Drugs and Biologicals
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus HMO
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Health Connector)

Policy

This policy applies to payment for medically necessary drugs and biologicals that are covered under the medical benefit (i.e., non self-administered drugs and biologicals). Medical benefit drugs are typically administered as an injection or infusion in a physician's office, clinic or hospital, and may also be administered in a member's home.

Medical Benefit drugs and biologicals are sometimes referred to as "Physician/Clinician-administered drugs," which include both injectable and noninjectable drugs and biologicals that are typically administered by medical professionals in physicians' offices, clinics, or hospitals.

Physician/Clinicianadministered drugs must be identified on a claim by a HCPCS Code, National Drug Code (NDC), NDC Qualifier and NDC Quantity. Fallon Health is contractually obligated to ensure that valid NDCs are included on claims for such drugs in order to facilitate the collection of manufacturer rebates for the Massachusetts Medicaid Program (MassHealth). The Social Security Act specifically exempts vaccines from the rebate requirement and therefore vaccines are excluded from the NDC reporting requirement.

Reimbursement

The Plan will reimburse contracted providers for the provision of medically necessary covered drugs and biologicals in accordance with the provider's contract. Some drugs and biologicals require prior authorizationas outlined in **Referral/notification/prior authorization requirements** below.

This policy applies to inpatient facilities excluding payments made as part of a Diagnosis Related Group (DRG) methodology.

Acute Outpatient Hospitals Reimbursed Under MassHealth Payment Methodology
Acute outpatient hospitals reimbursed under MassHealth payment methodology receive one episode-specific all-inclusive payment for each payable episode known as the Adjudicated Payment per Episode of Care (APEC). The APEC priced payment is to be considered payment in full for most MassHealth-covered physician administered drugs delivered to a member on a single calendar day.

Note there are exceptions to the APEC payment methodology for Physician/Clinician-administered drugs:

- Certain MassHealth covered Physician/Clinician-administered drugs and biologicals are reimbursed separate from the APEC. These drugs are identified in the "Certain MassHealth Outpatient Physician Administered Drugs to be Paid by Fee Schedule" section of the MassHealth Drug List (Fee Schedule Drugs). The list of Fee Schedule Drugs may be updated from time-to-time. Payment to hospitals for the Fee Schedule Drug will be the amount listed in the quarterly Medicare Part B Drug Average Sales Price for the Fee Schedule Drug, as set

forth on CMS's website at https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files.

- **MassHealth ACO Program APAD/APEC Carve Out Drug Requirements Effective April 1, 2025**: In accordance with MassHealth Managed Care Entity Bulletin 114 and Managed Care Entity Bulletin 125, providers must submit prior authorization requests for APAD/APEC carve-out drugs to the MassHealth Drug Utilization Review (DUR) program before they are administered. Providers should refer to the MassHealth Acute Hospital Carve-Out Drugs List to review the list of APAD and APEC carve-out drugs subject to this transition, in addition to details regarding the MassHealth DUR Program prior authorization review process and applicable PA forms. Claims for these drugs should also be submitted to MassHealth. Fallon Health will continue to review and reimburse for related hospital and professional services.

Referral/notification/prior authorization requirements

The ordering physician is required to obtain prior authorization for those drugs and biologicals that require Plan prior authorization. The list of drugs and biologicals that require prior authorization is available online at ***Fallon Health Pharmacy Prior Authorization***..

Prime Therapeutics
Since October 1, 2024, Fallon Health has partnered with Prime Therapeutics Management, LLC (Prime) to review prior authorization requests for Physician/Clinician-administered drugs (medical benefit drugs) provided in Place of Service 11, 12, 19 and 22.

Prior authorization requests can be submitted to Prime through their secure electronic portal (https://gateway.pa.com/). If the electronic portal is inaccessible, prior authorization forms can also be faxed to 1-888-656-6671. For more information about prior authorizations, providers can call Prime at 1-800-424-1740. General questions regarding the medical pharmacy program may be directed to Fallon at 1-866-275-3247, prompt 5, or by email (askfchp@fallonhealth.org).

For medical benefit drugs administered in Places of Service other than 11, 12, 19 and 22, the prior authorization request must be submitted to Fallon Health. Providers may submit prior authorization request to Fallon Health electronically, via fax and by regular mail. Fallon Health will also accept requests for prior authorization by telephone.

PACE Program Authorization Process
Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as approved by the Interdisciplinary Team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be approved by the Interdisciplinary Team.

