Chapter 3 Section 6

Processing And Payment Of Home Infusion Claims Before January 30, 2012

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Authority: 32 CFR 199.2 and 32 CFR 199.6(f)

1.0 ISSUE

Requirements for processing and payment of home infusion claims for home infusion services provided before January 30, 2012.

2.0 POLICY

2.1 General

Home infusion companies eligible for Corporate Services Provider (CSP) status as set forth in the TRICARE Policy Manual (TPM), Chapter 11, Section 12.1 will be paid under the CHAMPUS Maximum Allowable Charge (CMAC) reimbursement system on a fee-for-service basis for otherwise-covered professional services provided by TRICARE-authorized individual providers employed by or under contract with a freestanding corporate entity. Reimbursement of covered services, along with related drugs and supplies, will be made directly to the TRICARE-authorized corporate services provider under its own tax identification number. Payment will be allowable for services rendered in the authorized CSP's place of business, or in the beneficiary's home, under such circumstances as the contractor determines to be necessary for the efficient delivery of such in-home services. The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional service structure; i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates. Additional expenses by providers due to travel will also not be covered.

2.2 Processing and Payment Procedures

The contractor shall use the following processing and payment procedures for adjudication of home infusion claims.

2.2.1 TRICARE has been statutorily mandated under 10 United States Code (USC) 1079(h) to pay health care professional and other non-institutional health care providers, to the extent practicable, in accordance with the same reimbursement rules as Medicare. The Agency, in compliance with the above statutory mandate adopted the Medicare Modernization Act (MMA) provisions for physician reimbursement which inadvertently reduced home infusions drug payment from 95% of the Average Wholesale Price (AWP) to Average Sales Price (ASP) plus a given percentage as part of a routine CMAC update (April 1, 2005). Since Medicare's conversion to ASP for Part B physician reimbursement mandated under MMA was not intended for coverage of homes

infusion drugs (i.e., home infusion drugs were specifically exempted from the ASP conversion), Chapter 1, Section 15, paragraph 3.3.3, was revised for payment of home infusion drugs at 95% of AWP retroactive back to April 1, 2005. As a result, home infusion drugs must be billed using an appropriate "J" code along with a specific National Drug Code (NDC) for pricing. The Healthcare Common Procedure Coding System (HCPCS) "J" 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 for reporting purposes as long as the drugs are U.S. Food and Drug Administration (FDA) approved and have a specific NDC for pricing. Drugs that do not appear on the Medicare ASP file will also be priced using 95% of the AWP. Refer to Chapter 1, Section 15 for payment of drugs administered by other than oral method.

2.2.2 Separate payment will be allowed for supplies that are billed in association with a home infusion visit (e.g., supply codes A4221/A4222/A4223 will be paid separately from associated home infusion visits (Current Procedural Terminology (CPT)[1] procedure codes 99601 and 99602)). Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

2.2.3 Infused drugs administered in an Ambulatory Infusion Suite (AIS) will not qualify for exception to Medicare drug pricing (ASP plus six percent) since they are not being administered in a home setting.

2.2.4 The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will develop all home infusion claims with Medicare denial code PR-50 to determine whether or not the denial code was simply put on the claims because of Medicare benefit limitations or whether it was used because the services were truly not medically necessary. TRICARE should pay as primary if the services were denied because of Medicare benefit limitations (Chapter 4, Section 4, paragraph 1.3.1.3) or deny if Medicare's denial is not related to a benefit limitation (Chapter 4, Section 4, paragraph 1.3.1.2). Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

3.0 EXCLUSION

"S" codes [Temporary National Codes (Non-Medicare)] are used by the Blue Cross Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services and supplies for which there are no national codes but which are needed by the private sector to implement policies, programs or claims processing. These codes are not recognized by Medicare and are reserved solely for evolving technologies under the TRICARE program until permanent HCPCS/CPT codes can be assigned. As a CSP, home infusion companies are limited to the payment of professional services and drug and supplies provided in the direct treatment of a TRICARE eligible beneficiary. Payment is not allowed for the overall administrative charges/ expenses incorporated into the home infusion "S" code per diems.

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