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TRICARE  
MANAGEMENT ACTIVITY

MB&RB

CHANGE 7  
6010.57-M  
MAY 28, 2009

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to the 6010.57-M, issued February 2008.

**CHANGE TITLE:** OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) UPDATES

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change brings this TRICARE Policy Manual up-to-date with published Change 91 (December 22, 2008) and Change 95 (May 8, 2009) to the Aug 2002 TRICARE Policy Manual 6010.54-M.

**EFFECTIVE DATE:** May 1, 2009.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TOM, Change No. 6, Feb 2008 TRM, Change No. 7, and Feb 2008 TSM, Change No. 6.

Reta Michak  
Chief, Office of Medical Benefits and  
Reimbursement Branch

**ATTACHMENT(S):** 9 PAGE(S)  
**DISTRIBUTION:** 6010.57-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

**CHANGE 7**  
**6010.57-M**  
**MAY 28, 2009**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 12.1, page 1

Section 13.1, pages 1 and 2

**CHAPTER 2**

Section 2.3, pages 1 and 2

**CHAPTER 4**

Section 13.2, pages 1 and 2

Section 18.5, pages 1 and 2

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Section 13.2, pages 1 and 2

Section 18.5, pages 1 and 2

## Category III Codes

Issue Date: March 6, 2002

Authority: [32 CFR 199.2\(b\)](#) and [32 CFR 199.4\(g\)\(15\)](#)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

0003T, 0008T, 0016T - 0019T, 0021T, 0024T, 0026T - 0032T, 0041T - 0161T

### 2.0 DESCRIPTION

Category III codes are a set of temporary codes for emerging technology, services, and procedures. These codes are used to track new and emerging technology to determine applicability to clinical practice. When a Category III code receives a Category I code from the American Medical Association (AMA) it does not automatically become a benefit under TRICARE. However, the codes that may have moved from unproven to proven must be forwarded to the Office of Medical Benefits and Reimbursement **Branch** (MB&RB) for coverage determination/policy clarification.

### 3.0 POLICY

**3.1** Category III codes are to be used instead of unlisted codes to allow the collection of specific data. TRICARE has not opted to track Category III codes at this time.

**3.2** Category III codes are excluded from coverage since clinical safety and efficacy or applicability to clinical practice has not been established.

### 4.0 EXCEPTIONS

**4.1** Category III code 0024T may be covered under the Rare Disease Policy for children.

**4.2** FDA IDE (Category B) clinical trial. See [Chapter 8, Section 5.1](#).

**4.3** **Category III codes 0145T - 0151T as outlined in [Chapter 5, Section 1.1](#).**

### 5.0 EXCLUSION

Unlisted codes for **C**ategory III codes. Effective January 1, 2002.

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## Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

Issue Date: November 6, 2007  
Authority:

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### 1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

### 2.0 DESCRIPTION

**2.1** HCPCS "C" codes include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS assigned.

**2.2** HCPCS "S" codes are temporary codes used by the private sector to report drugs, services, and supplies for which there are no national codes.

### 3.0 POLICY

**3.1** Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For Hospital Outpatient Department (HOPD) services provided **on or before May 1, 2009** (implementation of TRICARE's OPPS), and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 24, paragraph 3.2](#).

**3.2** Under TRICARE, "S" codes are not reimbursable except as follows:

**3.2.1** S9122, S9123, and S9124 for the Extended Care Health Option (ECHO) respite care benefit and the ECHO Home Health Care (EHHC) benefit; S1040 for ECHO durable equipment;

**3.2.2** S0812, S1030, S1031, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2360, S2361, S2400, S2401, S2402, S2403, S2405, S2411, S3818, S3819, S3820, S3822, S3823, S8185, S8265, S8270, and S9430 for all beneficiaries; **and**

**3.2.3** S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 18, Section 9](#)).

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Chapter 1, Section 13.1

Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

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**3.3** Under TRICARE, HCPCS code S9999 is a recognized code for purposes of reporting sales tax but is not payable.

**4.0 EXCLUSIONS**

HCPCS "C" codes are not allowed to be billed by independent professional providers.