Billing/coding guidelines

Drugs and biologicals are identified on a professional claim (CMS 1500 or electronic equivalent) by an HCPCS code, and on a facility claim (UB-04 or electronic equivalent) by a revenue code and HCPCS code combination. If a drug does not have a unique HCPCS code, please assign the appropriate unlisted/not otherwise classified (NOC) HCPCS code.

Payment Rules for Post-Service Claims Edit (PSCE) Drugs
Drugs with a post-service claims edit (PSCE) will require an appropriate ICD-10 diagnosis attached to the claim for payment. The claim must also meet the appropriate frequency and unit quantity for payment. This list can be found in the Medical Benefit Drug Search section of the Plan's website. See link below:

https://fm.formularynavigator.com/FormularyNavigator/DocumentManager/Download?clientDocumentId=q0rFBp8AKkCU0tq0MP4Vhw.

National Drug Code (NDC) and 340B-Acquired Drugs Reporting Requirements

The NDC is a universal number that identifies a drug. When reporting an NDC, all of the following "NDC Information" is required:

- NDC Qualifier (F4)
- 11-digit NDC
- NDC Unit of Measure Qualifier (F2, GR, ME, UN, ML)
- NDC quantity

NDC Unit of Measure Qualifiers	
Qualifier	**Description**
F2	International unit (for example, anti-hemophilia factor)
GR	Gram (for creams, ointments and bulk powder)
ME	Milligrams (for creams, ointments and bulk powder)
UN	Unit (for tablets, capsules, suppositories and powder-filled vials)
ML	Milliliters (for liquids, suspensions and lotions)

For Fallon Medicare Plus and Community Care members, Fallon Health requires NDC Information, for all unlisted/not otherwise classified HCPCS codes including but not limited to: A9699, J3490, J3590, J7599, J7699, J7799, J7999, J8498, J8499, J8597, J8999, J9999 and C9399. Claims for unlisted/not otherwise classified HCPCS codes submitted without valid NDC Information will be denied. Claims may be resubmitted with the required NDC information. Timely filing and claim reconsideration requirements will need to be followed when resubmitting denied claims.

Additionally, for Fallon Medicare Plus, NaviCare HMO SNP, Summit ElderCare PACE and Fallon Health Weinberg PACE members, all 340B covered entities including hospital-based and non-hospital-based entities, that submit claims for separately payable Part B drugs and biologicals are required to report modifier JG or TB, as appropriate, on claim lines for drugs acquired through the 340B program for claims with dates of service January 1, 2024 through December 31, 2024. For claims with dates of service on or after than January 1, 2025, all 340B covered entities, including hospital-based and non-hospital-based entities, that submit claims for separately payable Part B drugs and biologicals, must report the TB modifier on claim lines for drugs acquired through the 340B program.

Medicare 340B Modifiers	
Modifier	**Description**
JG	Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes (terminated 12/31/2024)
TB	Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes for select entities

For MassHealth ACO, NaviCare HMO SNP, and Summit ElderCare members, to ensure MassHealth regulatory compliance, Fallon Health requires valid NDC Information (including NDC unit of measure and quantity) for clinician-administered drugs, for the following types of claims:

- All claims with drug HCPCS codes, regardless of revenue code or billed amount must be billed with a corresponding NDC.
- NDC information is required for physician administered drugs billed with revenue code 025X, when a single drug amount is equal to or greater than $10,000. If multiple drugs are combined on a revenue 025X claim line and the total billed is equal to or greater than $10,000, the provider must split the claim lines so that no single claim line for 025X drugs is equal to or greater than $10,000.
- Any claim line for a single-source drug (as defined in 42 CFR § 447.502) or any drug listed under 1927(a)(7)(B)(i) of the Social Security Act as a "Top 20 Multiple Source Covered Outpatient Physician Administered Drug" as listed by CMS requires an NDC regardless of billed amount or revenue code.

Additionally, for MassHealth ACO plan members, acute outpatient hospitals, community health centers and physicians billing for physician administered outpatient drugs are required to report modifier UD to identify a 340B-acquired drug.

MassHealth 340B Modifier	
Modifier	**Description**
UD	Drug or biological purchased through 340B program

MassHealth Acute Hospital Carve-Out Drugs
MassHealth maintains lists of Acute Hospital Adjudicated Payment Amount per Discharge (APAD) and Adjudicated Payment per Episode of Care (APEC) carve-out drugs. The list currently comprises CAR T-cell and gene therapies. The MassHealth Acute Hospital Carve-Out Drug List is available at: https://mhdl.pharmacy.services.conduent.com/MHDL/.

