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TRICARE  
MANAGEMENT ACTIVITY

MB&RS

CHANGE 57  
6010.55-M  
JANUARY 16, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/  
revision(s) to the 6010.55-M, issued August 2002.

**CHANGE TITLE:** JANUARY 2007 CHANGES TO HOSPITAL OUTPATIENT  
PROSPECTIVE PAYMENT SYSTEM (OPPS)

**PAGE CHANGE(S):** See pages 2 and 3.

**SUMMARY OF CHANGE(S):** Ongoing changes/clarifications to OPPS  
implementing instructions, revision to the TSM Chapter 2, Addendum O (Default  
HCPCS Codes), application of OPPS Bilateral Discounting, and including End Stage  
Renal Disease (ESRD) services under OPPS.

**EFFECTIVE AND IMPLEMENTATION DATE:** June 1, 2007.

This change is made in conjunction with Aug 2002 TOM, Change No. 43 and Aug  
2002 TSM, Change No. 40.

  
Reta Michak  
Chief, Office of Medical Benefits  
and Reimbursement Systems

ATTACHMENT(S): 113 PAGE(S)  
DISTRIBUTION: 6010.55-M

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

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**CHAPTER 4**

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Addendum A (FY2006), pages 1 - 24

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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)

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### I. APPLICABILITY

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

### II. ISSUE

How is surgery to be reimbursed?

### III. POLICY

#### A. Multiple Surgery.

1. The following rules are to be followed whenever there is a terminate surgical procedure on more than one surgical procedure performed during the same operative 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 June 1, 2007:

##### a. Discounting for Multiple Surgical Procedures.

(1) When more than one surgical procedure is performed during a single operative 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 PPS payment amount and beneficiary copayment/cost-share amount will be paid for all other procedures performed during the same operative 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.

b. Discounting for Bilateral Procedures.

(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 percent 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 percent of the appropriated allowable amounts referenced above.

## TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

### CHAPTER 1, SECTION 16

#### SURGERY

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2. Exceptions to the above policy prior to implementation of the hospital OPPS on June 1, 2007, 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.

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.

l. 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. Effective June 1, 2007, surgical procedures will be discounted in accordance with the provisions outlined in Chapter 13, Section 3, paragraph III.A.5.b. and c.

- END -

## HOSPITAL REIMBURSEMENT - OUTPATIENT SERVICES FOR ALL SERVICES PRIOR TO JUNE 1, 2007 AND THEREAFTER, FOR SERVICES NOT OTHERWISE REIMBURSED UNDER HOSPITAL OPPTS

ISSUE DATE: March 10, 2000

AUTHORITY: 32 CFR 199.14(a)(3) and (a)(5)

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### I. APPLICABILITY

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

### II. ISSUE

How are outpatient hospital services to be reimbursed for all services prior to June 1, 2007, and thereafter, for services that are not subject to the Hospital Outpatient Prospective Payment System (OPPS)?

### III. POLICY

A. When professional services or diagnostic tests (e.g., laboratory, radiology, EKG, EEG) that have CMAC pricing (Chapter 5, Section 3) are billed, the claim must have the appropriate 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 sufficient 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). Other services without allowable charges, such as facility charges, shall be paid as billed.

C. When sufficient coding information is provided, outpatient hospital services including emergency 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.

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CHAPTER 1, SECTION 24

HOSPITAL REIMBURSEMENT - OUTPATIENT SERVICES FOR ALL SERVICES PRIOR TO JUNE 1, 2007 AND THEREAFTER, FOR SERVICES NOT OTHERWISE REIMBURSED UNDER HOSPITAL OPPS

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D. Ambulatory Surgical Center services are to be reimbursed in accordance with Chapter 9, Section 1.

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 OPPS will be subject to the same multiple surgery guidelines and modifier requirements as prescribed under OPPS for services rendered on or after June 1, 2007. 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.

- END -

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 3, SECTION 1

REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

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$$\frac{1506.6}{250} = \$6.03$$

d. The conversion factors calculated for any profile year shall reflect prevailing charges calculated on the basis of charge data for the applicable profile year. Also, prevailing charges established through the use of a relative value scale and conversion factors, in effect, consist of two components. Consequently, the conversion factors used must be recalculated when there is an extensive change in the relative value units assigned to procedures (as may occur if the contractor begins to use a different or updated relative value scale but not if the unit value of a single procedure is changed) in order to ensure that the change(s) in unit values do not change resultant conversion factors.

e. Since conversion factors are a calculated amount and will only be used when multiplied by a relative value, conversion factors are to be rounded only to the nearest whole cent. It will not be acceptable to round to the nearest dollar or tenth dollar (dime).

E. Procedure Codes. The CPT<sup>2</sup> Coding System includes Level I: CPT Codes and Level II: Alpha Character and TMA approved codes for retail and mail order pharmacy. (Reference the TRICARE Systems Manual, Chapter 2, Addendum E and F.)

F. Professional surgical procedures will be subject to the same multiple surgery guidelines and modifier requirements as prescribed under the Outpatient Prospective Payment System (OPPS) for services rendered on or after June 1, 2007. 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. Prevention Of Gross Dollar Errors. Parameters Consistent With Private Business. The contractor shall establish procedures for the review and authorization of payment for all claims exceeding a predetermined dollar amount. These authorization schedules shall be consistent with the contractor's private business standards.

III. ALLOWABLE CHARGE METHOD: APPLICATION

A. Durable Medical Equipment (DME), Durable Equipment (DE), And Supplies. Also, see Chapter 1, Section 11 and the TRICARE Policy Manual, Chapter 8, Section 2.1.

B. Physician Assistant Services. The allowable charge for physician assistant services is determined in accordance with the provisions of Chapter 1, Section 6, and is based on a percentage of the allowed charge for the service when performed by the employing physician. Only the employing physician may bill for physician assistant services. Physician assistants' billed and allowed charges must be excluded from calculation of physician

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<sup>2</sup> CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

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## CHAPTER 3, SECTION 1

### REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

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profiles. Payment is made to the employing physician who is an authorized TRICARE provider.

C. Teaching Physicians. Payment for services of teaching physicians may be made on an allowable charge basis only if an attending physician relationship has been established between the teaching physician and the patient. Refer to Chapter 1, Section 4 for a full explanation of applicable prerequisites.

#### IV. ALTERNATIVE REIMBURSEMENT METHODS FOR NON-NETWORK PROVIDERS

The contractor, with the concurrence of the Executive Director, TMA (or a designee), may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to assure a high level of acceptance of the TRICARE-determined charge by the individual health care professionals or other non-institutional health care providers furnishing services and supplies to TRICARE beneficiaries. Alternative methods shall not result in reimbursement greater than under the allowable charge method above, nor result in a higher cost for the affected beneficiary population.

#### V. CHAMPUS MAXIMUM ALLOWABLE CHARGE SYSTEM

A. General. The CHAMPUS Maximum Allowable Charge (CMAC) System is effective for services rendered on and after May 1, 1992. Contractors shall process claims using the requirements specified in the TRICARE Policy Manual (specific TRICARE Policy Manual references follow). Adjustments shall be processed using the reimbursement system in place at the time the services were rendered. The zip code where the service was rendered determines the locality code to be used in determining the allowable charge under CMAC. In most instances the zip code used to determine locality code will be the zip code of the provider's office. For processing an adjustment on a claim which was reimbursed using CMAC, the zip code which was used to process the initial claim must be used to determine the locality for the allowable charge calculation for the adjustment. Adjustments shall be processed using the appropriate fee screen year, which shall be based on the date of service. Post Office Box zip codes are acceptable only for Puerto Rico and for providers whose major specialty is anesthesiology, radiology or pathology (see Chapter 5, Section 3).

B. Locality Code. For TED reporting, the locality code used in the reimbursement of the procedure code is to be reported for each payment record line item, i.e., on each line item where payment is based on a CMAC, the locality shall be reported. Any adjustment to a claim originally paid under CMAC without a locality code, shall include the locality code that it was priced on at the time of the initial payment. The locality code reported on the initial claim shall be used to process any future adjustments of that claim unless one of the conditions listed below occurs:

1. The adjustment is changing the type of pricing from CMAC to state prevailing in which case the locality code should be blank filled, or;

contractor. Non-network RTCs (see the TRICARE Operations Manual, Chapter 4) shall be reimbursed based on the rate established by TMA, using the methodology specified in Chapter 7, Section 4.

## VII. REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS

### A. General

1. Payment for facility charges for ambulatory surgical services will be made using prospectively determined rates. The rates will be divided into 11 payment groups representing ranges of costs and will apply to all ambulatory surgical procedures identified by TMA regardless of whether they are provided in a freestanding ambulatory surgical center (ASC), in a hospital outpatient clinic, or in a hospital emergency room.

2. TMA will provide the facility payment rates to the contractors on magnetic media and will provide updates each year. The magnetic media will include the locality-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. In addition, the contractors will be provided a zip code to MSA crosswalk.

3. Contractors are required to maintain only two sets of rates on their on-line systems at any time.

4. Professional services related to ambulatory surgical procedures will be reimbursed under the instructions for individual health care professionals and other non-institutional health care providers in Chapter 3, Section 1.

5. See Chapter 9, Section 1 for additional instructions.

B. Payment Procedures. All rate calculations will be performed by TMA (or its data contractor) and will be provided to each contractor. In pricing a claim, the contractor will be required to identify the zip code of the facility which provided the services (for the actual location, not the billing address, etc.) and the procedure(s) performed. The contractor shall use the zip code to MSA crosswalk to identify the rates applicable to that facility and then will select the rate applicable to the procedure(s) performed. Multiple procedures are to be reimbursed in accordance with the instructions in the TRICARE Policy Manual. Surgical procedures (both institutional and professional) will be subject to the multiple surgery guidelines and modifier requirement as prescribed under Chapter 1, Section 16, paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for services rendered on or after June 1, 2007.

C. Claims Form Requirements. Claims for facility charges must be submitted on a UB-92. Claims for professional charges may be submitted on either a UB-92 or a CMS 1500 claim form. The preferred form is the CMS 1500. When professional services are billed on a UB-92, the information on the UB-92 should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

## VIII. CLAIM ADJUSTMENTS

Facilities may not submit a late charge bill (frequency 5 in the third position of the bill type). They must submit an adjustment bill for any services required to be billed with HCPCS codes, units, and line item dates of service by reporting frequency 7 (replacement of a prior claim) or frequency 8 (void/cancel of a prior claim). Claims submitted with a frequency code of 7 or 8 should report the original claim number in Form Locator 37 on the UB-92 claim form.

## IX. PROPER REPORTING OF CONDITION CODES

Hospitals should report valid Condition Codes on the UB claim form as necessary.

A. Condition Codes are reported in FLs 24-30 when applicable.

B. The following are two examples of condition code reporting:

1. **Condition Code G (zero)** identifies 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.

a. 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.

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

2. **Condition Code 41** identifies a claim being submitted for Partial Hospitalization Program (PHP) Services.

- END -

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### CHAPTER 4, SECTION 3 COORDINATION OF BENEFITS

insurance which has paid \$1,645.00 on the claim. The wage adjusted TRICARE APC rate for the procedure performed is \$1,235.00.

- STEP 1:     \$ 1,235.00 - APC allowed amount  
              - 0.00 - Deductible and cost-sharing not applied since beneficiary is a Prime active duty family member  
              \$ 1,235.00 - Amount payable by TRICARE in the absence of other coverage
- STEP 2:     \$ 2,450.00 - Billed charge  
              - 1,645.00 - OHI payment  
              \$ 805.00 - Unpaid balance
- STEP 3:     TRICARE pays \$805.00 balance, since it is less than what TRICARE would have paid in the absence of double coverage.

NOTE: The above COB methodology for hospital outpatient services will not go into effect until implementation of the hospital outpatient prospective payment system. This new reimbursement system is tentatively scheduled to become effective on June 1, 2007.

#### VII. EXAMPLES OF COMPUTATION OF THE TRICARE SHARE WHEN THE BENEFICIARY'S LIABILITY IS LIMITED UNDER THE OHI

EXAMPLE 1: The bill for outpatient care for an active duty dependent is \$200.00, which is considered allowable by TRICARE. The TRICARE deductible has been met. The provider submitted the claim on a participating basis, along with an EOB from the OHI. The OHI discounted rate is \$100.00 and it paid \$90.00. The beneficiary's liability is limited to \$100.00 under the OHI, and this is evident on the EOB from the OHI. The provider submitted a claim for \$200.00.

- STEP 1:     \$ 200.00 - Allowable charges  
                x 80% - TRICARE portion for active duty dependents  
              \$ 160.00 - Amount payable by TRICARE in the absence of other coverage
- STEP 2:     \$ 100.00 - OHI amount allowed  
                - 90.00 - Paid by OHI  
              \$ 10.00 - Unpaid balance
- STEP 3:     TRICARE pays \$10.00 to the provider since this is the lower of the two computations. The beneficiary owes nothing, since the full legal liability has been paid.

EXAMPLE 2: A provider's normal charge for an outpatient service is \$160.00. The provider is a network provider and has a negotiated discount rate of 10% off the CMAC amount which is \$145.00. The provider also has a discounted rate of \$110.00 with the OHI and receives no OHI payment due to application of OHI deductible. The beneficiary is a retiree who is enrolled in Prime. The

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CHAPTER 4, SECTION 3  
COORDINATION OF BENEFITS

beneficiary's liability is limited to \$110.00 under the OHI, and this is evident on the EOB from the OHI.

