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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 146  
6010.54-M  
SEPTEMBER 7, 2011**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE POLICY MANUAL (TPM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** HOME INFUSION THERAPY

**CONREQ:** 15382

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change creates a preauthorization requirement for home infusion therapy, and requires non-homebound beneficiaries to obtain home infusion drugs from the TRICARE Pharmacy (TPharm) program.

**EFFECTIVE DATE:** September 30, 2011.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

**This change is made in conjunction with Aug 2002 TRM, Change No. 136.**

  
Ann N. Fazzini  
Chief, Medical Benefits and  
Reimbursement Branch

**ATTACHMENT(S): 16 PAGE(S)  
DISTRIBUTION: 6010.54-M**

**CHANGE 146**  
**6010.54-M**  
**SEPTEMBER 7, 2011**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 7.1, pages 1 and 2

**CHAPTER 8**

Table of Contents, pages i and ii

Section 9.1, pages 1 - 5

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**INDEX**

pages 11 and 12

**INSERT PAGE(S)**

Section 7.1, pages 1 and 2

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Section 9.1, pages 1 - 5

Section 20.1, pages 1 - 5

pages 11 and 12

## SPECIAL AUTHORIZATION REQUIREMENTS

ISSUE DATE: August 4, 1988

AUTHORITY: [32 CFR 199.4\(a\)\(12\)](#), [32 CFR 199.5\(h\)\(3\)](#) and [32 CFR 199.15\(b\)\(4\)](#)

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### I. POLICY

Unless otherwise specifically excepted, the adjudication of the following types of care is subject to the following authorization requirements:

- A. Adjunctive dental care must be preauthorized.
- B. Dental anesthesia and institutional benefit must be preauthorized. See [Chapter 8, Section 13.2, paragraph II.E.](#)
- C. Extended Care Health Option (ECHO) benefits must be authorized in accordance with [Chapter 9, Section 4.1.](#)
- D. Effective October 1, 1991, preadmission and continued stay authorization is required before nonemergency inpatient mental health services may be cost-shared (includes Residential Treatment Center (RTC) care and alcoholism detoxification and rehabilitation). Effective September 29, 1993, preadmission and continued stay authorization is also required for all care in a Partial Hospitalization Program (PHP).
- E. Effective November 18, 1991, psychoanalysis must be preauthorized.
- F. The Executive Director, TRICARE Management Activity (TMA), or designee, may require preauthorization of admission to inpatient facilities.
- G. Organ and stem cell transplants are required to be preauthorized. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in this Policy Manual, or until the approved transplant occurs.
- H. **Infusion therapy delivered in the home must be preauthorized in accordance with [Chapter 8, Section 20.1.](#)**
- I. Effective for dates of service **June 1, 2010**, Skilled Nursing Facility (SNF) care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer.

**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 1, SECTION 7.1

SPECIAL AUTHORIZATION REQUIREMENTS

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For those beneficiaries inpatient on the effective date, a preauthorization will be required August 1, 2010. See the TRICARE Operations Manual (TOM), [Chapter 7, Section 2](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 8, Section 2](#).

J. Each TRICARE Regional Managed Care Support Contractor (MCSC) may require additional care authorizations not identified in this section. Such authorization requirements may differ between regions. Beneficiaries and providers are responsible for contacting their contractor for a listing of additional regional authorization requirements.

NOTE: When a beneficiary has "other insurance" that provides primary coverage, preauthorization requirements in [paragraph I.J.](#) will not apply. Any medically necessary reviews the MCSC believes are necessary, to act as a secondary payor, shall be performed on a retrospective basis. The conditions for applying this exception are the same as applied to the Non-Availability Statement (NAS) exception in [Chapter 1, Section 6.1, paragraph III.A.](#)

K. Provider payments are reduced for the failure to comply with the preauthorization requirements for certain types of care. See the TRM, [Chapter 1, Section 28](#).

