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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 140
6010.55-M
SEPTEMBER 26, 2011**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002**

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

CHANGE TITLE: AVERAGE WHOLESALE PRICE (AWP)

CONREQ: 15536

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change removes references to Drug Topics Blue/Red Book and includes the AWP terminology that is in the 32 Code of Federal Regulations (CFR) 199.14(a)(6)(i)(I). The contractor is required to obtain AWP pricing.

EFFECTIVE DATE: September 26, 2011.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 148.

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Reimbursement Branch**

**ATTACHMENT(S): 10 PAGE(S)
DISTRIBUTION: 6010.55-M**

**CHANGE 140
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REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 15, pages 1 and 2

Section 15, pages 1 and 2

CHAPTER 12

Section 2, pages 25 - 30

Section 2, pages 25 - 30

CHAPTER 13

Section 3, pages 35 and 26

Section 3, pages 35 and 36

LEGEND DRUGS AND INSULIN

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(d\)\(3\)\(vi\)](#)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are legend drugs and insulin to be reimbursed?

III. POLICY

A. Pricing of legend drugs (those drugs that require a prescription by law) and insulin will depend on the claimant: beneficiary (consolidated drug claim) or provider (vendor pharmacy or physician).

B. For beneficiary submitted claims, reimbursement is to be based on the billed charge. For vendor pharmacy (participating provider) submitted claims, the allowable charge for outpatient prescription drugs paid to a vendor pharmacy will be the acquisition cost (taking into account the strength, quantity, and generic/nongeneric status) plus a flat amount determined by the contractor for each prescription. This fixed fee does not apply to insulin. The acquisition cost should include the sales tax.

C. The acquisition cost of drugs for participating providers, i.e., vendor pharmacies, physicians, etc., is to be determined from **a schedule of allowable charges based on the Average Wholesale Price (AWP)**.

D. Allergy preparations are custom made in a laboratory and are not considered prescription drugs. Since the cost of these allergy preparations are not found in **a schedule of allowable charges based on the AWP**, reimbursement will be based on the allowable charge methodology. The prevailing will include both the cost of the drug and the administrative fee. An allowance of a separate additional charge for an "office visit" would not be warranted where the services rendered did not really constitute a regular office visit.

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CHAPTER 1, SECTION 15

LEGEND DRUGS AND INSULIN

E. The Centers for Medicare and Medicaid Services Common Procedure Coding System, National Level II Medicare "J" codes are to be priced using the following. Drugs administered other than oral method, including chemotherapy drugs, are to be priced from the "J" code pricing file except for home infusion drugs furnished through a covered item of durable medical equipment which will be paid the lesser of the billed amount or 95 percent of the AWP retroactive back to April 1, 2005. However, this retroactive coverage will not require the contractors to research their claims history and adjust previously submitted home infusion drug claims unless brought to their attention by a provider. Home infusion drugs will be billed using the appropriate J-code along with a specific National Drug Code (NDC) for pricing. The unique HCPCS "J" code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. Drugs that do not appear on the Medicare "J" code pricing file will also be priced using 95% of the AWP.

F. A separate payment shall be made for the **pharmacy compounding and dispensing services under HCPCS S9430**.

- END -

lists of procedures will be issued annually in conjunction with the release of the yearly **Healthcare Common Procedure Coding System (HCPCS)** update:

- (a) **Addendum B** - list of **NRS** codes.
- (b) **Addendum C** - list of therapy codes.

C. Services exempt from home health consolidated billing (i.e., services that can be paid in addition to the prospective payment amount when the beneficiary is receiving home health services under a plan of treatment):

(1) Durable Medical Equipment (DME).

(a) DME can be billed as a home health service or as a medical/other health service.

