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TRICARE
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6010.55-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM)

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

CHANGE TITLE: OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)
- CALENDAR YEAR (CY) 2009 UPDATE CHANGES

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

SUMMARY OF CHANGE(S): This change reflects the Centers for Medicare and
Medicaid Services (CMS) CY 2009 changes that have already been incorporated into
contractor's claims processing systems through the Outpatient Code Editor (OCE)/
Pricer quarterly update process.

EFFECTIVE AND IMPLEMENTATION DATE: May 1, 2009.

This change is made in conjunction with Aug 2002 TOM, Change No. 78, Aug 2002
TPM, Change No. 95, and Aug 2002 TSM, Change No. 70.

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Branch

ATTACHMENT(S): 143 PAGE(S)
DISTRIBUTION: 6010.55-M

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SURGERY

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

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

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

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

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

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

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

C. Assistant Surgeons. See Chapter 1, Section 17.

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

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

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

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

G. Global Surgery for Major Surgical Procedures. Physicians who perform the entire global package which includes the surgery and the pre- and post-operative care should bill

for their services with the appropriate CPT code only. Do not bill separately for visits or other services included in this global package. The global period for a major surgery includes the day of surgery. The pre-operative period is the first day immediately before the day of surgery. The post-operative period is the 90 days immediately following the day of surgery. If the patient is returned to surgery for complications on another day, the post-operative period is 90 days immediately after the last operation.

H. Second Opinion.

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

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

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

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

- END -

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CHAPTER 1
SECTION 24

HOSPITAL REIMBURSEMENT - OUTPATIENT SERVICES FOR ALL SERVICES BEFORE MAY 1, 2009 (IMPLEMENTATION OF OPPTS), AND THEREAFTER, FOR SERVICES NOT OTHERWISE REIMBURSED UNDER HOSPITAL OPPTS

ISSUE DATE: March 10, 2000

AUTHORITY: [32 CFR 199.14\(a\)\(3\)](#) and [\(a\)\(5\)](#)

I. APPLICABILITY

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

II. ISSUE

How are outpatient hospital services to be reimbursed for all services prior to implementation of Outpatient Prospective Payment System (OPPS), and thereafter, for services performed in facilities that are not subject to the hospital OPPS?

III. POLICY

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

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

NOTE: All line items on the Centers of Medicare and Medicaid Services (CMS) 1450 UB-04 claim form must be submitted with a specific date of service. The header date of the CMS 1450 UB-04 may span dates of services. However, each line item date of service must fall within the span date billed or the claim will be denied.

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

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

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

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

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

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

- END -

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COST-SHARES AND DEDUCTIBLES

duty in support of operations that result from the terrorist attacks on the World Trade Center and the Pentagon on September 11, 2001.

(2) The cost-share is partially waived in certain cases for these beneficiaries. On claims from non-participating professional providers for services rendered to Standard beneficiaries, the allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CMAC. In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

(3) The exception to the deductible and cost-share requirements under Operation Noble Eagle/Operation Enduring Freedom for TRICARE Standard and Extra is effective for services rendered from September 14, 2001, through October 31, 2009.

d. For Certain Reservists. The Director, TRICARE Management Activity, may waive the individual or family deductible for dependents of a reserve component member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a reserve component member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 U.S.C. 101(a)(13). Also, for this purpose a dependent is a lawful husband or wife of the member or an eligible child.

B. TRICARE Prime.

1. Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See [Chapter 2, Addendum A](#) for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act, P.L. 106-398, for services provided on or after April 1, 2001, a \$0 copayment shall be charged to TRICARE Prime ADFMs of active duty service members (ADSMs) who are enrolled in TRICARE Prime. Pharmacy copayments and Point of Service charges are not waived by the FY 2001 Authorization Act.

2. In instances where the CMAC or allowable charge is less than the copayment shown on [Addendum A](#), network providers may only collect the lower of the allowable charge or the applicable copayment.

3. The TRICARE Prime copayment requirement for emergency room services is on a PER VISIT basis; this means that only one copayment is applicable to the entire emergency room episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers.

4. No copayments or authorizations are required for TRICARE Prime clinical preventive services which are described in the TPM, [Chapter 7, Section 2.2](#).

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5. Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply):

a. Diagnostic radiology and ultrasound services included in the CPT¹ procedure code range from 70000 through 76999, or any other code for associated contrast media;

b. Diagnostic nuclear medicine services included in the CPT¹ procedure code range from 78000 through 78999;

c. Pathology and laboratory services included in the CPT¹ procedure code range from 80000 through 89399; and

d. Cardiovascular studies included in the CPT¹ procedure code range from 93000 through 93350.

e. Venipuncture included in the CPT¹ procedure code range from 36400 - 36416.

f. Collection of blood specimens in the CPT¹ procedure code range from 36591 and 36592.

g. Fetal monitoring for CPT¹ procedure codes 59020, 59025, and 59050.