- STEP 1:      \$ 160.00 - Billed amount  
              \$ 145.00 - CMAC amount  
              \$ 130.50 - Negotiated rate (10% off the CMAC amount)  
              - 12.00 - TRICARE Prime copay for retirees  
              \$ 118.50 - Amount payable by TRICARE in the absence of other coverage
- STEP 2:      \$ 110.00 - OHI amount allowed  
              - 0.00 - Paid by OHI  
              \$ 110.00 - Unpaid balance
- STEP 3:      TRICARE pays \$110.00 since this is the lower of the two computations, and the beneficiary owes nothing.

EXAMPLE 3: The billed charge for seven days of inpatient care in March 2002 for a retiree is \$5,000.00. The claim is subject to the TRICARE DRG-based payment system, and the DRG-based amount is \$6,000.00. The hospital has agreed to a 10% discount off the DRG amount. The retiree cost-share under the DRG-based payment system is \$1,250.00, which is 25% of the billed charges. (This is lower than the per diem of \$414.00 reduced by the 10% discount and multiplied by 7 days.) The OHI discounted rate is \$4,200.00 and it paid \$4,000.00. The beneficiary's liability is limited to \$4,200.00 under the OHI, and this is evident on the EOB from the OHI. The hospital submits a claim for \$1,000.00 along with an EOB from the OHI.

- STEP 1:      \$ 6,000.00 - DRG-based amount  
              - 600.00 - 10% discount  
              \$ 5,400.00 - DRG amount reduced by the discount  
              - 1,250.00 - Cost-share  
              \$ 3,150.00
- STEP 2:      \$ 5,400.00 - DRG amount reduced by the discount  
              - 4,000.00 - OHI payment  
              \$ 1,400.00
- STEP 3:      \$ 4,200.00 - OHI amount allowed  
              - 4,000.00 - OHI payment  
              \$ 200.00
- STEP 4:      \$ 4,200.00 - OHI amount allowed  
              - 1,250.00 - Cost-share  
              \$ 2,950.00
- STEP 5:      TRICARE pays \$200.00, since it is the lowest amount of Steps 1 - 4. The beneficiary owes nothing, since the full legal liability has been paid.

- END -

## ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

ISSUE DATE: March 3, 1992

AUTHORITY: 32 CFR 199.14

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### I. APPLICABILITY

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

### II. ISSUE

How are allowable charge determinations to be made in the determination of reimbursement for 1992 and forward?

### III. POLICY

A. On September 6, 1991, the final rule was published in the Federal Register implementing the provisions of the Defense Appropriations Act for Fiscal Year 1991, Public Law 101-511, Section 8012, which limits payments to physicians and other individual health care providers.

B. The final rule provided for the setting of TRICARE payments at the Medicare locality levels. This required a zip code to Medicare locality crosswalk to be developed, and locally-adjusted appropriate charge data be maintained by the contractor for each locality.

1. This file shall contain all active zip codes. Nevertheless, contractors shall probably encounter zip codes that do not appear on the zip code/Medicare locality file. As needed, TMA shall inform the contractors of the Medicare locality of new zip codes. In rare instances where the contractors have not been notified of the Medicare locality for a zip code, the contractors shall be responsible for referring identified zip codes to TMA so that TMA can place the zip code in a Medicare locality.

2. The zip code/Medicare locality file will contain a 2-digit state code [both alphabetic abbreviations and Federal Information Processing System (FIPS) codes], the 5-digit zip code, and a 3-digit Medicare locality code for each zip code. The file will contain about 42,000 codes. In addition to the zip code/Medicare locality file, a listing of the corresponding 7-digit Medicare codes and how they correspond to each of the 3-digit codes will be provided to the contractors.

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CHAPTER 5, SECTION 3

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

3. The zip code/Medicare locality file has a file layout as follows:

DATA TYPE	COLUMNS	
State abbreviation	1-2	alphabetic
State FIPS code	3-4	numeric
Zip code	5-9	numeric
Locality	10-12	numeric

For example, the first two columns will be the State code, the third and fourth columns will be the State FIPS code, the fifth through ninth columns will be 5-digit zip code, and the 10th-12th columns will be the Medicare locality code. The most current locality for the zip code would always be in columns 10-12. Previous years localities would be in the columns next to columns 10-12 by year in descending order, newest to oldest. Eliminated zip codes shall be zero filled. The file is in ASCII format and will be provided on a 3.5" diskette.

a. When a claim is submitted to the contractor, the contractor shall use the provider's zip code (see below) to determine the provider's Medicare locality and then access the appropriate locality-specific procedure code file. The contractor shall thus need to maintain one file for every Medicare locality in the contractor's geographic area instead of one file for each state. Medicare locality codes consist of a three-digit code.

NOTE: The zip code where the service was rendered determines the locality code to be used in determining the allowable charge under CMAC. In most instances the zip code used to determine locality code will be the zip code of the provider's office. The contractors are to use the provider's zip code on the claim to determine place of service. A zip code of a P.O. Box would not be acceptable except in Puerto Rico. Anesthesiologists, radiologists and pathologists would be allowed to use the zip code of a P.O. Box (TRICARE Systems Manual, Chapter 2, Section 2.7, Element Name: Provider Zip Code). Contractors must use the zip code of the MTF for services provided under a partnership arrangement/ Resource Sharing. For hospital-based providers or providers in a teaching setting, the contractors must use the zip code of the hospital.

b. For payment purposes, the contractor shall determine whether this calculated amount (locally-adjusted CMAC for the appropriate payment locality) is lower than the billed charge. For partnership claims or claims where the provider has agreed to take a discount from the prevailing, this reduction must be taken into consideration. Therefore, for claims involving a discount, the prevailing must be discounted then compared to the billed charge to determine the lower of the two.

c. Categories of care not subject to the National Allowable Charge System. Pricing for certain categories of health care shall remain the responsibility of the contractor. The following categories will continue to be priced under current contractor procedures:

- Routine Dental (ADA codes)
- Ambulance

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D. The CHAMPUS Maximum Allowable Charge applies to all fifty states, Puerto Rico, and the Philippines. Further information regarding the reimbursement of professional services in the Philippines, see the TRICARE Policy Manual, Chapter 12, Section 11.1. Guam and the Virgin Islands are to still be paid as billed for professional services.

E. Provisions which affect the TRICARE allowable charge payment methodology.

NOTE: The first CMAC file update for 1999, raises all CMACs for physicians and psychologists that are priced using the Medicare RVUs to the Medicare Fee Schedule levels. CMACs for mental health providers such as social workers and counselors shall be reduced by 15 percent in 1999 and a further 10 percent in 2000 so that they will be equal to 75 percent of the CMAC for psychiatrists and psychologists by the year 2000. Medicare reimburses these providers at the same differential.

Effective for services provided on or after September 1, 2003, the payment for certain provider changes to the physician payment level. These providers include: podiatrists, oral surgeons, optometrists, occupational therapists, speech therapists, physical therapists, audiologists, and psychologists. Previously, psychologists were paid under the physician payment level, and the above remaining providers were paid under the non-physician payment level. Podiatrists, oral surgeons, and optometrists shall also come under the HPSA bonus payment. See Chapter 1, Section 33.

1. Reductions in maximum allowable payments to Medicare levels.

2. Balance billing limitation.

α. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. This limit is 115 percent of the TRICARE allowable charge, not to exceed the billed charge.

NOTE: When the billed amount is less than 115 percent of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit is to be applied to each line item on a claim.

EXAMPLE 1: No Other Health Insurance

Billed charge	\$500
Allowable charge	\$200
Amount billed to beneficiary (115% of \$200)	\$230

EXAMPLE 2: Other Health Insurance

Billed charge	\$500
Allowable charge	\$200
Amount paid by other health insurance to the beneficiary	\$200
Amount billable to beneficiary (115% of \$200)	\$230

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NOTE: When payment is made by other health insurance, this payment does not affect the amount billable to the beneficiary by the nonparticipating provider except, when it can be determined that the other health insurance limits the amount that can be billed to the beneficiary by the provider.

b. Failure to Comply. If a nonparticipating provider fails to comply with this balance billing limitation requirement, the provider shall be subject to exclusion from the TRICARE Program as an authorized provider and may be excluded as a Medicare provider.

c. Granting of Waiver of Limitation. When requested by a TRICARE beneficiary, the contractor, on a case-by-case basis, may waive the balance billing limitation. If the beneficiary is willing to pay the nonparticipating provider for his/her billed charges, then the waiver shall be granted. The contractor shall obtain a signed statement from the beneficiary stating that he/she is aware that the provider is billing above the 115 percent limit, however, they feel strongly about using that provider and they are willing to pay the additional money. The beneficiary shall be advised that the provider still may be excluded from the TRICARE program, if he/she is over billing other TRICARE beneficiaries and they object. The waiver is controlled by the contractor, not by the provider. The contractor is responsible for communicating the potential costs to the beneficiary if the waiver statement is signed. A decision by the contractor to waive or not to waive the limit is not subject to the appeals process. For the TRICARE Outpatient Prospective Payment System (OPPS), the granting of waivers for balance billing limitations applies only to EXEMPT OPPS providers.

3. Site of Service. CMAC payments based on site of service becomes effective for services rendered on or after April 1, 2005. Payment based on site of service is a concept used by Medicare to distinguish between services rendered in a facility setting as opposed to a non-facility setting. Prior to April 1, 2005, CMACs were established at the higher rate of the facility or non-facility payment level. For some services such as radiology and laboratory tests, the facility and non-facility payment levels are the same. In addition, prior to April 1, 2005, CMAC pricing was established by class of provider (1, 2, 3, and 4). These four classes of providers will be superseded by four categories.

a. Categories.

Category 1: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 510), residential treatment centers, ambulances, hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, etc.

Category 2: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a non-facility including provider offices, home settings, and all other non-facility settings.

Category 3: Services, of all other providers not found in category 1, provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 510), residential treatment centers, ambulances,

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hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, 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 TRICARE Management Activity (TMA) through its contractor that calculates the CMAC rates.

c. Payment of facility charges when the 510 and 760 series revenue codes are billed.

(1) Effective for services on or after April 1, 2005, payment of 510 and 760 series revenue codes shall begin. Payment would be made as billed unless a discounted negotiated rate can be obtained for OPPS exempt providers.

(2) Effective for services on or after June 1, 2007, payment of 510 and 760 series revenue codes will be based on the HCPCS codes submitted on the claim and reimbursed under the OPPS.

d. 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.

e. 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.

f. 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 June 1, 2007. 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.

- END -



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CHAPTER 9, SECTION 1

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(1) For each ambulatory surgery procedure, a median standardized cost was calculated on the basis of all ambulatory surgery charges nationally under TRICARE during the one-year database period. The steps in this calculation included:

(a) Standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare;

(b) Applying the cost-to-charge ratio using the Medicare cost-to-charge ratio for freestanding ambulatory surgery centers for 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.

(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

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same labor/non-labor-related cost ratio and hospital wage index as used for ambulatory surgery centers 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.

b. Procedures Which are Not in Chapter 9, Addendums A and B and Are Provided by an ASC. Only those procedures contained in Chapter 9, Addendums A and B are to be reimbursed under this reimbursement process. If a claim is received from an ASC for a procedure which is not in Chapter 9, Addendums A and B, the facility charges are to be reimbursed using the process in paragraph III.B. below.

c. Procedures Which Are Not in Chapter 9, Addendums A and B and Are Provided by a Hospital. If an ambulatory surgery procedure not contained in Chapter 9, Addendums A and B is provided by a hospital (either in an emergency room or in an outpatient department), the claim is to be reimbursed using the process in paragraph III.B. below.

d. 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. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for services rendered on or after June 1, 2007. For the facility charges, the following rules apply:

(1) Discounting for Multiple Surgical Procedures.

(a) If all the procedures on the claim are included in Chapter 9, Addendums A and B, the claim is to be reimbursed at 100 percent of the group payment rate for the major procedure (the procedure which allows the greatest payment) and 50 percent of the group payment rate for each of the other procedures. This applies regardless of the groups to which the procedures are assigned--i.e., if all the procedures are assigned to the same group, payment is to be made for each procedure.

(b) If the claim includes procedures included in Chapter 9, Addendums A and B as well as procedures not included in Chapter 9, Addendums A and B, 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 in Chapter 9, Addendums A and B is to be based on the appropriate group payment amount while the allowable amount for procedures not in Chapter 9, Addendums A and B is to be based on the process in paragraph III.B. below. Regardless of the method used for determining the reimbursement

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for each procedure, only one procedure (the procedure which allows the greatest payment) is to be reimbursed at 100 percent. All other procedures are to be reimbursed at 50 percent. 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. 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 in Chapter 9, Addendums A and B 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.

(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.

(d) 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).

(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.

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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 percent 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.

