does not routinely compensate for J9305 without a FDA-approved or an off-label recommended indication.
	Tufts Health Plan does not routinely compensate for J9305 if any of the following have not been billed by any provider for the same date of service or within the past 20 days: • 80050 (general health panel) • 80055 (obstetrical panel) • 85004 (blood count, automated differential WBC count) • 85007 (blood count; blood smear with manual differential WBC count) • 85009 (blood count, manual differential WBC count) • 85025 (CBC, automated with WBC), 85027 (CBC, automated) • 85032 (blood count; manual cell count) • 85048 (leukocyte, automated) • 85049 (blood count; platelet, automated) • 82575 (creatinine clearance) • G0306 (CBC, automated with WBC) • G0307 (CBC, automated)
	Tufts Health Plan does not routinely compensate for chemotherapy administration codes other than IV push when billed with J9305 and no other drug administered via chemotherapy administration has been billed for the same date of service.
	Tufts Health Plan limits coverage of J9305 to once every 19 days when billed by any provider.

Policy	Description
	Tufts Health Plan limits coverage of J9305 to 148 combined units per date of service for the diagnosis of bladder cancer, breast cancer, cervical cancer, colorectal cancer, non-small cell lung cancer, pancreatic cancer, or renal cell cancer when billed by any provider.
	Tufts Health Plan limits coverage of J9305 to 123 combined units per date of service by any provider when the diagnosis on the claim is gastric cancer, mesothelioma, non-small cell lung cancer, or thymoma and thymic malignancy.
	Tufts Health Plan does not routinely compensate 96409 or 96411 (IV chemotherapy administration) if billed with J9305 in any combination with more than one unit and no other drug administered by IV chemotherapy push has been billed for the same date of service by any provider.
Pertuzumab (Perjeta®)	Tufts Health Plan limits coverage of pertuzumab (J9306) to once every 19 days when billed by any provider.
	Tufts Health Plan does not routinely compensate for pertuzumab (J9306) unless HER2 testing has been billed within the past 18 months by any provider.
	Tufts Health Plan does not routinely compensate 96409 or 96411 (IV push chemotherapy administration) if billed with J9306 and no other drug administered by IV chemotherapy push has been billed for the same date of service by any provider.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9306 to 420 units when billed and J9306 has been billed in the previous six weeks and the diagnosis is HER2-positive breast cancer.
Ramucirumab	Tufts Health Plan limits J9308 to once every two weeks and/or 182 combined units per date of service by any provider if billed with a diagnosis of colorectal cancer, esophageal cancer, esophagogastric junction cancer or gastric cancer.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9308 when billed by any provider more than once every three weeks and the diagnosis is non-small cell lung cancer.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9308 when billed with a diagnosis of colorectal cancer and concomitant chemotherapy agent J9190 (5-Fluorouracil) or J9206 (Irinotecan) has not been billed by any provider for the same date of service.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9308 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 20.
Ranibizumab (Lucentis®)	Tufts Health Plan does not routinely compensate for ranibizumab (J2778) when a diagnosis of central retinal vein occlusion or branch retinal vein occlusion is billed and a diagnosis of retinal edema is not also present on the claim.
	Tufts Health Plan does not routinely compensate for ranibizumab (J2778) when a diagnosis of diabetic macular edema is billed and a diagnosis of diabetes mellitus with ophthalmic manifestations is not also present on the claim.
	Tufts Health Plan does not routinely compensate for ranibizumab (J2778) unless billed with intravitreal injection of a pharmacologic agent (67028).
	Tufts Health Plan does not routinely compensate for ranibizumab (J2778) when billed without an FDA-approved indication or an off-label indication.

