



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 56
6010.58-M
SEPTEMBER 26, 2011**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008**

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

CHANGE TITLE: AVERAGE WHOLESAL PRICE (AWP)

CONREQ: 15537

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 Feb 2008 TOM, Change No. 59.

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 8 PAGE(S)
DISTRIBUTION: 6010.58-M**

CHANGE 56
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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 23, 24, 27, 28

Section 2, pages 23, 24, 27, 28

CHAPTER 3

Section 3, pages 33 and 34

Section 3, pages 33 and 34

Legend Drugs And Insulin

Issue Date: August 26, 1985

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

1.0 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 the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

2.0 ISSUE

How are legend drugs and insulin to be reimbursed?

3.0 POLICY

3.1 General

In addition to the military branches' pharmacies, 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 (HHC). TRICARE uses a number of contractors to administer the benefit.

3.2 Pharmacy Claims

3.2.1 TRICARE reimburses the allowable cost for covered pharmaceuticals and supplies less the applicable beneficiary deductibles and cost-shares and payments made by Other Health Insurance (OHI). Allowable costs include the pharmaceutical agent's ingredient cost, a dispensing fee, and sales tax, if applicable. The TRICARE allowable cost will be the lesser of the usual and customary price or the maximum allowable cost (MAC) or TPharm contractor's contracted rate for ingredient cost. Dispensing fees will be the lesser of the Pharmacy Benefit Manager's (PBM's) negotiated rate with individual pharmacy or the PBM's contracted rate for dispensing fees.

3.2.2 Prescription and non-prescription Insulin and related supplies may be cost-shared in accordance with the TRICARE Policy Manual (TPM), [Chapter 8, Section 9.1](#).

3.2.3 Pharmacy reimbursements are subject to formulary requirements (prior authorizations, medical necessity, quantity limits, benefit exclusions, and non-formulary status) in accordance with the [32 CFR 199.21\(i\)](#) and TPM, [Chapter 8, Section 9.1](#).

3.3 Medical Claims That Include Drugs

3.3.1 The Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), 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 which will be paid the lesser of the billed amount or 95% of the Average Wholesale Price (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 or other person with an interest in the claim. Home infusion drugs will be billed using the appropriate J-code or any other appropriate HCPCS coding for home infusion drugs not appearing on the J-code pricing file along with a specific National Drug Code (NDC). The unique HCPCS code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding (e.g., J, Q, and S codes) for reporting purposes as long as the drugs are U.S. Food and Drug Administration (FDA)-approved and have specific NDCs for pricing. Drugs that do not appear on the "J" code pricing file will also be priced at the lesser of billed charges or 95% of the AWP.

3.3.2 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.

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

- END -

3.3.1.1 Consequently, billing for all such items and services is to be made to a single HHA overseeing that plan, and this HHA is known as the primary agency or HHA for HHA PPS billing purposes.

3.3.1.2 Payment will be made to the primary HHA without regard to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or whether any other contracting or consulting arrangements exist with the primary agency, or "otherwise". Payment for all items is included in the HHA PPS episode payment the primary HHA receives.

3.3.1.2.1 Types of services that are subject to the home health CB provision:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated with or under common control of that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

3.3.1.2.2 Contractors will deny any claims from other than the primary HHA that contain billing for the services and items above when billed for dates of service that have not been authorized by the contractor.

3.3.1.2.3 Lists of procedures are incorporated as addenda to this policy in order to facilitate adherence to the home health CB requirements. Procedure codes on these lists will be denied if billed by other than the HHA creating the episode (i.e., the primary provider designated under the contractors' preauthorization process for providing HHC to TRICARE eligible beneficiaries). The following lists of procedures will be issued annually in conjunction with the release of the yearly Health Care Financing Administration Common Procedure Coding System (HCPCS) update:

- [Addendum B](#) - list of **NRS** codes.
- [Addendum C](#) - list of therapy codes.

3.3.1.3 Services exempt from home health CB (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):

3.3.1.3.1 DME

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

3.3.1.3.1.2 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).

3.3.1.3.1.3 DME may be billed by a supplier to a contractor on a Centers for Medicare and Medicaid Services (CMS) 1500 (08/2005) claim form or billed by a HHA on a CMS 1450 UB-04 using TOBs 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:

- HHA providers required to submit line item dates on DME items.
- Providers instructed to bill each month's DME rental as a separate line item.
- HHAs allowed to bill DME not under a POC on the TOB 034X.

3.3.1.3.1.4 Crossover edits will be developed to prevent duplicate billing of DME.

- Since CB does not apply to DME, claims for equipment not authorized by the contractor will be denied. Appropriate appeal rights will apply.
- 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).
- System must be able to identify duplicative billing based on dates of services.

