TUFTS Health Plan

Drugs and Biologicals Payment Policy

Applies to the following Tufts Health Public Plans products:

☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)

☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)

☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)

☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

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

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.

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 Pharmaceutical waste and unused portions of pharmaceutical vials are not compensated if the pharmaceutical is withdrawn from a multidose vial.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 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 portal or by contacting Tufts Health Public Plans Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Unify, Tufts Health Together or Tufts Health RITogether 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 administrative code (i.e. "buy and bill"). For additional information refer to the Tufts Health Public Plans section of the Pharmacy section of our website.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

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

Refer to the Tufts Health Public Plans section of the Pharmacy section of our website for a list of drugs that are subject to Tufts Health Plan's prior authorization program.

For additional information for Tufts Health Plan members, refer to the Pharmacy Medical Necessity Guidelines in the Resource Center.

For drugs covered under the medical benefit, fax a complete prior authorization form to the following:

- Tufts Health Direct: fax the Massachusetts Standard form for Medication Prior Authorization Requests at 888.415.9055
- Tufts Health Together and Tufts Health Unify: fax the Standardized Prior Authorization Request Form at 888.415.9055
- Tufts RITogether: fax the Prior Authorization Request Form at 857.304.6404

For drugs covered under the pharmacy benefit, complete the appropriate medication request form located on the Pharmacy section of our website and fax it to the Pharmacy Utilization Department at the following:

- Tufts Health Together, Tufts Health RITogether and Tufts Health Direct: 617.673.0988
- Tufts Health Unify: 617.673.0956

Refer to the Pharmacy section of our website for additional information.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

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

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

Tufts Health Together

In accordance with MassHealth Acute Outpatient Hospital Bulletin 34, for dates of service on or after January 1, 2020, Tufts Health Plan requires all clinician-administered outpatient drugs (including 340B

drugs) to include the 11-digit National Drug Code (NDC). Refer to the MassHealth Acute Outpatient Hospital Bulletin 34 for any limited exceptions.

Submit modifier UD with the 11-digit NDC code when filing a claim for administering single-source drugs purchased under the 340B drug discount program.

Acute Hospital Carve-Out Drugs (Tufts Health Together)

High-cost drugs identified on the MassHealth Acute Hospital Carve-Out Drugs List must be submitted separately from facility claims in order to provide appropriate compensation. Providers must include the NDC, corresponding HCPCS code(s) and number of units administered to the member on the claim. Providers must also include the following supporting documentation, in accordance with MassHealth MCE Bulletin 42:

- The hospital's actual acquisition cost of the drug
- Copy of the invoice(s) for the drug from the drug manufacturer, supplier, distributor, or other similar party or agent
- Any additional supporting documentation, as necessary

Claims with supporting documentation cannot be submitted electronically and must be submitted on paper, in accordance with Tufts Health Plan's claim submission requirements. Refer to the Claim Requirements, Coordination of Benefits and Dispute Guidelines chapter of the Tufts Health Public Plans Provider Manual for more information on claim submission requirements.

Non-Hepatitis C Virus (HCV) High-Cost Drugs

Tufts Health Together

All claims for Non-HCV High Cost Drugs that have a typical treatment cost greater than $200,000 per patient per year, an FDA orphan designation, and treat an applicable condition that affects fewer than 20,000 individuals nationwide must be billed with the HCPCS Level II code and 11-digit NDC, including units and unit descriptors.

As a reminder, submit modifier UD with the 11-digit NDC code when filing a claim for administering single-source drugs purchased under the 340B drug discount program.

Tufts Health Direct, Tufts Health RITogether and Tufts Health Unify

Tufts Health Plan requires claims for single-source drugs administered by providers in a health care setting to include both the HCPCS Level II code and 11-digit National Drug Code (NDC), including units and unit descriptors, with the following exceptions:

- Inpatient claims
- Outpatient claims included in a bundled rate or global fee
- Claims for drugs purchased under the 340B drug discount program as designated by the Office of Pharmacy Affairs
- Claims for radiopharmaceuticals, contrast media, vaccines or devices

Submit modifier UD with the 11-digit NDC code when filing a claim for administering single-source drugs purchased under the 340B drug discount program.