## II. EXCEPTIONS

A. For Dual Eligible beneficiaries, these requirements apply when TRICARE is primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor will obtain the necessary information and perform a retrospective review.

B. The requirement that a TRICARE Prime enrollee obtain a referral/authorization from their Primary Care Manager (PCM) to receive the H1N1 immunization from a non-network, TRICARE-authorized provider has been temporarily waived from October 1, 2009 to May 1, 2010. During this period, Prime enrollees may obtain the H1N1 immunization from a non-network TRICARE-authorized provider without prior authorization or PCM referral. Point Of Service (POS) cost-shares normally associated with non-referred care obtained by Prime enrollees from non-network providers without appropriate authorization will not apply during this period.

- END -

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2.1	Durable Medical Equipment: Basic Program
2.2	Infantile Apnea Cardiorespiratory Monitor
2.3	External And Implantable Infusion Pump
2.4	Cold Therapy Devices For Home Use
2.5	Home Prothrombin Time (PT) International Normalized Ratio (INR) Monitor
2.6	Breast Pumps
2.7	Pulsed Irrigation Evacuation (PIE)
3.1	Orthotics
4.1	Prosthetic Devices And Supplies
5.1	Medical Devices
5.2	Neuromuscular Electrical Stimulation (NMES) Devices
5.3	Continuous Glucose Monitoring System (CGMS) Devices
6.1	Medical Supplies And Dressings (Consumables)
7.1	Nutritional Therapy
7.2	Liquid Protein Diets
8.1	Diabetes Self-Management Training (DSMT) Services
8.2	Therapeutic Shoes For Diabetics
9.1	Pharmacy Benefits Program
10.1	Oxygen And Oxygen Supplies
11.1	Podiatry
12.1	Wigs Or Hairpiece
13.1	Adjunctive Dental Care
13.2	Dental Anesthesia And Institutional Benefit
14.1	Physician-Assisted Suicide
15.1	Custodial Care Transitional Policy (CCTP)
16.1	Mucus Clearance Devices

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CHAPTER 8 - OTHER SERVICES

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SECTION SUBJECT

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17.1 Lymphedema

18.1 Continuous Passive Motion (CPM) Devices

19.1 Smoking Cessation Counseling

**20.1 Infusion Drug Therapy Delivered In The Home**

## PHARMACY BENEFITS PROGRAM

ISSUE DATE: August 2002

AUTHORITY: 32 CFR 199.2(b), (b)(2)(v), (b)(3)(iii), (b)(5)(v), (d)(3)(vi), (e)(11)(i),  
32 CFR 199.5(d)(12), and 32 CFR 199.17

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### I. DESCRIPTION

#### A. General

The TRICARE Pharmacy (TPharm) Benefit includes retail and mail order prescription services, medications provided by physicians and other appropriate clinicians, and medications provided in support of home health care. TRICARE uses a number of contractors to administer the benefit.

#### B. Retail Prescription Service

Retail pharmacy services, network and non-network, will be provided under a TPharm contract and will be subject to the Uniform Formulary. The TRICARE formulary is found at <http://www.tricareformularysearch.org>. The retail pharmacy contractor is responsible for administering claims related to pharmaceuticals dispensed by an authorized provider with a National Council of Prescription Drug Programs (NCPDP) or other nationally recognized pharmacy designation.

#### C. Mail Order Prescription Service

Mail order prescription services are provided under a TPharm contract and will be subject to the Uniform Formulary. The TRICARE formulary can be found at <http://tricareformularysearch.org>.

#### D. Other Pharmaceutical Delivery Venues

Adjudication of claims relating to pharmaceuticals dispensed in pharmacy delivery venues other than retail pharmacies or mail order (for example, physician's office, home health care agency, specialty pharmacy) are the responsibility of the Managed Care Support Contractor(s) (MCSC(s)).