2 Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100 percent 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 contained 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 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 ambulatory surgery center payments. Periodically the rates will be recalculated using the steps in paragraph III.A.4.d.

b. The rates were updated by 3.2 percent effective November 1, 1995. This update included the wage indexes as updated by Medicare.

c. The rates were updated by 2.6 percent effective November 1, 1996. This update included the wage indexes as updated by Medicare.

d. The rates were updated by 0.6 percent effective November 1, 1997. This update included the wage indexes as updated by Medicare.

e. There was no update to the rates effective November 1, 1998. However, the wage indexes were updated in accordance with Medicare.

f. The rates were updated by 0.8 percent effective November 1, 1999. This update included the wage indexes as updated by Medicare.

g. The rates were updated by 1.0 percent effective November 1, 2000. This update included the wage indexes as updated by Medicare.

h. The rates were updated by 0.9 percent effective November 1, 2001. This update included the wage indexes as updated by Medicare.

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

j. The group payment rates that are effective November 1, 2003, have been recalculated using the steps in paragraph III.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 percent of TRICARE ambulatory surgery services. In addition, the rates were updated by the Medicare update factor of 2.0 percent and included the wage indexes as updated by Medicare.

k. The rates were reduced by 2.0 percent effective April 1, 2004.

B. Reimbursement for procedures not in Chapter 9, Addendums A and B. Prior to January 28, 2000, these procedures were to be denied if performed in an ASC and reimbursed in accordance with Chapter 1, Section 25 if performed in a hospital. Effective January 28, 2000, ambulatory surgery procedures that are not in Chapter 9, Addendums A and B, and are performed in either a freestanding ASC or hospital may be cost-shared, but only if doing so results in no additional costs to the program.

#### C. Claims for Ambulatory Surgery.

1. Claims for facility charges must be submitted on a UB-92. Claims for professional charges may be submitted on either a UB-92 or a CMS 1500 claim form. The preferred form is the CMS 1500. When professional services are billed on a UB-92, the information on the UB-92 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) and indicate if the bill is for facility charges or professional charges. (If the claim is submitted on a UB-92, the procedure code will be shown in FL 44.)

b. TED Data. 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. These services are to be reported on the TED using one of the codes in the TRICARE Systems Manual, Chapter 2, Addendum O.

D. 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.

E. 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

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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.

- END -

## BIRTHING CENTERS

SECTION	SUBJECT
1	Freestanding And Hospital-Based Birthing Center Reimbursement
ADDENDUM A	Birthing Center Rate Non-Professional Component
	FIGURE 10-A-1 - Birthing Center Rate Non-Professional Component - FY 2004
	FIGURE 10-A-2 - Birthing Center Rate Non-Professional Component - FY 2005
	FIGURE 10-A-3 - Birthing Center Rate Non-Professional Component - FY 2006
	FIGURE 10-A-4 - Birthing Center Rate Non-Professional Component - FY 2007



## FREESTANDING AND HOSPITAL-BASED BIRTHING CENTER REIMBURSEMENT

ISSUE DATE: February 14, 1984

AUTHORITY: 32 CFR 199.6(b)(4)(xi)(A)(3) and 32 CFR 199.14(e)

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### I. APPLICABILITY

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

### II. DESCRIPTION

A birthing center is a freestanding or institution affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

### III. POLICY

A. A freestanding or institution affiliated birthing center may be considered for status as an authorized institutional provider.

B. Reimbursement for all-inclusive maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the TRICARE established all-inclusive rate or the billed charge.

C. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility. The rate includes physician services for routine consultation when certified nurse-midwife is the attending professional.

NOTE: The initial complete newborn examination by a pediatrician is not included in the Birthing Center all-inclusive fee and is to be cost-shared as a part of the maternity episode when performed within 72 hours of the delivery.

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D. Claims for professional services and tests where the beneficiary has been screened but rejected for admission into the program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, should be priced as individual services and items, subject to current policies for obstetrical care professional services and reported as appropriate CPT<sup>1</sup> procedure code with place of service "25" for birthing center.

E. Extraordinary maternity care services (services in excess of the quantity or type usually associated with all-inclusive maternity care and childbirth service for a normal pregnancy) may be cost-shared as part of the birthing center maternity episode and paid as the lesser of the billed charge or the allowable charge when the service is determined to be otherwise authorized and medically necessary and appropriate.

F. Calculation of the TRICARE maximum allowable birthing center all-inclusive rate.

1. The TRICARE maximum allowable all-inclusive rate is equal to the sum of the Class 3 CHAMPUS Maximum Allowable Charge (CMAC) for total obstetrical care for a normal pregnancy and delivery (CPT<sup>1</sup> procedure code 59400) plus the TMA supplied non professional price component amount. TMA will supply each contractor with non professional price components for each state annually (Chapter 10, Addendum A) to be effective for the forthcoming fiscal year.

2. The maximum allowable all-inclusive rate shall be updated with each CMAC professional charge data base update.

G. Claims processing.

1. The cost-share amount for birthing center claims is calculated using the ambulatory surgery cost-share formula.

2. Claims from birthing centers will be processed as outpatient hospital claims using revenue code 724 and the following CPT<sup>1</sup> procedure code with place of service "25" for birthing center.

59400 *Birthing Center, all-inclusive charge, complete*

3. Both the technical and professional components of usual tests are included in the all-inclusive rate.

H. Excluded services<sup>1</sup> when billed separately.

99071 *Patient education materials*

99078 *Group health education*

- END -

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<sup>1</sup> CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

## OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) - AMBULATORY PAYMENT CLASSIFICATIONS (APCs)

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

SECTION	SUBJECT
1	General
2	Billing And Coding Of Services Under APC Groups
	FIGURE 13-2-1 Revenue and HCPCS Level I and II Codes Used in Billing For Partial Hospitalization Services For CY 2003
	FIGURE 13-2-2 Required Diagnoses For Chest Pain
	FIGURE 13-2-3 Required Diagnoses For Asthma
	FIGURE 13-2-4 Required Diagnoses For Congestive Heart Failure
	FIGURE 13-2-5 Required Diagnoses For Maternity
3	Prospective Payment Methodology
	FIGURE 13-3-1 List Of Revenue Centers Packaged Into Major HCPCS Codes When Appearing In The Same Claim
	FIGURE 13-3-2 Discounting Formulas For Bilateral Procedures
	FIGURE 13-3-3 Application of Discounting Formulas
	FIGURE 13-3-4 Crosswalk From HCPCS Level I <sup>1</sup> Codes For Drug Administration To Drug Administration APCs
	FIGURE 13-3-5 OPPTS Drug Administration Codes
	FIGURE 13-3-6 Non-Chemotherapy Prolonged Infusion Codes That Require A Pump
	FIGURE 13-3-7 Vaccine Administration Codes And Status Indicators
	FIGURE 13-3-8 Assignment of Blood and Blood Product Codes
	FIGURE 13-3-9 Proportional Payment for "T" Line Items
4	Claims Submission And Processing Requirements
	FIGURE 13-4-1 Actions Taken When Multiple Medical Visits Occur On The Same Day
5	Medical Review Under the Outpatient Prospective Payment System (OPPS)

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CHAPTER 13 - OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) - AMBULATORY PAYMENT  
CLASSIFICATIONS (APCs)

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

SECTION	SUBJECT
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ADDENDUM A1	Development Schedule For TRICARE OCE/APC Quarterly Update
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ADDENDUM A2	OPPS OCE Notification Process For Quarterly Updates
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GENERAL

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

(3) Critical access hospitals. The contractors shall monitor TMA's website at <http://www.tricare.mil/opps> for updates to the critical access hospital list and update their systems to reflect the most current information on the list.

(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 Partial Hospitalization Programs (PHPs), Psych 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 OPSS 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) VA Hospitals.

2. Scope of Services.

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

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

- (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, home health agencies (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, 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.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

(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 nonphysician anesthetists (certified registered nurse anesthetists (CRNA) and anesthesiologists’ assistants) 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 partial hospitalization programs (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

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

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. They include the following:

(a) Surgical procedures.

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

(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.

NOTE: Because implantable items are now packaged into the APC payment rate for the service or procedure with which they are associated, certain items may be candidates for the transitional pass-through payment.

(i) Specific hospital outpatient services furnished to a beneficiary who is admitted to a Medicare-participating SNF but who is not considered to be a SNF resident, for purposes of SNF consolidated billing, with respect to those services that are beyond the scope of SNF comprehensive care plans. They include:

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- 1 Cardiac catheterization
  - 2 Computerized axial tomography (CAT) scans
  - 3 MRIs
  - 4 Ambulatory surgery involving the use of an operating room
  - 5 Emergency room services
  - 6 Radiation therapy
  - 7 Angiography
  - 8 Lymphatic and venous procedures
- (j) Certain preventive services furnished to healthy persons, such as colorectal cancer screening.
- (k) Acute dialysis (e.g., dialysis for poisoning).
- (l) End Stage Renal Disease (ESRD) Services. Since TRICARE does not have an ESRD composite rate, ESRD services are included in TRICARE's OPPS.

E. Description of APC Groups.

Group services identified by HCPCS codes and descriptors within APC groups are the basis for setting payment rates under the hospital OPPS.

1. Grouping of Procedures/Services Under APC System.

The APC system establishes groups of covered services so that the services within each group are comparable clinically and with respect to the use of resources.

a. Fundamental criteria for grouping procedures/services under the APC system:

(1) *Resource Homogeneity* - The amount and type of facility resources (e.g., operating room time, medical surgical supplies, and equipment) that are used to furnish or perform the individual procedures or services within each APC should be homogeneous. That is, the resources used are relatively constant across all procedures or services even though resource use may vary somewhat among individual patients.

(2) *Clinical Homogeneity* - The definition of each APC group should be "clinically meaningful"; that is, the procedures or services included within the APC group relate generally to a common organ system or etiology, have the same degree of

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extensiveness, and utilize the same method of treatment - for example, surgical, endoscopic, etc.

(3) *Provider Concentration* - The degree of provider concentration associated with the individual services that comprise the APC is considered. If a particular service is offered only in a limited number of hospitals, then the impact of payment for the services is concentrated in a subset of hospitals. Therefore, it is important to have an accurate payment level for services with a high degree of provider concentration. Conversely, the accuracy of payment levels for services that are routinely offered by most hospitals does not bias the payment system against any subset of hospitals.

(4) *Frequency of Service* - Unless there is a high degree of provider concentration, creating separate APC groups for services that are infrequently performed is avoided. Since it is difficult to establish reliable payment rates for low volume APC groups, HCPCS codes are assigned to an APC that is most similar in terms of resource use and clinical coherence.

#### F. Basic Reimbursement Methodology.

1. Under the OPSS, hospital outpatient services are paid on a rate-per-service basis that varies according to the APC group to which the service is assigned.

2. The APC classification system is composed of groups of services that are comparable clinically and with respect to the use of resources. Level I and Level II Healthcare Common Procedure Coding System (HCPCS) codes and descriptors are used to identify and group the services within each APC. Costs associated with items or services that are directly related and integral to performing a procedure or furnishing a service have been packaged into each procedure or service within an APC group with the exception of:

a. New temporary technology APCs for certain approved services that are structured based on cost rather than clinical homogeneity.

b. Separate APCs for certain medical devices, drugs, biologicals, radiopharmaceuticals and devices of brachytherapy under transitional pass-through provisions.

3. Each APC weight represents the median hospital cost of the services included in the APC relative to the median hospital cost of services included in APC 0601, Mid-Level Clinic Visits. The APC weights are scaled to APC 0601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

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 2 times greater than the lowest median cost for an item or service within the same group. However, exceptions may be made to the 2 times rule "in unusual cases, such as low volume items and services."

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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 OPSS.

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.

#### G. 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 Healthcare Common Procedure Coding System (HCPCS) codes for payment under the OPSS. The OPSS is an outpatient equivalent of the inpatient, DRG-based PPS. Like the inpatient system based on Diagnosis Related Groups (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 OPSS 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.

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

H. 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 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 OPPS 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 OPPS 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 OPPS PRICER within five weeks prior to the quarterly update. For example, statewide prevailings 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.

I. Geographical Wage Adjustments.

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

J. Provider-Based Status for Payment Under OPPS.

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 OPPS. The CMS will retain sole responsibility for determining provider-based status under the OPPS.

K. Implementing Instructions.

Since this issuance only deals with a general overview of the OPPS reimbursement

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methodology, the following cross reference is provided to facilitate access to specific implementing instructions within Chapter 13, Section 1 through 5:

IMPLEMENTING INSTRUCTIONS/SERVICES	
<b>POLICIES</b>	
General Overview	Chapter 13, Section 1
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 Under the Hospital OPSS	Chapter 13, Section 5
<b>ADDENDA</b>	
Development Schedule for TRICARE OCE/APC - Quarterly Update	Chapter 13, Addendum A1
OPSS OCE Notification Process for Quarterly Updates	Chapter 13, Addendum A2

L. OPSS Data Elements Available on TMA's web site.

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

1. APCs with Status Indicators (SIs) and Payment Rates.
2. Payment Status by HCPCS Code.
3. Payment Status Indicators.
4. CPT Codes That Are Paid Only as Inpatient Procedures.
5. Statewide Cost to Charge Ratios.
6. 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 OPSS.
7. Zip to Wage Index Crosswalk.

- 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)

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

### 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 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.

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- d. Use of an observation bed.
- 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 such as venipuncture.
- 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.

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C-codes:

(1) Hospitals are required to report device category codes on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPSS in order to improve the claims data used annually to update the OPSS payment rates.

(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. 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 emergency department.

1. If the patient dies in the emergency department, and the patient's status is outpatient, the hospital should bill for payment under the OPSS for the services furnished.