NOTE: Contractors are not required to search their files for claims for ancillary services which were not processed according to these guidelines. The contractor shall, however, if requested by an appropriate individual, adjust specific claims under these guidelines if the date of service is on or after March 26, 1998.

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

6. Point of Service (POS) option. See [Chapter 2, Section 3](#).

C. Basic Program: TRICARE Standard.

1. Deductible Amount: Outpatient Care.

a. For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(1) Deductible, Individual: Each beneficiary is liable for the first fifty dollars (\$50.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

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(2) Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

b. For care rendered on or after April 1, 1991, for all TRICARE beneficiaries except family members of active duty sponsors of pay grade E-4 or below.

(1) Deductible, Individual: Each beneficiary is liable for the first one hundred and fifty dollars (\$150.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

(2) Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed three hundred dollars (\$300.00).

c. TRICARE-Approved Ambulatory Surgery Centers (ASCs), Birthing Centers, or Partial Hospitalization Programs (PHPs). No deductible shall be applied to allowable amounts for services or items rendered to ADFMs or authorized NATO family members.

d. Allowable Amount Does Not Exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (or \$300.00 if [paragraph I.C.1.b.](#), applies), and no one beneficiary's allowable amounts exceed \$50.00 (or \$150.00 if [paragraph I.C.1.b.](#), applies), neither the family nor the individual deductible will have been met and no TRICARE benefits are payable.

e. In the case of family members of an active duty member of pay grade E-5 or above, with Persian Gulf conflict service who is, or was, entitled to special pay for hostile fire/imminent danger authorized by 37 U.S.C. 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm, the deductible shall be the amount specified in [paragraph I.C.1.b.](#), for care rendered after October 1, 1991.

NOTE: The provisions of [paragraph I.C.1.e.](#), also apply to family members of service members who were killed in the Gulf, or who died subsequent to Gulf service; and to service members who retired prior to October 1, 1991, after having served in the Gulf war, and to their family members.

f. Effective December 8, 1995, the annual TRICARE deductible has been waived for family members of selected reserve members called to active duty for 31 days or more in support of Operation Joint Endeavor (the Bosnia peacekeeping mission). Under a nationwide demonstration, TRICARE may immediately begin cost-sharing in accordance with standard TRICARE rules. These beneficiaries will be eligible to use established TRICARE Extra network providers at a reduced cost-share rate. Additionally, in those areas where TRICARE is in full operation, selected reserve members called to active duty for 31 days or more will have the option of enrolling their families in TRICARE Prime.

NOTE: This demonstration is effective December 8, 1995, and is in effect until such time as Executive Order 12982 expires. TRICARE eligible beneficiaries other than family members of reservists called to active duty in support of Operation Joint Endeavor are not eligible for participation. This demonstration is limited to the annual TRICARE Standard and

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Extra deductible; other TRICARE cost-sharing continues to apply. All current TRICARE rules, unless specifically provided otherwise, will continue to apply.

NOTE: Initially the option to enroll in TRICARE Prime was limited to family members of selected reserve members who were called to active duty for 179 days or more. This changed to 31 days or more as of March 10, 2003.

NOTE: Claims for these beneficiaries are to be paid from financially underwritten funds and reported as such. TMA periodically will calculate and reimburse the contractors for the additional costs incurred as a result of waiving the deductibles on these claims.

g. Adjustment of Excess. Any beneficiary identified under [paragraph I.C.1.d., e., and f.](#), above, who paid any deductible in excess of the amounts stipulated is entitled to an adjustment of any amount paid in excess against the annual deductible required under those paragraphs.

NOTE: The contractors need not search their records for deductibles paid in excess, but are authorized and required to adjust any deductible amounts paid in excess that are brought to their attention and that are verifiable.

h. The deductible amounts identified in this section shall be deemed to have been satisfied if the catastrophic cap amounts identified in [Chapter 2, Section 2](#) have been met for the same fiscal year in which the deductible applies.

2. Deductible Amount: Inpatient Care: None.

3. Cost-share Amount:

a. Outpatient Care.

(1) ADFM or Authorized NATO Beneficiary. The cost-share for outpatient care is 20% of the allowable amount in excess of the annual deductible amount. This includes the professional charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC or birthing center.

(2) Other Beneficiary. The cost-share applicable to outpatient care for other than active duty and authorized NATO family member beneficiaries is 25% of the allowable amount in excess of the annual deductible amount. This includes: partial hospitalization for alcohol rehabilitation; professional charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC.

b. Inpatient Care.