Policy	Description
	Tufts Health Plan limits coverage of ranibizumab (J2778) to one visit per month when billed by any provider.
Regadenoson (Lexiscan™)	Tufts Health Plan does not routinely compensate J2785 if billed and a myocardial stress test has not been billed on the same date of service.
Rituximab (Rituxan®)	Tufts Health Plan does not routinely compensate for intravenous push chemotherapy administration when billed with rituximab (J9310) unless another drug administered by chemotherapy administration has been billed for the same date of service.
	Tufts Health Plan does not routinely compensate for chemotherapy administration, IV infusion technique, first hour when billed with rituximab (J9310) unless chemotherapy administration, IV infusion technique, each additional hour has been billed for the same date of service.
	Tufts Health Plan does not routinely compensate for rituximab (J9310) when billed with a diagnosis of chronic graft-versus-host disease and a diagnosis of complications of transplanted stem cells is not also present.
	Tufts Health Plan does not routinely compensate for rituximab (J9310) 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
	Tufts Health Plan does not routinely compensate for rituximab (J9310) when billed more than one visit every two weeks by any provider for a diagnosis of: • Primary Sjögren's syndrome • Relapsing-remitting multiple sclerosis • Rheumatoid arthritis
	Tufts Health Plan limits coverage of rituximab (J9310) to 10 combined units per date of service by any provider when A9542 (Indium In-111 ibritumomab tiuxetan, diagnostic) or A9543 (Yttrium Y-90 ibritumomab tiuxetan, therapeutic) has not been billed for the same date of service and the diagnosis is not chronic lymphocytic leukemia, minimal change disease, or systemic lupus erythematosus.
	Tufts Health Plan will not routinely compensate for rituximab (J9310) when billed by any provider more than one visit every four days and the diagnosis is Evans syndrome or Waldenström's macroglobulinemia.
	Tufts Health Plan will not routinely compensate for rituximab (J9310) when billed by any provider more than 12 times in a member's lifetime and the diagnosis is chronic lymphocytic leukemia, hairy cell leukemia, large B-cell lymphoma, or mantle cell lymphoma.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9312 when billed by any provider more than eight visits per year and the diagnosis is Hodgkin's lymphoma [nodular lymphocyte-predominant] or rheumatoid arthritis.
Rituximab and Hyaluronidase	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9311 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.

Policy	Description
Romiplostim (Nplate®)	Tufts Health Plan does not routinely compensate J2796 if billed by any provider more than once a week and the diagnosis is chronic immune thrombocytopenia (ITP).
	Tufts Health Plan does not routinely compensate nonchemotherapy drug administration services (other than for subcutaneous technique) if billed with J2796 and no other drug administered by other than subcutaneous technique has been billed for the same date of service by any provider.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J2796 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J2796 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 25.
Sipuleucel-T	Tufts Health Plan does not routinely compensate Q2043 if billed with an inappropriate bill type.
Sodium hyaluronan or derivative (Euflexxa®)	Tufts Health Plan does not routinely compensate for J7321-J7328 if billed more than three times within a 35-day period.
	Tufts Health Plan does not routinely compensate for J7321-J7328 or Q9980 if arthrocentesis, aspiration and/or injection; major joint or bursa has not been billed for the same date of service.
	Tufts Health Plan does not routinely compensate for arthrocentesis, aspiration and/or injection; major joint when billed with sodium hyaluronan or derivative (J7321-J7328, Q9980) unless the diagnosis is osteoarthritis of the knee.
	Tufts Health Plan limits coverage of J7321, J7323-J7328, Q9980 to members 18 years of age or older on the date of service.
	Tufts Health Plan does not routinely compensate J7324 if billed more than 8 units every 28 days and the diagnosis is osteoarthritis of the knee.
TBO-filgrastim (GRANIX™)	Tufts Health Plan will not routinely compensate for J1447 if billed without an FDA-approved indication or an approved off-labeled indication.
	Tufts Health Plan does not routinely compensate for TBO-filgrastim (J1447) when billed by any provider on the same date of service as a cytotoxic chemotherapy drug.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1447 when billed and the diagnosis on the claim is agranulocytosis secondary to cancer chemotherapy and a diagnosis of neoplasm is not also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1447 when billed and the diagnosis on the claim is chemotherapy-induced neutropenia, HIV-induced neutropenia, myelodysplastic syndrome, post-hematopoietic cell transplant supportive care, or progenitor stem cell mobilization and a CBC has not been billed by any provider for the same date of service or within the past week.
Tocilizumab (Actemra®)	Tufts Health Plan limits coverage of tocilizumab (J3262) to 800 units for the diagnosis of rheumatoid arthritis or systemic juvenile idiopathic arthritis.
	Tufts Health Plan limits coverage of tocilizumab (J3262) to one visit within 26 days for the diagnosis of rheumatoid arthritis.