#### E. Infusion Drug Therapy Delivered In The Home

When injectable and infusion drug therapy are medically necessary, and delivery and administration in the home is appropriate the MCSC shall provide prior authorization of

injectable or infused drugs to a TRICARE authorized pharmacy in order for the pharmaceutical agent to be fulfilled under the pharmacy benefit pursuant to Section 20.1, "Infusion Drug Therapy Delivered in the Home".

## II. POLICY

### A. Formulary

Formulary management will be the responsibility of the Government as defined by 32 CFR 199.21, Pharmacy Benefits Program. This regulation establishes procedures for the inclusion of pharmaceutical agents on a Uniform Formulary based upon relative clinical effectiveness and cost effectiveness; establishes cost-sharing requirements, including a tiered co-payment structure, for generic, formulary and non-formulary pharmaceutical agents; establishes procedures to assure the availability of pharmaceutical agents not included on the Uniform Formulary to eligible beneficiaries at the non-formulary cost-share tier; establishes procedures to provide, when clinically necessary, pharmaceutical agents not included on the Uniform Formulary under the same terms and conditions as an agent on the Uniform Formulary; establishes procedures to assure the availability of clinically appropriate non-formulary pharmaceutical agents to members of the uniformed services; establishes procedures for prior authorization when required; and establishes a Department of Defense Pharmacy and Therapeutics Committee (DoD P&T Committee) and a Uniform Formulary Beneficiary Advisory Panel. All formulary decisions, to include prior authorization requirements, designation of non-formulary agents, quantity limits, and other medication use policies will be communicated to all contractors who have responsibility for administering the TRICARE Pharmacy benefit and to the Managed Care Support Contractors.

The prescription drug benefit under TRICARE provides cost-sharing for drugs and medicines that (1) are approved for marketing by the U.S. Food and Drug Administration (FDA), and (2) by United States law require a physician's or other authorized individual professional provider prescription (acting within the scope of their license), and (3) are actually ordered or prescribed by an authorized provider in accordance with state and federal law. The benefit does not include prescription drugs for medical conditions that are expressly excluded from the TRICARE benefit by statute or regulation. The Pharmacy Benefits Program will include a Uniform Formulary of pharmaceutical agents that will assure the availability of pharmaceutical agents in the complete range of therapeutic classes authorized under the TRICARE prescription drug benefit.

### B. Utilization Management

Utilization management is the responsibility of the contractor with contractual responsibility for the venue distributing the pharmaceuticals. Should another contractor require data about pharmaceutical prescribing practices of clinicians or the pharmaceuticals prescribed to a patient, the contractor requiring the information may submit a request for data to the contracting officer. The requesting contractor shall commit to paying all costs associated with retrieving and providing any data. No contractor will be required to develop or provide data that is not available in the contractor's data warehouse.

C. General Prescription Coverage

1. Labeled Indications. Drugs may be cost-shared when:

- a. The drug is approved for marketing by the U.S. Food and Drug Administration;
- b. The drug is prescribed by a provider, acting within the scope of his/her license, for its labeled indication; and
- c. The drug is furnished by a provider in accordance with all applicable state laws and licensing requirements.

2. Off-label use. Drugs may be cost-shared for off-label uses when determined, by the contractor with responsibility for the venue distributing the drugs, that reliable evidence demonstrates such usage is safe and effective. As presented in order of relative weight in [32 CFR 199.2](#), reliable evidence means:

- a. Well controlled studies of clinical meaningful endpoints, published in refereed medical literature.
- b. Published formal technology assessments.
- c. Published reports of national professional medical associations.
- d. Published national medical policy organizations.
- e. Published reports of national expert opinion organizations.

3. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be cost-shared as if FDA approved.

4. Insulin and related supplies may be cost-shared for diabetic patients, regardless of whether or not a prescription is required under state law.