(b) DME will be paid in accordance with the reimbursement guidelines set forth in **Chapter 1, Section 11**, less an appropriate cost-share/copayment and deductible (refer to **Figure 12-2-1**, for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

(c) DME may be billed by a supplier to a contractor on a **Centers for Medicare and Medicaid Services (CMS)** 1500 (08/05) claim form or billed by a HHA on a CMS 1450 UB-04 using bill types 032X, 033X, and 034X as appropriate. While the contractors' systems will allow either party to submit these claims, the following requirements will be initiated in order to prevent duplicative billing:

1 HHA providers required to submit line item dates on DME items.

2 Providers instructed to bill each month's DME rental as a separate line item.

3 HHAs allowed to bill DME not under a POC on the 034X type bill.

(d) Crossover edits will be developed to prevent duplicate billing of DME.

1 Since consolidated billing does not apply to DME, claims for equipment not authorized by the contractor will be denied. Appropriate appeal rights will apply.

2 DME can be billed by other than the Primary HHA under HHA PPS system when authorized by the contractor (i.e., by supplier/vendor or other HHA).

3 System must be able to identify duplicative billing based on dates of services.

(2) Osteoporosis Drugs.

(a) Osteoporosis drugs are subject to home health consolidated billing, even though they are paid outside the 60-day episode amount. When episodes are open for specific beneficiaries, only the primary HHAs serving these beneficiaries will be permitted to bill osteoporosis drugs for them.

(b) Osteoporosis Injections as a HHA Benefit.

1 Cover FDA approved injectable drugs for osteoporosis for female beneficiaries.

2 Only injectable drugs that meet the requirement have the generic name of calcitonin-salmon or calcitonin-human.

(c) Payment is **from a schedule of allowable charges based on a the Average Wholesale Price (AWP)**, less an appropriate cost-share/copayment and deductible (refer to [Figure 12-2-1](#), for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

1 The drug is billed on a CMS 1450 UB-04 under bill type 034X with revenue code 0636 and HCPCS code J0630.

2 The cost of administering the drug is included in the charge for the visit billed under bill type 032X or 033X, as appropriate.

3 If the service dates on the 034X claim fall within a HHA PPS episode that has been approved for a beneficiary, the system must edit to assure that the provider number on the 034X claim matches the provider number in the authorization. This is to reflect that, although the osteoporosis drug is paid separately from the HHA PPS episode rate, it is included in consolidated billing requirements.

(3) Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines.

(a) General Billing Requirements.

1 Bill on CMS 1450 UB-04 using type of bill 034X and revenue code 636 for the vaccine and revenue code 0771 for administration of the vaccine.

2 The vaccine and its administration may be on the same claim form (i.e., there is no requirement for a separate bill).

3 The following HCPCS codes will be used in billing for vaccines:

 a 90657 - Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular injection use;

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b 90658 - Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;

c 90732 - Pneumococcal polysaccharide vaccine, 23 valent, adult dosage, for subcutaneous or intramuscular use;

d 90744 - Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use;

e 90746 - Hepatitis B vaccine, adult dosage, for intramuscular use;

f 90747 - Hepatitis B vaccine, dialysis or immunosuppressed patient dosage;

g 90748 - Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use.

4 The following HCPCS codes will be used in billing for administration of the vaccines:

a G0008 - administration of the influenza virus vaccine;

b G0009 - administration of the pneumococcal polysaccharide vaccine;

c G0010 - administration of the hepatitis B vaccine.

5 Report code V04.8 for influenza virus vaccine, code V03.82 for pneumococcal polysaccharide vaccine (PPV), and code V05.3 for the hepatitis B vaccine if the sole purpose for the visit is to receive the vaccines, or if the vaccines are the only service billed on a claim.

(b) Special billing instructions for HHAs in various situations:

1 Where the sole purpose for an HHA visit is to administer a vaccine (influenza, PPV, or hepatitis B), a skilled nursing visit will not be paid under the HHA benefit. However, the vaccine and its administration will be covered under clinical preventive benefits (both Prime and Standard/Extra). The administration should include charges only for the supplies being used and the cost of the injection. Travel time and other expenses (i.e., gasoline) should not be charged. The vaccine and its administration should be billed under bill type 034X using revenue code 636 along with the appropriate HCPCS code for the vaccine, and revenue code 771 along with the appropriate HCPCS code for the administration.

