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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 110
6010.55-M
MARCH 11, 2010**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002**

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

**CHANGE TITLE: OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) TECHNICAL
CHANGES, FEBRUARY 2010**

CONREQ: 14925

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This changes contains OPPS changes to include Active Duty Service Member (ADSM) inpatient procedures performed on an outpatient basis, changes to the observation stay policy, and the addition of new modifiers.

EFFECTIVE DATE: May 1, 2009, unless otherwise indicated.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TOM, Change No. 94, Aug 2002 TPM, Change No. 119, and Aug 2002 TSM, Change No. 79.


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**ATTACHMENT(S): 76 PAGE(S)
DISTRIBUTION: 6010.55-M**

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CHAPTER 1

Section 16, pages 1 through 4

Section 24, pages 1 and 2

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CHAPTER 13

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SURGERY

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2)(i), (c)(2)(ii), (c)(3)(i), (c)(3)(iii), and (c)(3)(iv)

I. APPLICABILITY

Paragraphs III.A. through G. apply to reimbursement of services provided by network and non-network providers. Paragraphs III.H. and I. apply only to non-network providers.

II. ISSUE

How is surgery to be reimbursed?

III. POLICY

A. Multiple Surgery and Discounting Reimbursement.

1. The following rules are to be followed whenever there is a terminated procedure or more than one surgical procedure performed during the same operative or outpatient session. This applies to those facilities that are exempt from the hospital Outpatient Prospective Payment System (OPPS) and for claims submitted by individual professional providers for services rendered on or after **May 1, 2009** (implementation of OPPS):

a. Discounting for Multiple Procedures.

(1) When more than one surgical procedure code subject to discounting (see [Chapter 13, Section 3](#)) is performed during a single operative or outpatient session, TRICARE will reimburse the full payment and the beneficiary will pay the cost-share/copayment for the procedure having the highest payment rate.

(2) Fifty percent (50%) of the usual payment amount and beneficiary copayment/cost-share amount will be paid for all other procedures subject to discounting (see [Chapter 13, Section 3](#)) performed during the same operative or outpatient session to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

(a) The reduced payment would apply only to the surgical procedure with the lower payment rate.

(b) The reduced payment for multiple procedures would apply to both the beneficiary copayment/cost-share and the TRICARE payment.

NOTE: Certain codes are considered an add-on or modifier 51 exempt procedure for non-OPPS professional and facility claims, which should not apply a reduction as a secondary procedure. These codes should not be subject to OPPS discounting reduction defined in Chapter 13, Section 3. The source for these codes is the American Medical Association (AMA) Current Procedural Terminology (CPT) guide.

b. Discounting for Bilateral Procedures.

NOTE: Bilateral codes can be surgical and non-surgical.

(1) Following are the different categories/classifications of bilateral procedures:

(a) Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

(b) Inherent bilateral (i.e., procedure in and of itself is bilateral).

(c) Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures).

(2) Terminated bilateral procedures or terminated procedures with units greater than one should not occur. Line items with terminated bilateral procedures or terminated procedures with units greater than one are denied.

(3) Inherent bilateral procedures will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code.

(4) The above bilateral procedures will be discounted based on the application of discounting formulas appearing in Chapter 13, Section 3, paragraph III.A.5.c.(6) and (7).

c. Modifiers for Discounting Terminated Surgical Procedures.

(1) Industry standard modifiers may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers are essential for ensuring accurate processing and payment of these claim types.

(2) Industry standard modifiers are used to identify surgical procedures which have been terminated prior to and after the delivery of anesthesia.

(a) Modifiers 52 and 73 are used to identify a surgical procedure that is terminated prior to the delivery of anesthesia and is reimbursed at 50% of the allowable; i.e., the Ambulatory Surgery Center (ASC) tier rate, the Ambulatory Payment Classification

(APC) allowable amount for OPPS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.

(b) Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100% of the appropriated allowable amounts referenced above.

2. Exceptions to the above policy prior to implementation of the hospital OPPS, are:

a. If the multiple surgical procedures involve the fingers or toes, benefits for the third and subsequent procedures are to be limited to 25% to the prevailing charge.

b. Incidental procedures. No reimbursement is to be made for an incidental procedure.

3. Separate payment is not made for incidental procedures. The payment for those procedures are packaged within the primary procedure with which they are normally associated.

4. Data which is distorted because of these multiple surgery procedures (e.g., where the sum of the charges is applied to the single major procedure) must not be entered into the data base used to develop allowable charge profiles.

5. The OPPS inpatient only list shall apply to OPPS, non-OPPs, and professional providers. Refer to [Chapter 13, Section 2, paragraph III.D](#). The inpatient only list is available on TMA's web site at <http://www.tricare.mil/inpatientprocedures>.

B. Multiple Primary Surgeons. When more than one surgeon acts as a primary surgeon for multiple procedures during the same operative session, the services of each may be covered.

C. Assistant Surgeons. See [Chapter 1, Section 17](#).

D. Pre-Operative Care. Pre-operative care rendered in a hospital when the admission is expressly for the surgery is normally included in the global surgery charge. The admitting history and physical is included in the global package. This also applies to routine examinations in the surgeon's office where such examination is performed to assess the beneficiary's suitability for the subsequent surgery.

E. Post-Operative Care. All services provided by the surgeon for post-operative complications (e.g., replacing stitches, servicing infected wounds) are included in the global package if they do not require additional trips to the operating room. All visits with the primary surgeon during the 90 day period following major surgery are included in the global package.

NOTE: This rule does not apply if the visit is for a problem unrelated to the diagnosis for which the surgery was performed or is for an added course of treatment other than the normal recovery from surgery. For example, if after surgery for cancer, the physician who

performed the surgery subsequently administers chemotherapy services, these services are not part of the global surgery package.

F. Re-Operations for Complications. All medically necessary return trips to the operating room, for any reason and without regard to fault, are covered.

G. Global Surgery for Major Surgical Procedures. Physicians who perform the entire global package which includes the surgery and the pre- and post-operative care should bill for their services with the appropriate CPT code only. Do not bill separately for visits or other services included in this global package. The global period for a major surgery includes the day of surgery. The pre-operative period is the first day immediately before the day of surgery. The post-operative period is the 90 days immediately following the day of surgery. If the patient is returned to surgery for complications on another day, the post-operative period is 90 days immediately after the last operation.

H. Second Opinion.

1. Claims for patient-initiated, second-physician opinions pertaining to the medical need for surgery may be paid. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery.

2. In the event that the recommendations of the first and second physician differ regarding the medical need for such surgery, a claim for a patient-initiated opinion from a third physician is also reimbursable. Such claims are payable even though the beneficiary has the surgery performed against the recommendation of the second (or third) physician.

I. In-Office Surgery. Charges for a surgical suite in an individual professional provider's office, including charges for services rendered by other than the individual professional provider performing the surgery and items directly related to the use of the surgical suite, may not be cost-shared unless the suite is an approved ambulatory surgery center.

J. On May 1, 2009 (implementation of OPSS), surgical procedures will be discounted in accordance with the provisions outlined in [Chapter 13, Section 3, paragraph III.A.5.b.](#) and [c.](#) Multiple discounting will not be applied to the following CPT¹ procedure codes for venipuncture, fetal monitoring and collection of blood specimens; 36400-36416, 36591, 36592, 59020, 59025, 59050, and 59051.

- END -

¹ CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

HOSPITAL REIMBURSEMENT - OUTPATIENT SERVICES

ISSUE DATE: March 10, 2000

AUTHORITY: [32 CFR 199.14\(a\)\(4\)](#) and [\(a\)\(6\)](#)

I. APPLICABILITY

A. 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.

B. Hospital reimbursement - outpatient services for all services prior to implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of the Outpatient Prospective Payment System (OPPS), and thereafter, for services not otherwise reimbursed under hospital OPPS.

II. POLICY

A. When professional services or diagnostic tests (e.g., laboratory, radiology, EKG, EEG) that have CHAMPUS Maximum Allowable Charge (CMAC) pricing ([Chapter 5, Section 3](#)) are billed, the claim must have the appropriate Current Procedural Terminology (CPT) coding and modifiers, if necessary. Otherwise, the service shall be denied. If only the technical component is provided by the hospital, the technical component of the appropriate CMAC shall be used.

B. For all other services, payment shall be made based on allowable charges when the claim has Healthcare Common Procedure Coding System (HCPCS) (Level I, II, III) coding information (these may include ambulance, Durable Medical Equipment (DME) and supplies, drugs administered other than oral method, and oxygen and related supplies). For claims development, see TRICARE Operations Manual (TOM), [Chapter 8, Section 6](#). Other services without allowable charges, such as facility charges, shall be paid as billed. For reimbursing drugs administered other than oral method, see [Chapter 1, Section 15, paragraph III.E](#).

NOTE: Each line items on the Centers of Medicare and Medicaid Services (CMS) 1450 UB-04 claim form must be submitted with a specific date of service to avoid claim denial. The header dates of service on the CMS 1450 UB-04 may span, as long as all lines include specific dates of service within the span on the header.

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C. When coding information is provided, outpatient hospital services including emergency and clinical services, clinical laboratory services, rehabilitation therapy, venipuncture, and radiology services are paid using existing allowable charges. Such services are reimbursed under the allowable charge methodology that would also include the CMAC rates. In addition, venipuncture services provided on an outpatient basis by institutional providers other than hospitals are also paid on this basis. Professional services billed on a CMS 1450 UB-04 will be paid at the professional CMAC if billed with the professional service revenue code and enough information to identify the rendering provider.

D. Freestanding Ambulatory Surgical Center (ASC) services are to be reimbursed in accordance with [Chapter 9, Section 1](#).

NOTE: All hospital based ASC claims that are submitted to be paid under OPSS must be submitted with a Type Of Bill (TOB) 13X. If a claim is submitted to be paid with a TOB 83X the claim will be denied.

E. Outpatient hospital services including professional services, provided in the state of Maryland are paid at the rates established by the Maryland Health Services Cost Review Commission (HSCRC). Since hospitals are required to bill these rates, reimbursement for these services is to be based on the billed charge.

F. Surgical outpatient procedures which are not otherwise reimbursed under the hospital OPSS will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under OPSS for services rendered on or after implementation of OPSS. Refer to [Chapter 1, Section 16, paragraph III.A.1.a. through c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b. and c.](#) for further detail.

G. Industry standard modifiers and condition codes may be billed on outpatient hospital claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers and condition codes are essential for ensuring accurate processing and payment of these claims.

H. Effective December 1, 2009, hospital outpatient services provided in a CAH, including ambulatory surgery services, shall be paid under the reasonable cost method, reference [Chapter 15, Section 1](#).

- END -

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Category 2: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, and audiologists provided in a non-facility including provider offices, home settings, and all other non-facility settings. The non-facility CMAC rate applies to occupational therapy (OT), physical therapy (PT), or speech therapy (ST) regardless of the setting.

Category 3: Services, of all other providers not found in Category 1, provided in a facility including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered), RTCs, ambulances, hospices, MTFs, psychiatric facilities, CMHCs, SNFs, ASCs, etc.

Category 4: Services, of all other providers not found in Category 2, provided in a non-facility including provider offices, home settings, and all other non-facility settings.

b. Linking the site of service with the payment category. The contractor is responsible for linking the site of service with the proper payment category. The rates of payment are found on the CMAC file that are supplied to the contractor by TMA through its contractor that calculates the CMAC rates.

c. Payment of 0510 and 0760 series revenue codes.

(1) Effective for services on or after April 1, 2005, payment of 0510 and 0760 series revenue codes shall begin. Payment would be made as billed unless a discounted negotiated rate can be obtained for OPSS exempt providers.

(2) Effective for services on or after May 1, 2009 (implementation of OPSS), payment of 0510 and 0760 series revenue codes will be based on the HCPCS codes submitted on the claim and reimbursed under the OPSS for providers reimbursed under the OPSS methodology.

d. Reimbursement Hierarchy For Procedures Paid Outside The OPSS.

(1) CMAC Facility Pricing Hierarchy (No Technical Component (TC) Modifier).

(a) The following table includes the list of rate columns on the CMAC file. The columns are number 1 through 8 by description. The pricing hierarchy for facility CMAC is 8, 6, then 2 (global, clinical and laboratory pricing is loaded in Column 2).

COLUMN	DESCRIPTION
1	Non-facility CMAC for physician/LLP class
2	Facility CMAC for physician/LLP class
3	Non-facility CMAC for non-physician class
4	Facility CMAC for non-physician class

Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the Physician class TC rate. Otherwise, pay Facility CMAC for physician/LLP class.

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COLUMN	DESCRIPTION
5	Physician class Professional Component (PC) rate
6	Physician class TC rate
7	Non-physician class PC rate
8	Non-physician class TC rate

Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the Physician class TC rate. Otherwise, pay Facility CMAC for physician/LLP class.

NOTE: Hospital-based therapy services, i.e., OT, PT, and ST, shall be reimbursed at the non-facility CMAC for physician/LLP class, i.e., [Column 1](#).

(b) If there is no CMAC available, the contractor shall reimburse the procedure under Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

(2) DMEPOS. If there is no DMEPOS available, the contractor shall reimburse the procedure using state prevailings.

(3) State Prevailing Rate. If there is no state prevailing rate available, the contractor shall reimburse the procedure based on billed charges.

e. Informing the provider community of the pricing changes for 2005. The contractors are to inform the provider community of the pricing changes based on site of service beginning April 1, 2005, for services rendered on or after this date. Medicare has been using site of service for some time. TMA would simply be adopting this pricing from Medicare. Contractors may need to renegotiate agreements with providers reflecting this change.

f. Services and procedure codes not affected by site of service. Anesthesia services, laboratory services, component pricing services such as radiology, and "J" codes are some of the more common services and codes that will not be affected by site of service.

g. CMAC history files. The contractor is to retain and maintain previous years CMAC files for historical purposes. Since the 2005 CMAC file format is different, it will be more difficult to link to the previous years CMAC files.

4. Multiple Surgery Discounting. Professional surgical procedures which are reimbursed under the CMAC payment methodology will be subject to the same multiple surgery guidelines and modifier requirement as prescribed under the OPPS for services rendered on or after May 1, 2009 (implementation of OPPS). Refer to [Chapter 1, Section 16, paragraph III.A.1.a. through c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b. and c.](#) for further detail.

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ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

5. Industry standard modifiers and condition codes may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers and condition codes are essential for ensuring accurate processing and payment of these claims.

- END -

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(b) Applying the cost-to-charge ratio (CCR) using the Medicare CCR for freestanding ASCs for TRICARE ASCs.

(c) Calculating a median cost for each procedure; and

(d) Updating to the year for which the payment rates were in effect by the Consumer Price Index-Urban (CPI-U).

(2) Procedures were placed into one of ten groups by their median per procedure cost, starting with \$0 to \$299 for Group 1 and ending with \$1,000 to \$1,299 for Group 9 and \$1,300 and above for Group 10. Groups 2 through 8 were set on the basis of \$100 fixed intervals.

(3) The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

(4) Procedures for which there was no or insufficient (less than 25 claims) data were assigned to groups by:

(a) Calculating a volume-weighted ratio of TRICARE payment rates to Medicare payment rates for those procedures with sufficient data;

(b) Applying the ratio to the Medicare payment rate for each procedure; and

(c) Assigning the procedure to the appropriate payment group.

e. The amount paid for any ambulatory surgery service under these procedures cannot exceed the amount that would be allowed if the services were provided on an inpatient basis. The allowable inpatient amount equals the applicable DRG relative weight multiplied by the national large urban adjusted standardized amount. This amount will be adjusted by the applicable hospital wage index.

f. As of November 1, 1998, an eleventh payment group is added to this payment system. This group will include extracorporeal shock wave lithotripsy.

5. Payments.

a. General. The payment for a procedure will be the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the same labor/non-labor-related cost ratio and hospital wage index as used for ASCs by Medicare. This calculation will be done by TMA, or its data contractor. For participating claims, the ambulatory surgery payment rate will be reimbursed regardless of the actual charges made by the facility--that is, regardless of whether the actual charges are greater or smaller than the payment rate. For nonparticipating claims, reimbursement (TRICARE payment plus beneficiary cost-share plus any double coverage payments, if applicable) cannot exceed the lower of the billed charge or the group payment rate.