(1) ADFM: Except in the case of mental health services, ADFMs or their sponsors are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

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(Please reference daily rate chart below.) (For care provided on or after April 1, 2001, for Prime ADFMs, copayment is \$0.)

UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS

Use the daily charge (per diem rate) in effect for each day of the stay to calculate a cost-share for a stay which spans periods.

PERIOD	DAILY CHARGE
October 1, 1997 - September 30, 1998	\$10.20
October 1, 1998 - September 30, 1999	\$10.45
October 1, 1999 - September 30, 2000	\$10.85
October 1, 2000 - September 30, 2001	\$11.45
April 1, 2001 (for Prime ADFMs only)	\$0.00
October 1, 2001 - September 30, 2002 (for ADFMs not enrolled in Prime)	\$11.90
October 1, 2002 - September 30, 2003 (for ADFMs not enrolled in Prime)	\$12.72
October 1, 2003 - September 30, 2004 (for ADFMs not enrolled in Prime)	\$13.32
October 1, 2004 - September 30, 2005 (for ADFMs not enrolled in Prime)	\$13.90
October 1, 2005 - September 30, 2006 (for ADFMs not enrolled in Prime)	\$14.35
October 1, 2006 - September 30, 2007 (for ADFMs not enrolled in Prime)	\$14.80
October 1, 2007 - September 30, 2008 (for ADFMs not enrolled in Prime)	\$15.15
October 1, 2008 - September 30, 2009 (for ADFMs not enrolled in Prime)	\$15.65

(2) Other Beneficiaries: For services exempt from the DRG-based payment system and the mental health per diem payment system and services provided by institutions other than hospitals (i.e., RTCs), the cost-share shall be 25% of the allowable charges.

c. Cost-Shares: Maternity.

(1) Determination. Maternity care cost-share shall be determined as follows:

(a) Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded.

NOTE: Inpatient cost-share formula applies to prenatal and postnatal care provided in the office of a civilian physician or certified nurse-midwife in connection with maternity care ending in childbirth or termination of pregnancy in, or on the way to, a military treatment facility inpatient childbirth unit. ADFMs pay a per diem charge (or a \$25.00 minimum charge) for an admission and there is no separate cost-share for them for separately billed professional charges or prenatal or postnatal care.

(b) Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted, and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

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(c) Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

(d) Otherwise covered medical services and supplies directly related to “Complications of pregnancy”, as defined in the Regulation, will be cost-shared on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

(2) Otherwise authorized services and supplies related to maternity care, including maternity related prescription drugs, shall be cost-shared on the same basis as the termination of pregnancy.

(3) Claims for pregnancy testing are cost-shared on an outpatient basis when the delivery is on an inpatient basis.

(4) Where the beneficiary delivers in a professional office birthing suite located in the office of a physician or certified nurse-midwife (which is not otherwise a TRICARE-approved birthing center) the delivery is to be adjudicated as an at-home birth.

(5) Claims for prescription drugs provided on an outpatient basis during the maternity episode but not directly related to the maternity care are cost-shared on an outpatient basis.

(6) Newborn cost-share. Effective for all inpatient admissions occurring on or after October 1, 1987, separate claims must be submitted for the mother and newborn. The cost-share for inpatient claims for services rendered to an beneficiary newborn is determined as follows:

(a) IN A DRG HOSPITAL:

1 Same newborn date of birth and date of admission.

2 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

3 For newborn family members of other than active duty members, unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of the number of hospital days minus three (3) multiplied by the per diem amount, OR 25% of the total billed charges (less duplicates and DRG non-reimbursables such as hospital-based professional charges).

4 Different newborn date of birth and date of admission. For family members of active duty members, there will be no cost-share during the period the newborn is deemed enrolled in Prime. For all other beneficiaries, the cost-share is applied to all days in the inpatient stay unless the newborn is deemed enrolled in Prime.

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

VII. REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS (ASCs)

A. General

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

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

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

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

5. See [Chapter 9, Section 1](#) for additional instructions.

B. Payment Procedures. All rate calculations will be performed by TMA (or its data contractor) and will be provided to each contractor. In pricing a claim, the contractor will be required to identify the zip code of the facility which provided the services (for the actual location, not the billing address, etc.) and the procedure(s) performed. The contractor shall use the zip code to MSA crosswalk to identify the rates applicable to that facility and then will select the rate applicable to the procedure(s) performed. Multiple procedures are to be reimbursed in accordance with the instructions in the TRICARE Policy Manual (TPM). Surgical and bilateral procedures (both institutional and professional) will be subject to the multiple surgery discounting guidelines and modifier requirement as prescribed under [Chapter 1, Section 16, paragraph III.A.1.a. through c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b. and c.](#) for services rendered on or after **May 1, 2009** (implementation of the Outpatient Prospective Payment System (OPPS)).