In accordance with MassHealth Managed Care Entity Bulletin 125 (March 2025), effective April 1, 2025, Fallon Health transitioned the review and management of all APAD and APEC carve-out drugs to the MassHealth Drug Utilization Review (DUR) Program. Effective for dates of services on or after April 1, 2025, all prior authorization (PA) requests for APAD and APEC carve-out drugs must be submitted to the DUR Program for review and approval before administration. MassHealth will pay these claims directly for MassHealth ACO members consistent with Sections 5.B.8.b and 5.C.9 of the current MassHealth Acute Hospital Request for Applications (Acute Hospital RFA) for in-state acute hospitals and regulations at 130 CMR 450.233(D) for out-of-state acute hospitals. This change centralizes oversight to ensure appropriate utilization, enhance prior authorization efficiency, and streamline payment processes.

Note: Only the APAD and APEC carve-out drugs themselves will be reviewed by the MassHealth DUR Program and reimbursed by MassHealth. Fallon Health will continue to review prior authorization requests and pay claims for the professional and facility services related to the APAD and APEC carve-out drugs.

For additional information, acute inpatient and outpatient hospitals may refer to MassHealth Acute Inpatient Hospital Bulletin 201 (March 2025) and MassHealth Acute Outpatient Hospital Bulletin 41 (March 2025), respectively.

For Providers Submitting Paper Claims
CMS-1500 form
Bill both the HCPCS J code and NDC number in field 24D, please enter the NDC number under the Level II HCPCS code, bill units in field 24G.
To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

Additional information for reporting NDC
- When entering supplemental information, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity.
- The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas. (Examples: 1234.56, 2, 99999999.999)
- When a dollar amount is being reported, enter the following after the quantity: one space, dollar amount. Do not enter a dollar sign.

UB-04 form
Bill the Level II HCPCS code in field locator 44, the NDC number in field locator 43 and service units in field locator 46.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through 13. The NDC is to be preceded with the qualifier N4 and following immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded

portion. The quantity is to be preceded by the appropriate qualifier (UN, F2, GR or ML) There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g., UN2 or F2999999).

Medical Drug Wastage Program
This Program focuses on therapeutically appropriate, and cost-effective dose optimization of certain weight-based or body surface area (BSA) based infused medications. Fallon requires dose rounding (i.e. reduction) for infused drug products to the nearest lowest vial size if within 10% of the original prescribed dose. Providers must comply with this policy or otherwise request as part of prior authorization medical necessity for higher dosing. Refer to ***Medical Drug Wastage Program*** for comprehensive list of applicable drug products and details.

Part B Drugs and Biologicals Reimbursed under Medicare Payment Methodologies
Providers and suppliers billing for separately payable Part B drugs or biologicals from single-dose containers, are required to report all claims either the JW or JZ modifier, to identify any discarded amounts or to attest that there are no discarded amounts, respectively.

When a provider or supplier, must discard the remainder of a single-dose container or single-use package after administering a dose to a plan member, the Plan will provide payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label, when the claim is submitted with the JW modifier to identify the discarded amount.

When a provider or supplier administers or supplies a separately payable drug from a single-dose container and there are discarded amounts, the provider or supplier must file a claim with two lines for the drug. For the administered amount, one claim line must include the billing and payment code (such as a HCPCS code) describing the given drug, no modifier, and the number of units administered in the unit field. For the discarded amount, a second claim line must include the same billing and payment code as used for the administered amount, the JW modifier, and the number of units discarded in the units field. The Plan does not compensate for any drug billed with modifier JW unless another claim line for the same drug is billed on the claim.

Background:

Effective January 1, 2017, CMS required the use of the JW modifier (Drug amount discarded/not administered to any patient) to identify unused and discarded amounts (hereafter, discarded amounts) of separately payable Part B drugs and biologicals from single-dose containers or single-use packages. Additionally, providers and suppliers are required to document the discarded drug or biological in the member's medical record(Transmittal R3538CP; MLN Matters MM9603).

The discarded amount is any amount that is not part of the prescribed dose and not intended to have a therapeutic effect in the patient. Generally, the discarded amount is the labeled amount on the single-dose container (or containers if more than one is required) minus the dose (the dose being the prescribed amount of drug administered to the patient).

To align with the JW modifier policy, CMS established the requirement that providers and suppliers report the JZ modifier (zero drug amount discarded/not administered to any patient) when there are no discarded amounts of single-dose containers or single-use packages for which the JW modifier would be required if there were discarded amounts.