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b. Procedures Which Do Not Have An Ambulatory Surgery Rate and Are Provided by an ASC. Only those procedures that have an ambulatory surgery rate listed on TMA's ambulatory surgery web site (<http://www.tricare.mil/ambulatory>) are to be reimbursed under this reimbursement process. If a claim is received from an ASC for a procedure which is not listed on TMA's ambulatory web site, the facility charges are to be reimbursed using the process in [paragraph II.B](#).

c. Multiple and Terminated Procedures. The following rules are to be followed whenever there is a terminated surgical procedure or more than one procedure is included on an ambulatory surgery claim. The claim for professional services, regardless of what type of ambulatory surgery facility provided the services and regardless of what procedures were provided, is to be reimbursed according to the multiple surgery guidelines in [Chapter 1, Section 16, paragraph III.A.1.a.](#) through [c](#).

(1) Discounting for Multiple Surgical Procedures.

(a) If all the procedures on the claim are listed on TMA's ambulatory surgery web site, the claim is to be reimbursed at 100% of the group payment rate for the major procedure (the procedure which allows the greatest payment) and 50% of the group payment rate for each of the other procedures. This applies regardless of the groups to which the procedures are assigned.

(b) If the claim includes procedures listed on TMA's ambulatory surgery web site as well as procedures not listed on TMA's ambulatory surgery web site, the following rule is to be followed. Each service is to be reimbursed according to the method appropriate to it. That is, the allowable amount for procedures listed on TMA's ambulatory surgery web site is to be based on the appropriate group payment amount while the allowable amount for procedures not listed on TMA's ambulatory surgery web site is to be based on the process in [paragraph II.B](#). Regardless of the method used for determining the reimbursement for each procedure, only one procedure (the procedure which allows the greatest payment) is to be reimbursed at 100%. All other procedures are to be reimbursed at 50%. If the contractor is unable to determine the charges for each procedure (i.e., a single billed charge is made for all procedures), the contractor is to develop the claim for the charges using the steps contained in the TRICARE Operations Manual (TOM). If development does not result in usable charge data, the contractor is to reimburse the major procedure (the procedure for which the greatest amount is allowed) if that can be determined (e.g., the major procedure is on TMA's ambulatory surgery web site or is identified on the claim) and deny the other procedures using EOB message "Requested information not received". If the major procedure cannot be determined, the entire claim is to be denied.

NOTE: Certain codes are considered an add-on or modifier 51 exempt procedure for non-OPPS professional and facility claims, which should not apply a reduction as a secondary procedure. These codes should not be subject to OPPS discounting reduction defined in [Chapter 13, Section 3](#). The source for these codes is the American Medical Association (AMA) CPT guide.

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(2) Discounting for Bilateral Procedures.

(a) Following are the different categories/classifications of bilateral procedures:

1 Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

2 Inherent bilateral (i.e., procedure in and of itself is bilateral).

3 Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures).

(b) Terminated bilateral procedures or terminated procedures with units greater than one should not occur. Line items with terminated bilateral procedures or terminated procedures with units greater than one are denied.

(c) Inherent bilateral procedures will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code.

(3) Modifiers for Discounting Terminated Surgical Procedures.

(a) Industry standard modifiers may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers are essential for ensuring accurate processing and payment of these claim types.

(b) Industry standard modifiers are used to identify surgical procedures which have been terminated prior to and after the delivery of anesthesia.

1 Modifiers 52 and 73 are used to identify a surgical procedure that is terminated prior to the delivery of anesthesia and is reimbursed at 50% of the allowable; i.e., the ASC tier rate, the Ambulatory Payment Classification (APC) allowable amount for OPPS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.

2 Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100% of the appropriated allowable amounts referenced above.

(4) Unbundling of Procedures. Contractors should ensure that reimbursement for claims involving multiple procedures conforms to the unbundling guidelines as outlined in [Chapter 1, Section 3](#).

(5) Incidental Procedures. The rules for reimbursing incidental procedures as contained in [Chapter 1, Section 3](#), are to be applied to ambulatory surgery procedures reimbursed under the rules set forth in this section. That is, no reimbursement is to be made for incidental procedures performed in conjunction with other procedures which are not

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classified as incidental. This limitation applies to payments for facility claims as well as to professional services.

6. Updating Payment Rates.

a. The rates will be updated annually by TMA by the same update factor as is used in the Medicare annual updates for ASC payments. Periodically the rates will be recalculated using the steps in [paragraph II.A.4.d.](#)

b. The rates were updated by 3.0% effective November 1, 2002. This update included the wage indexes as updated by Medicare.

c. The group payment rates that are effective November 1, 2003, have been recalculated using the steps in [paragraph II.A.4.d.](#) However, we used 100 claims rather than 25 claims to calculate a rate for individual procedures, because it produced more statistically valid results while still resulting in calculated rates for about 83% of TRICARE ambulatory surgery services. In addition, the rates were updated by the Medicare update factor of 2.0% and included the wage indexes as updated by Medicare.

d. The rates were reduced by 2.0% effective April 1, 2004.

e. The rates were updated by 0.6% effective November 1, 2009.

B. Reimbursement for procedures not listed on TMA's ambulatory surgery web site. Prior to January 28, 2000, these procedures were to be denied if performed in an ASC and reimbursed in accordance with [Chapter 1, Section 24](#). Effective January 28, 2000, ambulatory surgery procedures that are not listed on TMA's ambulatory surgery web site, and are performed in either a freestanding ASC or hospital may be cost-shared. These procedures are reimbursed at the lesser of billed charges or network discount. On May 1, 2009 (implementation of OPSS), these non-ASC procedures are subject to [Chapter 13](#) discounting of surgical, bilateral and terminated procedures.

C. Reimbursement System On Or After May 1, 2009 (Implementation of OPSS).

1. For ambulatory surgery procedures performed in an OPSS qualified facility, the provisions in [Chapter 13](#) shall apply.

2. For ambulatory surgery procedures performed in freestanding ASCs and non-OPSS facilities, the provisions in [paragraph II.A.](#) shall apply, except as follows:

a. Contractors will no longer be allowed to group other procedures not listed on TMA's ambulatory surgery web site. On May 1, 2009 (implementation of OPSS), these groupers will be end dated. Only ambulatory surgery procedures listed on TMA's ambulatory surgery web site are to be grouped.

b. Multiple and Terminated Procedures. For services rendered on or after May 1, 2009 (implementation of OPSS), the professional services shall be reimbursed according to the multiple surgery guidelines in [Chapter 13, Section 3, paragraph III.A.5.b.](#) and [c.](#)

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c. Discounting for Multiple Surgical Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), discounting for multiple surgical procedures are subject to the provisions in [Chapter 13, Section 1](#).

d. Discounting for Bilateral Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), bilateral procedures will be discounted based on the application of discounting formulas appearing in [Chapter 13, Section 3, paragraph III.A.5.c.\(6\)](#) and [\(7\)](#).

D. CAHs. Effective December 1, 2009, ambulatory surgery services performed in CAHs shall be reimbursed under the reasonable cost method, reference [Chapter 15, Section 1](#).

E. Claims for Ambulatory Surgery.

1. Claims for facility charges must be submitted on a CMS 1450 UB-04. Claims for professional charges may be submitted on either a CMS 1450 UB-04 or a CMS 1500 (08/05) claim form. The preferred form is the CMS 1500 (08/05). When professional services are billed on a CMS 1450 UB-04, the information on the CMS 1450 UB-04 should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

2. Claim Data.

a. Billing Data. The claim must identify all procedures which were performed (by CPT-4 or HCPCS code). The facility claim shall be submitted on the CMS 1450 UB-04, the procedure code will be shown in Form Locator (FL) 44.

NOTE: Claims from ASCs must be submitted on the CMS 1450 UB-04 claim form. Claims not submitted on the appropriate claim form will be denied.

b. TRICARE Encounter Data (TED). All ambulatory surgery services are to be reported on the TED using the appropriate CPT-4 code. The only exception is services which are billed using a HCPCS code and for which no CPT-4 code exists.

F. Wage Index Changes. If, during the year, Medicare revises any of the wage indexes used for ambulatory surgery reimbursement, such changes will not be incorporated into the TRICARE payment rates until the next routine update. These changes will not be incorporated regardless of the reason Medicare revised the wage index.

G. Subsequent Hospital Admissions. If a beneficiary is admitted to a hospital subject to the DRG-based payment system as a result of complications, etc. of ambulatory surgery, the ambulatory surgery procedures are to be billed and reimbursed separately from the hospital inpatient services. The same rules applicable to emergency room services are to be followed.

H. Cost-Shares for Ambulatory Surgery Procedures. All surgical procedures performed in an outpatient setting shall be cost-shared at the ASC cost-sharing levels. Refer to [Chapter 2, Section 1, paragraph I.C.3.g](#).

- END -

patients (inpatients and outpatients), unless the services were furnished either directly or under arrangement with the hospital except for services of physician assistants, nurse practitioners and clinical nurse specialists. This facilitated the payment of services included within the scope of each Ambulatory Payment Classification (APC). The Act provided for the imposition of civil money penalties not to exceed \$2,000, and a possible exclusion from participation in Medicare, Medicaid and other Federal health care programs for any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service that violates the requirement for billing subject to the following exceptions:

1. Payment for clinical diagnostic lab may be made only to the person or entity that performed or supervised the performance of the test. In the case of a clinical diagnostic laboratory test that is provided under arrangement made by a hospital or Critical Access Hospital (CAH), payment is made to the hospital. The hospital is not responsible for billing for the diagnostic test if a hospital patient leaves the hospital and goes elsewhere to obtain the diagnostic test.

2. Skilled Nursing Facility (SNF) consolidated billing requirements do not apply to the following exceptionally intensive hospital outpatient services:

- a. Cardiac catheterization;
- b. Computerized Axial Tomography (CAT) scans;
- c. Magnetic Resonance Imagings (MRIs);
- d. Ambulatory surgery involving the use of an operating room;
- e. Emergency Room (ER) services;
- f. Radiation therapy;
- g. Angiography; and
- h. Lymphatic and venous procedures.

NOTE: The above procedures are subject to the bundling requirements while the beneficiary is temporarily absent from the SNF. The beneficiary is now considered to be a hospital outpatient and the services are subject to hospital outpatient bundling requirements.

D. Applicability and Scope of Coverage.

Following are the providers and services for which TRICARE will make payment under the OPSS.

1. Provider Categories.

a. Providers Included In OPSS:

(1) All hospitals participating in the Medicare program, except for those excluded under [paragraph III.D.1.b.](#)

(2) Hospital-based Partial Hospitalization Programs (PHPs) that are subject to the more restrictive TRICARE authorization requirements under [32 CFR 199.6\(b\)\(4\)\(xii\)](#). Following are the specific requirements for authorization and payment under the Program:

(a) Be certified pursuant to TRICARE certification standards.

(b) Be licensed and fully operational for a period of six months (with a minimum patient census of at least 30% of bed capacity) and operate in substantial compliance with state and federal regulations.

(c) Currently accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under the current edition of the **Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Development Disabilities Services**.

(d) Has a written participation agreement with TRICARE.

(3) Hospitals or distinct parts of hospitals that are excluded from the inpatient Diagnosis Related Groups (DRG) to the extent that the hospital or distinct part furnishes outpatient services.

NOTE: All hospital outpatient departments will be subject to the OPSS unless specifically excluded under this chapter. The marketing contractor will have responsibility for educating providers to bill under the OPSS even if they are not a Medicare participating/certified provider (i.e., not subject to the DRG inpatient reimbursement system).

(4) Small Rural and Sole Community Hospitals (SCHs) in Rural Areas

(a) Currently under Medicare, small rural and SCHs in rural areas are subject to Transitional Outpatient Payments (TOPs). These TOPs will expire on December 31, 2009.

(b) TRICARE will delay implementation of its OPSS for small rural hospitals with 100 or fewer beds and **rural** SCHs with 100 or fewer beds until January 1, 2010.

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b. Providers Excluded From OPPS:

(1) Outpatient services provided by hospitals of the Indian Health Service (IHS) will continue to be paid under separately established rates.

(2) Certain hospitals in Maryland that qualify for payment under the state's cost containment waiver.

(3) CAHs. The contractors shall monitor TMA's web site at <http://www.tricare.mil/hospitalclassification> for quarterly updates to the critical access hospital list and update their systems to reflect the most current information on the list. For additional information on CAHs, refer to [Chapter 15, Section 1](#).

(4) Hospitals located outside one of the 50 states, the District of Columbia, and Puerto Rico.

(5) Specialty care providers to include:

(a) Cancer and children's hospitals.

(b) Freestanding Ambulatory Surgery Centers (ASCs).

(c) Freestanding PHPs that offer psych and substance use treatments, and Substance Use Disorder Rehabilitation Facilities (SUDRFs).

(d) Comprehensive Outpatient Rehabilitation Facilities (CORFs).

(e) Home Health Agencies (HHAs).

(f) Hospice programs.

(g) Community Mental Health Centers (CMHCs).

NOTE: CMHC PHPs have been excluded from provider authorization and payment under the OPPS due to their inability to meet the more stringent certification criteria currently imposed for hospital-based and freestanding PHPs under the Program.

(h) Other corporate services providers (e.g., Freestanding Cardiac Catheterization, Sleep Disorder Diagnostic Centers, and Freestanding Hyperbaric Oxygen Treatment Centers).

NOTE: Antigens, splints, casts and hepatitis B vaccines furnished outside the patient's plan of care in CORFs, HHAs and hospice programs will continue to receive reimbursement under current TRICARE allowable charge methodology.

(i) Freestanding Birthing Centers.

(j) Veterans Affairs (VA) hospitals.

(k) Freestanding End Stage Renal Dialysis (ESRD) Facilities.

(l) SNFs.

(m) Residential Treatment Centers (RTCs).

2. Scope of Services.

o. Services excluded under the hospital OPPS and paid under the CHAMPUS Maximum Allowable Charge (CMAC) or other TRICARE recognized allowable charge methodology.

(1) Physician services.

(2) Nurse practitioner and clinical nurse specialist services.

(3) Physician assistant services.

(4) Certified nurse-midwife services.

(5) Services of qualified psychologists.

(6) Clinical social worker services.

(7) Services of an anesthetist.

(8) Screening and diagnostic mammographies.

(9) Influenza and pneumococcal pneumonia vaccines.

NOTE: Hospitals, HHAs, and hospices will continue to receive CMAC payments for influenza and pneumococcal pneumonia vaccines due to considerable fluctuations in their availability and cost.

(10) Clinical diagnostic laboratory services.

(11) Take home surgical dressings.

(12) Non-implantable DME, orthotics, prosthetics, and prosthetic devices and supplies (DMEPOS) paid under the DMEPOS fee schedule when the hospital is acting as a supplier of these items.

(a) An item such as crutches or a walker that is given to the patient to take home, but that may also be used while the patient is at the hospital, would be paid for under the hospital OPPS.

(b) Payment may not be made for items furnished by a supplier of medical equipment and supplies unless the supplier obtains a supplier number. However,

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since there is no reason to split a claim for DME payment under TRICARE, a separate supplier number will not be required for a hospital to receive reimbursement for DME.

(13) Hospital outpatient services furnished to SNF inpatients as part of his or her resident assessment or comprehensive care plan that are furnished by the hospital “under arrangements” but billable only by the SNF.

(14) Services and procedures designated as requiring inpatient care.

(15) Services excluded by statute (excluded from the definition of “covered Outpatient Department (OPD) Services”):

- (a) Ambulance services;
- (b) Physical therapy;
- (c) Occupational therapy;
- (d) Speech-language pathology.

NOTE: The above services are subject to the CMAC or other TRICARE recognized allowable charge methodology (e.g., statewide prevalings).

(16) Ambulatory surgery procedures performed in freestanding ASCs will continue to be reimbursed under the per diem system established in [Chapter 9, Section 1](#) of this manual.

b. Costs excluded under the hospital OPPS:

- (1) Direct cost of medical education activities.
- (2) Costs of approved nursing and allied health education programs.
- (3) Costs associated with interns and residents not in approved teaching programs.
- (4) Costs of teaching physicians.
- (5) Costs of anesthesia services furnished to hospital outpatients by qualified non-physician anesthetists (Certified Registered Nurse Anesthetists (CRNA) and Anesthesiologists’ Assistants (AAs)) employed by the hospital or obtained under arrangements, for hospitals.
- (6) Bad debts for uncollectible and coinsurance amounts.
- (7) Organ acquisition costs.
- (8) Corneal tissue acquisition costs incurred by hospitals that are paid on a reasonable cost basis.

c. Services included in payment under the OPPS (not an all-inclusive list).

(1) Hospital-based full- and half-day PHPs (psych and SUDRFs) which are paid a per diem OPPS. Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients who have profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

(2) All hospital outpatient services, except those that are identified as excluded. The following are services that are included in OPPS:

(a) Surgical procedures.