2 If the vaccine (influenza, PPV, or hepatitis B) is administered during the course of an otherwise covered home health visit (e.g., to perform wound care), the visit would be covered as normal but would not include the vaccine or its administration. The HHA would still be entitled to payment for the vaccine and its administration under the

clinical preventive benefit. The vaccine and its administration should be billed under bill type 034X using revenue code 636 along with the appropriate HCPCS code for the vaccine, and revenue code 771 along with the appropriate HCPCS code for the administration.

3 Payment is based on the CHAMPUS Maximum Allowable Charge (CMAC) of the vaccine, along with associated administration costs, less an appropriate cost-share/copayment and deductible (refer to [Figure 12-2-1](#), for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

(4) Oral Cancer Drugs.

(a) Self-administrable oral versions of covered injectable cancer drugs prescribed as an anti-cancer chemotherapeutic agent. To be covered, an oral cancer drug must:

- 1 Be prescribed by a physician or practitioner as an anti-cancer chemotherapeutic agent;
- 2 Be a drug or biological approved by the FDA;
- 3 Have the same active ingredients as a non-self-administrable anti-cancer chemotherapeutic drug or biological that is covered when furnished incidentally to a physician's service;
- 4 Be used for the same indications (including off-label uses) as the non-self-administrable version of the drug; and
- 5 Be reasonable and necessary for the individual patient.
- 6 Examples of covered oral cancer drugs:
 - a Cyclophosphamide
 - b Etoposide
 - c Methotrexate
 - d Melphalan

(b) Payment.

1 The reasonable cost of the cancer drugs furnished by a provider (i.e., the average wholesale price determined from [a schedule of allowable charges based on the AWP](#)), less an appropriate cost-share/copayment and deductible (refer to [Figure 12-2-1](#), for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

2 Bill on CMS 1450 UB-04, type of bill 034X.

a Enter revenue code 0636 in FL 42, the name and HCPCS of the oral drug in FLs 43 and 44, and the name of the tablets or capsules in FL 46 of the CMS 1450 UB-04.

b An exception is made for 50mg/ORAL of cyclophosphamide (J8530), which is shown as 2 units.

c Complete the remaining items in accordance with regular billing instructions.

d A cancer diagnosis must be entered in FLs 67 A-Q of the CMS 1450 UB-04 for coverage of an oral cancer drug.

(5) Antiemetic Drugs.

(a) TRICARE pays for self-administrable oral or rectal versions of self-administered antiemetic drugs when they are necessary for the administration and absorption of TRICARE covered oral anticancer chemotherapeutic agents when a likelihood of vomiting exists.

1 Self-administered antiemetics which are prescribed for use to permit the patient to tolerate the primary anticancer drug in high doses for longer periods are not covered.

2 Self-administered antiemetics used to reduce the side effects of nausea and vomiting brought on by the primary drug are not included beyond the administration necessary to achieve drug absorption.

3 Payment.

a The reasonable cost of the self-administered antiemetic drugs furnished by a provider (i.e., the average wholesale price determined from a **schedule of allowable charges based on the AWP**) less an appropriate cost-share/copayment and deductible (refer to [Figure 12-2-1](#), for the specific deductible and cost-sharing/copayment provisions for services paid in addition to the HHA PPS amount).

b Bill on CMS 1450 UB-04, type of bill 034X.

(1) Enter revenue code 0636 in FL42.

(2) Enter one of the following HCPCS codes in FL 44, as appropriate:

(a) K0415 - Prescription antiemetic drug, oral, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified; or

(b) K0416 - Prescription antiemetic drug, rectal, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified.

(3) Enter the name of the self-administered drug in FL 43 and the number of units in FL 46. Each milligram of the tablet, capsule, or rectal suppository is equal to one unit.

(4) Complete the remaining items in accordance with regular billing instructions.

(5) TRICARE does not pay for a visit solely for administration of self-administered antiemetic drugs in conjunction with oral anticancer drugs.