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 the CMS Transmittals/Memos/Publications for additional information.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

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 compensate 27412 (autologous chondrocyte implantation, knee) if billed and autologous cultured chondrocytes (J7330) has not been billed for the same date of service.

Tufts Health Plan does not routinely compensate for J7330 unless 27412 has also been billed for the same date of service.

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 will not routinely compensate J0881, J0885 or J0888 for non-end-stage renal disease (ESRD) ESA treatments when billed with modifier EB.

Tufts Health Plan will not routinely compensate J0881, J0885 or J0888 when billed with 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.

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
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 Claim Edits

Policy	Description
Abatacept (Orencia®)	Tufts Health Plan does not routinely compensate Abatacept(J0129) when billed with a nonchemotherapy or chemotherapy IV administration code (96365, 96367, 96368, 96413, 96417) and J0129 has been billed in the previous 12 days.
	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 Emstansine (Kadcyla®)	Tufts Health Plan does not compensate J9354 if billed without a diagnosis of breast cancer. **Note:** This applies to Tufts Health Together only.

Policy	Description
	Tufts Health Plan limits coverage of J9354 to the following: • 411 combined units per date of service • Once every 19 days
Aflibercept (Eylea®)	Tufts Health Plan will not routinely compensate for aflibercept (J0178) when billed by any provider more than two visits per 28 days.
Agalsidase beta (Fabrazyme®)	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.
Alemtuzumab	Tufts Health Plan limits J0202 to 12 combined units per date of service by any provider.
Alglucosidase alfa (Myozyme®, Lumizyme®)	Tufts Health Plan limits J0220 or J0221 to 228 combined units per date of service by any provider.
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.
Aprepitant	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0185 inf the following circumstances: • If billed and an FDA approved indication or an approved off-labeled indication is not present on the claim, or • If billed and a highly or moderately emetogenic chemotherapy agent has not been billed for the same date of service by any provider
Arsenic Trioxide	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9017 in the following circumstances: • If billed and an FDA approved indication or an approved off-labeled indication is not present on the claim, or • If billed by any provider more than 60 visits in 12 weeks and the diagnosis is acute promyelocytic leukemia (APL) or multiple myeloma
	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).
Atezolizumab	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9022 in the following circumstances: • If billed and an FDA approved indication or an approved off-labeled indication is not present on the claim, or • billed by any provider more than once every two weeks and the diagnosis is non-small cell lung cancer or urothelial carcinoma
BCG (Intravesical)	Tufts Health Plan limits J9031 to 1 unit per date of service or 1 visit per week if the diagnosis is urothelial carcinoma.
	Tufts Health Plan does not routinely compensate J9031 unless 50391 or 51720 (bladder installation administration) has also been billed for the same date of service.
Belatacept	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.
Bendamustine HCl (TREANDA®)	Tufts Health Plan limits coverage of J9033 to 296 combined units per date of service 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

<table>
<tr><th>Policy</th><th>Description</th></tr>
<tr><td rowspan="3"></td><td>Tufts Health Plan limits coverage of J9033 to 2,952 combined units in a 24-week period when the diagnosis is chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL).</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 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>Bevacizumab</td><td>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 any of the following:
• 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
• Rubeosis iridis.</td></tr>
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Policy	Description
Bevacizumab	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J9035 or Q5107 to the following: • 68 combined units per date of service by any provider when the diagnosis is hereditary hemorrhagic telangiectasia • 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.
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. **Note:** This applies to Tufts Health Unify only.
Bortezomib (Velcade®)	Tufts Health Plan does not routinely compensate J9041 if billed by any provider more than twice per week.
Botulinum Toxin A (Botox®)	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 **Note:** This applies to Tufts Health Unify only.
	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 the following: • 44 combined units per date of service by any provider and the diagnosis on the claim is hemifacial spasm • 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 J0588 to 120 combined units per date of service by any provider and the diagnosis is cervical dystonia (spasmodic torticollis).
	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.
Botulinum Toxin B	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.
Brentuximab Vedotin	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.
Certolizumab Pegol (Cimzia®)	Tufts Health Plan limits coverage of J0717 to 400 combined units per date of service. **Note:** This applies to Tufts Health Unify only.
Cetuximab (Erbitux®)	Tufts Health Plan does not routinely compensate 96409 or 96411 (chemotherapy IV administration) if billed with J9055 and no other drug administered by chemotherapy administration has been billed for the same date of service.
Cinacalcet	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0604 if billed and the diagnosis is secondary hyperparathyroidism in adult patients with chronic kidney disease on