Effective July 1, 2023, providers and suppliers are required to report the JZ modifier to attest that there are no amounts of drugs or biologicals from single-dose containers or single-use packages were unused and discarded for which the JW modifier would be required if there were discarded amounts (Transmittal R12067CP; MLN Matters MM13056).

Effective July 1, 2023, claims for separately payable Part B drugs or biologicals from single-dose containers or single-use packages that do not report the JW or JZ modifier, may be subject to provider audits (Transmittal R12067CP; MLN Matters MM13056).

Effective October 1, 2023, claims for separately payable Part B drugs or biologicals from single-dose containers or single-use packages that do not report the JW or JZ modifiers as appropriate, will be denied (Transmittal R12067CP; MLN Matters MM13056).

Using the JW and JZ modifiers:

- The use of the JW and JZ modifiers is not appropriate for drugs that are from multiple-dose containers.
- The JW and JZ modifier policy applies to providers and suppliers who purchase and bill separately payable Part B drugs and biologicals. The JW and JZ modifiers are mostly reported on claims from the physician's office and hospital outpatient or ambulatory surgical center settings for patients receive drugs incident to physicians' services. The JW and JZ modifier requirements also apply to Critical Access Hospitals (CAHs), since drugs are separately payable in the CAH setting.
- In the hospital outpatient department and ambulatory surgical center (ASC), only separately payable drugs and biologicals are subject to the JW and JZ modifier requirements.
    - The JW and JZ modifier requirement applies to separately payable drugs from single-dose containers assigned status indicators "G" (Pass-Through Drugs and Biologicals), or "K" (NonpassThrough Drugs and Nonimplantable Biologicals, Including Radiopharmaceuticals) under the OPPS for which there is a discarded amount.
    - The JW and JZ modifier requirement applies to separately payable drugs from single-dose containers assigned payment indicator "K2" (Drugs, biologicals, and radiopharmaceuticals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate) in the ASC for which there is a discarded amount.
- The requirements for using the JW and JZ modifiers are independent of revenue codes reporting. Providers and suppliers should always use the most appropriate revenue code that applies to the service they are reporting.
- The JW and JZ modifier policy does not apply for drugs that are not separately payable, such as packaged OPPS or ASC drugs, or to drugs administered in the Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC).
    - The JW and JZ modifiers do not apply to drugs assigned status indicator N (Items and Services Packaged into APC Rates) under the OPPS. Similarly, the JW and JZ modifiers do not apply to drugs assigned payment indicator "N1" (Packaged service/item; no separate payment made) under the ASC payment system.
    - Drugs administered in RHCs and FQHCs are generally not separately payable under Part B. Instead, their payment is included in the RHC's all-inclusive rate or the FQHC's prospective payment system rate for the patient's visit.
- The JW and JZ modifiers are not intended for use on claims for hospital inpatient admissions that are billed under the Medicare Inpatient Prospective Payment System (IPPS).
- The JW and JZ modifiers are not required for vaccines described under section 1861(s)(10) of the Act that are furnished from single-dose containers.
- The JW and JZ modifiers are not appropriate for billing for incident-to supplies, even if such incident-to supplies are separately payable.
- The JW modifier must not be used to report discarded amounts of overfill.

Further details regarding the JW and JZ modifiers are found in the Frequently Asked Questions (FAQ) available at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf.

Modifier	Description

JW	Drug amount discarded/not administered to any patient
JZ	Zero drug amount discarded/not administered to any patient

Drug Waste Reimbursement
This section is applicable when drug waste is reimbursable. This section is not applicable to Physician/Clinician-administered drugs reimbursed under Masshealth payment methodologies.

Providers should administer drugs and biologicals in the most cost-effective and clinically appropriate manner. Plan reimbursement is for drugs and biologicals which are administered to a Plan member, only up to the next incremental Level II HCPCS code unit.

The Plan does not reimburse for that portion of a multi-use vial of medication that is not administered to Plan members including, but not limited to, those that are determined to be contaminated, wasted, or unused, unless documentation within the patient's medical record file indicates the date, time, and name of clinical staff who wasted the portion of medication within a single-use vial. Providers will utilize the most appropriate sized single-use vial or combination of single-use vials to deliver the ordered dose of medication and minimize waste. Reimbursement will be made for discarded portions of single-use vials only when proper billing guidelines are followed as outlined in the Billing/Coding section of this policy.

The Plan reserves the right to audit to verify payment accuracy. Neither the Plan nor Plan members can be held financially responsible for any denied payments for drugs and biologicals that were not administered.

