May 2021 Provider Newsletter

PHARMACY

Pre-Payment, Post Service Claim Edit Program

Aspirus Health Plan is implementing a pre-payment, post service claim edit program starting August 1, 2021. The claim edit program applies edits to medical benefit claims that focus on eligible diagnosis, maximum dosage/units, duration and frequency. This ensures providers are utilizing physician office-billed drugs in accordance with FDA labels, and compendia-approved uses consistent with each drug policy. Please refer to the Pharmacy Clinical Resources webpage for details.

Each clinical policy provides specific guidelines used to determine pre-payment edits that can result in a partial or denied payment based on the submitted claim. The guidelines include, *but are not limited to,* covered and non-covered drugs, preferred/non-preferred drugs, step therapy requirements and exceptions, covered diagnosis code, maximum billable units, dose, frequency, and duration.

Prior authorization is not a requirement for all drugs in scope for pre-payment claims edits. However, the guidelines within their respective policies will still be applied to claims, specifically as it relates to: covered/non-covered drugs, preferred/non-preferred drugs, diagnosis, dose, frequency, duration, and maximum billable units. A list of drugs that do not require prior authorization, but are subject to pre-payment claims edits, can be found on our Pharmacy Clinical Resources webpage.

Drugs that require prior authorization will be included in our prior authorization list and will have a notation indicating the requirement. Their corresponding policies can be found in our Pharmacy Clinical Resources webpage.

Pharmacy Website

Aspirus Health Plan has recently revamped its Pharmacy Clinical Resources webpage. You can see the changes by going here. Now, each drug on our prior authorization list has a policy link next to it that you can view. In addition, there are a number of new policies that have been added for drugs on our prior authorization list. Please see our webpage to view the relevant policies.

Starting August 1, 2021, all botulinum toxin products, *except* Myobloc (Rimabotulinumtoxin B), will no longer require prior authorization. However, the clinical policy for these products will provide guidance on allowable indications, dosing, frequency, and maximum billable units. These products are subject to our pre-payment, post service claim edit program.

Starting August 1, 2021, all hyaluronic acid products will no longer require prior authorization. However, coverage will only be allowed for Synvisc, Synvisc-One, and Euflexxa. All other products are NOT covered. These products are subject to our pre-payment, post service claim edit program.

The following are prior authorization list changes:

Pepaxto (melphalan flufenamide) added effective 6/3/2021:
Abecma (idecabtagene vicleucel) added effective 4/20/2021:
The following medication was removed: Ixifi (infliximab-qbtx)

Important Drug Code Change

Darzalex Faspro (Daratumumab and hyaluronidase-fihj)

For services prior to December 31, 2020 – use code C9399 (unclassified drugs or biologicals), OR, J9999 (not otherwise classified, antineoplastic drugs)

For services on or after January 1, 2021 – use code J9144 (Injection, daratyumumab, 10mg and hyaluronidase-fihj)

J9144 can be used on both facility and professional billings. Use of a non-specific code when a specific code exists will be returned to the provider. A corrected claim will be required.

Drugs and Biologics must be reported with its method of administration