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TRICARE  
MANAGEMENT ACTIVITY

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FOR  
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- TRANSITIONAL TEMPORARY MILITARY  
CONTINGENCY PAYMENT ADJUSTMENTS (TMCPAs)

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

**SUMMARY OF CHANGE(S):** This change provides transitional payment  
adjustments under OPSS.

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

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

Reta Michak  
Chief, Office of Medical Benefits  
and Reimbursement Branch

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

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

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

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

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

D. Applicability and Scope of Coverage.

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

1. Provider Categories.

a. Providers Included In OPPTS:

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

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

(a) Be certified pursuant to TRICARE certification standards.

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

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

(d) Has a written participation agreement with TRICARE.

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

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

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

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

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

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b. Providers Excluded From OPSS:

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

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

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

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

(5) Specialty care providers to include:

(a) Cancer and children's hospitals.

(b) Freestanding Ambulatory Surgery Centers (ASCs).

(c) Freestanding PHPs, 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) Veterans Affairs (VA) hospitals.

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

(l) SNFs.

2. Scope of Services.

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

(1) Physician services.

(2) Nurse practitioner and clinical nurse specialist services.

(3) Physician assistant services.

(4) Certified nurse-midwife services.

(5) Services of qualified psychologists.

(6) Clinical social worker services.

(7) Services of an anesthetist.

(8) Screening and diagnostic mammographies.

(9) Influenza and pneumococcal pneumonia vaccines.

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

(10) Clinical diagnostic laboratory services.

(11) Take home surgical dressings.

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

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

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

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

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

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

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

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

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

b. Costs excluded under the hospital OPPS:

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

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

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

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

(a) Surgical procedures.

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

(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:

- 1 Cardiac catheterization;
- 2 CAT scans;
- 3 MRIs;
- 4 Ambulatory surgery involving the use of an operating room;
- 5 ER 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) ESRD Services. Since TRICARE does not have an ESRD composite rate, ESRD services are included in TRICARE's OPSS.

#### E. Description of APC Groups.

Group services identified by Healthcare Common Procedure Coding System (HCPCS) codes and descriptors within APC groups are the basis for setting payment rates under the hospital OPSS.

##### 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 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 OPPS, 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 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 OPPTS.

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

G. Reimbursement Hierarchy For Procedures Paid Outside The OPPTS.

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

a. The following tables includes the list of rate columns on the CMAC file. The columns are number 1 through 6 by description. The pricing hierarchy for facility CMAC is 8, 6, 4, then 2.

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

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

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

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

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

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

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

H. Outpatient Code Editor (OCE).

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

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

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

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

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

I. PRICER Program.

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

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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.

#### J. Geographical Wage Adjustments.

DRG wage indexes will be used for adjusting the OPPS standard payment amounts for labor market differences. Refer to the OPPS 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.

#### K. 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.

#### L. Implementing Instructions.

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

IMPLEMENTING INSTRUCTIONS/SERVICES	
<b>POLICIES</b>	
General Overview	<a href="#">Chapter 13, Section 1</a>
Billing and Coding of Services under APC Groups	<a href="#">Chapter 13, Section 2</a>
Reimbursement Methodology	<a href="#">Chapter 13, Section 3</a>
Claims Submission and Processing Requirements	<a href="#">Chapter 13, Section 4</a>
Medical Review And Allowable Charge Review Under The Hospital OPPS	<a href="#">Chapter 13, Section 5</a>
<b>ADDENDA</b>	
Development Schedule for TRICARE OCE/APC - Quarterly Update	<a href="#">Chapter 13, Addendum A1</a>
OPPS OCE Notification Process for Quarterly Updates	<a href="#">Chapter 13, Addendum A2</a>

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IMPLEMENTING INSTRUCTIONS/SERVICES	
Approval Of OPPS - OCE/APC And NGPL Quarterly Update Process	Chapter 13, Addendum A3

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

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

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

IV. EFFECTIVE DATE            May 1, 2009.

- END -

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CHAPTER 13, SECTION 3

PROSPECTIVE PAYMENT METHODOLOGY

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

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

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

(b) Subtract any applicable deductible:

$$\$400 - \$0 = \$400$$

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

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

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

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

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

(b) Subtract any applicable deductible:

$$\$400 - \$0 = \$400$$

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

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

(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 **ADFM** subject to an individual \$50 deductible (active duty sponsor is an E3) and 20% cost-share.