- For multi-use vials, bill only for the portion of the medication administered to the member; wasted pharmaceutical will not be reimbursed.
- Plan reimbursement is for drugs and biologicals which are administered to a Plan member, only up to the next incremental Level II HCPCS code unit. Wasted medication from a single-use vial will be reimbursed when the wasted medication is documented as such within the patient's medical record. Such documentation should include the date, time, and name of the clinical staff wasting the medication, as well as the amount wasted. Documentation of waste must be retained within the patient's medical record and/or made available to Plan audit representatives upon request.
- Providers will administer drugs to members in such a way that they can use the drugs most efficiently, in a clinically appropriate manner. Providers will utilize the most appropriate sized single-use vial or combination of single-use vials to deliver the ordered dose of medication and minimize waste.

Physician Administered Drugs Reimbursed under MassHealth Payment Methodologies
When billing for physician administered drugs in an office or other outpatient clinical setting (including an acute outpatient hospital), providers should report only the amount of drug administered to the member. The Plan does not reimburse drug waste from single or multidose vials. Providers need not report drug waste on claims for physician-administered drugs. Modifiers JW and JZ are not allowed for billing under MassHealth.

When billing for physician-administered drugs in an office or other outpatient clinical setting (including an acute outpatient hospital), providers should report the quantity of drug administered to the patient on one (1) claim line. Providers should not bill multiple claim lines with the same HCPCS code on the same date of service, even if the drug administered has multiple NDCs. Second and subsequent claim lines for the same HCPCS code for the same date of service will be denied.

When billing for physician administered drugs, except vaccines, report all of the following information:

- HCPCS code
- Quantity of the drug administered
- Qualifier N4
- 11-digit NDC code
- NDC unit of measure and quantity

Claims for physician administered drugs must include modifier UD to identify a 340B-acquired drug.

Under MassHealth payment methodology, acute outpatient hospitals receive one episode-specific all-inclusive payment for each payable episode known as the adjudicated payment per episode of care (APEC). Drug waste and the use of multiple NDCs to make a dose are included in the episode-specific all-inclusive APEC (3M EAPG) payment.

Billing for No Cost Drugs and Biologicals
Physicians and nonphysician practitioners (NPPs) who bill independently should not report no cost drugs and biologicals as there are no system edits in place that require them to do so and there is no field on the professional claim form to report a non-covered charge. There is one exception: the administration of state-supplied vaccines. For the administration of state-supplied vaccines, physicians and NPPs should:

- Submit the appropriate immunization administration CPT code (90460-90461 or 90471-90474) in addition to the vaccine/toxoid CPT code, and
- Attach the SL modifier to the vaccine/toxoid CPT code with a charge of $0.00 to indicate that the vaccine/toxoid was state-supplied.

Some billing systems require that a charge be reported, even for drugs and biologicals for which the physician or NPP incurs no cost. In that case, the physician or NPP may submit a token charge of less than $1.01 for the item in the Covered Charges field of the CMS-1500.
Generally, hospitals are not required to report no cost drug or biologicals, however there are situations where no cost drugs and biologicals may be reported on claims:

- For hospitals paid under the Medicare hospital Outpatient Prospective Payment System (OPPS), when a drug is provided at no cost (for example, a specialty pharmacy drug, or a drug supplied at no cost by a clinical trial sponsor), claims processing edits may prevent drug administration charges from being paid when the claim does not contain a covered/billable drug charge. Therefore, for drugs and biologicals provided at no cost in a hospital outpatient department, providers should report the HCPCS code for the drug or biological with appropriate units and a token charge of less than $1.01 for the item in the Covered Charges field and mirror this less than $1.01 amount in the Non-Covered Charge field.
- For hospitals reimbursed by other payment methodologies, if it is necessary for a hospital to report a charge for drugs and biologicals for which the hospital incurs no cost, for example, because the hospital's billing system requires that a charge be reported on the UB-04, the hospital may report the drug or biological with appropriate units and a token charge of less than $1.01 for the item in the Covered Charges field and mirror this less than $1.01 amount in the Non-Covered Charge field.

Home Infusion Drugs
For Medicare members, providers must adhere to CMS requirements for billing home infusion drugs that are covered under Part D: http://www.fchp.org/providers/pharmacy/online-drug-formulary.aspx.

Ophthalmologic Avastin (bevacizumab)
Claims (professional and facility) for bevacizumab for ophthalmologic indications should be submitted using HCPCS code J9035 (injection, bevacizumab, 10 mg), bill one unit per eye.

