Denied Drug Codes – Pharmacy Benefit Drugs (for Louisiana Only)

Policy Number: CSLA2020D0990F
Effective Date: November 1, 2020

Instructions for Use

Table of Contents Page

Application

This Medical Benefit Drug Policy only applies to the state of Louisiana.

Coverage Rationale

This Medical Benefit Drug Policy applies to UnitedHealthcare Community Plan Medicaid products.

This policy applies to services reported using both the 1500 Health Insurance Claim Form (a/k/a CMS-1500) and the UB-04 form, their electronic equivalent, and their successor forms. This policy applies to all:

- Network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.
- Network and non-network facilities including, but not limited to, non-network authorized and percent of charge contract facilities.

For UnitedHealthcare Community Plan Medicaid products with a pharmacy benefit that UnitedHealthcare Community Plan manages, there are certain specialty injectable products that are only covered under the members' pharmacy benefit. Therefore, they should not be reimbursed through the medical benefit on a medical claim. This policy serves two purposes:

- Prevent paying for the same medication for the same member twice, once on a pharmacy claim and once on a medical claim.
- Prevent inappropriate and/or excessive use of these medications that is not consistent with current practices and evidence-based literature. This is achieved through a clinical review of the medication, as performed by the UnitedHealthcare Community Plan pharmacy department, prior to claim processing on the pharmacy benefit through the Pharmacy Benefit Administrator.

The following specialty drugs (as identified by their CPT/HCPCS code) will be denied from paying on a medical professional and outpatient facility claim:

Medication/Brand Name	CPT/HCPCS Code	Description
Avonex	J1826	Injection, interferon beta-1a, 30 mcg
	Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use
Betaseron, Extavia	J1830	Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
Cimzia	J0717	Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
Copaxone, Glatiramer, Glatopa	J1595	Injection, glatiramer acetate, 20 mg
Enbrel	J1438	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
Firazyr	J1744	Injection, icatibant, 1 mg
Forteo	J3110	Injection, teriparatide, 10 mcg
Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Zomacton, Zorbtive (Somatroprin)	J2941	Injection, somatropin, 1 mg
Haegarda	J0599	Injection, C1 esterase inhibitor (human), (Haegarda), 10 units
Humira	J0135	Injection, adalimumab, 20 mg
Increlex	J2170	Injection, mecasermin, 1 mg
Infergen	J9212	Injection, interferon alfacon-1, recombinant, 1 mcg
Pegasys	S0145	Injection, PEGylated interferon alfa-2A, 180 mcg per ml
Peg-Intron	S0148	Injection, PEGylated interferon alfa-2B, 10 mcg
Pulmozyme	J7639	Dornase alfa, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per mg
Rebif	J1826	Injection, interferon beta-1a, 30 mcg
	Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use
Stelara	J3357	Ustekinumab, for subcutaneous injection, 1 mg
Synagis	90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
Tobramycin (for inhalation)	J7682	Tobramycin, inhalation solution, FDA-approved final product, noncompounded, unit dose form, administered through DME, per 300 mg
Tremfya	J1628	Injection, guselkumab, 1 mg
Xolair	J2357	Injection, omalizumab, 5 mg

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each

HCPCS Code	Description
J0135	Injection, adalimumab, 20 mg
J0599	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units
J0717	Injection, certolizumab pegol, 1 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1438	Injection, etanercept, 25 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1595	Injection, glatiramer acetate, 20 mg
J1628	Injection, guselkumab, 1 mg
J1744	Injection, icatibant, 1 mg
J1826	Injection, interferon beta-1a, 30 mcg
J1830	Injection interferon beta-1b, 0.25 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J2170	Injection, mecasermin, 1 mg
J2357	Injection, omalizumab, 5 mg
J2941	Injection, somatropin, 1 mg
J3110	Injection, teriparatide, 10 mcg
J3357	Ustekinumab, for subcutaneous injection, 1 mg
J7639	Dornase alfa, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram
J7682	Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, per 300 milligrams
J9212	Injection, interferon alfacon-1, recombinant, 1 mcg
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use
S0145	Injection, pegylated interferon alfa-2a, 180 mcg per ml
S0148	Injection, pegylated interferon alfa-2B, 10 mcg

References

American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services.

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets.

Policy History/Revision Information

Date	Summary of Changes
04/01/2021	Template Update • Removed *Related Policies* section • Updated *Instructions for Use*; replaced reference to "MCG™ Care Guidelines" with "InterQual® criteria"
02/01/2021	Template Update • Reformatted policy; transferred content to new template

Date	Summary of Changes

11/01/2020	**Coverage Rationale**
	• Reformatted and revised list of specialty drugs (as identified by their CPT/HCPCS code) that will be denied from paying on a medical professional and outpatient facility claim:
	  ○ Added Firazyr, Glatiramer, Glatopa, Haegarda, Pulmozyme, Stelara, Tobramycin (for inhalation), and Tremfya
	  ○ Added CPT/HCPCS code descriptions
	Applicable Codes
	• Updated list of applicable HCPCS codes; added J0599, J1628, J1744, J3357, J7639, and J7682
	Supporting Information
	• Archived previous policy version CSLA2019D0990E

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.