2. If the emergency department 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.

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c. If the patient was not admitted as an inpatient and the procedure designated as an inpatient-only procedure (by OPPS payment status indicator "C") is performed, the hospital should bill for payment under the OPPS 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 OPPS by the status indicator "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.*

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 status indicator "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 13X bill type for all services that were furnished, including the inpatient procedure (e.g., a procedure designated by OPPS payment status indicator "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 status indicator (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 emergency department codes will be used for medical screening examinations including ancillary services routinely available to the emergency department 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 emergency department code.

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**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

F. HCPCS/Revenue Coding Required Under OPPTS. Hospital outpatient departments should use the UB-92 Editor as a guide for reporting HCPCS and revenue codes under the OPPTS.

G. Treatment of Partial Hospitalization Services. Effective June 1, 2007, hospital-based PHPs (psych and SUDRFs) will be reimbursed a per diem payment under the OPPTS. Freestanding PHPs (psych and SUDRFs) will continue to be reimbursed under the existing PHP per diem payment.

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. Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in lieu of inpatient psychiatric care in a hospital outpatient department.

3. 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.

4. 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.

5. Per diem is the unit of payment since it defines the structure and scheduling of partial hospitalization services. The established per diem represents the median hospital cost of furnishing a day of partial hospitalization. The following are billing instructions for submission of partial hospitalization claims/services:

a. Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services.

b. The following is a complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services:

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**FIGURE 13-2-1 REVENUE AND HCPCS LEVEL I AND II CODES USED IN BILLING FOR PARTIAL HOSPITALIZATION SERVICES FOR CY 2003**

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I <sup>1</sup> AND II CODES
250	Pharmacy	HCPCS code not required
905	Intensive Outpatient Services - Psychiatric	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
906	Intensive Outpatient Services - Chemical Dependency	
911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
912	Partial Hospitalization Program - Less Intensive (Half-day PHP)	H0035
913	Partial Hospitalization Program - Intensive (Full-day PHP)	H0037
914	Individual Psychotherapy	90816- 90819, 90821- 90824, 90826-90829
915	Group Therapy	90849, 90853, 90857
916	Family Psychotherapy	90846, 90847, 90849
918	Psychiatric Testing	96100, 96115, 96117

<sup>1</sup> HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

c. To bill for partial hospitalization services under the hospital OPPS, hospitals are to use the above HCPCS and revenue codes and are to report partial hospitalization services under bill type 13X, along with condition code 41 on the HCFA 1450 claim form.

d. The claim must include a mental health diagnosis and an authorization on file for each day of service, along with a designated H-code (i.e., either H0035 for half-day PHP or H0037 for full-day PHP) and its accompanying revenue code, prior to assigning a full- or half-day partial hospitalization APC. Claims that do not meet the above criteria (e.g., claim filed without condition code 41, appropriate H-coding - H0035 or H0037, and/or revenue code) will undergo further prepayment review to ensure that outpatient department mental health procedures do not exceed the full-day partial hospitalization per diem amount; i.e., the sum of the individual mental health APC amounts on any particular day does not exceed the full-day partial hospitalization per diem amount. The following are basic reporting requirements for assigning full- and half-day partial hospitalization APCs:

**Reporting Requirements for PHP:**

- Bill Type 13x
- Mental Health (MH) Primary Diagnosis
- Condition code 41, PH HCPCS, PH revenue code (yes/no)

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- *Yes*
  - Authorization on File
    - *Yes*
      - H0035/RC 912 - APC T0001 (half-day PHP)
      - H0037/RC 913 - APC 0033 (full-day PHP)
    - *No* - deny claim
  - *No* (Bill Type 12x, 13x, 14x without condition code 41)
    - Sum of Mental Health APCs >PHP APC 0033 payment amount on a given day (yes/no)
      - *Yes*
        - Assign daily MH service payment APC 0034
        - Package all other MH services
        - Apply standard APC payment rule to non-MH services
      - *No* - Apply standard APC payment rules

(1) Each day of service will be assigned to a partial hospitalization APC, and the partial hospitalization per diem amount will be paid.

(2) Specific therapy codes (e.g., coding for family, group and individual psychotherapy) will be reported in addition to designated partial hospitalization codes H0035 and H0037 (refer to Figure 13-2-1 above for specific therapy coding). Specific mental health (MH) services will be packaged into a single PHP code for the same date of service with the exception of electroconvulsive therapy (ECT).

(3) Only one PHP APC will be paid per day.

(c) If multiples of the same H-code (either H0035 or H0037 but not both) appear on the claim for the same date of service, the first H-code will be designated for APC assignment and all other specific therapy codes will be packaged into the H-code line for remittance reporting.

(b) If both H-codes (H0035 and H0037) appear on the claim for the same date of service, payment will default to the less intensive treatment modality (half-day PHP); i.e., H0035 will be recognized for payment. Other therapy codes reported on the same date of service will be packaged into the less intensive H-code for remittance reporting.

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

(5) Revenue codes 912 and 913 must be accompanied by an appropriately designated HCPCS code (refer to Figure 13-2-1 for designated PHP coding). If revenue codes 912 and 913 are submitted without a HCPCS, the line and/or claim will be denied.

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(6) Claims that include days that do not meet the above requirements for assignment to a partial hospitalization APC will be identified for further review.

(7) The total amount payable for psychiatric services furnished in a hospital outpatient department (not under the partial hospitalization program) for an individual for one day will be limited to the APC per diem payment amount for full-day partial hospitalization.

(8) Half-day PHP per diem will be priced at 75 percent of the full-day PHP rate.

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

#### H. Billing and Payment Requirements for Observation Services.

1. Observation Stays with Diagnoses of Chest Pain, Asthma, Congestive Heart Failure or Maternity.

a. Two new HCPCS codes have been created to be used by hospitals to report all observation services, whether separately payable or packaged, and direct admission for observation care, whether separately payable or packaged:

(1) G0378 -- Hospital observation services, per hour, and

(2) G0379 -- Direct admission of patient for hospital observation care.

b. The determination of whether or not observation services are separately payable under APC 0339 (observation) has been shifted from the hospital billing department to the OPSS claims processing logic.

(1) The hospital will bill HCPCS code G0378 when observation services are provided to any patient admitted to "observation status", regardless of the patient's condition.

(2) In addition to the HCPCS code G0378, hospitals will bill HCPCS code G0379 when observation services are the result of a direct admission to "observation status" without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of or day before the observation services.

(3) The above HCPCS (G0378 & G0379) will be assigned a new status indicator "Q" (packaged service subject to separate payment based on criteria) that will trigger the OCE logic during the processing of the claim to determine if the observation service or direct admission service is packaged with the other separately payable hospital services provided, or if a separate APC payment for observation services or direct admission to observation is appropriate.

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(4) The units of services reported with HCPCS code G0378 will equal the number of hours the patient is in observation status.

c. Direct admission to observation will continue to be paid at a rate equal to that of a Low Level Clinic Visit (APC 600) when a beneficiary is seen by a physician in the community and then is directly admitted into a hospital outpatient department for observation care that does not qualify for separate payment under APC 0339, and under T0002.

(1) In order to receive separate payment for a direct admission into observation (APC 0600), the claim must show:

(a) Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service.

(b) That no service with status indicator "T" or "V" (clinic or emergency department visit) or critical care (APC 0620) were provided on the same day of service as HCPCS code G0379.

(c) The observation care does not qualify for separate payment under APC 0339.

d. Criteria for separate observation payments include:

(1) Documentation of specific ICD-9-CM diagnostic codes.

(a) The beneficiary must have one of four medical conditions: congestive heart failure, chest pain, asthma, or maternity.

(b) The hospital bill must report at least one of the ICD-9-CM diagnoses listed in Figure 13-2-2 through Figure 13-2-5 as the reason for visit or principal diagnosis:

1 The qualifying ICD-9-CM diagnosis code must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both, in order for the hospital to receive separate payment for APC 0339.

2 If a qualifying ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis field but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 will not be allowed.

**FIGURE 13-2-2 REQUIRED DIAGNOSES FOR CHEST PAIN**

ICD-9-CM	DESCRIPTION
411.0	Postmyocardial infarction syndrome
411.1	Intermediate coronary syndrome

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**FIGURE 13-2-2 REQUIRED DIAGNOSES FOR CHEST PAIN (CONTINUED)**

ICD-9-CM	DESCRIPTION
411.81	Coronary occlusion without myocardial infarction
411.89	Other acute ischemic heart disease
413.0	Angina decubitus
413.1	Pinzmetal angina
413.9	Other and unspecified angina pectoris
786.05	Shortness of breath
786.50	Chest pain, unspecified
786.51	Precordial pain
786.52	Painful respiration
786.59	Other chest pain

**FIGURE 13-2-3 REQUIRED DIAGNOSES FOR ASTHMA**

ICD-9-CM	DESCRIPTION
493.01	Extrinsic asthma with status asthmaticus
493.02	Extrinsic asthma with acute exacerbation
493.11	Intrinsic asthma with status asthmaticus
493.12	Intrinsic asthma with acute exacerbation
493.21	Chronic obstructive asthma with status asthmaticus
493.22	Chronic obstructive asthma with acute exacerbation
493.91	Asthma, unspecified with status asthmaticus
493.92	Asthma, unspecified with acute exacerbation

**FIGURE 13-2-4 REQUIRED DIAGNOSES FOR CONGESTIVE HEART FAILURE**

ICD-9-CM	DESCRIPTION
391.8	Other acute rheumatic heart disease
398.91	Rheumatic heart failure (congestive)
402.01	Malignant hypertensive heart disease with congestive heart failure
402.11	Benign hypertensive heart disease with congestive heart failure
402.91	Unspecified hypertensive heart disease with congestive heart failure
404.01	Malignant hypertensive heart and renal disease with congestive heart failure
404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure
404.11	Benign hypertensive heart and renal disease with congestive heart failure

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**FIGURE 13-2-4 REQUIRED DIAGNOSES FOR CONGESTIVE HEART FAILURE (CONTINUED)**

ICD-9-CM	DESCRIPTION
404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure
404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
404.93	Unspecified hypertensive heart and renal disease with congestive heart and renal failure
428.0	Congestive heart failure
428.1	Left heart failure
428.20	Unspecified systolic heart failure
428.21	Acute systolic heart failure
428.22	Chronic systolic heart failure
428.23	Acute or chronic systolic heart failure
428.30	Unspecified diastolic heart failure
428.31	Acute diastolic heart failure
428.32	Chronic diastolic heart failure
428.33	Acute or chronic diastolic heart failure
428.40	Unspecified combined systolic and diastolic heart failure
428.41	Acute combined systolic and diastolic heart failure
428.42	Chronic combined systolic and diastolic heart failure
428.43	Acute or chronic combined systolic and diastolic heart failure
428.9	Heart failure, unspecified

**FIGURE 13-2-5 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	

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**FIGURE 13-2-5 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		
V23.2	Pregnancy with history of abortion	
V23.3	Grand multiparity	
V23.4	Pregnancy with other poor obstetric history	
V23.41	Pregnancy with history of pre-term labor	
V23.49	Pregnancy with 4other 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

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**FIGURE 13-2-5 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		
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
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

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**FIGURE 13-2-5 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		
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
647.6	Other viral diseases	0, 3
647.8	Other specified infectious and parasitic diseases	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

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**FIGURE 13-2-5 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		
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
651.8	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
655.4	Suspected damage to fetus from other disease in the mother	0, 3
655.5	Suspected damage to fetus from drugs	0, 3

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**FIGURE 13-2-5 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		
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

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(2) Observation time requirements.

(a) Observation time must be documented in the medical record.

(b) A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

(c) A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

(d) The number of units reported with HCPCS code G0378 must equal or exceed 8 hours for observation stays with diagnoses of chest pain, asthma or congestive heart failure and a minimum of 4 hours for maternity observations services.

(3) Additional hospital services provided before, during and after receiving observation care.

(a) The hospital must provide on the same day or the day before and report on the same claim for asthma, chest pain and congestive heart failure:

1 An emergency department visit (APC 0310, 0611, or 0612); or

2 A clinic visit (APC 0600, 0601, or 0602); or

3 Critical care (APC 0620); or

4 Direct admission to observation services using HCPCS code G0379 (APC 0600).

NOTE: The above criteria does not apply to maternity observation stays.

(b) No procedure with a "T" status indicator can be reported on the same day or day before observation care is provided.

(4) Ongoing physician evaluation.

(a) The beneficiary must 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.

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

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e. Additional billing requirements.

(1) Separate payment for observation stays that meet the required conditions are only allowed when billed as a 13X bill type.

(2) Observation stays that qualify for separate payment will be reimbursed one observation APC for each qualifying occurrence.

(3) If the period of observation spans more than one calendar day, hospitals should include all of the hours for the entire period of observation on a single line and enter as the date of service for that line the date the patient is admitted to observation.

(4) If there are multiple maternity observation stays on the same day without condition code G0 or 27 to indicate that the visits were distinct and independent of each other, pay for the first listed observation stay and deny the rest; i.e., line item denial for all subsequent observation stays listed on that particular day.

(5) Do not allow separate payment for any hours a beneficiary spends in observation over 24 hours; all costs beyond 24 hours will be included in the APC payment for observation services.