There is one exception: outpatient hospitals and ambulatory surgical centers reimbursed under Medicare OPPS or ASC payment methodology use HCPCS code C9257 (injection, bevacizumab, 0.25 mg) to report ophthalmologic bevacizumab.

Since October 2021, the Plan does not require purchase invoices for ophthalmologic bevacizumab.

Opioid Reversal Agents for Community Care Members
In accordance with Massachusetts General Laws, Chapter 176G, Section 4TT, the Plan will provide coverage for prescribed, ordered or dispensed opioid antagonists, defined as naloxone or any other drug approved by the Food and Drug Administration as a competitive narcotic antagonist used in the reversal of overdoses caused by opioids. Coverage will be provided under

the medical benefit when the opioid antagonist is dispensed by the health care facility in which the opioid antagonist was prescribed or ordered, and under the pharmacy benefit when the opioid antagonist is dispensed by a pharmacist, including an opioid antagonist dispensed pursuant to section 19B of Chapter 94C, § 19B.

Opioid antagonists dispensed in accordance with Chapter 176G, Section 4TT will not require prior authorization or a prescription from a health care practitioner. In Massachusetts, there is a standing order that allows pharmacists to dispense naloxone without an individual prescription. Please refer to the standing order for naloxone at www.mass.gov/doc/naloxonestanding-order-1/download and M.G.L. c. 94C, § 19B for further information.

Opioid antagonists used in the reversal of overdoses caused by opioids will not be subject to deductibles, copayments or out-of-pocket limits for most Community Care plans; however, cost-sharing will be required for HSA-Qualified plans which are governed by the federal Internal Revenue Code and would lose tax-exempt status as a result of the prohibition on cost-sharing for these services.

Opioid antagonists dispensed by health care facilities must be billed using revenue code 0636 with the appropriate HCPCS and NDC codes, and ICD-10-CM Diagnosis codes F11.1 thru F11.99. The rate reimbursed under the medical benefit will not exceed the Plan's average in-network pharmacy benefit rate and the health care facility shall not balance bill the patient.

Please refer to the Plan's website for formulary information on opioid antagonist reversal agents. https://fallonhealth.org/providers/pharmacy/online-drug-formulary.

NDC	Product Label	GPI-14 Description	HCPCS Code
59467067901	KLOXXADO SPR 8MG	NALOXONE HCL NASAL SPRAY 8 MG/0.1ML	J3490
59011096010	NALMEFENE INJ 1MG/ML	NALMEFENE HCL INJ 1 MG/ML (BASE EQUIV)	J3490
00409121501	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
00409121521	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
00641613201	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
00641613225	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
36000030801	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
36000030810	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
55150032701	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
55150032710	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457029200	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457029202	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457059900	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457059902	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457064500	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457064502	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
70069007101	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
70069007110	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
70756065810	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
70756065825	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312

NDC	Product Label	GPI-14 Description	HCPCS Code
72572045001	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
72572045025	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
72603059010	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
72603059025	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
00409121901	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
55150032801	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
55150032810	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
67457029900	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
67457029910	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
67457098700	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
67457098710	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
70069007201	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
70069007210	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
00409178203	NALOXONE INJ 0.4MG/ML	NALOXONE HCL SOLN CARTRIDGE 0.4 MG/ML	J2312
00409178269	NALOXONE INJ 0.4MG/ML	NALOXONE HCL SOLN CARTRIDGE 0.4 MG/ML	J2312
36000031001	NALOXONE INJ 4MG/10ML	NALOXONE HCL INJ 4 MG/10ML	J2312
36000031002	NALOXONE INJ 4MG/10ML	NALOXONE HCL INJ 4 MG/10ML	J2312
68001064545	NALOXONE SPR	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
00781717606	NALOXONE SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
00781717612	NALOXONE SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
42291049301	NALOXONE SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
42291049302	NALOXONE SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
76329146901	NALOXONE HCL INJ 1MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76329336901	NALOXONE HCL INJ 1MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76329346901	NALOXONE HCL INJ 1MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
00641620501	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
00641620510	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
42023022401	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312