5. Orphan Drugs. Pharmaceutical agents with FDA "orphan drug" designation and marketing approval may be cost-shared when used in the treatment of a rare disease or condition. For the purpose of the pharmacy benefits program, TRICARE adopts the FDA definition of the term "rare disease or condition".

6. Legend vitamins may be cost-shared only when used as a specific treatment of a medical condition. In addition, prenatal vitamins that require a prescription in the United States may be cost-shared. Prenatal vitamins requiring a prescription are covered for prenatal care only.

7. Some drugs require prior authorization. For these drugs, prior authorization request forms and criteria, in addition to other formulary information, are available at: <http://www.pec.osd.mil> or [http://www.pec.osd.mil/PA\\_Criteria\\_and\\_forms.htm](http://www.pec.osd.mil/PA_Criteria_and_forms.htm).

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### CHAPTER 8, SECTION 9.1 PHARMACY BENEFITS PROGRAM

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#### D. Eligibility

1. Uniformed Service members who are on active duty;
2. All beneficiaries authorized TRICARE benefits per [32 CFR 199.3](#);
3. Medicare eligible beneficiaries:

a. Pursuant to Section 711 of the FY 2001 National Defense Authorization Act, Medicare Eligible beneficiaries based on age, whose TRICARE eligibility is determined by 10 U.S.C. Section 1086, are eligible for Medicare Part A and, except as provided in [paragraph III.B.](#) below, are enrolled in Medicare Part B, are eligible for the TRICARE pharmacy benefits program, effective April 1, 2001.

b. Individuals, who before April 1, 2001, have attained the age of 65 and who are not enrolled in Medicare Part B are eligible for the TRICARE Senior Pharmacy Program; and

4. Overseas TRICARE beneficiaries listed in DEERS (with APO or FPO address) are eligible for the TRICARE Mail Order Program. For these beneficiaries a prescription is required for a U.S. Food and Drug Administration approved prescription drug from an authorized provider who is licensed to practice in the United States.

#### E. Reimbursement

1. The prescription drug claims for eligible beneficiaries will be reimbursed in accordance with the applicable reimbursement sections of the TRICARE Reimbursement Manual. Beneficiaries shall pay a co-pay in accordance with [Chapter 12, Section 11.1](#) or TRICARE Reimbursement Manual, [Chapter 2, Addendum A](#) as appropriate. All deductibles and co-pays apply towards the catastrophic cap.

2. Beneficiary appeal rights are governed by [32 CFR 199.10](#).

### III. EXCLUSIONS

A. Drugs prescribed or furnished by a member of the patient's immediate family.

B. Drugs, including compounded preparations, that are available over the counter.

C. Group C Designation. Investigational drugs with FDA "Group C" designation have reproducible efficacy in one or more specific tumor types. Such a drug has altered or is likely to alter the pattern of treatment of the disease and can be safely administered by properly trained physicians without specialized supportive care facilities. TRICARE may not cost-share use of Group C designated drugs because authorization for Group C distribution for a specific indication is not equivalent to formal FDA approval for that indication. Medical care related to the use of Group C designated drugs may be cost-shared only when the care would have been provided in the absence of the use of the Group C designated drug.

D. Orphan drugs without marketing approval, but which are made available on a compassionate use basis, may not be cost-shared.

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CHAPTER 8, SECTION 9.1

PHARMACY BENEFITS PROGRAM

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E. Treatment Investigational New Drugs (IND). Under the FDA treatment IND (investigational new drug) regulations enacted in 1987, drugs that are in controlled clinical trials can be provided outside those trials to treat patients with serious or immediately life-threatening diseases for which no comparable or satisfactory alternate therapy exists. TRICARE may not cost-share treatment INDs because they have not received FDA marketing approval. However, medical care related to the use of treatment INDs may be cost-shared when the patient's medical condition warrants their administration and the care is provided in accordance with generally accepted standards of medical practice.