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

(b) Subtract any applicable deductible:

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

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

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

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

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

#### 5. Adjustments to APC Payment Amounts.

##### a. Adjustment for Area Wage Differences.

(1) A wage adjustment factor will be used to adjust the portion of the payment rate that is attributable to labor-related costs for relative differences in labor and labor-related costs across geographical regions with the exception of APCs with SIs **K** and **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 OPSS Provider File with Wage Indexes on TMA's OPSS home page at <http://www.tricare.mil/opps>).

(3) **Temporary Transitional Payment Adjustments (TTPAs), General and non-network Temporary Military Contingency Payment Adjustments (TMCPAs) are wage adjusted. The Transitional TMCPAs are not wage adjusted as the adjustment is applied at year end.**

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

##### (5) Steps in Applying Wage Adjusts under OPSS.

(a) Calculate 60% (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.

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(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% (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product in (d). 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 ADFM is \$60.80 (i.e., 20% of the wage-adjusted APC amount for the 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%), and the nonlabor-related portion of the payment rate is \$120 (\$300 x 40%). 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.

(c) 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 of 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.

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.

(c) 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).

(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

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**FIGURE 13-3-2 DISCOUNTING FORMULAS FOR BILATERAL PROCEDURES (CONTINUED)**

DISCOUNTING FORMULA NUMBER	FORMULAS
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)

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

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

			DISCOUNTING FORMULA NUMBER			
			TYPE "T" PROCEDURE		NON-TYPE "T" PROCEDURE	
PAYMENT AMOUNT	MODIFIER 52 OR 73	MODIFIER 50	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

For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (T) any applicable offset, will be applied prior to selecting the T procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first before the terminated procedure discount. This applies only on claims reimbursed under the OPPS reimbursement methodology.

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, and N**, with the exception of blood and blood products.

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

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

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

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

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

(6) **Example of outlier payment calculation.**

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

STEP 1: Identify all APCs on the claim.

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

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

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

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

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

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

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

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

STEP 6: Apply the cost test to each wage adjusted APC service or procedure to determine if it qualifies for an outlier payment. If the cost of a service (wage adjusted APC) exceeds both the APC multiplier threshold (1.75 times the wage adjusted APC payment rate) and the fixed dollar threshold (wage adjusted APC rate plus \$1,575), multiply the costs in excess of the wage adjusted APC multiplier by 50% to get the additional outlier payment.

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APC	WAGE ADJUSTED APC RATE	COSTS	FIXED DOLLAR THRESHOLD (WAGE ADJUSTED APC RATE + \$1,575)	MULTIPLIER THRESHOLD (1.75 X WAGE ADJUSTED APC RATE)	COSTS IN EXCESS OF MULTIPLIER THRESHOLD	OUTLIER PAYMENT COSTS OF WAGE ADJUSTED APC - (1.75 X WAGE ADJUSTED APC RATE) X 0.50
0616	\$315.51	\$2,170.01	\$1,890.51	\$552.14	\$1,618.87	\$808.43
0283	\$277.48	\$2,327.24	\$1,852.48	\$485.59	\$1,841.65	\$920.83
0099	\$24.79	\$202.41	\$1,599.79	\$43.38	\$159.03	-0*

\* Does not qualify for outlier payment since the APC's costs did not exceed the fixed dollar threshold (APC Rate + \$1,575).

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

e. Rural SCH payments will be increased by 7.1%. This adjustment will apply to all services and procedures paid under the OPPIs (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.

f. Temporary Transitional Payment Adjustments (TTPAs).