NOTE: Hospital-based ASC procedures will be included in the OPPS/ APC system even though they are currently paid under the ASC grouper system. The new OPPS/ APC system covers procedures on the ASC list when they are performed in a hospital outpatient department, hospital ER, or hospital-based ASC. ASC group payment will still apply when they are performed in freestanding ASCs.

NOTE: All hospital based ASC claims that are submitted to be paid under OPPS must be submitted with a Type Of Bill (TOB) 13X. If a claim is submitted to be paid with TOB 83X the claim will be denied.

(b) Radiology, including radiation therapy.

(c) Clinic visits.

(d) Emergency department visits.

(e) Diagnostic services and other diagnostic tests.

(f) Surgical pathology.

(g) Cancer chemotherapy.

(h) Implantable medical items.

1 Prosthetic implants (other than dental) that replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care and including replacement of these devices);

2 Implantable DME (e.g., pacemakers, defibrillators, drug pumps, and neurostimulators)

3 Implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

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4. The items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median cost for an item or service in the group is more than **two** times greater than the lowest median cost for an item or service within the same group. However, exceptions may be made to the **two** times rule “in unusual cases, such as low volume items and services.”

5. The prospective payment rate for each APC is calculated by multiplying the APC’s relative weight by the conversion factor.

6. A wage adjustment factor will be used to adjust the portion of the payment rate that is attributable to labor-related costs for relative differences in labor and non-labor-related costs across geographical regions.

7. Applicable deductible and/or cost-sharing/copayment amounts will be subtracted from the adjusted APC payment rate based on the eligibility status of the beneficiary at the time outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra, and Standard beneficiary categories). TRICARE will retain its current hospital outpatient deductibles, cost-sharing/copayment amounts and catastrophic loss protection under the OPPTS.

NOTE: The ASC cost-sharing provision (i.e., assessment of a single copayment for both the professional and facility charge for a Prime beneficiary) will be adopted as long as it is administratively feasible. This will not apply to Extra and Standard beneficiaries since their cost-sharing is based on a percentage of the total bill. The copayment is based on site of service, except for CPT¹/HCPCS 36400-36416, 36591, 36592, 59020, 59025, and 59050, for venipuncture and fetal monitoring. Reference [Chapter 2, Section 1, paragraph I.B.5.e.](#) and [g.](#)

G. Reimbursement Hierarchy For Procedures Paid Outside The OPPTS.

1. CMAC Facility Pricing Hierarchy (No Technical Component (TC) Modifier).

a. The following tables includes the list of rate columns on the CMAC file. The columns are number 1 through 8 by description. The pricing hierarchy for facility CMAC is 8, 6, then 2 (**global, clinical and laboratory pricing is loaded in Column 2**).

COLUMN	DESCRIPTION
1	Non-facility CMAC for physician/LLP class
2	Facility CMAC for physician/LLP class
3	Non-facility CMAC for non-physician class
4	Facility CMAC for non-physician class
5	Physician class Professional Component (PC) rate
6	Physician class Technical Component (TC) rate
7	Non-physician class PC rate

Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the physician class TC rate. Otherwise, pay Facility CMAC for physician/LLP class.

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COLUMN	DESCRIPTION
8	Non-physician class TC rate
Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the physician class TC rate. Otherwise, pay Facility CMAC for physician/LLP class.	

NOTE: Hospital-based therapy services, i.e., Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST), shall be reimbursed at the non-facility CMAC for physician/LLP class, i.e., [Column 1](#).

b. If there is no CMAC available, the contractor shall reimburse the procedure under DMEPOS.

2. DMEPOS. If there is no DMEPOS available, the contractor shall reimburse the procedure using state prevailings.

3. State Prevailing Rate. If there is no state prevailing rate available, the contractor shall reimburse the procedure based on billed charges.

H. Outpatient Code Editor (OCE).

1. The OCE with APC program edits patient data to help identify possible errors in coding and assigns APC numbers based on HCPCS codes for payment under the OPPTS. The OPPTS is an outpatient equivalent of the inpatient, DRG-based PPS. Like the inpatient system based on DRGs, each APC has a pre-established prospective payment amount associated with it. However, unlike the inpatient system that assigns a patient to a single DRG, multiple APCs can be assigned to one outpatient record. If a patient has multiple outpatient services during a single visit, the total payment for the visit is computed as the sum of the individual payments for each service. Updated versions of the OCE (MF cartridge) and data files CD, along with installation and user manuals, will be shipped from the developer to the contractors. The contractors will be required to replace the existing OCE with the updated OCE within 21 calendar days of receipt. See [Chapter 13, Addendum A1](#), for quarterly review/update process.

2. The OCE incorporates the National Correct Coding Initiatives (NCCI) edits used by the CMS to check for pairs of codes that should not be billed together for the same patient on the same day. Claims reimbursed under the OPPTS methodology are exempt from the claims auditing software referenced in [Chapter 1, Section 3](#).

3. Under certain circumstances (e.g., active duty claims), the contractor may override claims that are normally not payable.

4. CMS has agreed to the use of 900 series numbers (900-999) within the OCE for TRICARE specific edits.

NOTE: The questionable list of covered services may be different among the contractors. Providers will need to contact the contractor directly concerning these differences.

I. PRICER Program.

1. The APC PRICER will be straightforward in that the site-of-service wage index will be used to wage adjust the payment rate for the particular APC HCPCS Level I and II code (e.g., a HCPCS code with a designated Status Indicator (SI) of S, T, V, or X) reported off of the hospital outpatient claim. The PRICER will also apply discounting for multiple surgical procedures performed during a single operative session and outlier payments for extraordinarily expensive cases. TMA will provide the contractor's a common TRICARE PRICER to include quarterly updates. The contractors will be required to replace the existing PRICER with the updated PRICER within 21 days of receipt.

NOTE: Claims received with service dates on or after the OPSS quarterly effective dates (i.e., January 1, April 1, July 1 and October 1 of each calendar year) but prior to 21 days from receipt of either the OPSS OCE or PRICER update cartridge may be considered excluded claims as defined by the TOM, [Chapter 1, Section 3, paragraph 1.3.2](#).

2. The contractors shall provide 3M with those pricing files to maintain and update the TRICARE OPSS PRICER within five weeks prior to the quarterly update. For example, statewide prevalings for ambulance services and state specific non-professional component birthing center rates. Appropriate deductible, cost-sharing/copayment amounts and catastrophic caps limitations will be applied outside the PRICER based on the eligibility status of the TRICARE beneficiary at the time the outpatient services were rendered.

J. Geographical Wage Adjustments.

DRG wage indexes will be used for adjusting the OPSS standard payment amounts for labor market differences. Refer to the OPSS Provider File with Wage Indexes on TMA's OPSS home page at <http://www.tricare.mil/opss> for annual OPSS wage index updates. The annual DRG wage index updates will be effective January 1 of each year for the OPSS.

K. Provider-Based Status for Payment Under OPSS.

An outpatient department, remote location hospital, satellite facility, or provider-based entity must be either created or acquired by a main provider (hospital) for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial/administrative control of the main provider, in order to qualify for payment under the OPSS. The CMS will retain sole responsibility for determining provider-based status under the OPSS.

L. Implementing Instructions.

Since this issuance only deals with a general overview of the OPSS reimbursement methodology, the following cross reference is provided to facilitate access to specific implementing instructions within [Chapter 13, Section 1](#) through 5:

IMPLEMENTING INSTRUCTIONS/SERVICES	
POLICIES	
General Overview	Chapter 13, Section 1

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IMPLEMENTING INSTRUCTIONS/SERVICES	
Billing and Coding of Services under APC Groups	Chapter 13, Section 2
Reimbursement Methodology	Chapter 13, Section 3
Claims Submission and Processing Requirements	Chapter 13, Section 4
Medical Review And Allowable Charge Review Under The Hospital OPPS	Chapter 13, Section 5
ADDENDA	
Development Schedule for TRICARE OCE/APC - Quarterly Update	Chapter 13, Addendum A1
OPPS OCE Notification Process for Quarterly Updates	Chapter 13, Addendum A2
Approval Of OPPS - OCE/APC And NGPL Quarterly Update Process	Chapter 13, Addendum A3

M. OPPS Data Elements Available on TMA's web site.

The following data elements are available on TMA's OPPS web site at <http://www.tricare.mil/opps>.

1. APCs with SIs and Payment Rates.
2. Payment SI by HCPCS Code.
3. Payment SIs/Descriptions.
4. CPT Codes That Are Paid Only as Inpatient Procedures.
5. Statewide Cost-to-Charge Ratios (CCRs).
6. OPPS Provider File with Wage Indexes for Urban and Rural Areas, uses same wage indexes as TRICARE's DRG-based payment system, except effective date is January 1 of each year for OPPS.
7. Zip to Wage Index Crosswalk.

IV. EFFECTIVE DATE May 1, 2009.

- END -

CHAPTER 13
SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

ISSUE DATE: July 27, 2005

AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

I. APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

II. ISSUE

The billing and coding requirements for reimbursement under the hospital Outpatient Prospective Payment System (OPPS).

III. POLICY

A. To receive TRICARE Reimbursement under the OPPS providers must follow and contractors shall enforce all Medicare specific coding requirements.

NOTE: TMA will develop specific Ambulatory Payment Classifications (APCs) (those beginning with a "T") for those services that are unique to the TRICARE beneficiary population (e.g., maternity care). Reference TMA's OPPS web site at <http://www.tricare.mil/opps> for a listing of TRICARE APCs.

B. Packaging of Services Under APC Groups.

1. The prospective payment system establishes a national payment rate, standardized for geographic wage differences, that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. These costs include, but are not limited to:

- a. Use of an operating suite.
- b. Procedure room or treatment room.
- c. Use of the recovery room or area.
- d. Use of an observation bed.

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- e. Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations.
- f. Supplies and equipment for administering and monitoring anesthesia or sedation.
- g. Intraocular lenses (IOLs).
- h. Capital-related costs.
- i. Costs incurred to procure donor tissue other than corneal tissue.
- j. Incidental services.
- k. Implantable items used in connection with diagnostic X-ray testing, diagnostic laboratory tests, and other diagnostics.
- l. Implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices.

2. Costs associated with certain expensive procedures and services are not packaged within an APC payment rate. Instead, separate APC payment will be made for these particular items and services under the OPPS. Additional payments will be provided for certain packaged medical devices, drugs, and biologicals that are eligible for transitional pass-throughs (i.e., payments for expensive drugs or devices that are temporarily reimbursed in addition to the APC amount for the service or procedure to which they are normally associated), while strapping and casting will be paid under two new APC groupings (0058 and 0059).

a. Costs of drugs, biologicals and devices packaged into APCs to which they are normally associated.

The costs of drugs, biologicals and pharmaceuticals are generally packaged into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished. No separate payment is made under the OPPS for drugs, biologicals and pharmaceuticals whose costs are packaged into the APCs with which they are associated.

(1) For the drugs paid under the OPPS, hospitals can bill both for the drug and for the administration of the drug.

(2) The overhead cost is captured in the administration codes, along with the costs of all drugs that are not paid for separately.

(3) Each time a drug is billed with an administration code, the total payment thus includes the acquisition cost for the billed drug, the packaged cost of all other drugs and the overhead.

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(2) The Outpatient Code Editor (OCE) will include edits to ensure that certain procedure codes are accompanied by an associated device category code:

(a) These edits will be applied at the HCPCS I and II code levels rather than at the APC level.

(b) They will not apply when a procedure code is reported with a modifier 52, 73, or 74 to designate an incomplete procedure.

(c) Following are the device-dependent APCs for CY 2009:

FIGURE 13-2-1 CY 2009 DEVICE-DEPENDENT APCs

APC	SI	APC TITLE
0039	S	Level I Implantation of Neurostimulator
0040	S	Percutaneous Implantation of Neurostimulator Electrodes
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes
0082	T	Coronary or Non Coronary Atherectomy
0083	T	Coronary or Non Coronary Angioplasty and Percutaneous Valvuloplasty
0084	S	Level I Electrophysiologic Procedures
0085	T	Level II Electrophysiologic Procedures
0086	T	Level III Electrophysiologic Procedures
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes
0090	T	Insertion/Replacement of Pacemaker Pulse Generator
0104	T	Transcatheter Placement of Intracoronary Stents
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes
0107	T	Insertion of Cardioverter-Defibrillator
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads
0115	T	Cannula/Access Device Procedures
0168	T	Level II Urethral Procedures
0202	T	Level VII Female Reproductive Procedures
0222	S	Level II Implantation of Neurostimulator
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve
0227	T	Implantation of Drug Infusion Device
0229	T	Transcatheter Placement of Intravascular Shunts
0259	T	Level VII ENT Procedures
0293	T	Level V Anterior Segment Eye Procedures
0315	S	Level III Implantation of Neurostimulator
0384	T	GI Procedures with Stents
0385	S	Level I Prosthetic Urological Procedures
0386	S	Level II Prosthetic Urological Procedures
0418	T	Insertion of Left Ventricular Pacing Elect.
0425	T	Level II Arthroplasty or Implementation with Prosthesis
0427	T	Level II Tube or Catheter Changes or Repositioning

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FIGURE 13-2-1 CY 2009 DEVICE-DEPENDENT APCs

APC	SI	APC TITLE
0622	T	Level II Vascular Access Procedures
0623	T	Level III Vascular Access Procedures
0648	T	Level IV Breast Surgery
0652	T	Insertion of Intraperitoneal and Pleural Catheters
0653	T	Vascular Reconstruction/Fistula Repair with Device
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0674	T	Prostate Cryoblation
0680	S	Insertion of Patient Activated Event Recorders
0681	T	Knee Arthroplasty

f. Changes to Packaged Services for CY 2008 OPPS. Effective for services furnished on or after January 1, 2008, seven additional categories of HCPCS codes describing ancillary and supportive services have been packaged either conditionally or unconditionally, and four new composited APCs have been created.

(1) Each ancillary and supportive service HCPCS code has a Status Indicator (SI) of either **N** or **Q**.

(a) The payment for a HCPCS code with a SI of **N** is unconditionally packaged so that payment is always incorporated into the payments for the separately paid services with which it is reported.

(b) Payment for a HCPCS code with a SI of **Q** that is “STVX-packaged” is packaged unless the HCPCS code is not reported on the same day with a service that has a SI of **S**, **T**, **V**, or **X**, in which case it would be paid separately.

(c) Payment for a HCPCS code with a SI of “T packaged” is packaged unless the HCPCS code is not reported on the same day with a service that has a SI of **T**, in which case it would be paid separately.

(d) Payment for a HCPCS code with a SI of **Q** that is assigned to a composite APC is packaged into the payment for the composite APC when the criteria for payment of the composite APC are met.

(2) Categories of ancillary and supportive services for which the packaging status is changed for CY 2008 are as follows:

- (a) Guidance services.
- (b) Imaging processing services.
- (c) Intraoperative services.

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claim with the same date of service. The five CPT² codes involved in this composite APC are assigned to SI Q3 to identify their conditionally packaged status.

FIGURE 13-2-2 GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES UPON WHICH THE COMPOSITE APC 8000 IS BASED

CODES USED IN COMBINATION: AT LEAST ONE IN GROUP A AND ONE IN GROUP B	CY 2009		
	HCPCS CODE	FINAL SINGLE CODE APC	FINAL SI (COMPOSITE)
GROUP A			
Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording. His bundle recording including insertion and repositioning of multiple electrode catheters without induction or attempted induction of arrhythmia	93619	0085	Q3
Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	93620	0085	Q3
GROUP B			
Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	93650	0086	Q3
Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination	93651	0086	Q3
Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia	93652	0086	Q3

b The OCE will recognize when the criteria for payment of the composite APC are met and will assign the composite APC instead of the single procedure APCs as currently occurs. The Pricer will make a single payment for the composite APC that will encompass the program payment for the code in Group A and code in Group B, and any other codes reported in Groups A or B, as well as the packaged services furnished on the same date of services.

c The composite APC would have a SI of T so that payment for other procedures also assigned to SI T with lower payment rates would be reduced by 50% when furnished on the same date of service as the composite services.

d Separate payment will continue for other separately paid services that are not reported under the codes in Groups A and B (such as chest x-rays and electrocardiograms).

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Ⓔ Also where a service in Group A is furnished on a date of service that is different from the date of service for a code in Group B for the same beneficiary, payments would be made under the single procedure APCs and the composite APC would not apply.