- END -

## Outpatient Observation Stays

Issue Date: July 8, 1998

Authority: [32 CFR 199.4\(c\)\(2\)\(iv\)](#)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

99217, 99218 - 99220, 99234 - 99236

### 2.0 HCPCS PROCEDURE CODES

Upon implementation of the Outpatient Prospective Payment System (OPPS): G0378, G0379

### 3.0 DESCRIPTION

Outpatient observation stays are those services furnished by a hospital on a hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are provided when ordered by a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.

### 4.0 POLICY

**4.1** A person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight. When a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient to determine the need for further treatment or for inpatient admission.

**4.2** For observation stays **before May 1, 2009** (implementation of OPPS), the following provisions apply:

**4.2.1** Cost-sharing of observation services, subsequent to ambulatory surgery reimbursement under the prospective ambulatory group payment, is covered if determined that placement on observation is medically necessary.

**4.2.2** Cost-sharing of outpatient observation services is covered following care provided in an emergency setting.

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Chapter 2, Section 2.3

Outpatient Observation Stays

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**4.2.3** Cost-sharing at the observation level or outpatient level should be considered for inpatient denials when the services rendered are medically necessary, but provided at an inappropriate level of care.

**4.2.4** Cost-sharing of outpatient mental health observation is covered.

**4.2.5** Outpatient observation stays generally should not exceed 24 hours.

**4.2.6** Up to 48 hours of outpatient observation services may be authorized by the Contractor. If an observation stay exceeds 48 hours, the claim shall be denied as outpatient and the claim shall be resubmitted as an inpatient claim.

**4.2.7** Time spent in a recovery room following surgery should not be included in the 23 hour limit.

**4.2.8** The time of admission to an observation bed is counted as the first hour of observation and is rounded to the nearest hour. The number of hours of observation should be indicated in the units field on the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 claim form. If the patient has more than 23 hours of observation show all hours of services provided in the units field.

**4.2.9** Outpatient observation services are billed using the revenue code 0762 with the description listed as Observation Services. This code includes room and board services.

**4.3** For observation stays on or after May 1, 2009 (implementation of OPSS), the following provisions apply:

**4.3.1** Outpatient observation stays are separately payable when certain conditions are met for maternity patients having diagnosis of chest pain, asthma, congestive heart failure or maternity (refer to the TRICARE Reimbursement Manual (TRM), Chapter 13, Section 2, paragraph 3.9 for those specific conditions that must be met in order to receive separate payment under the hospital Outpatient Prospective Payment System (OPSS)). The above conditions will only apply to observation stays reimbursed under the OPSS.

**4.3.2** All other observation stays will be packaged under the primary procedure for payment. Hospitals are to report these observation charges under revenue code 0762 - "Observation Room", and HCPCS code G0378. The above packaging requirement is specific for observation stays reimbursed under the OPSS.

**4.3.3** Outpatient observation stays generally should not exceed 24 hours.

**4.3.4** For OPSS exempt hospitals, if an observation stay is for more than 48 hours, the claim shall be denied as outpatient. The claim shall be resubmitted as an inpatient claim.

**4.4** A separate authorization for outpatient observation is not required.

**4.5** Prime enrollees who receive emergency care as an outpatient observation stay must report their admission within 72 hours to the contractor.

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## Surgery For Morbid Obesity

Issue Date: November 9, 1982

Authority: [32 CFR 199.4\(e\)\(15\)](#), [\(g\)\(15\)](#), and 10 USC 1079(a)(11)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

43644, 43770 - 43774, 43842, 43846, 43848

### 2.0 HCPCS PROCEDURE CODES

S2083

### 3.0 DESCRIPTION

Morbid obesity means the body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the body weight is 200% or more of ideal weight for height and bone structure.

### 4.0 POLICY

**4.1** Gastric bypass, gastric stapling or gastroplasty by laparotomy or laparoscopy, to include vertical banded gastroplasty is covered when one of the following conditions is met:

**4.1.1** The patient is 100 pounds over the ideal weight for height and bone structure and has one of these associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders and severe arthritis of the weight-bearing joints.