Policy	Description
	Tufts Health Plan does not routinely compensate J3262 if billed with modifier JW and the units equal or exceed 80, and 96365-96368 (IV infusion) is present on the claim.
Trabectedin	Tufts Health Plan does not routinely compensate J9352 if billed more than once every three weeks and the diagnosis is liposarcoma or leiomyosarcoma by any provider.
Trastuzumab (Herceptin®)	Tufts Health Plan does not routinely compensate for J9355 if billed without an FDA-approved indication or an approved off-labeled indication.
	Tufts Health Plan does not routinely compensate for intravenous push chemotherapy administration when billed with J9355 unless another drug administered by chemotherapy administration has been billed for the same date of service.
	Tufts Health Plan limits coverage of J9355 if billed more than once every 12 days by any provider and the diagnosis is esophageal and gastroesophageal junction adenocarcinoma or gastric cancer.
	Tufts Health Plan limits J9355 to the following when billed by any provider: • 91 combined units per date of service • One unit if billed with J9355 and no other drug administered by chemotherapy administration has been billed
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9355 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.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9355 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.
Treprostinil	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J7686 to one unit per date of service by any provider when billed and the diagnosis is pulmonary arterial hypertension.
Triamcinolone acetonide, preservative-free, extended-release, microsphere formulation	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J3304 when billed and 20610 or 20611 (Arthrocentesis, aspiration and/or injection, major joint or bursa) has not been billed for the same date of service.
Triptorelin Pamoate (Trelstar®)	Tufts Health Plan does not routinely compensate for J3315 if billed without an FDA-approved indication or an approved off-label indication.
Vedolizumab (Entyvio®)	Tufts Health Plan will not routinely compensate J3380 if billed without a diagnosis of regional enteritis (Crohn's disease) or ulcerative colitis.
	Tufts Health Plan limits coverage of J3380 to 1500 combined units if billed in a 26-week period by any provider and the diagnosis is regional enteritis (Crohn's disease) or ulcerative colitis.
	Tufts Health Plan limits J3380 to 300 combined units per date of service and/or 5 times every 26 weeks by any provider and the diagnosis is regional enteritis (Crohn's disease) or ulcerative colitis.
Velaglucerase (VPRIV®)	Tufts Health Plan limits the coverage J3385 to 69 combined units within a 12-day period when billed by any provider.
Zoledronic acid (Reclast®, Zometa®)	Tufts Health Plan does not routinely compensate for IV push administration codes when billed with J3489 if no other drug requiring IV push administration has been billed for the same date of service.
	Tufts Health Plan does not routinely compensate for J3489 when billed without an FDA approved indication or an off-label recommended indication.

Policy	Description
	Tufts Health Plan does not routinely compensate for J3489 when billed more than once every three weeks and the diagnosis is bone metastases, liver transplant patient, or multiple myeloma.
	Tufts Health Plan limits coverage of J3489 to four units per date of service for the diagnosis of bone metastases, hypercalcemia of malignancy, monoclonal gammopathy of uncertain significance with osteopenia or osteoporosis, multiple myeloma, myositis ossificans, osteopenia in liver transplant patients and (drug induced) in cancer patients, or Volkmann's ischemic contracture.
	Tufts Health Plan does not routinely compensate for J3489 if billed more than once in 82 days for the diagnosis of osteopenia.
	Tufts Health Plan limits coverage of J3489 to five units per date of service.
	Tufts Health Plan limits coverage of J3489 to once per year when billed by any provider if the diagnosis on the claim is any of the following: • Glucocorticoid-induced osteoporosis • Myositis ossificans • Osteitis deformans (Paget's disease) • Osteoporosis in men • Postmenopausal osteoporosis • Secondary fracture prophylaxis • Volkmann's ischemic contracture
	Tufts Health Plan does not routinely compensate J3489 if billed with the following diagnoses, unless a diagnosis of disorder of bone and cartilage is also present: • Use of aromatase inhibitors and a diagnosis of personal history of breast cancer • Long-term use of other medications and a diagnosis of personal history of prostate cancer
	Tufts Health Plan does not routinely compensate J3489 when the member is less than six years, unless a diagnosis of glucocorticoid-induced osteoporosis is also present.

The following edits are applicable effective for dates of service on or after January 1, 2021:

Policy	Description
Aflibercept (J0178)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J0178 to four combined units per month by any provider and the diagnosis on the claim is diagnosis of branch retinal vein occlusion with macular edema, central retinal vein occlusion with macular edema, choroidal neovascularization due to ocular histoplasmosis syndrome, diabetic macular edema, diabetic retinopathy in patients with diabetic macular edema, neovascular (wet) age-related macular degeneration, or proliferative diabetic retinopathy.
Aripiprazole Extended Release (J0401)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J0401 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routine compensate J0401 when billed by any provider more than one unique visit every 26 days and the diagnosis on the claim is schizophrenia or bipolar I disorder.
Aripiprazole Lauroxil (J1943, J1944)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routine compensate J1943 or J1944 when billed and an FDA approved indication or an approved off labeled indication is not present on the claim.