3 Multiple Imaging Composite APCs (8004, 8005, 8006, 8007, and 8008)

Ⓕ Under current OPSS policy, hospitals receive a full APC payment for each imaging service on a claim, regardless of how many procedures are performed during a single session using the same imaging modality or whether the procedures are performed on contiguous body areas.

Ⓖ In CY 2009 will now utilize the three OPSS imaging families with contrast and without contrast in creation of five multiple imaging composite APCs:

8004 (Ultrasound Composite)

8005 (CT and CTA without Contrast Composite)

8006 (CT and CTA with Contrast Composite)

8007 (MRI and MRA without Contrast Composite)

8008 (MRI an MRA with Contrast Composite)

Ⓖ The composite APCs have SIs of S signifying that payment for the APC is not reduced when it appears on the same claim with other significant procedures.

Ⓖ One composite APC payment will be provided each time a hospital bills more than one procedure described by the HCPCS codes in an OPSS imaging family displayed in [Figure 13-2-3](#), on a single date of services.

Ⓔ If the hospital performs a procedure without contrast during the same session as a least one other procedure with contrast using the same imaging modality, then the hospital will receive payment for the “with contrast” composite APC.

Ⓕ A single imaging procedure, or imaging procedures reported with HCPCS codes assigned to different OPSS imaging families, will be paid according to the standard OPSS methodology through the standard (sole service) imaging APCs to which they are assigned in CY 2009.

Ⓖ Hospitals will continue to use the same HCPCS codes to report imaging procedures, and the OCE will determine when combinations of imaging procedures qualify for composite APC payment or map to standard APCs for payment.

Ⓕ Single payment will be made for those imaging procedures that qualify for composite APC payment, as well as any packaged services furnished on the same date of service.

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FIGURE 13-2-3 OPPTS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCs - FINAL CY 2009

FAMILY 1 - ULTRASOUND (US)	
APC 8004 (COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$188
76604	US exam, chest.
76700	US exam, abdom, complete
76705	Echo exam of abdomen.
76770	US exam abdo back wall, comp.
76775	US exam abdo back wall, lim.
76776	US exam k transpl w/Doppler
76831	Echo exam, uterus.
76856	US exam, pelvic, complete.
76857	US exam, pelvic
76870	US exam, scrotum.
FAMILY 2 – CT AND CTA WITH AND WITHOUT CONTRAST	
APC 8005 (WITHOUT CONTRAST COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$406
0067T	CT colonography; dex
70450	CT head/brain w/o dye.
70480	CT orbit/ear/fossa w/o dye.
70486	CT maxillofacial w/o dye.
70490	CT soft tissue neck w/o dye.
71250	CT thorax w/o dye.
72125	CT neck spine w/o dye.
72128	CT chest spine w/o dye.
72131	CT lumbar spine w/o dye.
72192	CT pelvis w/o dye.
73200	CT upper extremity w/o dye.
73700	CT lower extremity w/o dye.
74150	CT abdomen w/o dye
APC 8006 (WITH CONTRAST COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$621
70487	CT maxillofacial w/dye.
70460	CT head/brain w/dye.
70470	CT head/brain w/o & w/dye.
70481	CT orbit/ear/fossa w/dye.
70482	CT orbit/ear/fossa w/o & w/dye.
70488	CT maxillofacial w/o & w/dye.
70491	CT soft tissue neck w/dye.
70492	CT sft tsue nck w/o & w/dye.
70496	CT angiography, head.
70498	CT angiography, neck.

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FIGURE 13-2-3 OPPTS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCs - FINAL CY 2009 (CONTINUED)

71260	CT thorax w/dye.
71270	CT thorax w/o & w/dye.
71275	CT angiography, chest.
72126	CT neck spine w/dye.
72127	CT neck spine w/o & w/dye.
72129	CT chest spine w/dye.
72130	CT chest spine w/o & w/dye.
72132	CT lumbar spine w/dye.
72133	CT lumbar spine w/o & w/dye.
72191	CT angiograph pelv w/o & w/dye.
72193	CT pelvis w/dye.
72194	CT pelvis w/o & w/dye.
73201	CT upper extremity w/dye.
73202	CT upper extremity w/o & w/dye.
73206	CT angio up extrm w/o & w/dye.
73701	CT lower extremity w/dye.
73702	CT lwr extremity w/o & w/dye.
73706	CT angio lwr extr w/o & w/dye.
74160	CT abdomen w/dye.
74170	CT abdomen w/o & w/dye.
74175	CT angio abdomen w/o & w/dye.
75635	CT angio abdominal arteries.
FAMILY 3 – MRI AND MRA WITH AND WITHOUT CONTRAST	
APC 8007 (WITHOUT CONTRAST COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$695
70336	Magnetic image, jaw joint.
70540	MRI orbit/face/neck w/o dye.
70544	MR angiography head w/o dye.
70547	MR angiography neck w/o dye.
70551	MRI brain w/o dye.
70554	FMRI brain by tech.
71550	MRI chest w/o dye.
72141	MRI neck spine w/o dye.
72146	MRI chest spine w/o dye.
72148	MRI Lumbar spine w/o dye.
72195	MRI Pelvis w/o dye.
73218	MRI Upper extremity w/o dye.
73221	MRI joint up extremity w/o dye.
73718	MRI lower extremity w/o dye.
73721	MRI jnt of lwr extre w/0 dye.

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FIGURE 13-2-3 OPPTS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCs - FINAL CY 2009 (CONTINUED)

74181	MRI abdomen w/o dye.
75557	Cardiac mri for morph.
75599	Cardiac mri w/stress img.
C8901	MRA w/o cont. abd.
C8904	MRI w/o cont. breast, uni.
C8907	MRI w/o cont. breast, bi.
C8910	MRA w/o cont. chest
C8913	MRA w/o cont. lwr ext.
C8919	MRA w/o cont. pelvis.
APC 8008 (WITH CONTRAST COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$968
70549	Mr angiograph neck w/o & w/dye.
70542	MRI orbit/face/neck w/dye.
70543	MRI orbit/fac/nck w/o & w/dye.
70545	MR angiography head w/dye.
70546	MR angiograph head w/o & w/dye.
70548	MR angiography neck w/dye.
70552	MRI brain w/dye.
70553	MRI brain w/o & w/dye.
71551	MRI chest w/dye.
71552	MRI chest w/o & w/dye.
72142	MRI neck spine w/dye.
72147	MRI chest spine w/dye.
72149	MRI lumbar spine w/dye.
72156	MRI neck spine w/o & w/dye.
72157	MRI chest spine w/o & w/dye.
72158	MRI lumbar spine w/o & w/dye.
72196	MRI pelvis w/dye.
72197	MRI pelvis w/o & w/dye.
73219	MRI upper extremity w/dye.
73220	MRI upper extremity w/o & w/dye.
73222	MRI joint upr extreme w/dye.
73223	MRI joint upr extr w/o & w/dye.
73719	MRI lower extremity w/dye.
73720	MRI lwr extremity w/o & w/dye.
73722	MRI joint of lwr extr w/dye.
73723	MRI joint lwr extr w/o & w/dye.
74182	MRI abdomen w/dye.
74183	MRI abdomen w/o & w/dye.
75561	Cardiac mri for morph w/dye.

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FIGURE 13-2-3 OPPTS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCs - FINAL CY 2009 (CONTINUED)

75563	Cardiac mri w/stress img & dye.
C8900	MRA w/cont, abd.
C8902	MRA w/o fol w/cont, abd.
C8903	MRI w/cont, breast, uni.
C8905	MRI w/o fol w/cont, brst, un.
C8906	MRI w/cont, breast, bi.
C8908	MRI w/o fol w/cont, breast.
C8909	MRA w/cont, chest.
C8911	MRA w/o fol w/cont, chest.
C8912	MRA w/cont, lwr ext.
C8914	MRA w/o fol w/cont, lwr ext.
C8918	MRA w/cont, pelvis.
C8920	MRA w/o fol w/cont, pelvis

(b) The TRICARE OCE logic will determine the assignment of the composite APCs for payment.

(c) [Figure 13-2-4](#) provides the circumstances, effective January 1, 2008, under which a single composite APC payment will be made for multiple services that meet the criteria for payment through a composite APC. Where the criteria are not met, payment will occur under the usual associated non-composite APC to which the code is assigned.

FIGURE 13-2-4 COMPOSITE APCs AND CRITERIA FOR COMPOSITE PAYMENT

COMPOSITE APC	COMPOSITE APC TITLE	CRITERIA FOR COMPOSITE PAYMENT
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT* code 93619 or 93620 and at least one unit of CPT* code 93650, 93651, or 93652 on the same date of service.
8001	Low Dose Rate Prostate Brachytherapy Composite	One or more units of CPT* codes 55875 and 77778 on the same date of service.
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed— <ul style="list-style-type: none"> • On the same day as HCPCS code G0379; or • On the same day or the day after CPT* codes 99205 or 99215 and; 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed— <ul style="list-style-type: none"> • On the same date of service as HCPCS code G0378; or • On the date of service after CPT* 99284, 99285, or 99291 and; 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378.

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FIGURE 13-2-4 COMPOSITE APCs AND CRITERIA FOR COMPOSITE PAYMENT

COMPOSITE APC	COMPOSITE APC TITLE	CRITERIA FOR COMPOSITE PAYMENT
0034	Mental Health Services Composite	Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0173.
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C. Additional Payments Under The OPSS.

1. Clinical diagnostic testing (labwork).
2. Administration of infused drugs.
3. Therapeutic procedures including resuscitation that are furnished during the course of an emergency visit.
4. Certain high-cost drugs, such as the expensive “clotbuster” drugs that must be given within a short period of time following a heart attack or stroke.
5. Cases that fall far outside the normal range of costs. These cases will be eligible for an outlier adjustment.

D. Payment For Patients Who Die In The ED.

1. If the patient dies in the ED, and the patient’s status is outpatient, the hospital should bill for payment under the OPSS for the services furnished.
 2. If the ED or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient.
 - a. If the patient had been admitted as an inpatient, pay under the hospital DRG-based payment system.
 - b. If the patient was not admitted as an inpatient, pay under the OPSS (an APC-based payment) for the services that were furnished.
 - c. If the patient was not admitted as an inpatient and the procedure designated as an inpatient-only procedure (by OPSS payment SI of C) is performed, the hospital should bill for payment under the OPSS for the services that were furnished on that date and should include modifier -CA on the line with the HCPCS code for the inpatient procedure. Payment for all services other than the inpatient procedure designated under OPSS by the SI of C, furnished on the same date, is bundled into a single payment under APC 0375.
3. Billing and Payment Rules for Using New Modifier -CA. Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission.

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a. All the following conditions must be met in order to receive payment for services billed with modifier -CA:

- (1) The status of the patient is outpatient;
- (2) The patient has an emergent, life-threatening condition;
- (3) A procedure on the inpatient list (designated by payment SI of C) is performed on an emergency basis to resuscitate or stabilize the patient; and
- (4) The patient dies without being admitted as an inpatient.

b. If all of the conditions for payment are met, the claim should be submitted using a 013X bill type for all services that were furnished, including the inpatient procedure (e.g., a procedure designated by OPPS payment SI of C). The hospital should include modifier -CA on the line with the HCPCS code for the inpatient procedure.

NOTE: When a line with a procedure code that has a SI of C assigned and has a patient status of "20" (deceased) and one of the modifiers is "CA" (patient dies). The OCE software will change the SI of the procedure to S and price the line using the adjusted APC rate formula.

c. Payment for all services on a claim that have the same date of service as the HCPCS billed with modifier -CA is made under APC 0375. Separate payment is not allowed for other services furnished on the same date.

E. Medical Screening Examinations.

1. Appropriate ED codes will be used for medical screening examinations including ancillary services routinely available to the ED in determining whether or not an emergency condition exists.

2. If no treatment is furnished, medical screening examinations would be billed with a low-level ED code.

F. HCPCS/Revenue Coding Required Under OPPS. Hospital outpatient departments should use the CMS 1450 UB-04 Editor as a guide for reporting HCPCS and revenue codes under the OPPS.

G. Treatment of Partial Hospitalization Services. Effective on May 1, 2009 (implementation of OPPS), hospital-based Partial Hospitalization Programs (PHPs) (psych and Substance Use Disorder Rehabilitation Facilities (SUDRFs)) will be reimbursed a national per diem APC payment under the OPPS. Freestanding PHPs (psych and SUDRFs) will continue to be reimbursed under the existing PHP per diem payment. Effective November 30, 2009, separate TRICARE certification of hospital-based psychiatric PHPs shall no longer be required, making all hospital-based PHPs eligible for payment under TRICARE's OPPS.

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1. The National Quality Monitoring Contractor (NQMC) shall include in their authorized provider reports to the contractors additional data elements indicating whether the facility is a freestanding PHP (psych or SUDRF) or a hospital-based PHP (psych). The contractors shall identify hospital-based PHPs (SUDRFs) that are subject to the per diem payment under the OPPTS.

2. Services of physicians, clinical psychologists, Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs), and Physician Assistants (PAs) furnished to partial hospitalization patients will continue to be billed separately as professional services and are not considered to be partial hospitalization services.

3. Payment for PHP (psych) services represents the provider's overhead costs, support staff, and the services of Clinical Social Workers (CSWs) and Occupational Therapists (OTs), whose professional services are considered to be included in the PHP per diem rate. For SUDRFs, the costs of alcohol and addiction counselor services would also be included in the per diem.

a. Hospitals will not bill the contractor for the professional services furnished by CSWs, OTs, and alcohol and addiction counselors.

b. Rather, the hospital's costs associated with the services of CSWs, OTs, and alcohol and addiction counselors will continue to be billed to the contractor and paid through the PHP per diem rate.

4. PHP should be a highly structured and clinically-intensive program, usually lasting most of the day. Since a day of care is the unit that defines the structure and scheduling of partial hospitalization services, a two-tiered payment approach has been retained, one for days with three services (APC 0172) and one for days with four or more services (APC 0173) to provide PHPs scheduling flexibility and to reflect the lower costs of a less intensive day.

a. However, it was never the intention of this two-tiered per diem system that only three units of service should represent the number of services provided in a typical day. The intention of the two-tiered system was to cover days that consisted of three units of service only in certain limited circumstances; e.g., three-service days may be appropriated when a patient is transitioning towards discharge or days when a patient who is transitioning at the beginning of his or her PHP stay.

b. Programs that provide four or more units of service should be paid an amount that recognizes that they have provided a more intensive day of care. A higher rate for more intensive days is consistent with the goal that hospitals provide a highly structured and clinically-intensive program.

c. The OCE logic will require that hospital-based PHPs provide a minimum of three units of service per day in order to receive PHP payment. For CY 2009, payment will be denied for days when fewer than three units of therapeutic services are provided. The three units of service are a minimum threshold that permits unforeseen circumstances, such as medical appointments, while allowing payment, but still maintains the integrity of a comprehensive program.

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d. The following are billing instructions for submission of partial hospitalization claims/services:

(1) Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services. This means that each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of services are reported in Form Locator (FL) 45 "Services Date" (MMDDYY) of the CMS 1450 UB-04.

(2) The following is a complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services or other mental health services outside partial hospitalization:

FIGURE 13-2-5 REVENUE AND HCPCS LEVEL I AND II CODES USED IN BILLING FOR PARTIAL HOSPITALIZATION SERVICES AND OTHER MENTAL HEALTH SERVICES OUTSIDE PARTIAL HOSPITALIZATION FOR CY 2009¹

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I ⁵ AND II CODES
0250	Pharmacy	HCPCS code not required.
043X	Occupational Therapy	G0129 ²
0900	Behavioral Health Treatment/Services	90801 or 90802
0904	Activity Therapy (Partial Hospitalization)	G0176 ³
0911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90874, 90877 - 90879, and 90899
0914	Individual Psychotherapy	90816- 90819, 90821- 90824, 90826-90829, 90845, or 90865
0915	Group Therapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	Education Training	G0177 ⁴

¹ The contractor will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The contractor will not edit for matching the revenue code to HCPCS.

² The definition of code G0129 is as follows:
Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

³ The definition of code G0176 is as follows:
Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).

⁴ The definition of code G0177 is as follows:
Training and educational services related to the care and treatment of patient's disabling mental problems, per session (45 minutes or more).

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NOTE: Codes G0129 and G0176, are used only for PHPs. Code G0177 may be used in both PHPs and outpatient mental health setting. Revenue code 250 does not require HCPCS.

(3) To bill for partial hospitalization services under the hospital OPSS, hospitals are to use the above HCPCS and revenue codes and are to report partial

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hospitalization services under bill type 013X, along with condition code 41 on the CMS 1450 UB-04 claim form.