(6) The previous requirement for specific diagnostic testing for coverage/reimbursement of observation stays was removed. Instead clinical judgement, in combination with an internal and external quality review process, will be relied upon to ensure that appropriate diagnostic testing (which is expected to include some of the previously required diagnostic tests) is provided for patients receiving high quality medically necessary observation care.

(7) Medical review is no longer required for observation stays longer than 24 hours.

(8) All other observation stays (i.e., observation stays that do not meet the criteria/requirements for separate payment under HCPCS Code G0378) will be packaged under the primary procedure.

l. Inpatient Only Procedures.

1. The inpatient list on TMA's OPPTS 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.

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:

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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 OPPS web site at <http://www.tricare.mil/opps> 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 status indicator "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 status indicator "C" that is performed on an elective basis or scheduled to be performed on a patient whose status is that of an outpatient.

J. APC For Vaginal Hysterectomy.

When billing for vaginal hysterectomies, hospitals must use procedure code 58260, which will be assigned to APC 0202.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

K. Billing of Condition Codes Under OPPS.

The UB-04 claim form allows 10 values for condition codes, however, the OCE can only accommodate seven, therefore, OPPS hospitals should list those condition codes that affect outpatient pricing first.

- END -

## PROSPECTIVE PAYMENT METHODOLOGY

ISSUE DATE: July 27, 2005

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

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

### 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 TMA and specifically included in the network provider agreement.

### II. ISSUE

To describe the payment methodology for hospital outpatient services.

### III. POLICY

A. Basic Methodology for Determining Prospective Payment Rates for Outpatient Services.

#### 1. Setting of Payment Rates.

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

#### 2. Recalibration of Group Weights and Conversion Factor.

##### a. Relative Weights for Services Furnished on a Calendar Year (CY) basis.

(1) The most recent Medicare claims and facility cost report data are used in recalibrating the relative APC weights for services furnished on a CY basis.

(2) Weights are derived based on median hospital costs for services in the hospital outpatient APC groups. Billed charges are converted to costs and aggregated to the procedure or visit level. Calculation of the median hospital cost per APC group include the following steps:

(a) The statewide cost-to-charge ratio (CCR) is identified for each hospital's cost center ("statewide CCRs").

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(b) The statewide CCRs are then crosswalked to revenue centers. The CCRs included operating and capital costs but excluded costs associated with direct graduate medical education and allied health education.

(c) A cost is calculated for every billed line item charged on each claim by multiplying each revenue center charge by the appropriate statewide CCR.

(d) Revenue center charges that contain items integral to performing the procedure or visit are used to calculate the per-procedure or per-visit costs. Following is a list of revenue centers whose charges could be packaged into major HCPCS codes when appearing in the same claim.

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

REVENUE CODE	DESCRIPTION
250	Pharmacy
251	Generic
252	Nongeneric
253	Take Home Drugs
254	Pharmacy Incident to Other Diagnostic
255	Pharmacy Incident to Radiology
257	Nonprescription Drugs
258	IV Solutions
259	Other Pharmacy
260	IV Therapy, General Class
262	IV Therapy/Pharmacy Services
263	Supply/Delivery
264	IV Therapy/Supplies
269	Other IV Therapy
270	M&S Supplies
271	Nonsterile Supplies
272	Sterile Supplies
273	Take Home supplies
275	Pacemaker Drug
276	Intraocular Lens Source Drug
277	Oxygen Take Home
278	Other Implants
279	Other M&S Supplies

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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
280	Oncology
289	Other Oncology
370	General Classification
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to Other Diagnostic Services
374	Acupuncture
379	Other Anesthesia
390	Blood Storage and Processing
391	Blood Administration (e.g., transfusions)
399	Other Blood Storage and Processing
620	Medical/Surgical Supplies and Devices
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic
623	Surgical Dressings
624	Investigational Device (IDE)
630	Drugs Requiring Specific Identification, General Class
631	Single Source
632	Multiple
633	Restrictive Prescription
637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic COMA)
700	Cast Room
709	Other Cast Room
710	Recovery Room
719	Other Recovery Room
720	Labor Room
721	Labor
762	Observation Room
770	General Classification
771	Vaccine Administration
779	Other

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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.

(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. 60 percent 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 00601 (mid-level clinic visit), OPPS weights are listed on TMA's OPPS website 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.

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

### 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 outpatient prospective payment system (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:

a. "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, or CHAMPUS Maximum Allowable Charge (CMAC) reimbursement methodology for physicians.

b. "B" to indicate more appropriate code required for TRICARE OPPS.

c. "C" to indicate inpatient services that are not paid under the OPPS.

d. "E" to indicate items or services are not covered by TRICARE.

e. "F" to indicate acquisition of corneal tissue, which is paid on an allowable charge basis (i.e., paid based on the CMAC reimbursement system or statewide prevalings) and certain CRNA services and hepatitis B vaccines that are paid on an allowable charge basis.

f. "G" to indicate drug/biological pass-through that are paid in separate APCs under the OPPS.

g. "H" to indicate pass-through device categories, brachytherapy sources, and radiopharmaceutical agents allowed on a cost basis.

h. "K" to indicate non-pass-through drugs and biologicals and blood and blood products that are paid in separate APCs under the OPPS.

i. "N" to indicate services that are incidental, with payment packaged into another service or APC group.

j. "P" to indicate services that are paid only in partial hospitalization programs (PHPs).

k. "Q" to indicate packaged services subject to separate payment under OPPS.

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NOTE: HCPCS codes with SI "Q" are either separately payable or packaged depending on the specific circumstances of their billing. OCE claims processing logic will be applied to codes assigned SI "Q" in order to determine if the service will be packaged or separately payable.

l. "S" to indicate significant procedures for which payment is allowed under the hospital OPPS, but to which the multiple procedure reduction does not apply.

m. "T" to indicate surgical services for which payment is allowed under the hospital OPPS. Services with this payment indicator are the only services to which the multiple procedure payment reduction applies.

n. "V" to indicate medical visits (including clinic or emergency department visits) for which payment is allowed under the hospital OPPS.

o. "W" to indicate invalid HCPCS or invalid revenue code with blank HCPCS.

p. "X" to indicate an ancillary service for which payment is allowed under the hospital OPPS.

q. "Z" to indicate valid revenue code with blank HCPCS and no other SI assigned.

NOTE: The system payment logic looks to the SIs attached to the HCPCS codes and APCs for direction in the processing of the claim. A SI, as well as an APC, must be assigned so that payment can be made for the service identified by the new code. The SIs identified for each HCPCS code and each APC listed on TMA's OPPS web site at <http://www.tricare.mil/opps>.

#### 4. Calculating TRICARE Payment Amount.

a. The national APC payment rate that is calculated for each APC group is the basis for determining the total payment (subject to wage-index adjustment) the hospital will receive from the beneficiary and the TRICARE program. (Refer to TMA's OPPS web site at <http://www.tricare.mil/opps> for national APC payment rates.)

b. The TRICARE payment amount takes into account the wage index adjustment and beneficiary deductible and cost-share/copayment amounts.

c. The TRICARE payment amount calculated for an APC group applies to all the services that are classified within that APC group.

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d. The TRICARE payment amount for a specific service classified within an APC group under the OPSS is calculated as follows:

(1) Apply the appropriate wage index adjustment to the national payment rate that is set annually for each APC group. (Refer to the Provider File with Wage Indexes on TMA's OPSS home page at <http://www.tricare.mil/opss> for annual DRG wage indexes used in the payment of hospital outpatient claims, effective January 1 of each year.)

(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.

(3) Determine any outlier amounts and add them to the sum of either (1) or (2) above.

(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.

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 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 active duty family member copayment from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$$\$400 - \$0 = \$400 \text{ TRICARE final payment}$$

(d) TRICARE would pay 100 percent of the adjusted APC payment rate for active duty family members 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.

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(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.

$$\$400 - \$12 = \$388 \text{ TRICARE final payment}$$

(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 active duty family member subject to an individual \$50 deductible (active duty sponsor is an E3) and 20 percent cost-share.

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

(b) Subtract any applicable deductible:

$$\$400 - \$50 = \$350$$

(c) Subtract the standard active duty family member cost-share (i.e., 20 percent 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 "K" and

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“G”. 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 Provider File with Wage Indexes on TMA’s OPSS home page at <http://www.tricare.mil/opss>). This way only one wage index file will have to be maintained for both the OPSS and DRG-based payment system.

(3) 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 percent and the ASC labor factor of 34.45 percent, and is close to the labor-related costs under the inpatient DRG payment system attributed directly to wages, salaries and employee benefits (61.4 percent).

(4) Steps in Applying Wage Adjusts under OPSS.

(a) Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate that represents the portion of costs attributable, on average, to labor.

(b) Determine the wage index in which the hospital is located and identify the wage index level that applies to the specific hospital.

(c) Multiply the applicable wage index determined under (b) and (c) by the amount under (a) that represents the labor-related portion of the national unadjusted payment rate.

(d) Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product in (c). The result is the wage index adjusted payment rate for the relevant wage index area.

(e) If a provider is a SCH in a rural area, or is treated as being in a rural area, multiply the wage adjusted payment rate by 1.071 to calculate the total payment before applying the deductible and copayment/cost-sharing amounts.

(f) Applicable deductible and copayment/cost-sharing amounts would then be subtracted from the wage-adjusted APC payment rate, and the remainder would be the TRICARE payment amount for the services or procedure.

EXAMPLE: A surgical procedure with an APC payment rate of \$300 is performed in the outpatient department of a hospital located in Heartland, USA. The cost-sharing amount for the standard active duty family member is \$60.80 (i.e., 20 percent of the wage-adjusted APC amount for the

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procedure). The hospital inpatient DRG wage index value for hospitals located in Heartland, USA, is 1.0234. The labor-related portion of the payment rate is \$180 (\$300 x 60 percent), and the nonlabor-related portion of the payment rate is \$120 (\$300 x 40 percent). It is assumed that the beneficiary deductible has been met.

NOTE: Units billed x APC x 60% (labor portion) x wage index (hospital specific) + APC x 40% (nonlabor portion) = adjusted payment rate.

1 Wage-Adjusted Payment Rate (rounded to nearest cent):

$$= (\$180 \times 1.0234) = \$184.21 + \$120 = \$304.21$$

2 Cost-share for standard retiree family member (rounded to nearest cent):

$$= (\$304.21 \times .20) = \$60.84$$

3 Subtract the standard retiree family member cost-share from the wage-adjusted rate to get the final TRICARE payment

$$= (\$304.21 - \$60.84) = \$243.37$$

b. Discounting of Surgical and Terminating Procedures.

(1) OPPS payment amounts are discounted when more than one procedure is performed during a single operative session or when a surgical procedure is terminated prior to completion. Refer to Chapter 1, Section 16 for additional guidelines on discounting of surgical procedures.

(a) Line items with a SI of "T" are subject to multiple procedure discounting unless modifiers 76, 77, 78 and/or 79 are present.

(b) When more than one procedure with payment SI "T" is performed during a single operative session, TRICARE will reimburse the full payment and the beneficiary will pay the cost-share/copayment for the procedure having the highest payment rate.

(c) Fifty percent (50%) of the usual PPS payment amount and beneficiary copayment/cost-share amount would be paid for all other procedures performed during the same operative 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.

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1 The reduced payment would apply only to the surgical procedure with the lower payment rate.

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

(2) Hospitals are required to use modifiers on bills to indicate procedures that are terminated before completion.

(a) Fifty percent (50%) of the usual OPPS payment amount and beneficiary copayment/cost-share will be paid for a procedure terminated before anesthesia is induced.

1 Modifier -73 (Discontinued Outpatient Procedure Prior to Anesthesia Administration) would identify a procedure that is terminated after the patient has been prepared for surgery, including sedation when provided, and taken to the room where the procedure is to be performed, but before anesthesia is induced (for example, local, regional block(s), or general anesthesia).

2 Modifier -52 (Reduced Services) would be used to indicate a procedure that did not require anesthesia, but was terminated after the patient had been prepared for the procedure, including sedation when provided, and taken to the room where the procedure is to be performed.

(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).

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(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.

(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

Where:

D = discounting fraction (currently 0.5)

U = number of units

T = terminated procedure discount (currently 0.5)

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

**FIGURE 13-3-3 APPLICATION OF DISCOUNTING FORMULAS**

PAYMENT AMOUNT	MODIFIER 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	6	6	3	3
Not Highest	No	Yes	7	5	8	1
Not Highest	Yes	Yes	6	6	3	3

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.

d. 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 "P", "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 "G", "H", "K", "N", and "K", 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.

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(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 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.

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
99284	V	0612	High-level emergency visit	\$224.78	0.4471988
70481	S	0283	CT scan with contrast material	\$255.43	0.5081768
93041	S	0099	EKG	\$22.43	0.0446244

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

REVENUE CODE	OPPS SERVICE OR SUPPLY	TOTAL CHARGES
250	Pharmacy	\$2,986.50
270	Medical Supplies	\$3,957.80
350	CT scan	\$3,514.00
450	ER	\$2,597.00
730	EKG	\$237.00

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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)
0612	0.4471988	High-level emergency visit	\$1,335.56	\$1,769.92
0283	0.5081768	CT scan with contrast material	\$1,517.67	\$2,011.26
0099	0.0446244	EKG	\$133.27	\$176.61

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 (2 digit = rural, 5 digit = urban). Assume that the outpatient CCR is 31.4 percent.

