CHAPTER 13
SECTION 3.6

LEGEND DRUGS AND INSULIN

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I. ISSUE

How are legend drugs and insulin to be reimbursed?

II. 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 an amount determined by TRICARE ($3.00) 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 the Drug Topics Red Book or the Blue Book, both of which list the wholesale price. In all cases the contractor is to use the latest annual edition of the Red Book or the Blue Book as well as the monthly updates.

D. When a participating provider, i.e., physician or other authorized individual provider, submits charges for legend drugs dispensed directly to the patient, the charges may be paid at cost to the physician or other authorized individual provider only. No administrative or professional fee is allowed.

E. Allowable charge screens for injections (90782 - 90788) shall be based on: (a) the CHAMPUS allowable charge found on the CMAC file; plus (b) the current wholesale cost of the most frequently administered dosage of the drug, as reflected in the Drug Topics Red Book or the Blue Book. The CMAC includes the cost of supplies such as syringes, needles, cotton swabs, alcohol, etc. (The price of the smallest unit of packaging offered by the manufacturer that will include the most frequently administered dosage of the drug must be used in this regard.) However, in cases involving unusual circumstances, an additional allowance above the CMAC amount for the physician services may be considered, provided proper documentation is supplied. Also, when the claim is documented to indicate that the

dosage administered and the cost of the drug used were higher than the drug cost that would be applicable to the most frequently administered dosage, the higher drug cost may be allowed to the extent that it is reasonable.

F. The TRICARE/CHAMPUS national allowable charge system used to reimburse professional services discussed in Chapter 13, Section 1.1, Section 1.2, Section 1.3, and Section 1.5 does not apply to legend drugs and insulin claims. In addition, immunizations and allergy immunotherapy are excluded from the national allowable charge system. The above reimbursement guidelines are to be used by the contractors.

III. POLICY CONSIDERATIONS

A. If the contractor knows that the sole purpose of an "office visit" was for the patient to receive an injection, payment may be made only for the injection (if it is covered). For example, the contractor would reimburse for a 90030, minimal service (under CPT-4). 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.

B. All injection claims submitted to a contractor should include the specific name of the drug used. Identification of the drug will enable the contractor to correctly pay for the services rendered and help establish meaningful injection screens.

C. When the total charge made for an injection (i.e., for the service of the physician and/or his office nurse (or other authorized provider) in providing the injection, and for the cost of the drug and supplies used) does not exceed $7, the actual charge made may be determined to be an allowable charge without any further determination of the wholesale drug cost through use of the Drug Topics Red Book or the Blue Book. Thus, when the actual cost of the drug used was less than $2, use of the $7 tolerance would allow room for some cushioning to offset losses due to spoilage and spillage. If the contractor requests, but does not receive, an itemization of costs for supplies, drug, and administration service, and if this information cannot be obtained from the Red Book or Blue Book, the contractor is not to deny that line item but is to allow up to the $7.00 tolerance amount. Of course, in no case may the allowable charge exceed the actual charge made for an injection.

D. Injections such as those that require the precise placement of a needle into inflamed, painful, or target areas or the injection of dangerous drugs may require that only a physician (or other authorized provider practicing within their scope of practice) provide this service. Consequently, injections of this nature should not be considered routine, and appropriate allowances shall be made. In these instances, the contractor may establish prevailing charge screens to reflect the actual practice of providers in a state.

E. 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 the Drug Topics Red Book or the Blue Book, reimbursement will be based on the allowable charge methodology prescribed under Chapter 13, Section 1.1, Section 1.2, and Section 1.3 and OPM Part Two, Chapter 4. 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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