(4) The claim must include a mental health diagnosis and an authorization on file for each day of service. Since there is no HCPCS code that specifies a partial hospitalization related service, partial hospitalizations are identified by means of a particular bill type and condition code (i.e., 13X TOB with Condition Code 41) along with HCPCS codes specifying the individual services that constitute PHPs. In order to be assigned payment under Level II Partial Hospitalization Payment APC (0173) there must be four or more codes from PHP List B of which at least one code must come from PHP List A. In order to be assigned payment under Level I Partial Hospitalization Payment APC (0172) there must be at least three codes from PHP List B of which at least one code must come from PHP List A. List A is a subset of List B and contains only psychotherapy codes, while List B includes all PHP codes. (Refer to PHP Lists A and B in [Figure 13-2-6](#)). All other PHP services rendered on the same day will be packaged into the PHP APCs (0172 and 0173). All PHP lines will be denied if there are less than three codes/service appearing on the claim.

FIGURE 13-2-6 PHP FOR CY 2008

PHP LIST A	PHP LIST B	
90818	90801	90846
90819	90802	90847
90821	90816	90865
90822	90817	96101
90826	90818	96102
90827	90819	96103
90828	90821	96116
90829	90822	96118
90845	90823	96119
90846	90824	96120
90847	90826	G0129
90865	90827	G0176
G0410	90828	G0177
G0411	90829	G0410
	90845	G0411

(5) In order to assign the partial hospitalization APC to one of the line items (i.e., one of listed services/codes in [Figure 13-2-5](#)) the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC. All other partial hospital services on the same day are packaged; (i.e., the SI is changed from **Q** to **N**.) Partial hospitalization services with SI **E** (items or services that are not covered by TRICARE) or **B** (more appropriate code required for TRICARE OPPTS) are not packaged and are ignored in the PHP processing.

(6) Each day of service will be assigned to a partial hospitalization APC, and the partial hospitalization per diem will be paid. Only one PHP APC will be paid per day.

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(7) Non-mental health services submitted on the same day will be processed and paid separately.

(8) Hospitals must report the number of times the service or procedure was rendered, as defined by the HCPCS code.

(9) Dates of service per revenue code line for partial hospitalization claims that span two or more dates. Each service (revenue code) provided must be repeated as a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date." Following are examples of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

FIGURE 13-2-7 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - HIPAA 837 FORMAT

RECORD TYPE	REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGE
61	0915	90849	19980505	1	\$80
61	0915	90849	19980529	2	\$160

FIGURE 13-2-8 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - CMS 1450 FORMAT

REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGES
0915	90849	050598	1	\$80
0915	90849	052998	2	\$160

NOTE: Each line item on the CMS 1450 UB-04 claim form must be submitted with a specific date of service to avoid claim denial. The header dates of service on the CMS 1450 UB-04 may span, as long as all lines include specific dates of service within the span on the header.

5. Reimbursement for a day of outpatient mental health services in a non-PHP program (i.e., those mental health services that are not accompanied with a condition code 41) will be capped at the partial hospital per diem rate. The payments for all of the designated Mental Health (MH) services will be totaled with the same date of service. If the sum of the payments for the individual MH services standard APC rules, for which there is an authorization on file, exceeds the Level II Partial Hospitalization APC (0173), a special MH services composite payment APC (APC 0034) will be assigned to one of the line items that represent MH services. All other MH services will be packaged. The MH services composite payment APC amount is the same as the Level II Partial Hospitalization APC per diem rate. MH services with SI E or B are not included in payments that are totaled and are not assigned the daily mental health composited APC amount.

6. Freestanding psychiatric partial hospitalization services will continue to be reimbursed under all-inclusive per diem rates established under [Chapter 7, Section 2](#).

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H. Payment Policy For Observation Services.

1. Observations For Non-Maternity Conditions.

a. Effective for dates of service on or after January 1, 2008, no separate payment will be made for observation services reported with HCPCS code G0378. Instead these hourly observation services will be assigned the SI of N, signifying that payment is always packaged.

b. However, in certain circumstances when observation care is provided as an integral part of a patient's extended encounter of care, payment may be made for the entire care encounter through one of two composite APC when certain criteria are met.

(1) APC 8002 (Level I Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration (eight or more hours).

(2) APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration.

(3) There is no limitation on diagnosis for payment of these composite APCs; however, composite payment will not be made when observation services are reported in association with a surgical procedure (SI of T) or the hours of observation care reported are less than eight. Refer to [Figure 13-2-9](#) for specific criteria for composite payment:

FIGURE 13-2-9 CRITERIA FOR PAYMENT OF EXTENDED ASSESSMENT AND MANAGEMENT COMPOSITE APCs

COMPOSITE APC	COMPOSITE APC TITLE	CRITERIA FOR COMPOSITE PAYMENT
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed— <ul style="list-style-type: none"> • On the same day as HCPCS code G0379; or • On the same day or the day after CPT* codes 99205 or 99215; and 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378.
8003	Level II Extended Assessment and Management Composite	1) 8 or more units of HCPCS code G0378 are billed on the same date of service or the date of service after CPT* codes 99284, 99285, or 99291; and 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378.

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(4) The beneficiary must also be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician. The medical

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record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

c. The OCE will evaluate every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the OCE, in conjunction with the TRICARE OPSS Pricer, will determine the appropriate SI, APC, and payment for every code on the claim.

d. Direct Admission to Observation Care Using G0379.

(1) Hospitals should report G0379 when observation services are the result of a direct admission to observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or surgical procedure (T SI procedure) on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community.

(2) Payment for direct admission to observation will be made either:

(a) Separately as low level hospital clinic visit under APC 604

(b) Packaged into payment for composite APC 8002 (Level I Prolonged Assessment and Management Composite), or

(c) Packaged into payment for other separately payable services provided in the same encounter.

(3) Criteria for payment of HCPCS code G0379 under either APC 8002 or APC 0604 include:

(a) Both HCPCS codes G0378 (Hospital observation services, per hour) and G0379 (Direct admission of patient for hospital observation care) are reported with the same date of service.

(b) A service with a SI of T or V or Critical Care (APC 0617) is not provided on the same date of service as HCPCS code G0379.

(c) If either of the above criteria (i.e., [paragraph III.H.1.d.\(3\)\(a\)](#) or [\(b\)](#)) is not met, HCPCS code G0379 will be assigned a SI of N and will be packaged into payment for other separately payable services provided in the same encounter.

(d) The composite APC will apply, regardless of the patient's particular clinical condition, if the hours of observation services (HCPCS code G0378) are greater or equal to eight and billed on the same date as HCPCS code G0379 and there is not a T SI procedure on the same date or day before the date of HCPCS code G0378.

(e) If the composite is not applicable, payment for HCPCS code G0379 may be made under APC 0604. In general, this would occur when the units of observation

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reported under HCPCS code G0378 are less than eight and no services with a SI of T or V or Critical Care (APC 0617) were provided on the same day of service as HCPCS code G0379.

2. Observations For Maternity Conditions.

a. Maternity observation stays will continue to be paid separately under TRICARE APC T0002 using HCPCS code G0378 (Hospital observation services by hour) if the following criteria are met:

(1) The maternity observation claim must have a maternity diagnosis as Principal Diagnosis (PDX) or Reason Visit Diagnosis (VRDX). Refer to [Figure 13-2-10](#) for listing of maternity diagnoses.

(2) The number of units reported with HCPCS code G0378 must be at a minimum four hours per observation stay; and

(3) No procedure with a SI of T can be reported on the same day or day before observation care is provided.

b. If the above criteria are not met, the maternity observation will remain bundled (i.e., the SI for code G0378 will remain N).

c. Multiple maternity observations on a claim are paid separately if the required criteria are met for each observation and condition code "G0" is present on the claim or modifier 27 is present on additional lines with G0378.

d. If multiple payable maternity observations are submitted without condition code "G0" or modifier 27, the first encountered is paid and additional observations for the same day are denied.

FIGURE 13-2-10 REQUIRED DIAGNOSES FOR MATERNITY

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care:		
0 unspecified as to episode of care or not applicable		
1 delivered, with or without mention of antepartum condition		
2 delivered, with mention of postpartum complication		
3 antepartum condition or complication		
4 postpartum condition or complication		
V22	Normal pregnancy	
V22.0	Supervision of normal first pregnancy	
V22.1	Supervision of other normal pregnancy	
V22.2	Pregnant state, incidental	
V23	Supervision of high-risk pregnancy	
V23.0	Pregnancy with history of infertility	
V23.1	Pregnancy with history of trophoblastic disease	
V23.2	Pregnancy with history of abortion	
V23.3	Grand multiparity	

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FIGURE 13-2-10 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication		
V23.4	Pregnancy with other poor obstetric history	
V23.41	Pregnancy with history of pre-term labor	
V23.49	Pregnancy with other poor obstetric history	
V23.5	Pregnancy with other poor reproductive history	
V23.7	Insufficient prenatal care	
V23.81	Elderly primigravida	
V23.82	Elderly multigravida	
V23.83	Young primigravida	
V23.84	Young multigravida	
V23.89	Other high-risk pregnancy	
V23.9	Unspecified high-risk pregnancy	
630	Hydatidiform mole	
631	Other abnormal product of conception	
632	Missed abortion	
633.00	Abdominal pregnancy without intrauterine pregnancy	
633.01	Abdominal pregnancy with intrauterine pregnancy	
633.10	Tubal pregnancy without intrauterine pregnancy	
633.11	Tubal pregnancy with intrauterine pregnancy	
633.20	Ovarian pregnancy without intrauterine pregnancy	
633.21	Ovarian pregnancy with intrauterine pregnancy	
633.80	Other ectopic pregnancy without intrauterine pregnancy	
633.81	Other ectopic pregnancy with intrauterine pregnancy	
633.90	Unspecified ectopic pregnancy without intrauterine pregnancy	
633.91	Unspecified ectopic pregnancy with intrauterine pregnancy	
640.0	Threatened abortion	0, 3
640.8	Other specified hemorrhage in early pregnancy	0, 3
640.9	Unspecified hemorrhage in early pregnancy	0, 3
641.0	Placenta previa without hemorrhage	0, 3
641.1	Hemorrhage from placenta previa	0, 3
641.2	Premature separation of placenta	0, 3
641.3	Antepartum hemorrhage associated with coagulation defects	0, 3
641.8	Other antepartum hemorrhage	0, 3
641.9	Unspecified antepartum hemorrhage	0, 3
642.0	Benign essential hypertension complicating pregnancy, childbirth and the puerperium	0, 3

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FIGURE 13-2-10 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
<p>Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication</p>		
642.1	Hypertension secondary to renal disease, complicating pregnancy, childbirth and the puerperium	0, 3
642.2	Other pre-existing hypertension complicating pregnancy, childbirth and the puerperium	0, 3
642.3	Transient hypertension of pregnancy	0, 3
642.4	Mild or unspecified pre-eclampsia	0, 3
642.5	Severe pre-eclampsia	0, 3
642.6	Eclampsia	0, 3
642.7	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension	0, 3
642.9	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium	0, 3
643.0	Mild hyperemesis gravidarum	0, 3
643.1	Hyperemesis gravidarum with metabolic disturbance	0, 3
643.2	Late vomiting of pregnancy	0, 3
643.8	Other vomiting complicating pregnancy	0, 3
643.9	Unspecified vomiting of pregnancy	0, 3
644.0	Threatened premature labor	0, 3
644.1	Other threatened labor	0, 3
644.2	Early onset of delivery	0, 3
645.1	Post term pregnancy	0, 3
645.2	Prolonged pregnancy	0, 3
646.0	Papyraceous fetus	0, 3
646.1	Edema or excessive weight gain in pregnancy, without mention of hypertension	0, 3
646.2	Unspecified renal disease in pregnancy, without mention of hypertension	0, 3
646.3	Habitual aborter	0, 3
646.4	Peripheral neuritis in pregnancy	0, 3
646.5	Asymptomatic bacteriuria in pregnancy	0, 3
646.6	Infections of genitourinary tract in pregnancy	0, 3
646.7	Liver disorders in pregnancy	0, 3
646.8	Other specified complications of pregnancy	0, 3
646.9	Unspecified complication of pregnancy	0, 3
647.0	Syphilis	0, 3
647.1	Gonorrhea	0, 3
647.2	Other venereal diseases	0, 3
647.3	Tuberculosis	0, 3
647.4	Malaria	0, 3
647.5	Rubella	0, 3

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FIGURE 13-2-10 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication		
647.6	Other viral diseases	0, 3
647.8	Other specified infectious and parasitic diseases	0, 3
647.9	Unspecified infection or infestation	0, 3
648.0	Diabetes mellitus	0, 3
648.1	Thyroid dysfunction	0, 3
648.2	Anemia	0, 3
648.3	Drug dependence	0, 3
648.4	Mental disorders	0, 3
648.5	Congenital cardiovascular disorders	0, 3
648.6	Other cardiovascular diseases	0, 3
648.7	Bone and joint disorders of back, pelvis, and lower limbs	0, 3
648.8	Abnormal glucose tolerance	0, 3
648.9	Other current conditions classifiable elsewhere	0, 3
649.0	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium	0, 3
649.1	Obesity complicating pregnancy, childbirth, or the puerperium	0, 3
649.2	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium	0, 3
649.3	Coagulation defects complicating pregnancy, childbirth, or the puerperium	0, 3
649.4	Epilepsy complicating pregnancy, childbirth, or the puerperium	0, 3
649.5	Spotting complicating pregnancy	0, 3
649.6	Uterine size date discrepancy	0, 3
650	Normal delivery	
651.0	Twin pregnancy	0, 3
651.1	Triplet pregnancy	0, 3
651.2	Quadruplet pregnancy	0, 3
651.3	Twin pregnancy with fetal loss and retention of one fetus	0, 3
651.4	Triplet pregnancy with fetal loss and retention of one or more fetus(es)	0, 3
651.5	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es)	0, 3
651.6	Other multiple pregnancy with fetal loss and retention of one or more fetus(es)	0, 3
651.7	Multiple gestation following elective fetal reduction	0, 3
651.8	Other specified multiple gestation	0, 3
651.9	Unspecified multiple gestation	0, 3
655.0	Central nervous system malformation in fetus	0, 3
655.1	Chromosomal abnormality in fetus	0, 3
655.2	Hereditary disease in family possibly affecting fetus	0, 3
655.3	Suspected damage to fetus from viral disease in the mother	0, 3

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FIGURE 13-2-10 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
<p>Fifth digit subclassification denotes the current episode of care: 0 unspecified as to episode of care or not applicable 1 delivered, with or without mention of antepartum condition 2 delivered, with mention of postpartum complication 3 antepartum condition or complication 4 postpartum condition or complication</p>		
655.4	Suspected damage to fetus from other disease in the mother	0, 3
655.5	Suspected damage to fetus from drugs	0, 3
655.6	Suspected damage to fetus from radiation	0, 3
655.7	Decreased fetal movements	0, 3
655.8	Other known or suspected fetal abnormality, not elsewhere classified	0, 3
655.9	Unspecified	0, 3
656.0	Fetal-maternal hemorrhage	0, 3
656.1	Rhesus isoimmunization	0, 3
656.2	Isoimmunization from other and unspecified blood-group incompatibility	0, 3
656.3	Fetal distress	0, 3
656.4	Intrauterine death	0, 3
656.5	Poor fetal growth	0, 3
656.6	Excessive fetal growth	0, 3
656.7	Other placental conditions	0, 3
656.8	Other specified fetal and placental problems	0, 3
656.9	Unspecified fetal and placental problem	0, 3
657.0	Polyhydramnios	0, 3
658.0	Oligohydramnios	0, 3
658.1	Premature rupture of membranes	0, 3
658.2	Delayed delivery after spontaneous or unspecified rupture of membranes	0, 3
658.3	Delayed delivery after artificial rupture of membrane	0, 3
658.4	Infection of amniotic cavity	0, 3
658.8	Other	0, 3
658.9	Unspecified	0, 3
664.6	Anal sphincter tear	0
678.0	Fetal hematologic conditions	0, 3
678.1	Fetal conjoined twins	0, 3
679.0	Maternal complications from in utero procedure	0, 3
679.1	Fetal complications from in utero procedure	0, 3

l. Inpatient Only Procedures.

1. The inpatient list on TMA's OPSS web site at <http://www.tricare.mil/opps> specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. Denial of payment for procedures on the inpatient only list are appealable

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under the Appeal of Factual (Non-Medical Necessity) Determinations. Refer to the TRICARE Operations Manual (TOM), [Chapter 13, Section 5](#) for appeal procedures.