APC	OPPS SERVICE	TOTAL CHARGES	TOTAL CHARGES REDUCED TO COSTS (CCR = 0.3140)
0612	High-level emergency visit	\$5,702.48	\$1,790.58
0283	CT scan with contrast material	\$7,042.93	\$2,211.48
0099	EKG	\$546.88	\$171.72

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 \$1,250), multiply the costs in excess of the wage adjusted APC multiplier by 50 percent to get the additional outlier payment.

APC	WAGE ADJUSTED APC RATE	COSTS	FIXED DOLLAR THRESHOLD (WAGE ADJUSTED APC RATE + \$1,250)	MULTIPLIER THRESHOLD (1.75 x WAGE INDEX 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
0612	\$224.78	\$1,790.58	\$1,474.78	\$393.37	\$1,397.21	\$698.61
0283	\$255.43	\$2,211.48	\$1,505.43	\$447.00	\$1,764.48	\$882.24
0099	\$22.43	\$171.72	\$1,272.43	\$39.25	\$132.47	-0-**

\*\* Does not qualify for outlier payment since the APC's costs did not exceed the fixed dollar threshold (APC Rate + \$1,250).

The total outlier payment on the claim was: \$1,580.85.

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

(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.

B. Transitional Pass-Through for Innovative Medical Devices, Drugs, and Biologicals.

1. Items Subject to Transitional Pass-Through Payments.

a. Current Orphan Drugs.

A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

NOTE: Orphan drugs will be paid separately at the Average Sales Price (ASP) + 6 percent, which represents a combined payment for acquisition and overhead costs associated with furnishing these products. Orphan drugs will no longer be paid based on the use of drugs because all orphan drugs, both single-indication and multi-indication, will be paid under the same methodology. The TRICARE contractors will not be required to calculate orphan drug payments.

b. Current Cancer Therapy Drugs, Biologicals and Brachytherapy.

These items are drugs or biologicals that are used in cancer therapy, including (but not limited to) chemotherapeutic agents, antiemetics, hematopoietic growth factors, colony stimulating factors, biological response modifiers, biphosphonates, and a device of brachytherapy if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

c. Current Radiopharmaceutical Drugs and Biological Products.

A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

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d. New Medical Devices, Drugs, and Biologicals.

New medical devices, drugs, and biologic agents, will be subject to transitional pass-through payment in instances where the item was not being paid for as a hospital outpatient service as of December 31, 1996, and where the cost of the item is "not insignificant" in relation to the hospital OPPS payment amount.

2. Items eligible for transitional pass-through payments are generally coded under a Level II HCPCS code with an alpha prefix of "C".

a. Pass-through device categories are identified by SI "H".

b. Pass-through drugs and biological agents are identified by SI "G".

3. Payment of Pass-Through Drugs and Biologicals.

a. Pass-through drugs and biologicals, will be paid a rate equivalent to what would be received in a physician's office setting; i.e., the ASP methodology established under the Medicare physician fee schedule. Following is the applicable payment methodology for transitional pass-through drugs or biologicals:

(1) Calculation of ASP.

(a) The ASP for both multiple and sole source drug products included within the same billing payment code (or HCPCS code) is the volume-weighted average of the manufacturer's ASPs reported across all the National Drug Codes (NDCs) assigned to the HCPCS determined by:

1 Computing the sum of the products (for each National Code assigned to those drug products) of the manufacturer's ASP and the total number of units sold; and

2 Dividing the sum by the sum of the total number of units sold for all NDCs assigned to those drug products.

(b) The ASP is determined without regard to any special packaging, labeling, or identifiers on the dosage form, product or package.

(2) Payment Allowances for Single and Multiple Source Drugs.

(a) Single Source Drugs.

The payment allowance for a single source drug HCPCS code will be equal to the lesser of 106 percent of the ASP for the HCPCS code or 106 percent of the wholesale acquisition cost of the HCPCS code, subject to applicable deductible and copayment/cost-sharing and limitations related to widely available market prices and

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average manufacturer prices in the Medicaid drug rebate program. The payment limit may also be adjusted in response to public emergency.

(b) Multiple Source Drugs.

The payment allowance for a multiple source drug included within the same HCPCS code will be equal to 106 percent of the ASP for the HCPCS code subject to applicable deductible and copayment/cost-sharing, along with the same payment limitations/adjustments as described under the single source drug payment allowance outlined above.

b. Beneficiary copayments/cost-sharing will be based on the entire ASP of the transition pass-through drug or biological.

4. Transitional Pass-Through Device Categories.

a. Excluded Medical Devices.

Equipment, instruments, apparatuses, implements or items that are generally used for diagnostic or therapeutic purposes that are not implanted or incorporated into a body part, and that are used on more than one patient (that is, are reusable), are excluded from pass-through payment. This material is generally considered to be a part of hospital overhead costs reflected in the APC payments.

b. Included Medical Devices.

(1) The following implantable items may be considered for the transitional pass-through payments:

(a) Prosthetic implants (other than dental) that replace all or part of an internal body organ.

(b) Implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

NOTE: Any DME, orthotics, and prosthetic devices for which transitional pass-through payment does not apply will be paid under the DMEPOS fee schedule when the hospital is acting as the supplier (paid outside the PPS).

c. Pass-Through Payment Criteria for Devices.

Pass-through payments will be made for new or innovative medical devices that meet the following requirements:

(1) They were not recognized for payment as a hospital outpatient service prior to 1997 (i.e., payment was not being made as of December 31, 1996). However, the

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medical device shall be treated as meeting the time constraint (i.e., payment was not being made for the device as of December 31, 1996) if either:

(a) The device is described by one of the initial categories established and in effect, or

(b) The device is described by one of the additional categories established and in effect, and

1 An application under the Federal Food, Drug, and Cosmetic Act has been approved; or

2 The device has been cleared for market under section 510(k) of the Federal Food, Drug, and Cosmetic Act; or

3 The device is exempt from the requirements of section 510(k) of the Federal Food, Drug, and Cosmetic Act under section 510(l) or section 510(m) of the Act.

(2) They have been approved/cleared for use by the Food and Drug Administration (FDA).

(3) They are determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

(4) They are an integral and subordinate part of the procedure performed, are used for one patient only, are surgically implanted or inserted via a natural or surgically created orifice on incision, and remain with that patient after the patient is released from the hospital outpatient department.

(a) Reprocessed single-use devices that are otherwise eligible for pass-through payment will be considered for payment if they meet FDA's most recent regulatory criteria on single-use devices.

(b) It is expected that hospital charges on claims submitted for pass-through payment for reprocessed single-use devices will reflect the lower cost of these devices.

NOTE: The FDA published guidance for the processing of single-use devices on August 14, 2000 - "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals".

(5) They are not equipment, instruments, apparatuses, implements, or such items for which depreciation and financing expenses are recovered as depreciable assets.

(6) They are not materials and supplies such as sutures, clips, or customized surgical kits furnished incidental to a service or procedure.

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(7) They are not material such as biologicals or synthetics that may be used to replace human skin.

(8) No existing or previously existing device category is appropriate for the device.

(9) The associated cost is not insignificant in relation to the APC payment for the service in which the innovative medical equipment is packaged.

(10) The new device category must demonstrate that utilization of its devices provide substantial clinical improvement for beneficiaries compared with currently available treatments, including procedures utilizing devices in existing or previously existing device categories.

d. Duration of Transitional Pass-Through Payments.

(1) The duration of transitional pass-through payments for devices is for at least 2, but not more than 3 years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category.

(2) The costs of devices no longer eligible for pass-through payments will be packaged into the costs of the procedures with which they are normally billed.

e. General Coding and Billing Instructions and Explanations.

(1) Devices Implanted, Removed, and Implanted Again, Not Associated With Failure (Applies to Transitional Pass-Through Devices Only):

(a) In instances where the physician is required to implant another device because the first device fractured, the hospitals may bill for both devices - the device that resulted in fracture and the one that was implanted into the patient.

(b) It is realized that there may be instances where an implant is tried but later removed due to the device's inability to achieve the necessary surgical result or due to inappropriate size selection of the device by the physician (e.g., physician implants an anchor to bone and the anchor breaks because the bone is too hard or must be replaced with a larger anchor to achieve a desirable result). In such instances, separate reimbursement will be provided for both devices. This situation does not extend to devices that result in failure or are found to be defective. For failed or defective devices, hospitals are advised to contact the vendor/manufacturer.

NOTE: This applies to transitional pass-through devices only and not to devices packaged into an APC.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

(2) Kits - Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, codes for such kits have not been established. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payment, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

(3) Multiple units - Hospitals must bill for multiple units of items that qualify for transitional pass-through payments, when such items are used with a single procedure, by entering the number of units used on the bill.

(4) Reprocessed devices - Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with the enforcement guidance of the FDA relating to the reprocessing of devices applicable at the time the service is delivered.

f. Calculation of Transitional Pass-Through Payment for a Pass-Through Device.

(1) Device pass-through payment is calculated by applying the statewide CCR to the hospital's charges on the claim and subtracting any appropriate pass-through offset. Statewide CCRs are based on the geographical CBSA (2 digit = rural, 5 digit = urban).

(2) The following are two examples of the device pass-through calculations, one incorporating a device offset amount applicable to CY 2003 and the other only applying the CCR (offsets set to \$0 for CY 2005).

(3) The offset adjustment is applied only when a pass-through device is billed in addition to the APC<sup>1</sup>.

Example #1 Transitional Pass-Through Payment Calculation with Offset:

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = \$1,200.00

Associated procedure: HCPCS Level I<sup>1</sup> code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (standard active duty family member who has met his/her yearly deductible)

Total offset amount to be applied for each APC that contains device costs = \$802.06

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NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph III.B.4.f.(4) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

$$\$1,200 - \$802.06 = \$397.94$$

TRICARE program payment (before wage index adjustment) for APC 0083:

$$\$3,289.42 - \$657.88 = \$2,631.54$$

TRICARE payment for pass-through device C1884 = \$397.94

Beneficiary cost-share liability for APC 0083 = \$657.88

Total amount received by provider for APC 0083 and pass-through device C1884:

\$2,631.54	TRICARE program payment for HCPCS Level I <sup>1</sup> code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I <sup>1</sup> code 92982
397.94	Transitional pass-through payment for device
\$3,687.36	Total amount received by the provider

Example #2 Transitional Pass-Through Payment Calculation without Offset

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = \$1,500.00

Associated procedure: HCPCS Level I<sup>2</sup> code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (standard active duty family member who has met his/her yearly deductible)

Total offset amount to be applied for each APC that contains device costs = \$0.

NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph III.B.4.f.(4) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

$$\$1,500 - \$0 = \$1,500$$

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TRICARE program payment (before wage index adjustment) for APC 0083:

$$\$3,289.42 - \$657.88 = \$2,631.54$$

TRICARE payment for pass-through device C1884 = \$1,500

Beneficiary cost-share liability for APC 0083 = \$657.88

Total amount received by provider for APC 0083 and pass-through device C1884:

\$2,631.54	TRICARE program payment for HCPCS Level I <sup>2</sup> code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I <sup>2</sup> code 92982
<u>1,500.00</u>	Transitional pass-through payment for device
\$4,789.42	Total amount received by the provider

NOTE: Transitional payments for devices (SI=H) are not subject to beneficiary cost-sharing/copayments.

(4) Steps involved in applying multiple discounting factors to offset amounts prior to subtracting from the device cost.

STEP 1: For each APC with an offset multiply the offset by the discount percent (whether it is 50%, 75%, 100% or 200%) and the units of service.

$$(\text{Offset} \times \text{Discount Rate} \times \text{Units of Service})$$

STEP 2: Sum the products of Step 1.

STEP 3: Wage adjust the sum of the products calculated in Step 2.

$$(\text{Step 2 Amount} \times \text{Labor \%} \times \text{Wage Index}) + \text{Step 2 Amount} \times \text{Nonlabor \%}$$

STEP 4: If the units of service from the procedures with offsets are greater than the device units of service, then Step 3 is adjusted by device units divided by procedure offset units.

$$[(\text{Step 2 Amount} \times \text{Labor \%} \times \text{Wage Index}) + (\text{Step 2 Amount} \times \text{Nonlabor \%}) \times (\text{Device Units} \div \text{Offset Procedure Units})]$$

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otherwise

$(\text{Step 2 Amount} \times \text{Labor \%} \times \text{Wage Index}) \text{ Step 2 Amount} \times \text{Non-Labor \%}$

EXAMPLE: If there are 2 procedures with offsets but only 1 device, then the final offset is reduced by 50 percent.

STEP 5: If there is only one line item with a device, then the amount calculated in Step 4 is subtracted from the line item charge adjusted to cost.

$[\text{Step 4 Amount} - (\text{Line Item Charge} \times \text{State CCR})]$

If there are multiple devices, then the amount from Step 4 is allocated to the line items with devices based on their charges.

$(\text{Line Item Device Charge} \div \text{Sum of Device Charges})$

C. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status.

1. Radiopharmaceuticals, drugs, and biologicals which do not have pass-through status, are paid in one of three ways:

- a. Packaged payment, or
- b. Separate payment (individual APCs), or
- c. Allowable charge.

2. The cost of drugs and radiopharmaceuticals are generally packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished:

a. Hospitals do not receive separate payment for packaged items and supplies; and

b. Hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or services.