(1) On May 1, 2009 (implementation of TRICARE's OPPIs), the TTPAs shall apply to all network and non-network hospitals. For network hospitals, the TTPAs will cover a four year period. The four year transition will set higher payment percentages for the 10 APC codes 604-609 and 613-616 during the first year, with reductions in each of the transition years. For non-network hospitals, the adjustment will cover a three year period, with reductions in each of the transition years for the same 10 APC codes. Figure 13-3-4 provides the TTPA percentage adjustments for the 10 visit APC codes for network and non-network hospitals.

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

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

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

g. Temporary Military Contingency Payment Adjustments (TMCPAs).

Under the authority of the last paragraph of 32 CFR 199.14(a)(5)(ii), the following OPPS adjustments are authorized.

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

(2) General TMCPAs. The TMA Director, or designee at any time after OPPS implementation, also has the authority to adopt, modify and/or extend temporary adjustments for TRICARE network hospitals located within MTF Prime Service Areas (PSAs) and deemed essential for military readiness and support during contingency operations. The TMA Director may approve a TMCPA for hospitals that serve a disproportionate share of ADSMs and ADDs. In order to qualify for the General TMCPAs the hospital outpatient revenue from TRICARE ADSMs and ADDs must be at least 10% of the hospital's total outpatient revenue.

(a) Annual Data Requirements for General TMCPAs.

1 Hospital required data submissions to the Managed Care Support Contractor (MCSC) for review and consideration:

a Hospital-specific Medicare outpatient CCR based on the hospital's most recent cost reporting period.

b Hospital's Medicare outpatient payment to charge ratio based on the corresponding Medicare cost reporting period.

c The hospital's percent of TRICARE outpatient visits (Emergency Room (ER) and Hospital Outpatient Department (HOPD)); i.e., the TRICARE outpatient visits divided by total outpatient visits.

d The hospital's percent of TRICARE outpatient revenue (ER and HOPD); i.e., the TRICARE outpatient revenue divided by total outpatient revenue.

e The hospital's percent of ADSMs and ADDs outpatient visits (ER and HOPD); i.e., the TRICARE ADSMs and ADDs divided by total outpatient beneficiary visits.

f The hospital's recommended percentage adjustment as supported by the above data requirement submissions.

(b) Annual MCSC data review requirements.

1 Data Requirements for Evaluation of Network Adequacy Necessary to Support Military Contingency Operations:

a Number of available primary care and specialist providers in the network locality;

b Availability (including reassignment) of military providers in the locations or nearby;

c Appropriate mix of primary care and specialists needed to satisfy demand and meet appropriate patient access standards (appointment/waiting time, travel distance, etc.);

d Efforts that have been made to create an adequate network, and

e Other cost effective alternatives and other relevant factors.

2 If upon initial evaluation, the MCSC determines the hospital meets the disproportionate share criteria in [paragraph III.A.5.g.\(2\)](#), and is essential for continued network adequacy, the request from the hospital along with the above supporting documentation shall be submitted to the TRICARE Regional Office (TRO) for review and determination.

(c) The DTRO shall conduct a thorough analysis and recommend the appropriate percentage adjustments to be applied for that year; i.e., the General TMCPAs will be reviewed and approved on an annual basis. The recommendation with a cost estimate shall be submitted to the Office of Medical Benefits and Reimbursement Branch (MB&RB) to be forwarded to the Director, TMA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RB for TMA Director review and approval.

(d) TMA Director, or designee review.

1 The Director, TMA or designee is the final approval authority.

2 A decision by the Director TMA or designee to adopt modify or extend TMCPAs is not subject to appeal.

3 Signed letters of intent to accept the percentage adjustments approved by the TMA, Director or designee, must be submitted prior to approval of TMCPAs.

(3) Non-Network TMCPAs.

TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that the procedures cannot be obtained timely enough from a network hospital. This determination will be based on the MCSC's and TRO's evaluation of network adequacy data related to the specific procedures for which the TMCPA is being requested as outlined under paragraph III.A.5.g.(2)(b).

(4) Temporary Adjustment Process.

(a) Transitional TMCPAs will be year-end adjusted based on a voucher prepared by the MCSCs in accordance with the requirements of the TRICARE Operations Manual (TOM) and sent to the TMA Contract Resource Management (CRM) Office for clearance before releasing the checks.