<table>
<tr><td rowspan="5">Atezolizumab (J9022)</td><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routine compensate 96409, 96411 (Intravenous push chemotherapy administration) when billed with J9022 and no other drug administered by intravenous push technique has been billed for the same date of service by any provider.</td></tr>
<tr><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9022 to 84 combined units per date of service by any provider and the diagnosis on the claim is breast cancer.</td></tr>
<tr><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9022 to 1176 combined units in 26 weeks by any provider and the diagnosis on the claim is non-small cell lung cancer or urothelial carcinoma.</td></tr>
<tr><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9022 when billed with a diagnosis of breast cancer and testing for PD-L1 (88360) has not been billed by any provider in the patient's lifetime.</td></tr>
<tr><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9022 when billed with a diagnosis of renal cell carcinoma and J9035, Q5107, or Q5118 bevacizumab has not been billed for the same date of service by any provider.</td></tr>
<tr><td>Avelumab (J9023)</td><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9023 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.</td></tr>
<tr><td>BCG (Intravesical) (J9030)</td><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9030 to 50 combined units per date of service by any provider and the diagnosis on the claim is urothelial carcinoma.</td></tr>
<tr><td>Belimumab (J0490)</td><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 96374-97376, 96409, 96411 (Nonchemotherapy or chemotherapy administration intravenous push technique) when billed with J0490 and no other drug administered by an intravenous push technique has been billed for the same date of service by any provider.</td></tr>
<tr><td>Bendamustine HCI (J9034) (Bendeka)</td><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9034 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.</td></tr>
<tr><td>Bendamustine HCl (J9033, J9036) (Treanda, Belrapzo)</td><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9033 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 25.</td></tr>
<tr><td>Bevacizumab (C9257)</td><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate C9257 and 67028 (Intravitreal injection of a pharmacologic agent) when the diagnosis is an ophthalmologic indication and C9257 has been billed with 67028 in the previous month.</td></tr>
<tr><td>Biosimilar Drugs</td><td>Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9355 (Injection, trastuzumab, excludes biosimilar, 10 mg) when billed and Q5112 (Injection, trastuzumab-dttb, biosimilar, [Ontruzant], 10 mg), Q5113 (Injection, trastuzumab-pkrb, biosimilar, [Herzuma], 10 mg), Q5114 (Injection, trastuzumab-dkst, biosimilar, [Ogivri], 10 mg), Q5116 (Injection, trastuzumab-qyyp, biosimilar, [Trazimera], 10 mg), Q5117 (Injection, trastuzumab-anns, biosimilar, [Kanjinti], 10 mg) has been billed by any provider on the same date of service.</td></tr>
</table>

Biosimilar Drugs	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate Q5106 (Injection, epoetin alfa, biosimilar, (Retacrit) (for non-ESRD use), 1000 units) when billed and Q5105 (Injection, epoetin alfa, biosimilar, (Retacrit) (for ESRD on dialysis), 100 units), J0885 (Injection, epoetin alfa, (for non-ESRD use), 1000 units)), Q4081 (Injection, epoetin alfa, 100 units (for ESRD on dialysis)), or has been billed by any provider on the same date service.
Botulinum Toxin A (J0586)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J0586 to 200 combined units per date of service by any provider and the diagnosis on the claim is cervical dystonia.
Cemiplimab (J9119)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9119 to 350 combined units per date of service by any provider and the diagnosis is squamous cell skin cancer.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9119 when billed more than one unique visit every three weeks by any provider and the diagnosis on the claim is squamous cell skin cancer.
Daratumumab (J9145)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9145 to 218 combined units per date of service by any provider and the diagnosis on the claim is multiple myeloma or systemic light chain amyloidosis.
Darbepoetin Alfa [Non-ESRD] (J0881)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will Iimit (Initial Non-EPO Conversion Dose (Adult)) J0881 to 62 combined units per date of service when the diagnosis is anemia in patients with chronic kidney disease not on dialysis and the patient is greater than 18 years of age, and J0881 has not been billed in the previous month, and J0885, Q4081, Q5105, or Q5106 has not been billed in the previous two weeks by any provider.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J0881 to 300 combined units per date of service by any provider and the diagnosis is anemia of chronic inflammatory disease.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J0881 when billed and iron status studies (82728, 83540, or 84466) has not been billed by any provider on the same day or within the past three months.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J0881 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J0881 when billed and the diagnosis is neoplasm, encounter for antineoplastic chemotherapy or immunotherapy, or personal history of antineoplastic chemotherapy, and a claim for either chemotherapy administration or a chemotherapy drug has not been billed for the same date of service or in the previous four months by any provider.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J0881 when billed more often than once every two weeks by any provider and the diagnosis is anemia related to hepatis C treatment with ribavirin, or anemia related to treatment with zidovudine for HIV.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J0881 when billed and a diagnosis for anemia in other chronic diseases classified elsewhere is present and a diagnosis of an underlying condition is not also present.