Policy	Description
	hemodialysis and serum calcium testing has not been billed by any provider in the previous month.
Collagenase clostridium histolyticum (Xiaflex®)	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 20527 or J0775 has not been billed for the same date of service or in the previous three days.
Corticotropin	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.
Daratumumab (Darzalex®)	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
Darbepoetin Alfa (Aranesp®)	Tufts Health Plan does 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
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0882 under the following circumstances: • If billed and an FDA approved indication or an approved off-labeled indication is not present on the claim, or • If billed and the diagnosis is end stage renal disease, and a diagnosis for anemia in chronic kidney disease or dependence on renal dialysis is not also present
	Tufts Health Plan limits coverage of coverage of J0882 to 52 combined units when 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 by any provider.
	Tufts Health Plan does not routinely compensate for 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)

Policy	Description
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J0881 under the following circumstances: • If billed and a diagnosis for anemia in neoplastic disease is present and a diagnosis of neoplasm is not also present, or • If any of the following hemoglobin studies have not been billed by any provider on the same day or within the past month: – 80050 (general health panel) – 80055 (obstetrical panel) – 80081 (obstetrical panel) – 85013 (hematocrit, spun) – 85014 (hematocrit) – 85018 (hemoglobin) – 85025 (CBC, automated with WBC) – 85027 (CBC, automated) – G0306 (CBC, automated with WBC) – G0307 (CBC, automated)
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 J0897 to 120 combined units per date of service if the diagnosis is bone metastases, giant cell tumor of bone, hypercalcemia of malignancy or multiple myeloma.
Dexamethasone, Intravitreal Implant (Ozurdex®)	Tufts Health Plan does not routinely compensate dexamethasone (J7312) if a diagnosis for diabetic macular edema, macular edema following branch or central retinal vein occlusion, or non-infectious uveitis affecting the posterior segment is not present on the claim.
	Tufts Health Plan limits coverage of compensate of dexamethasone (J7312) to 14 combined units per date of service.
	Tufts Health Plan does not compensate dexamethasone (J7312) when billed without intravitreal injection of a pharmacologic agent (67028).
	Tufts Health Plan does not compensate 67028 (Intravitreal injection of a pharmacologic agent [separate procedure]) when billed with dexamethasone (J7312) and modifier LT (Left side), RT (Right side), or 50 (Bilateral procedure) is not appended to code 67028.
Docetaxel (Taxotere®)	Tufts Health Plan limits coverage of docetaxel (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 with a diagnosis of thyroid carcinoma.
Doxorubicin HCL Liposome (Doxil®, Lipo-Dox®)	Tufts Health Plan does not routinely compensate for 96401-96411, 96420-96450, 96542, Q0083 when billed with doxorubicin HCL liposome (Q2049-Q2050) and when another drug administered by chemotherapy administration has not been billed for the same date of service.
	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 under the following circumstances:

Policy	Description
	• If billed and an FDA approved indication or an approved off-labeled indication is not present on the claim • If billed by any provider more than one visit every two weeks and the diagnosis is non-small cell lung cancer or urothelial carcinoma, or • If billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 12.
	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.
Ecallantide (Kalbitor®)	Tufts Health Plan does not compensate Ecallantide (J1290) when billed and a diagnosis of hereditary angioedema is not present on the claim.
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 does not routinely compensate for epoetin alfa HCl (Q4081) when billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
	Tufts Health Plan limits coverage of epoetin alfa (J0885) to 60 combined units per date of service when the diagnosis on the claim is End Stage Renal Disease, chronic kidney disease, non-myeloid malignancy, or personal history of antineoplastic chemotherapy, and the patient is greater than 17 years of age, and epoetin alfa (J0885, or Q4081) has been billed in the previous week by any provider.
	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 • 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
Eribulin Mesylate (Halaven®)	Tufts Health Plan does not routinely compensate 96401-96406,96413-96450,96542, 96549 (Chemotherapy administration by other than intravenous push technique code), when billed with eribulin mesylate (J9179) and no other drug administered via chemotherapy administration is billed for the same date of service by any provider.