(b) General and non-network TMCPA will be adjusted on a claim-by-claim basis.

(5) Application of Cost-Sharing.

(a) Transitional TMCPAs are not subject to cost-sharing.

(b) General and non-network TMCPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

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%, 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.

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#### 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 OPSS 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 OPSS was implemented.

#### 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 OPSS 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 (ASP + 6%) (i.e., the ASP methodology established under the Medicare physician fee schedule) or the rate under section 1847B of the Social Security Act (Competitive Acquisition Program (CAP)) if the drug or biological is covered under CAP and has subsequently been granted pass-through status as part of the Centers of Medicare and Medicaid Services (CMS) application process. Following is the applicable payment methodology for transitional pass-through drugs or biologicals.

b. Otherwise, the drugs and biologicals will be paid at ASP + 5% for CY 2008.

c. New radiopharmaceuticals with pass-through will be paid based on the Wholesale Acquisition Cost (WAC) or, if WAS is not available, based on 95% of the product's most recent Average Wholesale Price (AWP).

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

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e. The drugs and biologicals that are continuing pass-through status or have been granted pass-through status as of January 2008 for CY 2008 are included in [Figure 13-3-5](#).

**FIGURE 13-3-5 DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2008**

HCPCS	DESCRIPTOR	SI	APC
C9239	Inj, temsirolimus	G	1168
C9352	Neuragen nerve guide, per cm	G	9350
C9353	Neurawrap nerve protector, cm	G	1169
J0129	Abatacept injection	G	9230
J0348	Anadulafungin injection	G	0760
J0894*	Decitabine injection	G	9231
J1300	Eculizumab injection	G	9236
J1740	Ibandronate sodium injection	G	9229
J1743	Idursulfase injection	G	9232
J2248	Micafungin sodium injection	G	9227
J2323	Natalizumab injection	G	9126
J2778	Ranibizumab injection	G	9233
J3243	Tigecycline injection	G	9228
J3473	Hyaluronidase recombinant	G	0806
J3488	Reclast injection	G	0951
J7348	Tissuemend tissue	G	9351
JJ7349	Primatrix tissue	G	1141
J9261	Nelarabine injection	G	0825
J9303	Panitumumab injection	G	9235

\* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology while identified as pass-through under the OPPS.

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.

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

NOTE: Any Durable Medical Equipment (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 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.

(c) 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.

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(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.

(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 two, but not more than three 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.

(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. Current Device Categories Subject to Pass-Through Payment. Two device categories were established for pass-through payment as a January 1, 2007, HCPCS code C1821 (interspinous process distraction device (implantable)) and HCPCS code L8690 (auditory osseointegrated device, includes all internal and external components), will be active categories for pass-through payment for two years as of January 1, 2007, i.e., these categories will expire from pass-through payment as of December 31, 2008.

g. Reduction of Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups.

(1) Each new device category will be reviewed on a case-by-case basis to determine whether device costs associated with the new category were packaged into the existing APC structure.

(2) If it is determined that, for any new device category, no device costs associated with the new category were packaged into existing APCs, the offset amount for the new category would be set to \$0 for CY 2008.

h. 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 (two digit = rural, five 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 ADFM who has met his/her yearly deductible)

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

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.h.\(4\)](#) 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

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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>397.94</u>	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 ADFM 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.h.\(4\)](#) 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

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.

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(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.

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

**otherwise**

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

EXAMPLE: If there are two procedures with offsets but only one device, then the final offset is reduced by 50%.

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

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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 OPSS 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.

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 \$60. Separate APC payment is established for drugs and radiopharmaceuticals for which the median cost per day exceeds \$60.

3. An exception to the packaging rule is being made for injectable oral forms of antiemetics, listed in [Figure 13-3-6](#).

**FIGURE 13-3-6 ANTIEMETICS EXEMPTED FROM CY 2008 \$60 PACKAGING THRESHOLD**

HCPCS CODE	SHORT DESCRIPTOR
J1260	Dolasetron mesylate
J1626	Granisetron HCl Injection
J2405	Ondansetron HCl Injection
J2469	Palonosetron HCl
Q0166	Granisetron HCl 1 mg oral
Q0179	Ondansetron HCl 8 mg oral
Q0180	Dolasetron Mesylate oral

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.