	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J0881 when billed and a diagnosis for encounter for other preprocedural examination or encounter for other procedures for purposes other than remedying health state is present and a diagnosis of anemia is not also present.
Epoetin Alfa (ESRD) (Q4081, Q5105)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate Q4081 or Q5105 when billed and the diagnosis is ESRD and a diagnosis of dependence on renal dialysis is not also present.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate Q4081 or Q5105 when billed and an iron status study (82728, 83540, or 83550) has not been billed by any provider on the same day or within the past three months.
Epoetin Alfa (Non-ESRD) (J0885, Q5106)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J0885 or Q5106 to 20 combined units per date of service by any provider when the diagnosis is myelofibrosis.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J0885 or Q5106 when billed with a diagnosis of anemia in other chronic diseases classified elsewhere and a diagnosis of an underlying condition is not also present.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J0885 or Q5106 to 34 combined units per date of service by any provider and the diagnosis is multiple myeloma.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J0885 or Q5106 when billed and a laboratory service that includes hemoglobin testing is not billed for the same date of service or in the previous 12 weeks by any provider.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J0885 or Q5106 to six combined units per week by any provider and the diagnosis is anemia in patients with congestive heart failure.
Eribulin Mesylate (J9179)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9179 when billed by any provider more than twice within a three-week period and the diagnosis on the claim is breast cancer or soft tissue sarcoma.
Goserelin Acetate Implant (J9202)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9202 to two combined units per date of service when billed by any provider and the diagnosis on the claim is breast cancer.
Immune Globulins, IM (90281, J1460, J1560)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 90281, J1460, or J1560 when billed and the patient is less than 12 years of age and the diagnosis on the claim is rubella prophylaxis in exposed, susceptible pregnant women.
Immune Globulins, SQ (90284, J1559, J1562)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 96365-96368, or 96372-96379 (Non-chemotherapy administration, other than subcutaneous infusion technique) when billed with 90284, J1559, or J1562 and no other non-chemotherapy drug administered by other than subcutaneous infusion has been billed for the same date of service by any provider.
Infliximab (J1745, Q5103, Q5104, Q5109)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate Q5109 when billed by any provider more than two visits every 26 weeks and the diagnosis on the claim is immune checkpoint inhibitor-related toxicities.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J1745, Q5103, Q5104, or Q5109 when billed by any provider more than four visits every 26 weeks and the diagnosis on the claim is hidradenitis suppurativa.

	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J1745, Q5103, Q5104, or Q5109 when billed by any provider more than six visits every 26 weeks and the diagnosis on the claim is adult ankylosing spondylitis, SAPHO syndrome, or sarcoidosis.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J1745, Q5103, Q5104, or Q5109 to 440 combined units in 26 weeks by any provider when the diagnosis on the claim is adult juvenile idiopathic arthritis, juvenile ankylosing spondylitis, or juvenile idiopathic arthritis.
Iron Sucrose (J1756)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J1756 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 50.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J1756 when billed and the patient is less than two years of age and the diagnosis is cancer-induced anemia, chemotherapy-induced anemia, iron deficiency anemia associated with chronic heart failure, iron deficiency anemia due to malabsorption disorders, iron deficiency anemia in patients with chronic kidney disease, or iron deficiency anemia of pregnancy.
Natalizumab (J2323)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J2323 to 300 combined units per date of service by any provider and the diagnosis on the claim is multiple sclerosis.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 96409 or 96411 (Intravenous push chemotherapy administration) when billed with J2323 and no other drug administered by IV push chemotherapy administration has been billed for the same date of service by any provider.
Nivolumab (J9299)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9299 to 480 combined units per date of service by any provider and the diagnosis on the claim is anal carcinoma, head and neck cancer, hepatocellular carcinoma, Hodgkin's lymphoma [classical], melanoma, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer, non-small cell lung cancer, renal cell carcinoma, or urothelial carcinoma.
Nusinersen (J2326)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J2326 when billed and 96450 (Intrathecal drug administration) has not been billed by any provider for the same date of service.
Obinutuzumab (J9301)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9301 when billed by any provider more than one visit per week and the diagnosis on the claim is follicular lymphoma, B-cell lymphoma [other than follicular lymphoma], Castleman's disease (B-cell), or post-transplant lymphoproliferative disorder (B-cell).
Obinutuzumab (J9301)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 96413 (Chemotherapy administration, IV infusion, first hour) when billed with J9301 and 96415 (Chemotherapy administration, IV infusion technique, each additional hour) has not been billed for the same date of service.
Paliperidone Palmitate (J2426)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J2426 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.