Policy	Description
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.
Factor VIII (Advate, Helixate FS, Kogenate FS, Recombinate)	Effective for dates of service on or after April 1, 2020, Tufts Health Public Plans will limit J7192 to 27,200 units per date of service by any provider and the diagnosis is hemophilia A.
Ferric Carboxymaltose	Effective for dates of service on or after April 1, 2020, Tufts Health Public Plans will not routinely compensate J1439 under the following circumstances: • If billed and an FDA approved indication or an approved off-labeled indication is not present on the claim • If billed with a diagnosis of anemia in chronic kidney disease and a diagnosis of chronic kidney disease is not also present • If billed with a diagnosis of anemia complicating pregnancy and a diagnosis of iron deficiency anemia is not also present • If 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 • If billed with a diagnosis of anemia in other chronic diseases and a diagnosis of one of the following: – Crohn's disease – Celiac disease – Chronic heart failure – Intestinal malabsorption unspecified – Other malabsorption due to intolerance – Excessive and frequent menstruation – Irregular menstruation – Ulcerative colitis – Adverse effect of iron and its compounds – Adverse effects of unspecified drugs, medicaments, and biological substances is not also present, or • If billed and the patient is less than 18 years of age and the diagnosis is one of the following: – 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 – Restless legs syndrome [Willis-Ekbom disease]
Ferumoxytol (Feraheme®)	Tufts Health Plan does not routinely compensate Q0138 under the following circumstances: • If billed without an FDA approved indication or an approved off-label indication is not present on the claim • If billed with a diagnosis of anemia in chronic kidney disease and a diagnosis of ESRD is not present. • If billed with a diagnosis of anemia complicating pregnancy and a diagnosis of iron deficiency anemia is not present.
	Tufts Health Plan does not routinely compensate non-chemotherapy administration other than intravenous push or short-term intravenous infusion (96366, 96369-96373, 96377) if billed with Q0138 and no other drug administered with non-chemotherapy administration other than intravenous push or short-term intravenous is billed for the same date of service by any provider.

Policy	Description
	Tufts Health Plan limits Q0138 to 510 combined units per date of service by any provider and a diagnosis of iron deficiency in chronic kidney disease is 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 one of the following: • Iron deficiency anemia in patients with chronic kidney disease • Iron deficiency anemia in patients with intolerance to oral iron • 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	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J1442, Q5101, or Q5110 under the following circumstances: • If 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, or • If 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).
Fluocinolone Acetonide, Intravitreal Implant (Retisert®)	Tufts Health Plan does not compensate Fluocinolone acetonide (J7311) if billed without a diagnosis of chronic noninfectious uveitis affecting the posterior segment.
Fulvestrant	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 under the following circumstances: • If billed by any provider more than once every two weeks and the diagnosis is breast cancer, or • If billed by any provider more than once per month and the diagnosis is endometrial carcinoma
Gemcitabine HCl (Gemzar®)	Tufts Health Plan limits J9201 to the following: • 27 units per date of service • 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 • 16 units per date of service 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.

Policy	Description
Goserelin Acetate Implant (Zoladex®)	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 if billed by any provider more than three units within a three-month period.
Human Antithrombin III	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7197 if billed and an FDA approved indication or an approved off-labeled indication is not present on the claim.
Hydroxyprogesterone Caproate (Makena™)	Tufts Health Plan will limit coverage of hydroxyprogesterone caproate (J1725) to the following: • 250 combined units per date of service when the diagnosis is pregnancy with history of singleton spontaneous preterm birth or test for endogenous estrogen production • One unique visit per week if the diagnosis is singleton pregnancy with history of singleton spontaneous preterm birth • One visit per 6 days
Infliximab (Remicade®)	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
	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.
Intrauterine Contraceptive Systems and Contraceptive Implants	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7296, J7297, or J7301 under the following circumstances: • If billed and the diagnosis is not prevention of pregnancy, endometrial hyperplasia, endometriosis or menopausal symptoms, or • If 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.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7298 under the following circumstances: • If billed and the diagnosis is not endometriosis, menopausal symptoms, menorrhagia, endometrial hyperplasia or prevention of pregnancy, or • If 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
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7300 under the following circumstances: • If billed and the diagnosis is not prevention of pregnancy, or • If 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
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J7307 under the following circumstances:

<table>
<tr><th>Policy</th><th>Description</th></tr>
<tr><td></td><td>If billed and the diagnosis is not endometriosis, chronic pelvic pain of female, associated with pelvic congestion syndrome or prevention of pregnancy, or
If 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="3">Ipilimumab (Yervoy™)</td><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 if 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>
<tr><td rowspan="4">Irinotecan (Camptosar®)</td><td>Tufts Health Plan limits coverage of Irinotecan (J9206) to three 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>Iron dextran (INFed®)</td><td>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.</td></tr>
</table>

Policy	Description
	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 iron sucrose (J1756) to the following: • 500 combined units per date of service when billed by any provider • 300 combined units per date of service when the diagnosis is cancer-induced anemia or chemotherapy-induced anemia
	Tufts Health Plan does not routinely compensate J1756 if billed with a diagnosis of ESRD unless a diagnosis of dialysis status is also present.
	Effective for dates of service on or after April 1, 2020, Tufts Health Public Plans will not routinely compensate J1756 under the following circumstances: • If billed with a diagnosis of anemia in neoplastic disease and a diagnosis of non-myeloid malignancy is not also present • If billed with a diagnosis of encounter for antineoplastic chemotherapy and a diagnosis of non-myeloid malignancy is not also present • billed with a diagnosis of chronic heart failure and a diagnosis of iron deficiency anemia is not also present, or • billed with a diagnosis of anemia complicating pregnancy and a diagnosis of iron deficiency anemia is not also present
Ixabepilone (Ixempra®)	Tufts Health Plan does 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.
Lanreotide (Somatuline Depot®)	Tufts Health Plan does not routinely compensate for lanreotide (J1930) under the following circumstances: • If an approved indication or approved off-label indication is not also billed **Note:** Effective for dates of service on or after April 1, 2020 for Tufts Health Together. • If billed by any provider more than once every 26 days and the diagnosis is acromegaly or gastroenteropancreatic neuroendocrine tumors
Leuprolide acetate depot, 3.75 mg (Lupron Depot®, Eligard®)	Tufts Health Plan does not routinely compensate for leuprolide acetate (J1950) under the following circumstances: • If billed by any provider more than once per month • If billed and the patient's age is less than 18 years and the diagnosis is other than central precocious puberty • **Note:** This does not apply to Tufts Health Together.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will limit J1950 to three combined units in ten weeks by any provider when the diagnosis on the claim is any of the following: • Benign prostatic hyperplasia • Breast cancer • Endometriosis • Premenstrual syndrome • 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©, Eligard©)	Tufts Health Plan does not routinely compensate for leuprolide acetate (J9217) when billed and the patient is less than 18 years of age and the diagnosis is other than central precocious puberty. **Note:** This does not apply to Tufts Health Together.

Policy	Description
	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 any of the following: • Amenorrhea induction prior to bone marrow transplant • Central precocious puberty • Ovarian cancer/fallopian tube cancer/primary peritoneal cancer • Prostate cancer • Salivary gland tumor • Stuttering priapism
Leuprolide Acetate, 1 mg (Lupron®)	Tufts Health Plan does not routinely compensate for Leuprolide acetate (J9218) when billed and the patient's age is less than 18 years and the diagnosis is other than central precocious puberty. **Note:** This does not apply to Tufts Health Together.
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 Public Plans will not routinely compensate J2182 if billed by any provider more than once per month and the diagnosis is eosinophilic granulomatosis with polyangiitis or severe asthma of eosinophilic phenotype.
Nivolumab (OPDIVO®)	Tufts Health Plan does not routinely compensate for nivolumab (J9299) when billed and an FDA approved indication is not present on the claim.
	Tufts Health Plan does 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 patient's lifetime.
	Tufts Health Plan limits coverage of nivolumab (J9299) to 342 combined units per date of service by any provider and the diagnosis is Hodgkin's lymphoma (classical).
	Tufts Health Plan does not routinely compensate for nivolumab (J9299) when billed by any provider more than one visit every 12 days and the diagnosis is Hodgkin's lymphoma [classical], kidney cancer, melanoma and non-small cell lung cancer.
	Tufts Health Plan does 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 if billed with J9228 and the diagnosis is melanoma.
	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.
Ocriplasmin (Jetrea®)	Tufts Health Plan does not compensate Ocriplasmin (J7316) when billed and an FDA approved indication is not present on the claim.
Octreotide Acetate Depot (Sandostatin LAR®)	Tufts Health Plan limits coverage of octreotide acetate depot (J2353) to 40 combined units per date of service when billed by any provider.
	Tufts Health Plan does not routinely compensate for octreotide acetate depot (J2353) when billed more than one visit every 12 days by any provider.
Ofatumumab (ARZERRA™)	Tufts Health Plan does 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].