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

(1) Specified outpatient drugs and biologicals will be paid a combined rate of the ASP + 5% which is reflective of the present hospital acquisition and overhead costs for separately payable drugs and biologicals under the OPPS. In the absence of ASP data, the 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% of the most recent AWP.

(2) Since there is no ASP data for separately payable specified radiopharmaceuticals, reimbursement will be based on charges converted to costs. Refer to [Section 2, Figure 13-2-13](#), for a list of therapeutic radiopharmaceuticals that will continue to be reimbursed under the cost-to-charge methodology up through January 1, 2010.

(a) Therapeutic radiopharmaceuticals must have a mean per day cost of more than \$60 in order to be paid separately.

(b) Diagnostic radiopharmaceuticals and contrast agents are packaged regardless of per day cost since they are ancillary and supportive of the therapeutic procedures in which they are used.

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 Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data.

a. These new drugs and biologicals with HCPCS codes as of January 1, 2008, but which do not have pass-through status and are without OPPS hospital claims data, will be paid at ASP + 5% consistent with its final payment methodology for other separately payable non-pass-through drugs and biologicals.

b. Payment for all new non-pass-through diagnostic radiopharmaceuticals will be packaged.

c. In the absence of ASP data, the WAC will be used for the product to establish the initial payment rate for new non-pass-through drugs and biologicals with HCPCS codes, but which are without OPPS claims data. If the WAC is also unavailable, payment will be made at 95% of the product’s most recent AWP.

d. SI K will be assigned to HCPCS codes for new drugs and biologicals for which pass-through application has not been received.

e. Payment for new therapeutic radiopharmaceuticals with HCPCS codes as of January 1, 2008, but which do not have pass-through status, will be assigned SI H and continue to be reimbursed under the cost-to-charge methodology up through January 1, 2010.

f. In order to determine the packaging status of these items for CY 2008 an estimate of the per day cost of each of these items was calculated by multiplying the payment rate for each product based on ASP + 5%, by a estimated average number of units of each product that would typically be furnished to a patient during one administration in the hospital outpatient setting. Items for which the estimated per day cost is less than or equal to \$60 will be packaged.

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 OPPS under Medicare, but were not eligible for pass-through status; and

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(2) Historically packaged with the procedures with which they were billed, even though their median cost per day was above the \$60 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 OPSS:

(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% 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 OPSS update.

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 13-3-7 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
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion pump	S	0440
90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	S	0437

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**FIGURE 13-3-7 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
90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	S	0438
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	S	0437
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	S	0438
90776	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	N	
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	S	0436
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0438
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0438
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0438
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0438
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0441
96420	Chemotherapy administration, intra-arterial; push technique	S	0439
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0441
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	S	0438
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	0441
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0441
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0441
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0441
96521	Refilling and maintenance of portable pump	S	0440
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	S	0440
96523	Irrigation of implanted venous access device for drug delivery systems	Q	0624
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0438
96549	Unlisted chemotherapy procedure	S	0436

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2. 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 13-3-8](#)).

**FIGURE 13-3-8 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	0441

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3. 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 of N that will be used as the basis for setting median costs for each drug administration HCPCS Level I code in the future.

4. 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.

5. Drugs for which the median cost per day is greater than \$60 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 \$60 will result in more equitable payment for both the drugs and their administration.

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.

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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 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% of AWP or 106 of the ASP, whichever is higher.

b. However, for drugs where 106% of ASP would exceed 95% of AWP, payment would be capped at 95% 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.

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

3. See [Figure 13-3-9](#) for vaccine administration codes and SIs.

**FIGURE 13-3-9 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS**

HCPCS LEVEL 1 <sup>1</sup> CODE	DESCRIPTION	SI	APC
G0008	Influenza vaccine administration	S	0350
G0009	Pneumococcal vaccine administration	S	0350
G0010	Hepatitis B vaccine administration	B	--
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	--

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**FIGURE 13-3-9 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS (CONTINUED)**

HCPCS LEVEL I <sup>1</sup> CODE	DESCRIPTION	SI	APC
90468	Immunization admin, under 8 yrs old, with counseling; each additional intranasal or oral	N	--
90471	Immunization admin, one vaccine injection	X	0437
90472	Immunization admin, each additional vaccine injections	X	0436
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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I. 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 \$60.
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% of its AWP.
3. Radiopharmaceuticals will be excluded from receiving outlier payments.
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).