Palonosetron HCl (J2469)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J2469 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed three.
Panitumumab (J9303)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9303 when billed by any provider more than one visit every two weeks and the diagnosis on the claim is colorectal cancer.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9303 when billed with a diagnosis of colorectal cancer and testing for a RAS mutation status (0111U, 81275, 81276, 81311, 81405, 81442, 81445, 81450, 81455), or if J9303, has not been previously billed by any provider in the patient's lifetime.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 96409 or 96411 (Intravenous push chemotherapy administration) when billed with J9303 and no other chemotherapy drug administered by intravenous push technique has been billed for the same date of service by any provider.
Patisiran (C9036, J0222)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate C9036 or J0222 when billed by any provider more than one unique visit every three weeks and the diagnosis on the claim is polyneuropathy of hereditary transthyretin-mediated amyloidosis.
Pegfilgrastim (J2505, Q5108, Q5111)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit Q5108 or Q5111 to 12 combined units per date of service when billed by any provider and the diagnosis on the claim is chemotherapy-induced neutropenia, myelosuppressive radiation exposure, or post-stem cell transplant supportive care.
Pertuzumab (J9306)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 96409 or 96411 (Intravenous push chemotherapy administration) when billed with J9306 and no other drug administered by intravenous push chemotherapy administration has been billed for the same date of service by any provider.
Plerixafor (J2562)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J2562 when billed and the diagnosis on the claim is mobilization of hematopoietic progenitor cells in patients with non-Hodgkin's lymphoma, or multiple myeloma and J1442, J1447, Q5101, or Q5110 (Granulocyte-colony stimulating factor) has not been billed in the previous four days by any provider.
Plerixafor (J2562)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J2562 when billed and the diagnosis on the claim is mobilization of hematopoietic progenitor cells in patients with non-Hodgkin's lymphoma, or multiple myeloma and J1442, J1447, Q5101, or Q5110 (Granulocyte-colony stimulating factor) has not been billed for the same date of service by any provider.
Radium Ra-223 Dichloride (A9606)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate A9606 when billed with a diagnosis of secondary malignant neoplasm of bone and bone marrow, and a diagnosis of prostate cancer is not also present on the claim.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate A9606 when billed by any provider with a diagnosis on the claim of prostate cancer and hematologic testing (neutrophils, platelets, hemoglobin) has not been billed for the same date of service or in the previous six days.
Ramucirumab (J9308)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 96409 or 96411 (Intravenous push