F. Irinotecan (Camptosar®) for treatment of metastatic esophageal cancer is unproven.

IV. EFFECTIVE DATES

A. Labeled uses: the date of FDA approval for the specific indication.

B. Off-labeled uses: the date that reliable evidence establishes the safety and efficacy of the drug for that specific use.

C. Orphan drugs: the date of FDA marketing approval.

- END -



## INFUSION DRUG THERAPY DELIVERED IN THE HOME

ISSUE DATE: September 7, 2011

AUTHORITY: [32 CFR 199.2](#) and [32 CFR 199.6\(f\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

99601, 99602

### II. HCPCS CODE

S9430

### III. BACKGROUND

#### A. [32 CFR 199.2](#) defines appropriate medical care as:

1. Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;

2. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and

3. The services are furnished economically. For purposes of this part, "economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by CHAMPUS.

#### B. [32 CFR 199.2](#) defines homebound as:

A beneficiary's condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment--including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in the--state shall not disqualify an individual

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from being considered to be confined to his home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. An exception is made to the above homebound definitional criteria for beneficiaries under the age of 18 and those receiving maternity care. The only homebound criteria for these special beneficiary categories is written certification from a physician attesting to the fact that leaving the home would place the beneficiary at medical risk. In addition to the above, absences, whether regular or infrequent, from the beneficiary's primary residence for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.

C. In addition to infusion therapy provided in the home, infusion therapy may also be provided in alternative settings which include hospital outpatient departments, ambulatory infusion suites, physician's offices, or in inpatient settings.

#### IV. DESCRIPTION

Infusion therapy delivered in the home may include:

- A. Skilled nursing services to administer the drug;
- B. The drug and associated compounding services; and
- C. Medical supplies and Durable Medical Equipment (DME).

#### V. POLICY

Coverage may be extended for infusion therapy delivered in the home when preauthorized by the Managed Care Support Contractor (MCSC). Preauthorization shall be required when:

- A. Homebound Beneficiaries.

Contractors shall ensure the following criteria are met for homebound beneficiaries receiving Home Health Care (HHC) under a Plan of Care (POC) as described in the TRICARE Reimbursement Manual (TRM), [Chapter 12](#):

1. Homebound beneficiaries who require skilled services (e.g., skilled nursing) for administration of a home infusion drug must receive those skilled services from a Home Health Agency (HHA), in accordance with the policy described in the TRM, [Chapter 12](#). See TRM [Chapter 2, Addendum A](#) for beneficiary cost shares for HHC services. See TRM [Chapter 12, Section 2, Figure 12-2-1](#) for beneficiary cost-shares for services reimbursed outside the Home Health Agency Prospective Payment System (HHA PPS) when receiving home health services under a POC.

2. Homebound beneficiaries who desire to self-administer (or have a caregiver administer) an infusion drug obtained from a TRICARE authorized pharmacy under the TPharm contract may do so when a physician or other authorized individual professional provider certifies that self-administration is medically appropriate. Physician or other authorized individual professional provider certification that self-administration is medically appropriate will be noted in the patient's POC described in the TRM, [Chapter 12](#) or in the medical record.

3. The MCSC shall be responsible for beneficiary and provider education on cost-share requirements associated with infusion therapy provided in the home and cost-sharing advantages of self-administration, if self-administration is medically appropriate. See TRM, [Chapter 2, Addendum A](#) for beneficiary cost-shares for HHC services. See TRM, [Chapter 2, Addendum B](#) for beneficiary cost-shares for TPharm Benefits Program.

B. Non-Homebound Beneficiaries.

MCSC shall provide preauthorization for non-homebound beneficiaries to receive infusion therapy in the home when:

1. Long-term infusion therapy services are needed (more than five sequential infusions). The MCSC shall preauthorize infusion therapy in the home when all of the following criteria are met:

a. Individual Professional Provider Certification.