<sup>4</sup> HCPCS Level I/CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

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4. Payment rates for blood and blood products will be determined based on median costs. Refer to [Figure 13-3-10](#) for APC assignment of blood and blood product codes.

**FIGURE 13-3-10 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
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

5. For CY 2007, blood clotting factors will be paid at ASP + 6%, plus an additional payment for the furnishing fee that is also a part of the payment for blood clotting factors furnished in physician's offices. The CY 2007 furnishing fee was \$0.152 per unit.

6. For CY 2008, blood clotting factors will be paid at ASP + 5%, plus an additional furnishing fee amount of \$0.158 per unit.

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

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

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

3. If the APC to which the procedure is assigned is one of the APCs listed in [Figure 13-3-12](#), the contractor will reduce the unadjusted payment rate for the procedure by an amount equal to the percent in [Figure 13-3-12](#) for partial credit device replacement multiplied by the unadjusted payment rate.

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

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

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

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

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

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

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

3. The presence of the modifier "FB" ["Item Provided Without Cost to Provider, Supplier, or Practitioner or Credit Received for Replacement (examples include, but are not

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limited to devices covered under warranty, replaced due to defect, or provided as free samples)"] would trigger the adjustment in payment if the procedure code to which modifier "FB" was amended appeared in [Figure 13-3-11](#) and was also assigned to one of the APCs listed in [Figure 13-3-12](#).

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

DEVICE	DESCRIPTION
C1721	AICD, dual chamber
C1722	AICS, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep Dev urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual rate-resp
C1786	Pmkr, single rate-resp
C1813	Prostheses, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro, rechg bat sys
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Pmkr, other than sing/dual
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system

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**FIGURE 13-3-12 ADJUSTMENTS TO APCs IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED FOR CY 2008**

APC	SI	APC GROUP TITLE	REDUCTION FOR PARTIAL CREDIT CASE (PERCENT)	REDUCTION FOR FULL CREDIT CASE (PERCENT)	PAYMENT RATE	ADJUSTED PAYMENT FOR PARTIAL CREDIT CASE	ADJUSTED PAYMENT FOR FULL CREDIT CASE
0039	S	Level I Implantation of Neurostimulator	41.37	82.73	\$11,877	\$6,964	\$2,051
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	28.14	56.27	\$4,063	\$2,920	\$1,177
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	30.30	60.60	\$5,278	\$3,679	\$2,079
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	36.50	72.99	\$7,748	\$4,921	\$2,093
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	38.01	76.01	\$6,423	\$3,982	\$1,541
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	28.13	56.25	\$4,428	\$3,183	\$1,937
0107	T	Insertion of Cardioverter-Defibrillator	44.56	89.11	\$21,262	\$11,789	\$2,315
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	44.62	89.24	\$25,787	\$14,281	\$2,775
0222	S	Implantation of Neurological Device	42.43	84.86	\$15,337	\$8,830	\$2,322
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	40.29	80.57	\$14,061	\$8,397	\$2,732
0227	T	Implantation of Drug Infusion Devices	40.73	80.73	\$11,713	\$6,985	\$2,257
0229	T	Transcatheter Placement of Intravascular Shunts	41.47	82.94	\$25,046	\$14,659	\$4,273
0259	T	Level IV ENT Procedures	43.08	86.15	\$17,199	\$8,790	\$2,382
0315	S	Level II Implantation of Neurostimulator	25.78	51.56	\$5,327	\$3,954	\$2,580
0385	S	Level I Prosthetic Urological Procedures	31.77	63.53	\$9,180	\$6,264	\$3,348
0386	S	Level II Prosthetic Urological Procedures	41.26	82.52	\$16,544	\$9,718	\$2,892
0418	T	Insertion of Left Ventricular Pacing Elect	29.44	58.88	\$5,207	\$3,674	\$2,141
0625	T	Level IV Vascular Access Procedures	38.57	77.13	\$6,961	\$4,276	\$1,592