3.3.1.3.2 Osteoporosis Drugs

3.3.1.3.2.1 Osteoporosis drugs are subject to home health CB, 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.

3.3.1.3.2.2 Osteoporosis injections as a HHA benefit.

- Cover U.S. Food and Drug Administration (FDA) approved injectable drugs for osteoporosis for female beneficiaries.
- Only injectable drugs that meet the requirement have the generic name of calcitonin-salmon or calcitonin-human.

3.3.1.3.2.3 Payment is established from a schedule of allowable charges based on 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).

- The drug is billed on a CMS 1450 UB-04 under TOB 034X with revenue code 0636 and HCPCS code J0630.
- The cost of administering the drug is included in the charge for the visit billed under TOB 032X or 033X, as appropriate.

3.3.1.3.4.2 Payment.

3.3.1.3.4.2.1 The reasonable cost of the cancer drugs furnished by a provider (i.e., the **AWP** 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).

3.3.1.3.4.2.2 Bill on CMS 1450 UB-04, TOB 034X.

- Enter revenue code 0636 in Form Locator (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.
- An exception is made for 50mg/ORAL of cyclophosphamide (J8530), which is shown as two units.
- Complete the remaining items in accordance with regular billing instructions.
- A cancer diagnosis must be entered in FLs 67 A - Q of the CMS 1450 UB-04 for coverage of an oral cancer drug.

3.3.1.3.5 **Antiemetic Drugs**

3.3.1.3.5.1 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.

3.3.1.3.5.1.1 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.

3.3.1.3.5.1.2 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.

3.3.1.3.5.1.3 Payment.

3.3.1.3.5.1.3.1 The reasonable cost of the self-administered antiemetic drugs furnished by a provider (i.e., the **AWP** 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).

3.3.1.3.5.1.3.2 Bill on CMS 1450 UB-04, TOB 034X.

3.3.1.3.5.1.3.2.1 Enter revenue code 0636 in FL42.

3.3.1.3.5.1.3.2.2 Enter one of the following HCPCS codes in FL 44, as appropriate:

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

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- K0416 - Prescription antiemetic drug, rectal, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified.
- 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.
- Complete the remaining items in accordance with regular billing instructions.
- TRICARE does not pay for a visit solely for administration of self-administered antiemetic drugs in conjunction with oral anticancer drugs.

3.3.1.3.6 Orthotics and Prosthetics

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

3.3.1.3.6.1 Orthotics and prosthetics may be billed by a supplier to a contractor on a CMS 1500 (08/2005) claim form or billed by a HHA on a CMS 1450 UB-04 using Type of Bills (TOBs) 032X, 033X and 034X as appropriate.

3.3.1.3.6.2 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).

3.3.1.3.7 Enteral and Parenteral Nutritional Therapy

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

3.3.1.3.7.2 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).

3.3.1.3.7.3 Enteral and Parenteral supplies and equipment may be billed by a supplier to a contractor on a CMS 1500 (08/2005) claim form, or billed by a HHA on a CMS 1450 UB-04 using TOBs 032X, 033X, and 034X as appropriate.

3.3.1.3.8 Drugs and Biologicals Administered By Other Than Oral Method

3.3.1.3.8.1 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:

- Prescribed by a physician or practitioner;
- Approved by the FDA; and
- Reasonable and necessary for the individual patient.

3.4.7 Drugs and Biologicals Not Eligible for Pass-Through Status and Receiving Separate Non-Pass-Through Payment

3.4.7.1 Payment will be based on median costs derived from CY claims data for drugs and biologicals that have been:

- Separately paid since implementation of the OPPS under Medicare, but were not eligible for pass-through status; and
- Historically packaged with the procedures with which they were billed, even though their median cost per day was above the \$60 packaging threshold.

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

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

3.4.8.1 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:

- 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."
- When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.
- 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.
- The above approach enables hospitals to bill and receive payment for a new drug, biological or radiopharmaceutical concurrent with its approval by the FDA.

3.4.8.2 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.

3.4.9 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.

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

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

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Prospective Payment Methodology

3.4.10 Drugs And Non-Implantable Biologicals With Expiring Pass-Through Status

3.4.10.1 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.

3.4.10.2 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**.

3.5 Drug Administration Coding and Payment

3.5.1 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 I CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs

HCPCS LEVEL I* CODE	DESCRIPTION	SI	APC
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	X	0353
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	X	0359
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	X	0352
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0116
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0116
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0116
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0116
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0117
96420	Chemotherapy administration, intra-arterial; push technique	S	0116
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0117
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	A	--
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	0117
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0116
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0116
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0116
96521	Refilling and maintenance of portable pump	T	0125
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	T	0125

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