NDC	Product Label	GPI-14 Description	HCPCS Code
43598075010	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
43598075011	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
55150034501	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
55150034510	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
67457099202	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76045011201	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76045011220	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76045011401	NALOXONE HCL SOL 0.4MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 0.4 MG/ML	J2312
76045011410	NALOXONE HCL SOL 0.4MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 0.4 MG/ML	J2312
00480347819	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
00480347868	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
45802057800	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
45802057884	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
45802081100	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
45802081184	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
60219210407	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
69238210401	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
69238210407	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
69547035302	NARCAN SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
69547062702	NARCAN SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
12496000301	OPVEE SPR 2.7/0.1	NALMEFENE HCL NASAL SPRAY 2.7 MG/0.1ML (BASE EQUIV)	J3490
12496000302	OPVEE SPR 2.7/0.1	NALMEFENE HCL NASAL SPRAY 2.7 MG/0.1ML (BASE EQUIV)	J3490

NDC	Product Label	GPI-14 Description	HCPCS Code
76329366902	REXTOVY SPR 4/0.25ML	NALOXONE HCL NASAL SPRAY 4 MG/0.25ML	J3490
78670014002	ZIMHI SOL	NALOXONE HCL SOLN PREFILLED SYRINGE 5 MG/0.5ML	J2313
78670014011	ZIMHI SOL	NALOXONE HCL SOLN PREFILLED SYRINGE 5 MG/0.5ML	J2313

Spravato® (Esketamine) Nasal Spray Billing and Coding Update
Effective 09/01/2025, providers must use HCPCS G2082 or G2083 to report the provision of Spravato® and associated professional services for Medicare HMO, NaviCare, Summit ElderCare PACE, and Fallon Health Weinberg PACE members.

Effective 12/01/2025, providers must use HCPCS G2082 or G2083 to report the provision of Spravato® and associated professional services for Community Care members.

Reimbursement for G2083 and G2083 includes the evaluation and management of an established patient, provision of Spravato® and 2 hours post-administration observation. Only 1 unit of G2082 or G2082 may be reported per date of service.

Under circumstances where the health care professional supervising the self-administration and post-administration observation does not also provide the Spravato®, the provider cannot report HCPCS codes G2082 or G2083. Rather, the visit and the extended observation (by either the billing professional or clinical staff) can be reported using the existing evaluation and management codes that describe the visit and the prolonged service of the professional or the clinical staff.

Spravato® (HCPCS codes G2082, G2083) requires prior authorization. Please refer to the Plan's website for information on Spravato® https://fallonhealth.org/providers/pharmacy/online-drug-formulary.

Code	Description
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care provider and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care provider and provision of greater than 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation.

Claims for HCPCS code S0013 (Esketamine, nasal spray, 1 mg) will deny vendor liable for Medicare HMO, NaviCare, Summit ElderCare PACE, and Fallon Health Weinberg PACE members effective 09/01/2025. The Medicare Physician Fee Schedule Status Indicator for HCPCS S0013 is I = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services.

Claims for HCPCS code S0013 (Esketamine, nasal spray, 1 mg) will deny vendor liable for Community Care members effective 12/1/2025.

Long-Acting Injectable (LAI) for MassHealth ACO Members
Long-Acting Injectable (LAI) Antipsychotics are antipsychotic medications that are administered through intramuscular injection and provide medication coverage for a period of weeks to months. LAI Antipsychotics does not refer to the administration of the medications.

LAI Antipsychotics are identified on the Long-Acting Injectable Antipsychotic Medications Administered in Inpatient Psychiatry Units document maintained on the MassHealth Drug List. The MassHealth Drug List is published on the MassHealth website at https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do.

The list of "Long-Acting Injectable Antipsychotic Medications Administered in Inpatient Psychiatry Units" identifies the current long-acting injectable antipsychotic medications that, when administered in an inpatient psychiatry unit, are reimbursable outside of the applicable per diem rates, for in-state acute inpatient hospitals with DMH licensed beds.

In-state acute inpatient hospital providers with DMH licensed beds will be paid for Long-Acting Injectable Antipsychotic Medications Administered in Inpatient Psychiatry Units, effective May 15, 2024, under a new payment methodology. To ensure proper payment, hospitals must follow these billing instructions.

1. Charges corresponding to the LAI Antipsychotics must be excluded from any facility/institutional claim that the hospital submits for the member's acute inpatient hospital stay.
2. The hospital must instead claim separate payment for the LAI Antipsychotic on a professional claim form (CMS-1500 or electronic equivalent), using the appropriate HCPCS and NDC Information for the drug and submit the claim to Fallon Health.

Drug specific prior authorization criteria, if applicable, must be met as a condition of payment.

Place of service

This policy applies to services rendered in the outpatient and inpatient setting , including professional offices, outpatient clinics, hospitals and in some cases, the patient's home.