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**FIGURE 13-3-12 ADJUSTMENTS TO APCs IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED FOR CY 2008 (CONTINUED)**

APC	SI	APC GROUP TITLE	REDUCTION FOR PARTIAL CREDIT CASE (PERCENT)	REDUCTION FOR FULL CREDIT CASE (PERCENT)	PAYMENT RATE	ADJUSTED PAYMENT FOR PARTIAL CREDIT CASE	ADJUSTED PAYMENT FOR FULL CREDIT CASE
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	37.31	74.62	\$8,919	\$5,591	\$2,264
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	36.58	73.15	\$4,497	\$2,852	\$1,208
0680	S	Insertion of Patient Activated Event Recorders	41.43	82.86	\$17,495	\$10,244	\$2,993
0681	T	Knee Arthroplasty	41.43	82.86	\$17,495	\$10,244	\$2,993

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

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

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

M. Policies Affecting Payment of New Technology Services.

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

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

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

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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.

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).

(c) 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.

(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 OPPS.

#### N. Coding And Payment Of ED Visits.

1. CPT defines an ED as “an organized hospital based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must available 24 hours a day.”

2. Prior to CY 2007, under the OPPS the billing of ED CPT codes was restricted to services furnished at facilities that met this CPT definition. Based on the above definition, facilities open less than 24 hours a day could not report ED CPT codes.

3. Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on Medicare-participating hospitals that offer emergency services. These obligations concern individuals who come to a hospital’s dedicated emergency department (DED) and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. Section 1867(h) of the Act specifically prohibits a delay in providing required screening or stabilization services in order to inquire about the individual’s payment method or insurance status.

4. These provisions are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA). The EMTALA regulations define DED “as any department or facility of the hospital, regardless of whether it is located on or off the main campus, that meets at least one of the following requirements:

a. It is licensed by the State in which it is located under applicable State law as an emergency room or ED;

b. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

c. During the calendar year immediately preceding the calendar year in which a determination under the regulations is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its

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outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring previously scheduled appointment.

5. There are some departments or facilities of hospitals that met the definition of a dedicated ED under the EMTALA regulations, but did not meet the more restrictive CPT definition of ED. For example, a hospital department or facility that met the definition of a DED might not have been available 24 hours a day, seven days a week.

6. To determine whether visits to EDs of facilities (referred to as Type B ED) that incur EMTALA obligations, but do not meet the more prescriptive expectations that are consistent with the CPT definition of an ED (referred to as Type A ED) have different resource costs than visits to either clinics or Type A EDs, five G codes were developed for use by hospitals to report visits to all entities that meet the definition of a DED under the EMTALA regulations, but that are not Type A EDs. These codes are called "Type B ED visit codes." EDs meeting the definition of a DED under the EMTALA regulations, but which are not Type A EDs (i.e., they may meet the DED definition but are not available 24 hours a day, seven days a week).

**FIGURE 13-3-13 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDs**

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0380	Level 1 Hosp Type B Visit	Level 1 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0381	Level 2 Hosp Type B Visit	Level 2 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

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**FIGURE 13-3-13 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDs (CONTINUED)**

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0382	Level 3 Hosp Type B Visit	Level 3 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0384	Level 4 Hosp Type B Visit	Level 4 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0385	Level 5 Hosp Type B Visit	Level 5 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

7. The five new Type B ED visit codes for services provided in a Type B ED will be assigned to the five newly established Clinical Visit APCs 0604, 0605, 0606, 0607, and 0608.

8. For CY 2007, the five CPT E/M ED visit codes for services provided in a Type A ED were assigned to the five newly-created ED Visit APCs 0609, 0613, 0614, 0615, and 0616.

9. The definition of Type A and Type B EDs was not modified for CY 2008 because its current definition accurately distinguished between these two types of ED.