2. The following criteria are used when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under OPPTS:

a. Most outpatient departments are equipped to provide the services to the Medicare population.

b. The simplest procedure described by the code may be performed in most outpatient departments.

c. The procedure is related to codes that we have already removed from the inpatient list.

d. It has been determined that the procedure is being performed in multiple hospitals on an outpatient basis.

3. Under the hospital outpatient PPS, payment will not be made for procedures that are designated as "inpatient only". Refer to TMA's Inpatient Procedures web site at <http://www.tricare.mil/inpatientprocedures> for a list of "inpatient only" procedures.

4. The list will be updated in response to comments as often as quarterly to reflect current advances in medical practice.

5. On rare occasions, a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient.

a. Hospitals are instructed to submit an outpatient claim for all services furnished, including the procedure code with SI of C to which a newly designated modifier (-CA) is attached.

b. Such patients would typically receive services such as those provided during a high-level emergency visit, appropriate diagnostic testing (X-ray, CT scan, EKG, and so forth) and administration of intravenous fluids and medication prior to the surgical procedure.

c. Because these combined services constitute an episode of care, claims will be paid with a procedure code on the inpatient list that is billed with the new modifier under new technology APC 0375 (Ancillary Outpatient Services when Patient expires). Separate payment will not be allowed for other services furnished on the same date.

d. The -CA modifier is not to be used to bill for a procedure with SI of C that is performed on an elective basis or scheduled to be performed on a patient whose status is that of an outpatient.

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J. APC For Vaginal Hysterectomy.

When billing for vaginal hysterectomies, hospitals shall report the appropriate CPT code.

K. Billing of Condition Codes Under OPPS.

The CMS 1450 UB-04 claim form allows 11 values for condition codes, however, the OCE can only accommodate seven, therefore, OPPS hospitals should list those condition codes that affect outpatient pricing first.

L. Special Billing/Codings Requirements as of January 1, 2008.

1. Payment for Cardiac Rehabilitation Services. Cardiac rehabilitation programs require that programs must be comprehensive and to be comprehensive they must include a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education and counseling. For CY 2008, hospitals will continue to use CPT³ code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT³ code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)) to report cardiac rehabilitation services.

a. However, effective with dates of service January 1, 2008 or later, hospitals may report more than one unit of HCPCS codes 93797 or 93798 for a date of service if more than one cardiac rehabilitation session lasting at least one hour each is provided on the same day.

b. In order to report more than one session for a given date of service, each session must be a minimum of 60 minutes. For example, if the services provided on a given day total one hour and 50 minutes, then only one session should be billed to report the cardiac rehabilitation services provided on that day.

2. Billing for Wound Care Services.

a. Following CPT³ codes are classified as "sometimes therapy" services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care:

- (1) 97597 - Active wound care/20 cm or <
- (2) 97598 - Active wound care > 20 cm
- (3) 97602 - Wound(s) care non-selective
- (4) 97605 - Neg press wound tx, < 50 cm
- (5) 97606 - Neg pres wound tx, >50cm

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b. Hospitals would receive separate payment under the OPSS when they bill for wound care services described by CPT⁴ codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by individuals independent of a therapy plan of care.

c. When these services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, **GP** for physical therapy, **GO** for occupational therapy, and **GN** for speech-language pathology) or report their charges under a therapy revenue code (that is, 0420, 0430, or 0440) or both, to receive payment under the professional fee schedule.

d. The OCE logic assigns these services to the appropriate APC for payment under the OPSS if the services are not provided under a certified therapy plan of care or directs contractors to the fee schedule payment rates if the services are identified on hospital claims with therapy modifier or therapy revenue code as a therapy service.

e. Revised the list of therapy revenue codes effective January 1, 2008, that may be reported with CPT⁴ codes 97597, 97598, 97602, 97605, and 97606 to designate them as services that are performed by a qualified therapist under a certified therapy plan of care and payable under the professional fee schedule - revenue codes expanded to 042X, 043X, or 044X.

3. Billing for Bone Marrow and Stem Cell Processing Services.

a. Effective January 1, 2008, the three Level II HCPCS codes (G0265, G0266, and G0267) for the special treatment of stem cells prior to transplant will be deleted.

b. Hospital are required to bill the appropriate CPT⁴ codes, specifically 38207 through 38215, in order to report bone marrow and stem cell processing services under OPSS.

FIGURE 13-2-11 BILLING FOR BONE MARROW AND STEM CELL PROCESSING SERVICES

HCPCS CODE	CPT* CODE
G0265	38207
G0266	38208, 38209
G0267	38210, 38211, 38212, 38213, 38214, 38215
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c. For CY 2008, CPT⁴ codes 38207, 38208, and 38209 for cryopreserving, thawing, and washing bone marrow and stem cells will be assigned to APC 0110, with a median cost of approximately \$214 and a SI of S. In addition, CPT⁴ codes 38210 - 38215, reported for depletion services of bone marrow and stem cells will be assigned APC 0393, which is renamed "Hematologic Processing and Studies," with a median cost of approximately \$358 and a SI of S.

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4. Billing for Implantable Cardioverter Defibrillators (ICDs).

Effective January 1, 2008, the four Level II HCPCS codes (G0297, G0298, G0299, and G0300) for ICD insertion procedures will be deleted. Hospitals are required to bill the appropriate CPT codes, specifically CPT⁵ codes 33240 or 33249, as appropriate, along with the applicable device C codes, for payment under the OPFS.

5. Payment for Brachytherapy Sources.

a. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, enacted on July 15, 2008, extended the use of the cost-to-charge payment methodology for Brachytherapy through December 31, 2009 with the exception of C2637, which is non-payable.

b. For CY 2009 will continue to pay all brachytherapy sources, assigned to SI of U at charges adjusted to cost. As such, brachytherapy will not be eligible for outlier payments or rural Sole Community Hospital (SCH) adjustments up through December 31, 2009.

c. Providers should bill for the number of units of the appropriate source HCPCS C code according to the number of brachytherapy sources in the strand (billing for stranded sources). They should not bill as one unit per strand.

d. Following is a list of brachytherapy sources that will continue to be reimbursed under the cost-to-charge payment methodology up through December 31, 2009:

FIGURE 13-2-12 COMPREHENSIVE LIST OF BRACHYTHERAPY SOURCES PAID UNDER COST-TO-CHARGE METHODOLOGY UP THROUGH DECEMBER 31, 2009

CPT/ HCPCS	LONG DESCRIPTOR	SI	APC
A9257	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	U	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	U	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	U	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	U	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	U	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	U	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	U	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	U	2636
C2638	Brachytherapy source, stranded, Iodine-125, per source	U	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	U	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	U	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	U	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	U	2642

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FIGURE 13-2-12 COMPREHENSIVE LIST OF BRACHYTHERAPY SOURCES PAID UNDER COST-TO-CHARGE METHODOLOGY UP THROUGH DECEMBER 31, 2009 (CONTINUED)

CPT/ HCPCS	LONG DESCRIPTOR	SI	APC
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	U	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	U	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	U	2699

6. Billing for Drugs, Biologicals, and Radiopharmaceuticals.

a. Hospitals should report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used.

b. It is also important that the reported units of the service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used, as reflected in the longer descriptor of the HCPCS code.

c. If commercially available products are being mixed together to facilitate concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code).

(1) If the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted code (J9999 or J3490).

(2) It is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

d. Following are new HCPCS codes which have been created for reporting drugs, biologicals in the hospital outpatient setting for CY 2008.

FIGURE 13-2-13 NEW HCPCS CODES EFFECTIVE FOR CERTAIN DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS IN CY 2008

2008 HCPCS	2008 SHORT DESCRIPTOR	2008 SI	2008 APC
A9501	Tc99m tebroxmine	N	
A9509	I 123 sodium iodide, dx	N	
A9569	Technetium TC-99m auto WBC	N	
A9570	Indium In-111 auto wbc	N	
A9571	Indium In-111 auto platelet	N	
A9576	Inj prohance multipack	N	
A9577	Inj multihance	N	
A9578	Inj multihance multipack	N	
C9237	Injection, lanreotide acetate	K	9237
C9238	Inj. Levetiracetam	K	9238

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FIGURE 13-2-13 NEW HCPCS CODES EFFECTIVE FOR CERTAIN DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS IN CY 2008 (CONTINUED)

2008 HCPCS	2008 SHORT DESCRIPTOR	2008 SI	2008 APC
C9239	Inj. Temsirolimus	G	1168
C9240	Injection, ixabepilone	K	9240
C9354	Veritas collagen matrix, cm2	G	9354
C9355	Neuromatrix nerve, cuff, cm	G	9355
J0400	Aripiprazole injections	K	1165
J1573	Hepagam B intravenous, inj	K	1138
J2724	Protein C concentrate	K	1139
J92266	Supprelin LA implant	K	1142

e. Changes in HCPCS code descriptors for drugs, biologicals and radiopharmaceuticals effective in CY 2008. Also deletion of several temporary C codes and replacement with new permanent codes. The affected HCPCS codes are listed below:

FIGURE 13-2-14 HCPCS CODE AND DOSAGE DESCRIPTOR CHANGES EFFECTIVE FOR CERTAIN DRUGS, BIOLOGICALS AND RADIOPHARMACEUTICALS IN CY 2008

CY 2007		CY 2008	
HCPCS	DESCRIPTOR	HCPCS	DESCRIPTOR
C9232	Injection, idusulfase, 1mg	J1743	Injection, idusulfase, 1mg
C9233	Injection, ranilbizumab, 0.5 mg	J2778	Injection, ranilbizumab, 0.1 mg
C9234	Injection, agucosidase alfa, 10 mg	J0220	Injection, agucosidase alfa, 10 mg
C9235	Injection, panitumumab, 10 mg	J9303	Injection, panitumumab, 10 mg
C9236	Injection, eculizumab, 10 mg	J1300	Injection, eculizumab, 10 mg
C9350	Microporous collagen tube of nonhuman origin, per centimeter length	C9352	Microporous collagen implantable tube (Neuragen Nerve Guide), per centimeter length
C9350	Microporous collagen tube of nonhuman origin, per centimeter length	C0353	Microporous collagen implantable tube (Neuragen Nerve Protector), per centimeter length
C9351	Acellular dermal tissue matrix of nonhuman origin, per square centimeter (Do not report C9351 in conjunction with J7345)	J7348	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (tissuemend) per square centimeter
C9351	Acellular dermal tissue matrix of nonhuman origin, per square centimeter (Do not report C9351 in conjunction with J7345)	J7349	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (primatrix) per square centimeter

f. New HCPCS Drug Codes Separately Payable under OPSS as of January 1, 2008.

FIGURE 13-2-15 NEW DRUG CODES SEPARATELY PAYABLE UNDER OPSS AS OF JANUARY 1, 2008

HCPCS CODE	APC	SI	LONG DESCRIPTOR
C9237	9237	K	Injection, lanreotide acetate, 1 mg
C9240	9240	K	Injection, ixabepilone, 1mg

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g. Drugs and biologicals with payment based on Average Sales Price (ASP) effective January 1, 2008. The updated payment rates for drugs and biologicals based on ASPs effective January 1, 2008, can viewed on the TRICARE web site.

h. Correct Reporting of Units for Drugs.

(1) Hospitals should ensure that units of drugs used in the care of patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor--that is, units should be reported in multiples of the units included in the HCPCS descriptor.

EXAMPLE: 1: If the description for the drug code is 6 mg, and 6 mg of the drug was used in the care of the patient the units billed should be one.

EXAMPLE: 2: If the description for the drug code is 50 mg but 200 mg of the drug was used in the care of the patient, the units billed should be four.

(2) Hospitals should not bill the units based on the way the drug is packaged, stored or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of drug was used, the hospital should bill 10 units, even though only one vial was used.

7. Payment for Therapeutic Radiopharmaceuticals.

a. The MIPPA of 2008, enacted on July 15, 2008, extended the use of the cost-to-charge payment methodology for therapeutic radiopharmaceuticals through December 31, 2009.

b. As a result, the SIs for therapeutic radiopharmaceutical HCPCS codes will remain "H," and as such, therapeutic radiopharmaceuticals will not be eligible for outlier payments or rural SCH adjustments up through December 31, 2009.

c. Following is a list of therapeutic radiopharmaceuticals that will continue to be reimbursed under the cost-to-charge payment methodology up through December 31, 2009:

FIGURE 13-2-16 COMPREHENSIVE LIST OF THERAPEUTIC RADIOPHARMACEUTICALS PAYABLE AS OF JANUARY 1, 2009

CPT/ HCPCS	LONG DESCRIPTOR	SI	APC
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	H	1064
A9520	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	H	1150
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	H	1643
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	H	1645
A9563	Sodium phosphate P-32, therapeutic, per millicurie	H	1675
A0564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	H	1676
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	H	0701
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	H	0702

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d. Hospitals are required to submit the diagnostic radiopharmaceutical on the same claim as the nuclear medicine procedure along with the date that a particular service was provided.

e. Therapeutic radiopharmaceuticals are defined as those radiopharmaceuticals that contain the word “therapeutic” in their long HCPCS code descriptors.

8. Drug Administration.

a. A five-level APC structure for drug administration services has been implemented for CY 2009 with the assignment of HCPCS codes displayed in [Figure 13-2-17](#).

b. Hospitals are to report all drug administration services, regardless of whether they are separately paid or packaged.

FIGURE 13-2-17 NEW DRUG ADMINISTRATION CPT CODES EFFECTIVE IN CY 2009

APC	HCPCS ¹	LONG DESCRIPTOR
0436	90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid).
	90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in additions to code for primary procedure).
	90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).
	90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).
	96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure).
	96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).
	96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code primary procedure).
	96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
	96379	Unlisted therapeutic prophylactic, or diagnostic intravenous or intr-arterial injection or infusion.
	95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection.
	95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections.
	95145	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom.
	95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses).

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FIGURE 13-2-17 NEW DRUG ADMINISTRATION CPT CODES EFFECTIVE IN CY 2009 (CONTINUED)

APC	HCPCS ¹	LONG DESCRIPTOR
0436	95170	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses).
	96549	Unlisted chemotherapy procedure.
0437	96367	Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure).
	96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
	96373	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra arterial.
	96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.
	96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure).
	95144	Profession services for the supervision of preparation and provision of antigens for allergen immunotherapy, single does vial(s) (specify number of vials).
	95148	Profession services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms.
	96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic.
	96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic.
	96405	Chemotherapy administration; intralesional, up to and including 7 lesions.
0438	96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure).
	96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hours.
	96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s).
	95146	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms.
	95147	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms
	96406	Chemotherapy administration; intralesional, more than 7 lesions.
	96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure).
	96417	Chemotherapy administration; intravenous, push technique, each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure).
0439	96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure).
	96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); Initial, up to 1 hour.
	95149	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms.

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FIGURE 13-2-17 NEW DRUG ADMINISTRATION CPT CODES EFFECTIVE IN CY 2009 (CONTINUED)

APC	HCPCS ¹	LONG DESCRIPTOR
0439	96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug.
	96420	Chemotherapy administration, intra-arterial' push technique.
	96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial).
	96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents.
0440	95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular).
	95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician.
	96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug.
	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump.
	96422	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hours.
	96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump.
	96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis.
	96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis.
	96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture.
	96521	Refilling and maintenance of portable pump.
	C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of a portable or implantable pump.

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9. Billing for Cardiac Echocardiography Services.

a. Cardiac Echocardiography Without Contrast. Hospitals are instructed to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT⁶ code(s) (93303-93350).

b. Cardiac Echocardiograph With Contrast.

(1) Hospitals are instructed to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in [Figure 13-2-18](#).

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(2) Hospitals should also report the appropriated units for the HCPCS code for the contrast agents used in the performance of the echocardiograms.