(6) Orthotics and prosthetics, can be billed as a home health service or as a medical/other health service.

(a) Orthotics and prosthetics may be billed by a supplier to a contractor on a claim form CMS 1500 (08/05) or billed by a HHA on a CMS 1450 UB-04 using bill types 032X, 033X, and 034X as appropriate.

(b) Payment will be paid in accordance with the reimbursement guidelines set forth in [Chapter 1, Section 11](#), less an appropriate cost-share/copayment and deductible (refer to [Figure 12-2-1](#), for the specific deductible and cost-sharing/copayment provisions under each TRICARE program).

(7) Enteral and Parenteral Nutritional Therapy.

(a) Enteral and parenteral supplies and equipment can be billed as a home health service or as a medical and other health service.

(b) Payment is based on the reasonable purchase cost less an appropriate cost-share/copayment and deductible (refer to [Figure 12-2-1](#), for the specific deductible and cost-sharing/copayment provisions under each TRICARE program).

(c) Enteral and Parenteral supplies and equipment may be billed by a supplier to a contractor on a claim form CMS 1500 (08/05) or billed by a HHA on a CMS 1450 UB-04 using bill types 032X, 033X, and 034X as appropriate.

(8) Drugs and Biologicals Administered By Other Than Oral Method.

(a) TRICARE will allow payment in addition to the prospective payment amount for drugs and biologicals administered by other than an oral method (i.e., drugs and biologicals that are injected either subcutaneous, intramuscular, or intravenous) when:

- 1 Prescribed by a physician or practitioner;
- 2 Approved by the FDA; and

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PROSPECTIVE PAYMENT METHODOLOGY

(2) Historically packaged with the procedures with which they were billed, even though their median cost per day was above the \$60 packaging threshold.

b. Payment based on median costs should be adequate for hospitals since these products are generally older or low-cost items.

8. Payment for New Drugs, Biologicals and Radiopharmaceuticals Before HCPCS Codes Are Assigned.

a. The following payment methodology will enable hospitals to begin billing for drugs and biologicals that are newly approved by the FDA and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup that could qualify them for pass-through payment under the OPPS:

(1) Hospitals should be instructed to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code C9399, "Unclassified Drug or Biological."

(2) When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.

(3) The new drug, biological and/or radiopharmaceutical will be priced at 95% of its AWP from a schedule of allowable charges based on the AWP, and process the claim for payment.

(4) The above approach enables hospitals to bill and receive payment for a new drug, biological or radiopharmaceutical concurrent with its approval by the FDA.

b. Hospitals will discontinue billing C9399 and the NDC upon implementation of a HCPCS code, SI, and appropriate payment amount with the next quarterly OPPS update.

9. Package payment for any biological without pass-through status that is surgically inserted or implanted (through a surgical incision or a natural orifice) into the payment for the associated surgical procedure.

a. As a result, HCPCS codes C9352, C9353, and J7348 are packaged and assigned SI of N.

b. Any new biologicals without pass-through status that are surgically inserted or implanted will be packaged beginning in CY 2009.

10. Drugs and non-implantable biologicals with expiring pass-through status.

a. CY 2009 payment methodology of packaged or separate payment based on their estimated per day costs, in comparison with the CY 2009 drug packaging threshold.

b. Packaged drugs and biologicals are assigned SI of N and drugs and biologicals that continue to be separately paid as non-pass-through products are assigned SI of K.

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PROSPECTIVE PAYMENT METHODOLOGY

E. Drug Administration Coding and Payment.

1. The following HCPCS Level I drug administration codes will be assigned to their respective APCs for payment:

FIGURE 13-3-7 CROSSWALK FROM HCPCS LEVEL I¹ CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion pump	S	0440
90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	S	0437
90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	S	0438
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	S	0437
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	S	0438
90776	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	N	
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	S	0436
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0438
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0438
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0438
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0438
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0441
96420	Chemotherapy administration, intra-arterial; push technique	S	0439
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0441
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	S	0438
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0441
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0441
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0441

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