Policy history

Origination date:	11/1/09
Previous revision date(s):	07/01/2010 – updated language in the Policy, Reimbursement and Billing/coding guidelines sections to indicate policy and process regarding pharmaceutical waste. 01/01/2012 - Updated billing/coding guidelines to add discussion about revenue code 0636. 05/01/2012 - Removed requirement for itemized invoice with revenue code 0636. 11/1/2012 – Removed requirement to submit modifier JW - drug amount discarded and that the amount discarded from single-use vial drugs will not be reimbursed. 02/01/2013 – Updated NDC billing requirements for members enrolled through MassHealth. 09/01/2013 - Updated discussion of drug waste and reimbursement for multi vs. single use vials. 07/01/2014 - Clarified discussion about drug waste. 11/01/2015 - Moved to new Plan template and updated Exhibit A. 11/01/2016 - Annual review, no changes were made to Exhibit A per MassHealth. Still no CMS guidance on NDC requirements for radiopharmaceuticals. 03/01/2017 - Updated prior authorization requirements section. 05/01/2017 - Added JW modifier update.
Connection date & details:	November 2017 – Added implantable definition and updated Exhibit A with most recent listing from MassHealth. April 2018 – Clarified JW modifier billing requirements October 2018 – Policy is now applicable to in-patient services, policy name changes from Outpatient Drugs to Drugs and Biologicals.

April 2019 – Updated addendum A for clarifying PA requirements and removing termed codes.
July 2019 - Added Unit of Measurement requirements to Billing/Coding Guidelines for Masshealth and NaviCare
October 2019 – Clarified billing guidelines, added Table B medical drug criteria.
January 2020 – Updated Masshealth NDC exlusions and Table A required codes.
June 2020 – Added Post Service Claims Edit (PSCE) description and removed Appendix B medical drug criteria as it will now be posted on the Fallon medical benefit drug lookup and updated monthly. Removed Exhibit A.
October 2020 – Clarified NDC requirements for physician-administered drugs, added information about billing for MassHealth Carve-Out Drugs.
January 2021 – Added information about billing for no cost drugs and biologicals; documented existing requirement specific to billing for home infusion drugs under Medicare Part D.
April 2021 – Added information about NDC-HCPCS validation for MassHealth ACO and NaviCare members; clarified billing requirements for 340B drugs.
October 2021 – Updated to include billing information for ophthalmologic Avastin (bevacizumab).
January 2023 – Under Referral/notification/prior authorization requirements, clarified that for medical benefit drugs administered in POS other than 11, 12, 19 and 22, the prior authorization request must be submitted to Fallon Health; added instructions for use of the JW and JZ modifier under Billing/coding guidelines, clarified that modifier UD must be reported on claims for physician/clinician-administered outpatient drugs acquired under the 340B program.
July 2024 – Updated Billing/coding guidelines to include new section on Drugs Designated for Exclusion from 340B Coverage.
January 2025 – Updated to reflect Magellan Rx rebrand to Prime Therapeutics Management effective October 1, 2024; added new paragraph for Medical Drug Wastage Program under Billing/coding guidelines; under Billing/coding guidelines updated to indicate that effective January 1, 2025 Medicare is requiring that all 340B drugs are submitted with modifier JB. Modifier JG is being discontinued effective 12/31/2024.
April 2025 – Under Billing/coding guidelines, removed section Drugs Designated from 340B Coverage for MassHealth ACO members (no longer applicable), updated MassHealth Acute Hospital Carve-Out Drugs section, by deleting all previous content and replacing it with new guidance from MassHealth effective April 1, 2025.
July 2025 – Under Billing/coding guidelines, added new section for Opioid Reversal Agents; under Billing/coding guidelines, added new section Spravato® (Esketamine) Nasal Spray Billing and Coding Update; under Billing/coding guidelines, added new section for Long-Acting Injectable (LAI) Antipsychotics Administered in Inpatient Psychiatry Units for MassHealth ACO Members.
October 2025 – Under Reimbursement, added new section for Acute Outpatient Hospitals Reimbursed Under MassHealth Payment Methodology; under Billing/coding guidelines, added

	new section for Physician Administered Drugs Reimbursed under MassHealth Payment Methodologies, and updated Spravato® (Esketamine) Nasal Spray Billing and Coding Update section to include Community Care effective 12/01/2025. January 2026 – Under Reimbursement, Part B Drugs and Biologicals Reimbursed under Medicare Payment Methodologies, further clarified the use of the JW and JZ modifiers.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.