FIGURE 13-2-18 HCPCS CODE(S) FOR BILLING ECHOCARDIOGRAMS WITH CONTRAST

HCPCS	LONG DESCRIPTOR
C8921	Transthoacic echocardiography with contrast for congenital cardiac anomalies; complete
C8922	Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study
C8923	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording complete
C8924	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-code recording; follow-up or limited study
C8925	Transesophageal echocardiograph (TEE) with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
C8926	Transesophageal echocardiograph (TEE) with contrast for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927	Transesophageal echocardiograph (TEE) with contrast for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928	Transthoracic echocardiography with contrast, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

IV. EFFECTIVE DATE May 1, 2009.

- END -

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FIGURE 13-3-1 LIST OF REVENUE CENTERS PACKAGED INTO MAJOR HCPCS CODES WHEN APPEARING IN THE SAME CLAIM (CONTINUED)

REVENUE CODE	DESCRIPTION
0379	Other Anesthesia
0390	Blood Storage and Processing
0391	Blood Administration (e.g., transfusions)
0399	Other Blood Storage and Processing
0621	Supplies Incident to Radiology
0622	Supplies Incident to Other Diagnostic
0623	Surgical Dressings
0624	Investigational Device (IDE)
0631	Single Source
0632	Multiple
0633	Restrictive Prescription
0637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic COMA)
0700	Cast Room
0709	Other Cast Room
0710	Recovery Room
0719	Other Recovery Room
0720	Labor Room
0721	Labor
0762	Observation Room
0770	General Classification
0771	Vaccine Administration

1 Some instructions have been issued that require that specific revenue codes be billed with certain HCPCS codes, such as specific revenue codes that must be used when billing for devices that qualify for pass-through payments.

NOTE: If the revenue code is not listed above, refer to the TRICARE Systems Manual (TSM), [Chapter 2, Addendum O](#), for reporting requirements.

2 Where specific instructions have not been issued, contractors should advise hospitals to report charges under the revenue code that would result in the charges being assigned to the same cost center to which the cost of those services were assigned in the cost report.

EXAMPLE: Operating room, treatment room, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, casts and splints, and donor tissue, bone, and organ charges were used in calculating surgical procedure costs. The charges for items such as medical and surgical supplies, drugs and observation were used in estimating medical visit costs.

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(e) Costs are standardized for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the current hospital Inpatient Prospective Payment System (IPPS) wage index. Sixty percent (60%) is used to represent the estimated portion of costs attributable, on average, to labor.

(f) Standardized labor related cost and the nonlabor-related cost component for each billed item are summed to derive the total standardized cost for each procedure or medical visit.

(g) Each procedure or visit cost is mapped to its assigned APC.

(h) The median cost is calculated for each APC.

(i) Relative payment weights are calculated for each APC, by dividing the median cost of each APC by the median cost for APC 00606 (mid-level clinic visit), Outpatient Prospective Payment System (OPPS) weights are listed on TMA's OPPS web site at <http://www.tricare.mil/opps>.

(j) These relative payment weights may be further adjusted for budget neutrality based on a comparison of aggregate payments using previous and current CY weights.

b. Conversion Factor Update.

(1) The conversion factor is updated annually by the hospital inpatient market basket percentage increase applicable to hospital discharges.

(2) The conversion factor is also subject to adjustments for wage index budget neutrality, differences in estimated pass-through payments, and outlier payments.

(3) The market basket increase update factor of 3.6% for CY 2009, the required wage index budget neutrality adjustment of approximately 1.0013, and the adjustment of 0.02% of projected OPPS spending for the difference in the pass-through set aside resulted in a full market basket conversion factor for CY 2009 of \$66.059.

3. Payment Status Indicators (SIs).

A payment SI is provided for every code in the HCPCS to identify how the service or procedure described by the code would be paid under the hospital OPPS; i.e., it indicates if a service represented by a HCPCS code is payable under the OPPS or another payment system, and also which particular OPPS payment policies apply. One, and only one, SI is assigned to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same SI as the APC to which it is assigned. The following are the payment SIs and descriptions of the particular services each indicator identifies:

o. A to indicate services that are paid under some payment method other than OPPS, such as the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule, CHAMPUS Maximum Allowable Charge (CMAC) reimbursement methodology for physicians, or State prevalings.

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(2) Multiply the wage adjusted APC payment rate by the OPSS rural adjustment (1.071) if the provider is a Sole Community Hospital (SCH) in a rural area with 100 or more beds. Effective January 1, 2010, the OPSS rural adjustment will apply to all SCHs in rural areas.

(3) Determine any outlier amounts and add them to the sum of either paragraph III.A.4.d.(1) or (2).

(4) Subtract from the adjusted APC payment rate the amount of any applicable deductible and/or cost-sharing/copayment amounts based on the eligibility status of the beneficiary at the time the outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra and Standard beneficiary categories). Refer to Chapter 2, Addendum A for applicable deductible and/or cost-sharing/copayment amounts for Outpatient Hospital Departments and Ambulatory Surgery Centers (ASCs).

e. Examples of TRICARE payments under OPSS based on eligibility status of beneficiary at the time the services were rendered:

(1) Example #1. Assume that the wage adjusted rate for an APC is \$400; the beneficiary receiving the services is an Active Duty Family Member (ADFM) enrolled under Prime, and as such, is not subject to any deductibles or copayments.

(a) Adjusted APC payment rate: \$400.

(b) Subtract any applicable deductible: $\$400 - \$0 = \$400$

(c) Subtract the Prime ADFM copayment from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$\$400 - \$0 = \$400$ TRICARE final payment

(d) TRICARE would pay 100% of the adjusted APC payment rate for ADFMs enrolled in Prime.

(2) Example #2. Assume that the wage adjusted rate for an APC is \$400 and the beneficiary receiving the outpatient services is a Prime retiree family member subject to a \$12 copayment. Deductibles are not applied under the Prime program.

(a) Adjusted APC payment rate: \$400.

(b) Subtract any applicable deductible: $\$400 - \$0 = \$400$

(c) Subtract the Prime retiree family member copayment from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$\$400 - \$12 = \$388$ TRICARE final payment

(d) In this case, the beneficiary pays zero (\$0) deductible and a \$12 copayment, and the program pays \$388 (i.e., the difference between the adjusted APC payment rate and the Prime retiree family member copayment).

(3) Example #3. This example illustrates a case in which both an outpatient deductible and cost-share are applied. Assume that the wage-adjusted payment rate for an APC is \$400 and the beneficiary receiving the outpatient services is a standard ADFM subject to an individual \$50 deductible (active duty sponsor is an E-3) and 20% cost-share.

(a) Adjusted APC payment rate: \$400.

(b) Subtract any applicable deductible: $\$400 - \$50 = \$350$

(c) Subtract the standard ADFM cost-share (i.e., 20% of the allowable charge) from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$$\$350 \times .20 = \$70 \text{ cost-share}$$

$$\$350 - \$70 = \$280 \text{ TRICARE final payment}$$

(d) In this case, the beneficiary pays a deductible of \$50 and a \$70 cost-share, and the program pays \$280, for total payment to the hospital of \$400.

5. Adjustments to APC Payment Amounts.

a. Adjustment for Area Wage Differences.

(1) A wage adjustment factor will be used to adjust the portion of the payment rate that is attributable to labor-related costs for relative differences in labor and labor-related costs across geographical regions with the exception of APCs with SIs of **K, G, H, R, and U**. The hospital DRG wage index will be used given the inseparable, subordinate status of the outpatient department within the hospital.

(2) The OPSS will use the same wage index changes as the TRICARE DRG-based payment system, except the effective date for the changes will be January 1 of each year instead of October 1 (refer to the OPSS Provider File with Wage Indexes on TMA's OPSS home page at <http://www.tricare.mil/opss>).

(3) Temporary Transitional Payment Adjustments (TTPAs) are wage adjusted. The Transitional, **General, and non-network Temporary Military Contingency Payment Adjustments (TMCPAs)** are not wage adjusted.

(4) Sixty percent (60%) of the hospital's outpatient department costs are recognized as labor-related costs that would be standardized for geographic wage differences. This is a reasonable estimate of outpatient costs attributable to labor, as it fell between the hospital DRG operating cost labor factor of 71.1% and the ASC labor factor of 34.45%, and is close to the labor-related costs under the inpatient DRG payment system attributed directly to wages, salaries and employee benefits (61.4%).

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(b) Full payment will be received for a procedure that was started but discontinued after the induction of anesthesia, or after the procedure was started.

1 Modifier -74 (Discontinued Procedure) would be used to indicate that a surgical procedure was started but discontinued after the induction of anesthesia (for example, local, regional block, or general anesthesia), or after the procedure was started (incision made, intubation begun, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient.

2 This payment would recognize the costs incurred by the hospital to prepare the patient for surgery and the resources expended in the operating room and recovery room of the hospital.

c. Discounting for Bilateral Procedures.

(1) Following are the different categories/classifications of bilateral procedure:

(a) Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

(b) Inherent bilateral (i.e., procedure in and of itself is bilateral).

(c) Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures)).

(2) Terminated bilateral procedures or terminated procedures with units greater than one should not occur, and for type T procedures, have the discounting factor set so as to result in the equivalent of a single procedure. Line items with terminated bilateral procedures or terminated procedure with units greater than one are denied.

(3) For non-type T procedures there is no multiple procedure discounting and no bilateral procedure discounting with modifier 50 performed. Line items with SI other than T are subject to terminated procedure discounting when modifier 52 or 73 is present. Modifier 52 or 73 on a non-type T procedure line will result in a 50% discount being applied to that line.

(4) The discounting factor for bilateral procedures is the same as the discounting factor for multiple type T procedures.

(5) Inherent bilateral procedures will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code.

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(6) Following are the different discount formulas that can be applied to a line item:

FIGURE 13-3-2 DISCOUNTING FORMULAS FOR BILATERAL PROCEDURES

DISCOUNTING FORMULA NUMBER	FORMULAS
1	1.0
2	$(1.0 + D (U - 1))/U$
3	T/U
4	$(1 + D)/U$
5	D
6*	TD/U
7*	$D (1 + D)/U$
8	2.0
9	2D/U
Where: D = discounting fraction (currently 0.5) U = number of units T = terminated procedure discount (currently 0.5)	
*These discount formulas are discounted prior to OPSS implementation.	

(7) The following figure summarizes the application of above discounting formulas:

FIGURE 13-3-3 APPLICATION OF DISCOUNTING FORMULAS

PAYMENT AMOUNT	MODIFIER 52 OR 73	MODIFIER 50**	DISCOUNTING FORMULA NUMBER			
			TYPE "T" PROCEDURE		NON-TYPE "T" PROCEDURE	
			CONDITIONAL OR INDEPENDENT BILATERAL	INHERENT OR NON-BILATERAL	CONDITIONAL OR INDEPENDENT BILATERAL	INHERENT OR NON-BILATERAL
Highest	No	No	2	2	1	1
Highest	Yes	No	3	3	3	3
Highest	No	Yes	4	2	8*	1
Highest	Yes	Yes	3	3	3	3
Not Highest	No	No	5	5	1	1
Not Highest	Yes	No	3	3	3	3
Not Highest	No	Yes	9	5	8*	1
Not Highest	Yes	Yes	3	3	3	3

For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (T) any applicable offset, will be applied prior to selecting the T procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first before the terminated procedure discount.

*If not terminated, non-type T Conditional bilateral procedures with modifier 50 will be assigned discount formula #8. Non-type T Independent bilateral procedures with modifier 50 will be assigned to formula # 8.

**If modifier 50 is present on an independent or conditional bilateral line that has a composite APC or a separately paid STVX/T-packaged procedure, the modifier is ignored in assigning the discount formula.

NOTE: For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (T) will be applied prior to selecting the type T procedure with the highest payment amount.

(8) In those instances where more than one bilateral procedure and they are medically necessary and appropriate, hospitals are advised to report the procedure with a modifier -76 (repeat procedure or service by same physician) in order for the claim to process correctly.

d. Multiple discounting will not be applied to the following CPT¹ procedure codes for venipuncture, fetal monitoring and collection of blood specimens: 36400 - 36416, 36591, 36592, 59020, 59025, and 59050 - 59051.

e. Outlier Payments.

An additional payment is provided for outpatient services for which a hospital's charges, adjusted to cost, exceed the sum of the wage adjusted APC rate plus a fixed dollar threshold and a fixed multiple of the wage adjusted APC rate. Only line item services with SIs of **P, R, S, T, V, or X** will be eligible for outlier payment under OPPS. No outlier payments will be calculated for line item services with SIs of **G, H, K, N, and U** with the exception of blood and blood products.

(1) Outlier payments will be calculated on a service-by-service basis. Calculating outliers on a service-by-service basis was found to be the most appropriate way to calculate outliers for outpatient services. Outliers on a bill basis requires both the aggregation of costs and the aggregation of OPPS payments, thereby introducing some degree of offset among services; that is, the aggregation of low cost services and high cost services on a bill may result in no outlier payment being made. While service-based outliers are somewhat more complex to administer, under this method, outlier payments will be more appropriately directed to those specific services for which a hospital incurs significantly increased costs.

(2) Outlier payments are intended to ensure beneficiary access to services by having the TRICARE program share the financial loss incurred by a provider associated with individual, extraordinarily expensive cases.

(3) Outlier thresholds are established on a CY basis which requires that a hospital's cost for a service exceed the wage adjusted APC payment rate for that service by a specified multiple of the wage adjusted APC payment rate and the sum of the wage adjusted APC rate plus a fixed dollar threshold (\$1,800 for CY 2009) in order to receive an additional outlier payment. When the cost of a hospital outpatient service exceeds both of these thresholds a predetermined percentage of the amount by which the cost of furnishing the services exceeds the multiple APC threshold will be paid as an outlier.

(4) Outlier payments are not subject to cost-sharing.

(5) TTPAs and TMCPAs shall not be included in cost outlier calculations.

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(6) Example of outlier payment calculation.

EXAMPLE: Following are the steps involved in determining if services on a claim qualify for outlier payments using the appropriate CY multiple and fixed dollar thresholds.

STEP 1: Identify all APCs on the claim.

STEP 2: Determine the ratio of each wage adjusted APC payment to the total payment of the claim (assume for this example a wage index of 1.0000).

HCPCS CODE	SI	APC	SERVICE	WAGE ADJUSTED APC PAYMENT RATE	RATIO OF APC TO TOTAL PAYMENT
99285	V	0616	Level 5 Emergency Visit	\$315.51	0.5107157
70481	S	0283	CT scan with contrast material	\$277.48	0.4491566
93041	S	0099	Electrocardiogram	\$24.79	0.0401275

STEP 3: Identify billed charges of packaged items that need to be allocated to an APC.

REVENUE CODE	OPPS SERVICE OR SUPPLY	TOTAL CHARGES
0250	Pharmacy	\$3,435.50
0270	Medical Supplies	\$4,255.80
0350	CT scan	\$3,957.00
0450	Emergency Room	\$2,986.00
0730	Electrocardiogram	\$336.00

STEP 4: Allocate the billed charges of the packaged items identified in Step 3 to their respective wage adjusted APCs based on their percentages to total payment calculated in Step 2.

APC	RATIO ALLOCATION	OPPS SERVICE	250 (PHARMACY)	270 (MEDICAL SUPPLIES)
0616	0.5107157	Level 5 Emergency Visit	\$1,754.56	\$2,173.50
0283	0.4491566	CT scan with contrast material	\$1,543.08	\$1,911.52
0099	0.0401275	Electrocardiogram	\$137.36	\$170.77

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STEP 5: Calculate the total charges for each OPPS service (APC) and reduce them to costs by applying the statewide CCR. Statewide CCRs are based on the geographical CBSA (two digit = rural, five digit = urban). Assume that the outpatient CCR is 31.4%.

APC	OPPS SERVICE	TOTAL CHARGES	TOTAL CHARGES REDUCED TO COSTS (CCR = 0.3140)
0616	Level 5 Emergency Visit	\$6,914.06	\$2,170.01
0283	CT scan with contrast material	\$7,411.60	\$2,327.24
0099	Electrocardiogram	\$644.63	\$202.41

STEP 6: Apply the cost test to each wage adjusted APC service or procedure to determine if it qualifies for an outlier payment. If the cost of a service (wage adjusted APC) exceeds both the APC multiplier threshold (1.75 times the wage adjusted APC payment rate) and the fixed dollar threshold (wage adjusted APC rate plus \$1,800), multiply the costs in excess of the wage adjusted APC multiplier by 50% to get the additional outlier payment.

APC	WAGE ADJUSTED APC RATE	COSTS	FIXED DOLLAR THRESHOLD (WAGE ADJUSTED APC RATE + \$1,800)	MULTIPLIER THRESHOLD (1.75 x WAGE ADJUSTED APC RATE)	COSTS IN EXCESS OF MULTIPLIER THRESHOLD	OUTLIER PAYMENT COSTS OF WAGE ADJUSTED APC - (1.75 x WAGE ADJUSTED APC RATE) x 0.50
0616	\$315.51	\$2,170.01	\$2,115.51	\$552.14	\$1,618.87	\$808.43
0283	\$277.48	\$2,327.24	\$2,077.48	\$485.59	\$1,841.65	\$920.83
0099	\$24.79	\$202.41	\$1,824.79	\$43.38	\$159.03	-0*

* Does not qualify for outlier payment since the APC's costs did not exceed the fixed dollar threshold (APC Rate + \$1,800).