10. For CY 2008, Type A Ed visits will continue to be paid based on the five ED Visit APCs, while Type B ED visits would continue to be paid based on the five Clinic Visit APCs.

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11. A new "G" code (G0390 - Trauma response team activation associated with hospital critical care services) was also created (effective January 1, 2007) to be used in addition to CPT<sup>5</sup> procedure codes 99291 and 99292 to address the meaningful cost difference between critical care when billed with and without trauma activation.

a. If critical care is provided without trauma activation, the hospital will bill with either CPT<sup>5</sup> procedure code 99291, receiving payment for APC 0617.

b. However if trauma activation occurs, the hospital would be called to bill one unit of "G" code (G0390), report with revenue code 68x on the same date of service, thereby receiving payment for APC 0618.

12. The CPT Evaluation and Management (E/M) codes and other HCPCS codes currently assigned to the clinic visit APCs have been mapped in [Figure 13-3-14](#) to 11 new APCs; five for clinic visits; five for ED visits; and one for critical care services, based on median costs and clinical consideration.

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

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 1 Hospital Clinic Visits	0604	92012	Eye exam, established pat
		99201	Office/outpatient visit, new (Level 1)
		99211	Office/outpatient visit, est (Level 1)
		99241	Office consultation
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam Pt lops
		G0379	Direct admit hospital observ
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level 2)
		99212	Office/outpatient visit, est (Level 2)
		99213	Office/outpatient visit, est (Level 3)
		99243	Office consultation (Level 3)
		99242	Office consultation (Level 2)
		99273	Confirmatory consultation (Level 3)
		99272	Confirmatory consultation (Level 2)
		99431	Initial care, normal newborn
		G0246	Follow-up eval of foot pt lop
		G0344	Initial preventive exam

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

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 3 Hospital Clinic Visits	0606	90862	Medication management
		92004	Eye exam, new patient
		99203	Office/outpatient visit, new (Level 3)
		99214	Office/outpatient visit, est (Level 4)
		99274	Confirmatory consultation (Level 4)
		99244	Office consultation (Level 4)
		M0064	Visit for drug monitoring
Level 4 Hospital Clinic Visits	0607	99204	Confirmatory consultation (Level 1)
		99215	Office/outpatient visit, est (Level 5)
		99245	Office consultation (Level 5)
		99275	Confirmatory consultation (Level 5)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level 5)
		G0175	OPPS service, sched team conf
Level 1 Type A Emergency Visits	0609	99281	Emergency department visit
Level 2 Type A Emergency Visits	0613	99282	Emergency department visit
Level 3 Type A Emergency Visits	0614	99283	Emergency department visit
Level 4 Type A Emergency Visits	0615	99284	Emergency department visit
Level 5 Type A Emergency Visits	0616	99285	Emergency department visit
Critical Care	0617	99291	Critical care, first hour
Trauma Activation	0618	G0390	Trauma Respon. w/hosp criti

O. OPPTS PRICER.

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

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

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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 CCRs as provided in CMS Final Rule;
- c. Locality Code: Based on CBSA - two digit = rural and five digit = urban;
- d. Hospital Type: Rural SCH = 1 and All Others = 0

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

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

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

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
T	\$19,999	\$6,000	\$12,000
T	\$1	\$3,000	\$6,000

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

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**FIGURE 13-3-15** PROPORTIONAL PAYMENT FOR “T” LINE ITEMS (CONTINUED)

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
T	\$0	\$1,000	\$2,000
Total	\$20,000	\$10,000	\$20,000

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

P. TRICARE Specific Procedures/Services.

1. TRICARE specific APCs have been assigned for half-day PHPs.
2. Other procedures that are normally covered under TRICARE but not under Medicare will be assigned SI of A (i.e., services that are paid under some payment method other than OPPS) until they can be placed into existing or new APC groups.

Q. Validation Reviews.

OPPS claims are not subject to validation review.

R. 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 CPT<sup>6</sup> procedure code 59400 and the state specific non-professional component, will lag two months (i.e., April 1 instead of February 1).

IV. EFFECTIVE DATE            May 1, 2009.

- END -

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