3. Although diagnostic and therapeutic radiopharmaceutical agents are not classified as drugs or biologicals, separate payment has been established for them under the same packaging threshold policy that is applied to drugs and biologicals; i.e., the same adjustments will be applied to the median costs for radiopharmaceuticals that will apply to non-pass-through, separately paid drugs and biologicals.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

D. Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals.

1. Generally, the cost of drugs and radiopharmaceuticals are packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished. However, packaging for certain drugs and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

2. Payments for drugs and radiopharmaceuticals are packaged into the APCs with which they are billed if the median cost per day for the drug or radiopharmaceutical is less than \$50. Separate APC payment is established for drugs and radiopharmaceuticals for which the median cost per day exceeds \$50.

3. An exception to the packaging rule is being made for injectable oral forms of antiemetics.

4. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged.

a. "Specified Covered Outpatient Drugs" Classification

(1) Special classification (i.e., "specified covered outpatient drug") is required for certain separately payable radiopharmaceutical agents and drugs or biologicals for which there are specifically mandated payments.

(2) A "specified covered outpatient drug" is a covered outpatient drug for which a separate APC exists and that is either a radiopharmaceutical agent or drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

(3) The following drugs and biologicals are designated exceptions to the "specified covered outpatient drugs" definition (i.e., not included within the designated category classification):

(a) A drug or biological for which payment was first made on or after January 1, 2003, under the transitional pass-through payment provision.

(b) A drug or biological for which a temporary HCPC code has been assigned.

(c) Orphan drugs.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

b. Payment of Specified Outpatient Drugs, Biological and Radiopharmaceuticals.

(1) Specified outpatient drugs and biologicals will be paid a combined rate of the ASP plus 6 percent which is reflective of the present hospital acquisition and overhead costs for separately payable drugs and biologicals under the OPPS.

(2) Since there is no ASP data for separately payable specified radiopharmaceuticals, reimbursement will be based on charges converted to costs. This is the best proxy for the average acquisition cost of a radiopharmaceutical until better alternative information/data sources become available; e.g., basing payments on mean costs derived from hospital claims or creating charge-based payment rates.

(3) The following payment methods will be employed for separately payable specified outpatient drugs, biologicals and radiopharmaceuticals whose HCPCS codes will be payable for the first time under OPPS but whose codes do not crosswalk to other HCPCS codes previously recognized under the OPPS:

(a) Payment will be based on ASP plus 6 percent in accordance with the ASP methodology used in the physician office setting.

(b) In the absence of ASP data, the wholesale acquisition cost (WAC) will be used for the product to establish the initial payment rate. If the WAC is also unavailable, then payment will be calculated at 95 percent of the most recent average wholesale prices (AWP).

c. Designated SI.

The HCPCS codes for the above three categories of "specified covered outpatient drugs" are designated with the SI "K" - non-pass-through drugs, biologicals, and radiopharmaceuticals paid under the hospital OPPS (APC Rate). Refer to TMA's OPPS web site at <http://www.tricare.mil/opps> for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

5. Payment for New Drugs and Biologicals With HCPCS Codes and Without Pass-Through Application and Reference AWP or Hospital Claims Data.

a. New drugs and biologicals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals will be paid a rate that is equivalent to the payment they would receive in the physician office setting (i.e., the ASP plus 6 percent).

b. These new drugs and biologicals will be treated the same irrespective of whether pass-through status has been determined. SI "K" will be assigned to HCPCS codes for new drugs and biologicals for which pass-through applications have not been received.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

6. Drugs and Biologicals Not Eligible for Pass-Through Status and Receiving Separate Nonpass-Through Payment.

a. Payment will be based on median costs derived from CY claims data for drugs and biologicals that have been:

(1) Separately paid since implementation of the OPPTS under Medicare, but were not eligible for pass-through status; and

(2) Historically packaged with the procedures with which they were billed, even though their median cost per day was above the \$50 packaging threshold.

b. Payment based on median costs should be adequate for hospitals since these products are generally older or low-cost items.

7. Payment for New Drugs, Biologicals and Radiopharmaceuticals Before HCPCS Codes Are Assigned.

a. The following payment methodology will enable hospitals to begin billing for drugs and biologicals that are newly approved by the FDA and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup that could qualify them for pass-through payment under the OPPTS:

(1) Hospitals should be instructed to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code C9399, "Unclassified Drug or Biological."

(2) When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.

(3) The new drug, biological and/or radiopharmaceutical will be priced at 95 percent of its AWP using Red Book or an equivalent recognized compendium, and process the claim for payment.

(4) The above approach enables hospitals to bill and receive payment for a new drug, biological or radiopharmaceutical concurrent with its approval by the FDA.

b. Hospitals will discontinue billing C9399 and the NDC upon implementation of a HCPCS code, SI, and appropriate payment amount with the next quarterly OPPTS update.

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E. Drug Administration Coding and Payment.

1. The following HCPCS Level I drug administration codes will be assigned to their respective APCs for payment:

**FIGURE 13-3-4 CROSSWALK FROM HCPCS LEVEL I<sup>1</sup> CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs**

HCPCS LEVEL I <sup>1</sup> CODE	DESCRIPTION	SI	APC
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	X	0353
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	X	0359
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	X	0352
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0116
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0116
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0116
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0116
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0117
96420	Chemotherapy administration, intra-arterial; push technique	S	0116
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0117
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	A	--
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0117
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0116
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0116

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**FIGURE 13-3-4 CROSSWALK FROM HCPCS LEVEL I<sup>1</sup> CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs (CONTINUED)**

HCPCS LEVEL I <sup>1</sup> CODE	DESCRIPTION	SI	APC
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0116
96521	Refilling and maintenance of portable pump	T	0125
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	T	0125
96523	Irrigation of implanted venous access device for drug delivery systems	N	--
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0116
96549	Unlisted chemotherapy procedure	S	0116
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2. Only 20 of the 33 drug administration CPT codes are being adopted for billing and payment purposes under OPFS.

3. Six new HCPCS C-codes are being used instead of the remaining 13 CPT codes not recognized under the OPFS. The following C-codes (see Figure 13-3-5) are being adopted in an effort to minimize the administrative burden of adopting all 33 drug administrative CPT codes.

a. The C-codes will permit straightforward billing of types of pushes for the first hour and then each additional hour of infusion or for each intravenous push.

b. The OCE logic will determine the appropriate payments to make for a single drug administration encounter in one day or multiple separate encounters in the same day.

**FIGURE 13-3-5 OPFS DRUG ADMINISTRATION CODES**

HCPCS LEVEL I <sup>1</sup> CODE	DESCRIPTION	SI	APC
C8950	Intravenous infusion for therapy/diagnosis; up to 1 hour	S	0120
C8951	Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950)	N	--
C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push	X	0359
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**FIGURE 13-3-5 OPPTS DRUG ADMINISTRATION CODES (CONTINUED)**

HCPCS LEVEL I <sup>1</sup> CODE	DESCRIPTION	SI	APC
C8953	Chemotherapy administration, intravenous; push technique	S	0116
C8954	Chemotherapy administration, intravenous; infusion technique, up to one hour	S	0117
C8955	Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)	N	--

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4. The following non-chemotherapy HCPCS codes have also been created that are similar to CPT codes for initiation of prolonged chemotherapy infusion requiring a pump and pump maintenance and refilling codes so hospitals can bill for services when provided to patients who require extended infusions for non-chemotherapy medications including drugs for pain (see Figure 13-3-6 below).

**FIGURE 13-3-6 NON-CHEMOTHERAPY PROLONGED INFUSION CODES THAT REQUIRE A PUMP**

HCPCS LEVEL I <sup>1</sup> CODE	DESCRIPTION	SI	APC
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0120

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5. Packaged HCPCS Level I codes for drug administration should continue to be billed to ensure accurate payment in the future. These are bill changes for HCPCS Level I codes with SI = N that will be used as the basis for setting median costs for each drug administration HCPCS Level I code in the future.

6. HCPCS Level I<sup>3</sup> codes 90772-90774 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

7. Drugs for which the median cost per day is greater than \$50 are paid separately and are not packaged into the payment for the drug administration. Separate payment for drugs with a median cost in excess of \$50 will result in more equitable payment for both the drugs and their administration.

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F. Coding and Payment Policies for Drugs and Supplies.

1. Drug Coding.

a. Drugs for which separate payment is allowed are designated by SI "K" and must be reported using the appropriate HCPCS code.

b. Drugs that are reported without a HCPCS code will be packaged under the revenue center code, under OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633.

c. Drugs billed using revenue code 636 ("Drugs requiring detailed coding") require use of the appropriate HCPCS code, or they will be denied.

d. Reporting charges of packaged drugs is critical because packaged drug costs are used for calculating outlier payments and hospital costs for the procedure and service with which the drugs are used in the course of the annual OPPS updates.

2. Payment for the Unused Portion of a Drug.

a. Once a drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, hospitals are encouraged to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a TRICARE patient, the provider may bill for the amount of the drug discarded, along with the amount administered.

b. In the event that a drug is ordered and reconstituted by the hospital's pharmacy, but not administered to the patient, payment will be made under OPPS.

EXAMPLE 1: Drug X is available only in a 100-unit size. A hospital schedules three patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to OPPS on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen, and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

EXAMPLE 2: An appropriate hospital staff member must administer 30 units of drug X to a patient, and it is not practical to schedule another patient for the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and does not know the patient's condition. The hospital

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bills for 100 units on behalf of the patient, and OPPS pays for 100 units.

c. Coding for Supplies.

(1) Supplies that are an integral component of a procedure or treatment are not reported with a HCPCS code.

(2) Charges for such supplies are typically reflected either in the charges on the line for the HCPCS for the procedure, or on another line with a revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

(3) Hospitals should report drugs that are treated as supplies because they are an integral part of a procedure or treatment under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs.

G. Orphan Drugs.

1. Continue to use the following criteria for identifying single indication orphan drugs that are used solely for orphan conditions:

a. The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan condition(s).

b. The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

2. Twelve single indication orphan drugs have currently been identified as having met these criteria.

3. Payment Methodology.

a. Pay all 12 single indication orphan drugs at the rate of 88 percent of AWP or 106 of the ASP, whichever is higher.

b. However, for drugs where 106 percent of ASP would exceed 95 percent of AWP, payment would be capped at 95 percent of AWP, which is the upper limit allowed for sole source specified covered outpatient drugs.

H. Vaccines.

1. Hospitals will be paid for influenza, pneumococcal pneumonia and hepatitis B vaccines based on allowable charge methodology; i.e., will be paid the CMAC rate for these vaccines.

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2. Separately payable vaccines other than influenza, pneumococcal pneumonia and hepatitis B will be paid under their own APC.

3. See Figure 13-3-7 below for vaccine administration codes and SIs.

**FIGURE 13-3-7 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS**

HCPCS LEVEL 1 <sup>1</sup> CODE	DESCRIPTION	SI	APC
G0008	Influenza vaccine administration	X	0350
G0009	Pneumococcal vaccine administration	X	0350
G0010	Hepatitis B vaccine administration	N	--
90465	Immunization admin, under 8 yrs old, with counseling; first injection	N	--
90466	Immunization admin, under 8 yrs old, with counseling; each additional injection	N	--
90467	Immunization admin, under 8 yrs old, with counseling; first intranasal or oral	N	--
90468	Immunization admin, under 8 yrs old, with counseling; each additional intranasal or oral	N	--
90471	Immunization admin, one vaccine injection	X	0353
90472	Immunization admin, each additional vaccine injections	X	0353
90473	Immunization admin, one vaccine by intranasal or oral	N	
90474	Immunization admin, each additional vaccine by intranasal or oral	N	--

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l. Payment Policy for Radiopharmaceuticals.

Separately paid radiopharmaceuticals are classified as “specified covered outpatient drugs” subject to the following packaging and payment provisions:

1. The threshold for the establishment of separate APCs for radiopharmaceuticals is \$50.

2. A radiopharmaceutical that is covered and furnished as part of covered outpatient department services for which a HCPCS code has not been assigned will be reimbursed an amount equal to 95 percent of its AWP.

3. Radiopharmaceuticals will be excluded from receiving outlier payments.

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4. Applications will be accepted for pass-through status; however, in the event the manufacturer seeking pass-through status for a radiopharmaceutical does not submit data in accordance with the requirements specified for new drugs and biologicals, payment will be set for the new radiopharmaceutical as a “specified covered outpatient drug.”

J. Blood and Blood Products.

1. Since the OPPS was first implemented, separate payment has been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. The APCs for these products are intended to recover the costs of the products.

2. Administrative costs for the processing and storage specific to the transfused blood product are included in the APC payment, which is based on hospitals’ charges.

3. Payment for the collection, processing, and storage of autologous blood, as described by HCPCS Level I<sup>4</sup> code 86890 and used in transfusion, is made through APC 347 (Level III Transfusion Laboratory Procedures).

4. Payment rates for blood and blood products will be determined based on median costs. Refer to Figure 13-3-8 for APC assignment of blood and blood product codes.