**4.1.2** The patient is 200% or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.

**4.1.3** The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second operation (a revision or takedown).

**4.2** In determining the ideal body weight for morbid obesity using the Metropolitan Life Table, contractors must apply 100 pounds (or 200%) to both the lower and higher end of the weight range. Payment will be allowed when beneficiaries meet all requirements for morbid obesity surgery including the ideal weight within the newly determined range.

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**5.0 EXCLUSIONS**

**5.1** Nonsurgical treatment of obesity, morbid obesity, dietary control, or weight reduction.

**5.2** Biliopancreatic bypass (jejunoileal bypass, Scopinaro procedure) for treatment of morbid obesity is unproven (CPT<sup>2</sup> procedure code 43645, 43845, 43847, or 43633).

**5.3** Gastric bubble or balloon for treatment of morbid obesity is unproven.

**5.4** Gastric wrapping/open gastric banding (CPT<sup>2</sup> procedure code 43843) for treatment of morbid obesity is unproven.

**5.5** Unlisted CPT<sup>2</sup> procedure codes 43659 (laparoscopy procedure, stomach); 43999 (open procedure, stomach); and 49329 (laparoscopy procedure, abdomen, peritoneum and omentum) for gastric bypass procedures.

**6.0 EFFECTIVE DATES**

**6.1** Laparoscopic surgical procedure for gastric bypass and gastric stapling (gastroplasty), including vertical banded gastroplasty are covered, effective December 2, 2004.

**6.2** Laparoscopic adjustable gastric banding is covered, effective February 1, 2007.

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## Fetal Surgery

Issue Date: **April 17, 2003**  
Authority: **32 CFR 199.4(c)(2)(i)**

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### 1.0 HCPCS PROCEDURE CODES

S2400 - S2403, S2405, S2411

### 2.0 DEFINITION

Fetal surgery is defined as an intervention consisting of opening of the gravid uterus (by either a traditional cesarean surgical incision or through single or multiple fetoscopic port incisions), surgically correcting a fetal abnormality, and either returning the fetus to the uterus (or restoring uterine closure, if the intervention has been accomplished without removal of the fetus) for completion of gestational development.

### 3.0 POLICY

**3.1** Fetal surgery is covered for the following indications:

**3.1.1** Prenatal surgical intervention consisting of vesicoamniotic shunting in fetuses with hydronephrosis due to bilateral urinary tract obstruction together with evidence of progressive oligohydramnios and evidence of adequate renal function as generally defined by normal urinary electrolytes, and with no other lethal abnormalities or chromosomal defects.

**3.1.2** Prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with a prenatal diagnosis of CDH, gestational age of less than 25 weeks at time of diagnosis, and with evidence of liver herniation, and other indicators of poor prognosis, such as a low lung-to-head ratio.

**3.1.3** Prenatal intervention of either an open in-utero resection of malformed pulmonary tissue or placement of a thoraco-amniotic shunt in cases of hydrothorax or large cystic lesions for fetuses congenital cystic adenomatoid malformation or extralobar pulmonary sequestration, who are of less than 32 weeks' gestation and who have evidence of progressive hydrops, placentomegaly and/or the beginnings of maternal mirror syndrome.

**3.1.4** Twin-twin transfusion syndrome, gestation age of less than 25 weeks' gestation at the time of diagnosis.

**3.1.5** Sacrococcygeal teratoma in the presence of fetal hydrops and/or placentomegaly in fetuses with less than 28 weeks of gestation.

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Chapter 4, Section 18.5

Fetal Surgery

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**3.2** Other conditions when determined by medical review to be medically necessary and appropriate treatment for the patient's medical condition and that reliable evidence has established in-utero surgery as safe and effective treatment.

**4.0 CONSIDERATION**

The Department of Defense (DoD) In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial Demonstration Project can be referenced in the TRICARE Operations Manual (TOM), [Chapter 18, Section 3](#).

**5.0 EXCLUSIONS**

**5.1** The in-utero repair for myelomeningocele (HCPCS S2404) and aqueductal stenosis (HCPCS S2409) and procedures performed in-utero, not otherwise classified).

**5.2** In-utero surgery for other conditions for which the safety and effectiveness has not been established.

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