Policy	Description
Olaratumab	Tufts Health Plan does not routinely compensate J9285 if billed more than 2 visits every 3 weeks and the diagnosis is soft tissue sarcoma.
Omalizumab (Xolair®)	Tufts Health Plan limits coverage of omalizumab (J2357) to 150 combined units per date of service by any provider when the diagnosis is latex allergy.
	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 does not routinely compensate oxaliplatin (J9263) if billed more than once every 12 days and the diagnosis on the claim is one of the following: • Colorectal cancer • Esophageal cancer • Head and neck cancer • Non-Hodgkin's lymphoma • Occult primary • Pancreatic cancer • Small intestine cancer
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J9263 under the following circumstances: • If billed by any provider more than once every three weeks and the diagnosis on the claim is breast cancer or ovarian cancer, or • If billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 100
Paclitaxel protein-bound particles (Abraxane®)	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.
Panitumumab	Effective for dates of service on or after October 1, 2018, Tufts Health Plan will limit 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 pegfilgrastim (J2505) under the following circumstances: • If billed more than once every 12 days and the diagnosis is chemotherapy-induced neutropenia, mobilization of peripheral blood progenitor cells prior to autologous stem cell transplantation, or post-peripheral blood progenitor cell transplant supportive care, or **Note:** This does not apply to Tufts Health Direct. • If billed and the patient is less than 18 years of age 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 under the following circumstances:

<table>
<tr><th>Policy</th><th>Description</th></tr>
<tr><td></td><td>If billed and an FDA approved indication or an approved off-labeled indication is not present on the claim, or
Note: This applies to Tufts Health Unify only.
billed and the diagnosis on the claim is chemotherapy-induced neutropenia, and a diagnosis of neoplasm is not also present</td></tr>
<tr><td rowspan="2">Pegloticase (Krystexxa®)</td><td>Tufts Health Plan does not compensate pegloticase (J2507) if billed without a diagnosis of chronic gout in adult patients refractory to conventional treatment.
Note: This applies to Tufts Health Unify <u>only</u>.</td></tr>
<tr><td>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.</td></tr>
<tr><td rowspan="2">Pembrolizumab (Keytruda®)</td><td>Tufts Health Plan does not routinely compensate for pembrolizumab HCl (J9271) if an approved indication or an approved off-labeled indication is not present on the claim.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate 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.</td></tr>
<tr><td rowspan="2">Pemetrexed (Alimta®)</td><td>Tufts Health Plan limits coverage of pemetrexed (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.</td></tr>
<tr><td>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.</td></tr>
<tr><td rowspan="3">Pertuzumab (Perjeta®)</td><td>Tufts Health Plan does not compensate Pertuzumab (J9306) when billed without a diagnosis of breast cancer or if trastuzumab (J9355) has not been billed for the same date of service.
Note: This applies to Tufts Health Together <u>only</u>.</td></tr>
<tr><td>Tufts Health Plan does not routinely compensate 96409 or 96411 (IV chemotherapy administration) if billed with J9306 and no other drug administered by IV chemotherapy administration has been billed for the same date of service by any provider.</td></tr>
<tr><td>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.</td></tr>
<tr><td rowspan="2">Ramucirumab</td><td>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.</td></tr>
<tr><td>Effective for dates of service on or after April 1, 2020, Tufts Health Public Plans will not routinely compensate J9308 under the following circumstances:
If billed by any provider more than once every three weeks and the diagnosis is non-small cell lung cancer
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, or
billed with modifier JW (Drug amount discarded/not administered to any patient) and the units equal or exceed 20</td></tr>
</table>