**FIGURE 13-3-8 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES**

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9010		K	Whole blood for transfusion	0950
P9011		K	Split unit of blood	0967
P9012		K	Cryoprecipitate each unit	0952
P9016		K	RBC leukocytes reduced	0954
P9017		K	Plasma 1 donor frz w/in 8 hr	9508
P9019		K	Platelets, each unit	0957
P9020		K	Platelet rich plasma unit	0958
P9021		K	Red blood cells unit	0959
P9022		K	Washed red blood cells unit	0960
P9023		K	Frozen plasma, pooled, sd	0949
P9031		K	Platelets leukocytes reduced	1013
P9032		K	Platelets, irradiated	9500
P9033		K	Platelets leukoreduced irradiated	0968
P9034		K	Platelets, pheresis	9507

<sup>4</sup> HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

**FIGURE 13-3-8 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES (CONTINUED)**

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9035		K	Platelets pheresis leukoreduced	9501
P9036		K	Platelet pheresis irradiated	9502
P9037		K	Platelet pheresis leukoreduced irradiated	1019
P9038		K	RBC irradiated	9505
P9039		K	RBC deglycerolized	9504
P9040		K	RBC leukoreduced irradiated	0969
P9043		K	Plasma protein fract, 5%, 50 ml	0956
P9044		K	Cryoprecipitate reduced plasma	1009
P9048		K	Granulocytes, pheresis unit	9506
P9051	C1010	K	Blood, L/R, CMV-NEG	1010
P9052	C1011	K	Platelets, HLA-m, L/R, unit	1011
P9053	C1015	K	Plt, pher, L/R, CMV, irradiated	1020
P9054	C1016	K	Blood, L/R, Froz/Degly/Washed	1016
P9055	C1017	K	Plt, Aph/Pher, L/R, CMV-Neg	1017
P9056	C1018	K	Blood, L/R, Irradiated	1018
P9057	C1020	K	RBC, frz/deg/wash, L/R irradiated	1021
P9058	C1021	K	RBC, L/R, CMV-Neg, irradiated	1022
P9059	C1022	K	Plasma, frz within 24 hours	0955
P9060	C9503	K	Fresh frozen plasma, ea unit	9503

K. 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.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

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.

8. The new technology APC groups have established payment rates for the APC groups based on the midpoint of ranges of possible costs; for example, the payment amount for a new technology group reflecting a range of costs from \$300 to \$500 would be set at \$400. The cost range for the groups reflects current cost distributions, and TRICARE reserves the right to modify the ranges as it gains experience under the OPPS.

9. There are two parallel series of technology APCs covering a range of costs from less than \$50 to \$6,000.

a. The two parallel sets of technology APCs are used to distinguish between those new technology services designated with a SI of "S" and those designated as "T". These APCs allow assignment to the same APC group procedures that are appropriately subject to a multiple procedure payment reduction (T) with those that should not be discounted (S).

b. Each set of technology APC groups have identical group titles and payment rates, but a different SI.

c. The new series of APC numbers allow for the narrowing of the cost bands and flexibility in creating additional bands as future needs may dictate. Following are the narrowed incremental cost bands for the two series of new technology APCs:

- (1) From \$0 to \$50 in increments of \$10.
- (2) From \$50 to \$100 in a single \$50 increment.
- (3) From \$100 through \$2,000 in intervals of \$100.
- (4) From \$2,000 through \$6,000 in intervals of \$500.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

10. Beneficiary cost-sharing/copayment amounts for items and services in the new technology APC groups are dependent 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 cost-sharing/copayment amounts for outpatient hospital services.)

11. Process and Criteria for Assignment to a New Technology APC Group.

a. Services Paid Under New Technology APCs.

(1) Limit eligibility for placement in new technology APCs to complete services and procedures.

(2) Items, material, supplies, apparatuses, instruments, implements, or equipment that are used to accomplish a more comprehensive service or procedure would not be eligible for placement in a new technology APC.

(3) A service that qualifies for a new technology APC may be a complete, stand-alone service (for example, water-induced thermotherapy of the prostate or cryosurgery of the prostate), or it may be a service that would always be billed in combination with other services (for example, coronary artery brachytherapy).

(a) In the latter case, the new technology procedure, even though billed in combination with other, previously existing procedures, describes a distinct procedure with a beginning, middle, and end.

(b) Drugs, supplies, devices, and equipment in and of themselves are not distinct procedures with a beginning, middle and end. Rather drugs, supplies, devices, and equipment are used in the performance of a procedure.

(4) Unbundled components that are integral to a service or procedure (for example, preparing a patient for surgery or preparation and application of a wound dressing for wound care) are not eligible for consideration for a new technology.

b. Criteria for determining whether a service will be assigned to a new technology APC.

(1) The most important criterion in determining whether a technology is "truly new" and appropriate for a new APC is the inability to appropriately, and without redundancy, describe the new, complete (or comprehensive) service with any combination of existing HCPCS Level I and II codes. In other words, a "truly new" service is one that cannot be appropriately described by existing HCPCS codes, and a new HCPCS code needs to be established in order to describe the new procedure.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

(2) The service is one that could not have been adequately represented in the claims data being used for the most current annual payment update; i.e., the item is one service that could not have been billed to the Medicare program in 1996 or, if it was available in 1996, the costs of the service could not have been adequately represented in 1996 data.

(3) The service does not qualify for an additional payment under the transitional pass-through provisions.

(4) The service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs. It is unnecessary to assign a new service to a new technology APC if it may be appropriately placed in a current APC.

(5) The service falls within the scope of TRICARE benefits.

(6) The service is determined to be reasonable and necessary.

NOTE: The criterion that the service must have a HCPCS code in order to be assigned to a new technology APC has been removed. This is supported by the rationale that in order to be considered for a new technology APC, a truly new service cannot be adequately described by existing codes. Therefore, in the absence of an appropriate HCPCS code, a new HCPCS code will be created that describes the new technology service. The new HCPCS would be solely for hospitals to use when billing under the OPPTS.

#### L. 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)

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PROSPECTIVE PAYMENT METHODOLOGY

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

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);
- b. Statewide cost-to-charge ratios as provided in CMS Final Rule;
- c. Locality Code: Based on CBSA - 2 digit = rural and 5 digit = urban;
- d. Hospital Type: Rural Sole community Hospital = 1 and All Others = 0

4. The outpatient PRICER will return the line item APC pricing information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary explanation of benefits (EOB) with exception for an electronic 835 transaction. 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 OPPTS methodology's, e.g., CMAC (SI = A) when applicable.

5. If a claim has more than one service with a SI of "T" (SI of "S" has been removed from this rule), and any lines with SI "T" have less than \$1.01 as charges, charges for all "T" lines will be summed and the charges will then be divided up proportionately to the payment rates for each "T" line (refer to Figure 13-3-9 below). The new charge amount will be used in place of the submitted charge amount in the line item outlier calculator.

**FIGURE 13-3-9 PROPORTIONAL PAYMENT FOR "T" LINE ITEMS**

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
T	\$19,999	\$6,000	\$12,000

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

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CHAPTER 13, SECTION 3

PROSPECTIVE PAYMENT METHODOLOGY

FIGURE 13-3-9 PROPORTIONAL PAYMENT FOR "T" LINE ITEMS (CONTINUED)

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
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 "T" gets \$6,000 of the \$10,000 total payment, the new charge for that line is  $\$6,000/\$10,000 \times \$20,000 = \$12,000$ .

M. 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 "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.

N. Validation Reviews.

OPSS claims are not subject to validation review.

O. Hospital Based Birthing Centers.

Hospital based birthing centers will be reimbursed the same as freestanding birthing centers except the all inclusive rate consisting of the CMAC for procedure code 59400 and the state specific non-professional component, will lag 2 months (i.e., April 1 instead of February 1).

- END -

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)

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

### 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 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 OPPS.

All outpatient hospital bills (bill types 13X with condition code 41, 13X without condition code 41), with the exception of bills from providers excluded under Section 1, paragraph III.D.1.b.(5) of this Chapter 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 prior to June 1, 2007 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.

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

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 13X effective for claims with dates of service on or after June 1, 2007.

2. They must submit an adjustment bill for any services required to be billed with 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 137 and 138 should report the original claim number in Form Location 37 on the UB-92 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 OCE under OPPS.

NOTE: The contractors will take appropriate action in those situations where either a replacement claim (TOB 137) or voided/cancelled claim (TOB 138) is received without an initial claim (TOB 131) being on file. Resulting adjustments may result in offset recoupment which would ultimately depend on OPPS claims volume.

D. Claim Adjustments. Adjustments to OPPS 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 (3) 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 24-30 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.

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CLAIMS SUBMISSION AND PROCESSING REQUIREMENTS

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

4. Proper reporting of Condition Code G0 allows for proper payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.

5. The following figure describes actions the OCE will take when multiple medical visits occur on the same day in the same revenue code center:

**FIGURE 13-4-1 ACTIONS TAKEN WHEN MULTIPLE MEDICAL VISITS OCCUR ON THE SAME DAY**

EVALUATION & MANAGEMENT (E&M)	REVENUE CENTER	CONDITION CODE	OCE ACTION
2 or more	Two or more E&M codes have the same revenue center	No G0	Assign medical APC to each line item with E&M code and deny all line items with E&M code except the line item with the highest APC payment
2 or more	Two or more E&M codes have the same revenue center	G0	Assign medical APC to each line item with E&M code

F. Clinical Diagnostic Laboratory Services Furnished to Outpatients.

1. Payment for clinical diagnostic laboratory services will not be paid under OPPS.
2. Payment for these services will be made under the CHAMPUS Maximum Allowable Charge (CMAC) System.
3. Hospitals should report HCPCS codes for clinical diagnostic laboratory services.

G. OPPS Modifiers.

TRICARE requires the reporting of HCPCS Level I and II modifiers for accuracy in reimbursement, coding consistency, and editing.

- END -



CHAPTER 13  
 ADDENDUM A1

DEVELOPMENT SCHEDULE FOR TRICARE OCE/APC  
 QUARTERLY UPDATE

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

CRITICAL TASKS & MILESTONES			
#	WHO	EVENT	DAYS
1	3M	Preliminary CMS edit & logic changes to TRICARE (new edits, logic, flags, etc.)	
2	TMA/ Contractors	Provide TRICARE-specific edit/logic changes to 3M	10 days
3	3M	CMS data changes to TRICARE (new codes, APC, SI) Plus Intersection Report	
4	TMA/ Contractors	Provide TRICARE-specific data changes to 3M (APC, SI, edit assignment, ...) (see Chapter 13, Addendum A2)	10 days
5	3M	Update TC Working specifications	3 days
6	3M	Write code for TRICARE program logic/edit and product changes: (Component, MF)	5 days
7	3M	Update TC mods files & Build TC Read-Only-Tables	6 days
8	3M	TRICARE Working specs & Data Summary to TRICARE - For Review / Approval	5 days
9	3M	Unit test TC program & product changes - Component, MF (need ROT from step 7)	1 day
10	3M	Build TC ROT #2 ... If necessary. (To correct errors or make late CMS changes)	3 days
11	3M	Create User Documentation	12 days
12	3M	Test case creation	7 days
		Alpha testing	8 days
		Install testing	2 days
13	3M	Media and Documents production	1 day
14	3M	Release - General Release to TRICARE and Contractors	

**NOTE: The above quarterly time expectations are ideal, but may be subject to change.**

- END -



## OPPS OCE NOTIFICATION PROCESS FOR QUARTERLY UPDATES

**Note: This reimbursement system is tentatively scheduled to become effective on June 1, 2007.**

	MCSC: OCE Version: Summary of Data Changes: OCE/APC Working Specification: Effective Date:			
4 days (Checklist)	<b>Review Updates:</b> 1. HCPC/CPT Procedure Code Changes <ul style="list-style-type: none"> <li>• Adds/Deletes procedure code</li> <li>• HCPC Changes - APC, Status Indicator and/or Edit Assignment</li> </ul> 2. Diagnosis Code Changes <ul style="list-style-type: none"> <li>• Adds/Deletes diagnosis</li> <li>• Age/Sex Relations</li> </ul>		3. Revenue Codes (Appendix K) <ul style="list-style-type: none"> <li>• Add Revenue Codes</li> <li>• Revenue Code Status Indicator Changes</li> </ul> 4. Government No Pay List Updates 5. HCPC Intersection Report (compare SI differences between CMS and TRICARE) 6. Edit Assignment (applicable TRICARE edits)	
	<b>Impacts:</b>			
	File format changes <input type="checkbox"/>	Describe:		
	(record layout)			
	New values: <input type="checkbox"/>	Describe:		
	Policy: <input type="checkbox"/>	Manual: TRM	Chapter:	Sections:
		Manual: TRM	Chapter:	Sections:
		Manual: TRM	Chapter:	Sections:
	Comments:			
3 days	Gather feedback for all Primes - Prime responsibility for OCE response to 3M will rotate quarterly. <ul style="list-style-type: none"> <li>• Schedule meeting with Primes</li> <li>• Assigned resource will consolidate feedback using 3M templates</li> </ul>			
1 day	Submit feedback to TMA <ul style="list-style-type: none"> <li>• TMA sends to 3M and copies OCE Quarterly Update Team</li> <li>• Notify TMA of changes impacting TRICARE policy</li> </ul>			
1 day	Meet with 3M on feedback (maintain open date on Thursdays at 11:00 a.m. EDT/EST or 8:00 a.m. Pacific) <ul style="list-style-type: none"> <li>• Review responses</li> <li>• Address policy impacts (TMA)</li> <li>• Update changes (if needed)</li> <li>• Concur on changes</li> </ul>			

NOTE: The above quarterly time expectations are ideal, but may be subject to change.

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