The total outlier payment on the claim was: \$1,730.26.

f. Rural SCH payments will be increased by 7.1%. This adjustment will apply to all services and procedures paid under the OPPS (SIs of P, S, T, V, and X), excluding drugs, biologicals and services paid under the pass-through payment policy (SIs of G and H).

(1) The adjustment amount will not be reestablished on an annual basis, but may be reviewed in the future, and if appropriate, may be revised.

(2) The adjustment is budget neutral and will be applied before calculating outliers and copayments/cost-sharing.

g. Temporary Transitional Payment Adjustments (TTPAs).

(1) On May 1, 2009 (implementation of TRICARE's OPPS), the TTPAs shall apply to all network and non-network hospitals. For network hospitals, the TTPAs will cover

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a four year period. The four year transition will set higher payment percentages for the 10 APC codes 604-609 and 613-616 during the first year, with reductions in each of the transition years. For non-network hospitals, the adjustment will cover a three year period, with reductions in each of the transition years for the same 10 APC codes. [Figure 13-3-4](#) provides the TTPA percentage adjustments for the 10 visit APC codes for network and non-network hospitals. **An applicable Explanation of Benefits (EOB) message will be applied.**

(2) TTPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

FIGURE 13-3-4 TTPA ADJUSTMENT PERCENTAGES FOR 10 VISIT APC CODES

YEARS	NETWORK		NON-NETWORK	
	EMERGENCY ROOM	HOSPITAL CLINIC	EMERGENCY ROOM	HOSPITAL CLINIC
Year 1	200%	175%	140%	140%
Year 2	175%	150%	125%	125%
Year 3	150%	130%	110%	110%
Year 4	130%	115%	100%	100%
Year 5	100%	100%	100%	100%

h. Temporary Military Contingency Payment Adjustments (TMCPAs).

Under the authority of the last paragraph of [32 CFR 199.14\(a\)\(6\)\(ii\)](#), the following OPPS adjustments are authorized.

(1) Transitional TMCPAs. In view of the ongoing military operations in Afghanistan and Iraq, the TMA Director has determined that it is impracticable to support military readiness and contingency operations without adjusting OPPS payments for network hospitals that provide a significant portion of the health care of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs). Therefore, network hospitals that have received OPPS payments of \$1.5 million or more for care to ADSMs and ADDs during a one-year period shall be granted a Transitional TMCPA in addition to the TTPAs for that year. The total TRICARE OPPS payments for each one of these qualifying hospitals will be increased by 20% by way of an additional payment within three months after the end of the year; i.e., 15 months after implementation of OPPS to ensure that the adjustment is based on a full 12 months of claims history (May 1, 2009 through April 30, 2010). Second and subsequent year adjustments (assuming a hospital continues to meet the \$1.5 million threshold) will be reduced by 5% per year until the OPPS payment levels are reached; (i.e., 15% year two, 10% year three, and 5% year four). In year five, the outpatient payments will be at established APC levels. The adjustment will be applied to the total year OPPS payment amount received by the hospital for all active duty members and all TRICARE beneficiaries (including ADDs, retirees and their family members but excluding TRICARE For Life (TFL) beneficiaries) for whom TRICARE is primary payer.

(c) Contractors will run a query of their claims history to determine which network hospitals qualify for Transitional TMCPAs at year end; i.e., those network hospitals receiving OPPS payments of \$1.5 million or more for care of ADSMs and ADDs

K. Adjustment to Payment in Cases of Devices Replaced with Partial Credit for the Replaced Device.

1. Hospitals will be required to append the modifier "FC" to the HCPCS code for the procedure in which the device was inserted on claims when the device that was replaced with partial credit under warranty, recall, or field action is one of the devices in [Figure 13-3-11](#). Hospitals should not append the modifier to the HCPCS procedure code if the device is not listed in [Figure 13-3-11](#).

2. Claims containing the "FC" modifier will not be accepted unless the modifier is on a procedure code with SI S, T, V, or X.

3. If the APC to which the procedure is assigned is one of the APCs listed in [Figure 13-3-12](#), the **Pricer** will reduce the unadjusted payment rate for the procedure by an amount equal to the percent in [Figure 13-3-12](#) for partial credit device replacement (i.e., 50% of the device offset when both a device code listed in [Figure 13-3-11](#) is present on the claim and the procedure code maps to an APC listed in [Figure 13-3-12](#)) multiplied by the unadjusted payment rate.

4. The partial credit adjustment will occur before wage adjustment and before the assessment to determine if the reductions for multiple procedures (signified by the presence of more than one procedure on the claim with a SI of T), discontinued service (signified by modifier 73) or reduced service (signified by modifier 52) apply.

L. Payment When Devices Are Replaced Without Cost or Where Credit for a Replacement Device is Furnished to the Hospital.

1. Payments will be reduced for selected APCs in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. The amount of the reduction to the APC rate will be calculated in the same manner as the offset amount that would be applied if the implanted device assigned to the APC has pass-through status.

2. This permits equitable adjustments to the OPPS payments contingent on meeting all of the following criteria:

a. All procedures assigned to the selected APCs must require implantable devices that would be reported if device replacement procedures are performed;

b. The required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedures, at least temporarily; and

c. The offset percent for the APC (i.e., the median cost of the APC without device costs divided by the median cost of the APC with device costs) must be significant-- significant offset percent is defined as exceeding 40%.

3. The presence of the modifier "FB" ["Item Provided Without Cost to Provider, Supplier, or Practitioner or Credit Received for Replacement (examples include, but are not limited to devices covered under warranty, replaced due to defect, or provided as free

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samples)"] would trigger the adjustment in payment if the procedure code to which modifier "FB" was amended appeared in [Figure 13-3-11](#) and was also assigned to one of the APCs listed in [Figure 13-3-12](#). OPPS payments for implantation procedures to which the "FB" modifier is appended are reduced to 100% of the device offset for no-cost/full credit cases.

FIGURE 13-3-11 DEVICES FOR WHICH "FC" AND "FB" MODIFIERS MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL OR PARTIAL CREDIT FOR A REPLACEMENT DEVICE

DEVICE HCPCS CODE	SHORT DESCRIPTOR
C1721	AICD, dual chamber
C1722	AICS, single chamber
C1728	Cath, brachytx seed adm
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep Dev urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual rate-resp
C1786	Pmkr, single rate-resp
C1789	Prosthesis, breast, imp
C1813	Prostheses, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro, rechg bat sys
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Pmkr, other than sing/dual
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8600	Implant breast silicone/eq
L8614	Cochlear device/system
L8685	Implt nrostm pls gen sng rec

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FIGURE 13-3-11 DEVICES FOR WHICH “FC” AND “FB” MODIFIERS MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL OR PARTIAL CREDIT FOR A REPLACEMENT DEVICE (CONTINUED)

DEVICE HCPCS CODE	SHORT DESCRIPTOR
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

FIGURE 13-3-12 ADJUSTMENTS TO APCs IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED FOR CY 2009

APC	SI	APC GROUP TITLE	DEVICE OFFSET PERCENTAGE FOR NO-COST/FULL CREDIT CASE	DEVICE OFFSET PERCENTAGE FOR PARTIAL CREDIT CASE
0039	S	Level I Implantation of Neurostimulator	84	42
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	57	29
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes	62	31
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	72	36
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74	37
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes	43	21
0107	T	Insertion of Cardioverter-Defibrillator	89	45
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	89	44
0222	S	Level II Implantation of Neurological Device	85	42
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	62	31
0227	T	Implantation of Drug Infusion Devices	82	41
0229	T	Transcatheter Placement of Intravascular Shunts	84	42
0259	T	Level IV ENT Procedures	88	44
0315	S	Level III Implantation of Neurostimulator	59	29
0385	S	Level I Prosthetic Urological Procedures	69	34
0386	S	Level II Prosthetic Urological Procedures	71	36
0418	T	Insertion of Left Ventricular Pacing Elect	59	29
0425	T	Level II Arthroplasty or Implantation with Prosthesis	46	23
0648	T	Level IV Breast Surgery	77	38
0625	T	Level IV Vascular Access Procedures	76	38
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	71	36
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	71	35
0680	S	Insertion of Patient Activated Event Recorders	71	36
0681	T	Knee Arthroplasty	71	35

4. If the APC to which the device code (i.e., one of the codes in [Figure 13-3-11](#)) is assigned is on the APCs listed in [Figure 13-3-12](#), the unadjusted payment rate for the procedure APC will be reduced by an amount equal to the percent in [Figure 13-3-12](#) times the unadjusted payment rate.

5. In cases in which the device is being replaced without cost, the hospital will report a token device charge. However, if the device is being inserted as an upgrade, the hospital will report the difference between its usual charge for the device being replaced and the credit for the replacement device.

6. Multiple procedure reductions would also continue to apply even after the APC payment adjustment to remove payment for the device cost, because there would still be the expected efficiencies in performing the procedure if it was provided in the same operative session as another surgical procedure. Similarly, if the procedure was interrupted before administration of anesthesia (i.e., there was modifier 52 or 73 on the same line as the procedure), a 50% reduction would be taken from the adjusted amount.

M. Policies Affecting Payment of New Technology Services.

1. A process was developed that recognizes new technologies that do not otherwise meet the definition of current orphan drugs, or current cancer therapy drugs and biologicals and brachytherapy, or current radiopharmaceutical drugs and biologicals products. This process, along with transitional pass-throughs, provides additional payment for a significant share of new technologies.

2. Special APC groups were created to accommodate payment for new technology services. In contrast to the other APC groups, the new technology APC groups did not take into account clinical aspects of the services they were to contain, but only their costs.

3. The SI K is used to denote the APCs for drugs, biologicals and pharmaceuticals that are paid separately from, and in addition to, the procedure or treatment with which they are associated, yet are not eligible for transitional pass-through payment.

4. New items and services will be assigned to these new technology APCs when it is determined that they cannot appropriately be placed into existing APC groups. The new technology APC groups provide a mechanism for initiating payment at an appropriate level within a relatively short time frame.

5. As in the case of items qualifying for the transitional pass-through payment, placement in a new technology APC will be temporary. After information is gained about actual hospital costs incurred to furnish a new technology service, it will be moved to a clinically-related APC group with comparable resource costs.

6. If a new technology service cannot be moved to an existing APC because it is dissimilar clinically and with respect to resource costs from all other APCs, a separate APC will be created for such services.

7. Movement from a new technology APC to a clinically-related APC will occur as part of the annual update of APC groups.

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FIGURE 13-3-14 ASSIGNMENT OF CPT E/M CODES AND OTHER HCPCS CODES TO NEW VISIT APCs FOR CY 2007 (CONTINUED)

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 4 Type A Emergency Visits	0615	99284	Emergency department visit
Level 5 Type A Emergency Visits	0616	99285	Emergency department visit
Critical Care	0617	99291	Critical care, first hour
Trauma Activation	0618	G0390	Trauma Respon. w/hosp criti

O. OPPTS PRICER.

1. Common PRICER software will be provided to the contractor that includes the following data sources:

- a. National APC amounts
- b. Payment status by HCPCS code
- c. Multiple surgical procedure discounts
- d. Fixed dollar threshold
- e. Multiplier threshold
- f. Device offsets
- g. Other payment systems pricing files (CMAC, DMEPOS, and statewide prevalings)

2. The following data elements will be extracted and forwarded to the outpatient PRICER for line item pricing.

- a. Units;
- b. HCPCS/Modifiers;
- c. APC;
- d. Status payment indicator;
- e. Line item date of service;
- f. Primary diagnosis code; and
- g. Other necessary OCE output.

3. The following data elements will be passed into the PRICER by the contractors:

- a. Wage indexes (same as DRG wage indexes);

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b. Statewide CCRs as provided in the CMS Final Rule and listed on TMA's OPSS web site at <http://www.tricare.mil/opps>;

c. Locality Code: Based on CBSA - two digit = rural and five digit = urban;

d. Hospital Type: Rural SCH = 1 and All Others = 0

4. The outpatient PRICER will return the line item APC and cost outlier pricing information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary EOB with exception for an electronic 835 transaction. Paper EOBs and remits will reflect APCs at the line level and will also include indication of outlier payments and pricing information for those services reimbursed under other than OPSS methodology's, e.g., CMAC (SI of A) when applicable.

5. If a claim has more than one service with a SI of T or a SI of S within the coding range of 10000 - 69999, and any lines with SI of T or a SI within the coding range of 10000 - 69999 have less than \$1.01 as charges, charges for all lines will be summed and the charges will then be divided up proportionately to the payment rates for each line (refer to [Figure 13-3-15](#)). The new charge amount will be used in place of the submitted charge amount in the line item outlier calculator.

FIGURE 13-3-15 PROPORTIONAL PAYMENT FOR "T" LINE ITEMS

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
T	\$19,999	\$6,000	\$12,000
T	\$1	\$3,000	\$6,000
T	\$0	\$1,000	\$2,000
Total	\$20,000	\$10,000	\$20,000

NOTE: Because total charges here are \$20,000 and the first SI of T gets \$6,000 of the \$10,000 total payment, the new charge for that line is $\$6,000/\$10,000 \times \$20,000 = \$12,000$.

P. TRICARE Specific Procedures/Services.

1. TRICARE specific APCs have been assigned for half-day PHPs.

2. Other procedures that are normally covered under TRICARE but not under Medicare will be assigned SI of A (i.e., services that are paid under some payment method other than OPSS) until they can be placed into existing or new APC groups.

Q. Validation Reviews.

OPSS claims are not subject to validation review.

CHAPTER 13
SECTION 4

CLAIMS SUBMISSION AND PROCESSING REQUIREMENTS

ISSUE DATE: July 27, 2005

AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

I. APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by 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.

II. ISSUE

To describe additional claims submission and processing requirements.

III. POLICY

Appropriate Bill Types:

A. Bill types subject to Outpatient Prospective Payment System (OPPS).

All outpatient hospital bills (bill types 013X with condition code 41, 013X without condition code 41, **014X for diagnostic services**), with the exception of bills from providers excluded under [Chapter 13, Section 1, paragraph III.D.1.b.\(5\)](#) will be subject to the OPPS.

B. Reporting Requirements.

1. Payment of outpatient hospital claims will be based on the “from” date on the claim.

EXAMPLE: Claims with from dates before May 1, 2009 (implementation of OPPS) will not process as OPPS - this will also apply to version changes and pricing changes.

2. Hospitals should make every effort to report all services performed on the same day on the same claim to ensure proper payment under OPPS.

3. **Each** line item on the CMS 1450 UB-04 claim form must be submitted with a specific date of service **to avoid claim denial**. The header dates of **service on** the CMS 1450

UB-04 may span, **as long as all lines include specific** dates of service within the span **on** the header.

C. Procedures for Submitting Late Charges.

1. Hospitals may not submit a late charge bill (frequency 5 in the third position of the bill type) for bill types 013X effective for claims with dates of service on or after May 1, 2009 (implementation of OPSS).

2. They must submit an adjustment bill for any services required to be billed with Healthcare Common Procedure Coding System (HCPCS) codes, units, and line item dates of service by reporting frequency 7 or 8 in the third position of the bill type. Separate bills containing only late charges will not be permitted. Claims with bill type 0137 and 0138 should report the original claim number in Form Location (FL) 64 on the CMS 1450 UB-04 claim form.

3. The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing of Outpatient Code Editor (OCE) under OPSS.

NOTE: The contractors will take appropriate action in those situations where either a replacement claim (TOB 0137) or voided/cancelled claim (TOB 0138) is received without an initial claim (TOB 0131) being on file. Adjustments resulting in overpayments will be set for recoupment allowing an auto offset.

D. Claim Adjustments. Adjustments to OPSS claims shall be priced based on the from date on the claim (using the rules and weights and rates in effect on that date) regardless of when the claim is submitted. Contractor's shall maintain at least three years of APC relative weights, payment rates, wage indexes, etc., in their systems. If the claim filing deadline has been waived and the from date is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest APC weights and rates on the contractor's system.

E. Proper Reporting of Condition Code G0 (Zero).

1. Hospitals should report Condition Code G0 on FLs 18-28 when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day - in the morning for a broken arm and later for chest pain.

2. Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim.

3. Claims with condition code G0 should not be automatically rejected as a duplicate claim.