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 Defense Health Agency (DHA) 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.

3.3.1.1 Drugs (except for home infusion drugs) administered other than oral method, including chemotherapy drugs, are to be priced from the Medicare Average Sales Price (ASP) file.

3.3.1.2 Drugs that do not appear on the Medicare ASP file will be priced at the lesser of billed charges or 95% of the Average Wholesale Price (AWP). Effective August 15, 2019, vaccines that appear on the Centers for Disease Control (CDC) Private Sector Vaccine Price List and do not appear on the Medicare ASP file will be priced at 106% of the CDC rate. Vaccines that are neither on the CDC price list nor the Medicare ASP file will be priced at 95% of the AWP. Vaccines with more than one CDC Private Sector Vaccine price (per Current Procedural Terminology (CPT) code) will be averaged prior to applying the 106%. CDC vaccine pricing will be updated quarterly and included in the Quarterly Injectable Drug Updates.

3.3.1.3 Home infusion drugs provided prior to January 30, 2012: Home infusion drugs will be paid the lesser of the billed amount or 95% 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 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 Medicare ASP 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.

3.3.1.4 Home infusion drugs provided on or after January 30, 2012: Home infusion drugs must be provided in accordance with the TPM, Chapter 8, Section 20.1. Home infusion drugs will be paid the lesser of the billed amount or 95% of the AWP only in cases where the home infusion drug is not available through the TPharm, or the beneficiary is not required by the TPM, Chapter 8, Section 20.1 to obtain the drug from the TPharm. Home infusion drugs not provided through the TPharm will be billed using the appropriate "J" code or any other appropriate HCPCS coding for home infusion drugs not appearing on the Medicare ASP file along with a specific 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 FDA-approved and have specific NDCs for pricing.

3.3.1.5 Effective January 1, 2017, drugs infused through Durable Medical Equipment (DME) shall be priced at ASP plus 6%, in accordance with Section 5004 of the 21st Century Cures Act, and TRICARE's requirement at 10 USC Section 1079 to reimburse like Medicare, where practicable.

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.

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