The attending physician certifies that the non-homebound beneficiary (or caregiver, such as a spouse) is capable and willing to learn to self-administer the infusion drug, and that self-administration in the home is medically appropriate; and

b. Skilled Nursing.

The MCSC shall preauthorize up to five sequential skilled nursing visits (CPT<sup>2</sup> procedure codes 99601 and 99602) by a TRICARE authorized provider to administer and instruct the non-homebound beneficiary or caregiver to self-administer the drug. Additional visits may be authorized when medically necessary and appropriate (i.e., a change in condition requires additional visits). Claims for skilled nursing are the responsibility of the MCSC; and

c. Drug and Compounding Services.

The MCSC shall coordinate and provide a referral to the TPharm for the drug and compounding services. If the drug is available from the TPharm, it must be provided through the TPharm Benefits Program. In the case that the drug is not available through the TPharm, the MCSC shall coordinate provision of the drug through an appropriate TRICARE authorized provider or direct the non-homebound beneficiary to care in an alternative setting; and

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d. Medical Supplies and DME.

The MCSC is responsible for ensuring the beneficiary has a referral to all medically necessary and appropriate services and supplies for infusion therapy in the home, including medical supplies and DME. Claims for medical supplies and DME are the responsibility of the MCSC; and

e. Coordination of Services.

The MCSC shall coordinate delivery of infusion therapy in the home between the referring individual professional provider, the beneficiary, and necessary TRICARE authorized providers to meet the requirement of this policy of delivering care in the most medically appropriate and economical manner.

NOTE: See TRM, [Chapter 2, Addendum A](#) for information on beneficiary cost-shares for services of individual professional providers. See TRM, [Chapter 2, Addendum B](#) for beneficiary cost-shares for TPharm Benefits Program.

2. Short-term (five or fewer) therapy services are needed. If a non-homebound beneficiary requires five or fewer sequential infusions, the MCSC shall preauthorize up to five sequential skilled nursing visits (CPT<sup>3</sup> procedure codes 99601 and 99602) to administer the drug. The beneficiary is not required to learn to self-administer. The MCSC will coordinate and provide a referral for the infusion drug, DME and medical supplies in accordance with paragraphs [V.B.1.c.](#), [V.B.1.d.](#), and [V.B.1.e.](#)

C. See [Section 6.1](#) for coverage and policy related to medical supplies, [Section 2.1](#) for coverage and policy related to DME, and [Section 5.1](#) for coverage and policy related to medical devices.

D. See the TRM, [Chapter 3, Section 6](#) for information on the processing and payment of home infusion claims for home-based services provided by Corporate Service Providers (CSPs), and the TRM, [Chapter 1, Section 15](#) for information on legend drugs and insulin reimbursement.

E. See [Section 9.1](#) for information on the Pharmacy Benefits Program.

F. Provider payments are reduced for the failure to comply with the preauthorization requirements in this section. See TRM, [Chapter 1, Section 28](#).

## VI. EXCEPTIONS

In the event that a non-homebound beneficiary: (1) is unable or unwilling to learn to self-administer and requires skilled services to administer the infusion drug; (2) requires long-term infusion therapy; and (3) infusion therapy in the home is requested and is medically appropriate, the MCSC shall preauthorize infusion therapy in the home when it is determined that infusion in the home setting, provided in the same manner as described in [paragraph V.B.2.](#) without the limit of five visits, is less costly to the government than infusion

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in an alternative setting.

VII. EXCLUSIONS

- A. "S" codes, except those described in [Chapter 1, Section 17.1](#).
- B. Long-term infusion therapy in the home for non-homebound beneficiaries who are unwilling to learn to self-administer.
- C. TRICARE dual-eligible beneficiaries are not subject to the requirements in this policy.
- D. TRICARE Overseas Program (TOP) beneficiaries are not subject to the requirements of this policy.
- E. Beneficiaries with Other Health Insurance (OHI), where TRICARE is not the primary payor, are not subject to the requirements of this policy.

- END -



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