Policy	Description
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 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 does not routinely compensate rituximab (J9310) under the following circumstances: • If billed more than once every four days and the diagnosis is Evans syndrome or Waldenström macroglobulinemia • If billed by any provider more than 12 times in a patient'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.
Romiplostim (Nplate®)	Tufts Health Plan does not routinely compensate J2796 if billed 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.
	Effective for dates of service on or after April 1, 2020, Tufts Health Plan will not routinely compensate J2796 under the following circumstances: • If billed and an FDA approved indication or an approved off-labeled indication is not present on the claim, or • If 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 J7324 if billed more than 8 units every 28 days and the diagnosis is osteoarthritis of the knee.
TBO-Filgrastim (GRANIX™)	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.
	Tufts Health Plan does not routinely compensate for TBO-filgrastim (J1447) when billed 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 under the following circumstances: • If billed and the diagnosis on the claim is agranulocytosis secondary to cancer chemotherapy and a diagnosis of neoplasm is not also present, or • If 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.

Policy	Description
Tocilizumab (Actemra®)	Tufts Health Plan limits coverage of trastuzumab (J9355) to once every 12 days and the diagnosis is esophageal and gastroesophageal junction adenocarcinoma or gastric cancer.
Trastuzumab (Herceptin®)	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
	Tufts Health Plan does not routinely compensate vedolizumab (J3380) if billed without a diagnosis of regional enteritis (Crohn's disease) or ulcerative colitis. **Note:** This applies to Tufts Health Unify only.
	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 one of the following: • Esophageal cancer • Esophagogastric junction cancer • Gastric cancer • 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.
Vedolizumab (Entyvio®)	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.
	Tufts Health Plan limits coverage of vedolizumab (J3380) to 1500 combined units when billed in a 26-week period by any provider and the diagnosis is regional enteritis (Crohn's disease) or ulcerative colitis.

DOCUMENT HISTORY

- February 2021: Clarified existing billing requirements for clinician-administered outpatient drugs in accordance with MassHealth requirements for Tufts Health Together members
- December 2020: Added Acute Hospital Carve-Out Drugs billing requirements for Tufts Health Together members, in accordance with MassHealth MCE Bulletin 42
- 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

- June 2020: Revised claim requirements for single-source drugs administered by providers in a health care setting for Tufts Health Together members
- February 2020: Added edits for Autologous cultured chondrocytes**;** Antihemophilic Factor IX (Idelvion), Antihemophilic Factor VIII (Xyntha), Aprepitant, Arsenic Trioxide, Atezolizumab, Belatacept, Bevacizumab, Bezlotoxumab, Botulinum Toxin A (Botox®), Botulinum Toxin B, Brentuximab Vedotin, Cinacalcet, Darbepoetin Alfa (Aranesp®), Durvalumab, Etelcalcetide, Ferric Carboxymaltose, Ferumoxytol (Feraheme®), Filgrastim, Fluocinolone Acetonide, Intravitreal Implant (Iluvien), Fulvestrant, Goserelin Acetate Implant (Zoladex®), Human Antithrombin III, Infliximab (Remicade®), Intrauterine Contraceptive Systems and Contraceptive Implants, Ipilimumab (Yervoy™), Iron Sucrose (Venofer®), Lanreotide (Somatuline Depot®), Leuprolide acetate depot, 3.75 mg (Lupron Depot®, Eligard®), Mepolizumab, Oxaliplatin (Eloxatin®), Pegfilgrastim (Neulasta®), Pegloticase (Krystexxa®), Pertuzumab (Perjeta®), Ramucirumab, Rituximab (Rituxan®), Rituximab and Hyaluronidase, Romiplostim (Nplate®), TBO-Filgrastim (GRANIX™), Trastuzumab (Herceptin®), Treprostinil, Triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, VIII (Advate, Helixate FS, Kogenate FS, Recombinate) effective for dates of service on or after April 1, 2020
- April 2019: Policy created

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.