	chemotherapy administration) when billed with J9308 and no other chemotherapy drug administered by intravenous push technique has been billed for the same date of service by any provider.
Ranibizumab (J2778)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J2778 to 10 units per month when billed by any provider and an FDA approved or an approved off-labeled indication is present.
Reslizumab (J2786)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J2786 when billed by any provider more than once per month and the diagnosis on the claim is severe asthma with eosinophilic phenotype
Risperidone (J2794) (Risperdal Consta)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J2794 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J2794 when billed by any provider more than one unique visit every two weeks and the diagnosis on the claim is bipolar I disorder or schizophrenia.
Rituximab (J9312, Q5115)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9312 or Q5115 to 98 combined units per date of service by any provider and the diagnosis on the claim is acquired factor VIII deficiency, acute lymphoblastic leukemia, AIDS-related B-cell lymphoma, ANCA-associated vasculitis, anti-MAG polyneuropathy, autoimmune hemolytic anemia, bullous pemphigoid, Castleman's disease, chronic graft-versus-host disease, cryoglobulinemia-induced renal disease, epidermolysis bullosa acquisita, Epstein-Barr virus disease prophylaxis in stem cell transplantation, Evan's syndrome, granulomatosis with polyangiitis [Wegener's granulomatosis], hairy cell leukemia, Hodgkin's lymphoma [nodular lymphocyte-predominant], human herpesvirus 8 (HHV-8) infection, immune checkpoint inhibitor-related toxicities, malignant ascites in non-Hodgkin's lymphoma, microscopic polyangiitis, myasthenia gravis, non-Hodgkin's lymphoma (B-cell lymphomas), post-transplant lymphoproliferative disorder [PTLD], primary cutaneous B-cell lymphoma, thrombotic thrombocytopenic purpura, or Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9312 or Q5115 to 100 combined units per date of service when the diagnosis on the claim is cicatricial pemphigoid, cryoglobulinemia, dermatopolymyositis, Grave's disease ophthalmopathy, immune (idiopathic) thrombocytopenic purpura, lupus nephritis, minimal change disease, neuromyelitis optica, pemphigus foliaceus, pemphigus vulgaris, pre-renal transplant to suppress anti-HLA antibodies, rheumatoid arthritis, Sjogren's syndrome, or systemic lupus erythematosus.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9312 or Q5115 to 130 combined units per date of service when the diagnosis on the claim is chronic lymphocytic leukemia/small lymphocytic lymphoma [CLL/SLL] or primary central nervous system lymphoma.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J9312 or Q5115 to 392 combined units in a patient's lifetime by any provider and the diagnosis on the claim is cryoglobulinemia or dermatopolymyositis.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9312 or Q5115 when billed with

Rituximab (J9312, Q5115)	modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed ten.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9312 or Q5115 when billed by any provider more than eight visits in a patient's lifetime and the diagnosis is acute lymphoblastic leukemia, autoimmune hemolytic anemia, Castleman's disease, chronic graft-versus-host disease, epidermolysis bullosa acquisita, human herpesvirus 8 (HHV-8) infection, leptomeningeal metastases, or thrombotic thrombocytopenic purpura.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9312 or Q5115 when billed by any provider more than six visits in a patient's lifetime and the diagnosis is cryoglobulinemia-induced renal disease or hairy cell leukemia.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9312 or Q5115 when billed by any provider more than 20 visits in a patient's lifetime and the diagnosis is AIDS-related B-cell lymphoma or non-Hodgkin's lymphoma (B-cell lymphomas).
Rituximab and Hyaluronidase (J9311)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9311 when billed and J9312 or Q5115 (Rituximab) has not been billed in the previous 21 weeks by any provider and the diagnosis is diffuse large B-cell lymphoma (DLBCL).
Sodium Hyaluronan or Derivative (J7318, J7320-J7329, J7331, J7332)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J7321, J7323, J7324, J7326, or J7327 to two combined units per date of service by any provider and the diagnosis on the claim is osteoarthritis of the knee.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J7325 to 96 combined units per date of service by any provider and the diagnosis on the claim is osteoarthritis of the knee.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 20610 or 20611 (Arthrocentesis, aspiration and/or injection, major joint or bursa) when billed with J7318, J7320-J7329, J7331, or J7332 and modifier LT (Left side) or RT (Right side), or 50 (Bilateral procedure) is not appended to 20610 or 20611.
TBO-Filgrastim (J1447)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J1447 to 300 units per date of service by any provider and the diagnosis on the claim is myelodysplastic syndrome.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J1447 to 680 units per date of service by any provider and the diagnosis on the claim is chemotherapy-induced neutropenia, or post-hematopoietic cell transplant supportive care.
Tocilizumab (J3262)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J3262 to 162 combined units per date of service by any provider when the diagnosis on the claim is giant cell arteritis.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will limit J3262 to 5600 combined units every 26 weeks by any provider and the diagnosis on the claim is rheumatoid arthritis.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J3262 when billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 80, and 96365-96368 (IV infusion) is present on the claim.
Trabectedin (J9352)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9352 when billed and an FDA

	approved indication or an approved off-labeled indication is not present on the claim.
Triamcinolone acetonide, preservative-free, extended-release, microsphere formulation (J3304)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J3304 when billed and an FDA-approved indication or an approved off-labeled indication is not present on the claim.
	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate 20610 or 20611 (Arthrocentesis, aspiration and/or injection, major joint or bursa) when billed with J3304 and modifier LT (Left side) or RT (Right side), or 50 (Bilateral procedure) is not appended to 20610 or 20611.
Ustekinumab (J3357, J3358)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J3358 when billed and J3357 or J3358 has been billed by any provider in the previous eight weeks and the diagnosis on the claim is regional enteritis [Crohn's disease] or ulcerative colitis.
Ziv-Aflibercept (J9400)	Effective for dates of service on or after January 1, 2021, Tufts Health Plan will not routinely compensate J9400 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.

Edits applicable to Senior Products only:

Policy	Description
Pegfilgrastim	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J2505, Q5108, or Q5111 when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Bezlotoxumab	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0565 when billed with a diagnosis of clostridium difficile infection (CDI), and clostridium difficile specific testing (87324, 87493) has not been billed in the previous week by any provider.

DOCUMENT HISTORY

- 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
- October 2020: Updated code J9145
- February 2020: Corrected claim edit for Epoetin alfa to 40 units covered for myelodysplastic syndrome
- January 2020: Added edits for antihemophilic factor IX, antihemophilic factor VIII, aprepitant, arsenic trioxide, atezolizumab, autologous cultured chondrocytes implant, azacytidine, belatacept, bevacizumab, bezlotoxumab, botulinum toxin A and B, brentuximab vedotin, cinacalcet, darbepoetin alfa, durvalumab, eribulin mesylate, etelcalcetide, ferric carboxymaltose, ferumoxytol, filgrastim, fluocinolone acetonide intravitreal implant, fulvestrant, goserelin acetate implant, human antithrombin III, infliximab, intrauterine contraceptive systems and contraceptive implants, ipilimumab, iron sucrose, lanreotide, leuprolide acetate depot, 3.75 mg, leuprolide acetate depot, 7.5 mg, mepolizumab, oxaliplatin, pegfilgrastim, pegloticase, pertuzumab, ramucirumab, rituximab and hyaluronidase, romiplostim, TBO-filgrastim, trastuzumab, treprostinil, triamcinolone acetonide preservative-

free extended-release microsphere formulation, effective for dates of service on or after April 1, 2020.
- July 2019: Removed female breast cancer as an indication for leuprolide acetate depot, 7.5 mg (J9217)
- November 2018: Added claim edits for self-administered drugs, effective for dates of service on or after January 1, 2019
- August 2018: Added edits for abatacept, agalsidase beta, alemtuzumab, alglucosidase alfa, BCG (Intravesical), bendamustine HCI, bortezomib, botulinum toxin A, cetuximab, collagenase clostridium histolyticum, corticotropin, daratumumab, darbepoetin alfa, decitabine, denosumab, docetaxel, doxorubicin HCL liposome, eculizumab, epoetin alfa, ferumoxytol, gemcitabine HCl, goserelin acetate implant, hydroxyprogesterone caproate, ipilimumab, irinotecan, iron dextran, iron sucrose, nivolumab, ocriplasmin, paclitaxel protein-bound particles, panitumumab, pegfilgrastim, pembrolizumab, pemetrexed, pertuzumab, ramucirumab, regadenoson, romiplostim, sipuleucel-T, tocilizumab, trastuzumab, and vedolizumab, effective for dates of service on or after October 1, 2018; removed edit for J9355 for units representing a multiple of an entire vial, as it is no longer active as of August 1, 2018
- June 2018: Template updates
- May 2018: Added claim edit for paclitaxel (J9267), effective for dates of service on or after July 1, 2018
- February 2018: Added claim edits for autologous cultured chondrocytes, ESAs in cancer and related neoplastic conditions, effective for dates of service on or after April 1, 2018
- September 2017: Added language regarding drugs covered under the member's medical benefit
- July 2017: Added edits for Ado-trastuzumab emtansine, Aflibercept, Amphotericin B liposome, Bendamustine HCl, botulinum Toxin A and B, certolizumab pegol, darbepoetin alfa, docetaxel, doxorubicin hcl liposome, epoetin alfa, infliximab, irinotecan, iron sucrose, ixabepilone, lanreotide, leuprolide acetate, leuprolide acetate depot, nivolumab, ofatumumab, omalizumab, oxaliplatin, pegfilgrastim, pembrolizumab, pemetrexed, rituximab, TBO-filgrastim, trastuzumab, and vedolizumab, effective for dates of service on or after October 1, 2017
- January 2017: Template updates

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan 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, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan 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 Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.