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

VIII. CLAIM ADJUSTMENTS

Facilities may not submit a late charge bill (frequency 5 in the third position of the bill type). They must submit an adjustment bill for any services required to be billed with HCPCS codes, units, and line item dates of service by reporting frequency 7 (replacement of a prior claim) or frequency 8 (void/cancel of a prior claim). Claims submitted with a frequency code of 7 or 8 should report the original claim number in Form Locator (FL) 64 on the CMS 1450 UB-04 claim form. **Facilities should not submit claims on bill type 135 as this bill type is not allowed under TRICARE and will be denied.**

IX. PROPER REPORTING OF CONDITION CODES

Hospitals should report valid Condition Codes on the CMS 1450 UB-04 claim form as necessary.

A. Condition Codes are reported in FLs 18-28 when applicable.

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

1. **Condition Code G (zero)** identifies when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day - in the morning for a broken arm and later for chest pain.

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

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

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

- END -

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

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

NOTE: The above COB methodology for hospital outpatient services will not go into effect until implementation of the hospital outpatient prospective payment system. This new reimbursement system is scheduled to become effective May 1, 2009 (implementation of the Outpatient Prospective Payment System (OPPS)).

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

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

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

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

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

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

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

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

- END -

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CHAPTER 5, SECTION 3

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for further detail.

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

- END -

MENTAL HEALTH

SECTION	SUBJECT
1	Hospital Reimbursement - TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System
2	Psychiatric Partial Hospitalization Program (PHP) Reimbursement Before May 1, 2009 (Implementation Of OPPS), And Thereafter, Freestanding Psychiatric PHP Reimbursement
3	Substance Use Disorder Rehabilitation Facilities Reimbursement
4	Residential Treatment Center (RTC) Reimbursement
ADDENDUM A	Table Of Regional Specific Rates For Psychiatric Hospitals And Units With Low TRICARE Volume (FY 2007 - FY 2009)
ADDENDUM B	Table Of Maximum Rates For Partial Hospitalization Programs (PHPs) Before May 1, 2009 (Implementation Of OPPS), And Thereafter, Freestanding Psychiatric PHP Reimbursement (FY 2007 - FY 2009)
ADDENDUM C	Participation Agreement For Substance Use Disorder Rehabilitation Facility (SUDRF) Services For TRICARE/CHAMPUS Beneficiaries
ADDENDUM D	TRICARE/CHAMPUS Standards For Inpatient Rehabilitation And Partial Hospitalization For The Treatment Of Substance Use Disorders (SUDRFs)
ADDENDUM E	Participation Agreement For Residential Treatment Center (RTC)
ADDENDUM F	Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates
ADDENDUM G	(FY 2007) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2006
ADDENDUM G	(FY 2008) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2007
ADDENDUM G	(FY 2009) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2008
ADDENDUM H	TRICARE/CHAMPUS Standards For Residential Treatment Centers (RTCs) Serving Children And Adolescents

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CHAPTER 7 - MENTAL HEALTH

SECTION	SUBJECT
ADDENDUM I	Participation Agreement For Hospital-Based Psychiatric Partial Hospitalization Program Services
ADDENDUM J	Participation Agreement For Freestanding Psychiatric Partial Hospitalization Program Services

PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM (PHP) REIMBURSEMENT BEFORE MAY 1, 2009 (IMPLEMENTATION OF OPPS), AND THEREAFTER, FREESTANDING PSYCHIATRIC PHP REIMBURSEMENT

ISSUE DATE: July 14, 1993

AUTHORITY: [32 CFR 199.14\(a\)\(2\)\(ix\)](#)

I. APPLICABILITY

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

II. ISSUE

Reimbursement of Psychiatric Partial Hospitalization Programs (PHPs) before May 1, 2009 (implementation of Outpatient Prospective Payment System (OPPS)), and thereafter, freestanding psychiatric PHPs.

III. POLICY

A. Per diem payment for psychiatric partial hospitalization services. Psychiatric partial hospitalization services authorized and provided under [32 CFR 199.4\(b\)\(10\)](#) and provided by psychiatric PHPs authorized under [32 CFR 199.4\(b\)\(3\)\(xii\)](#) are reimbursed on the basis of prospectively determined, all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all PHP services provided. The following services and supplies are included in the per diem rate approved for an authorized PHP and are not covered even if separately billed by an individual professional provider. Effective on May 1, 2009 (implementation of OPPS), hospital-based PHP services are reimbursed under the hospital OPPS as described in [Chapter 13, Section 2, paragraph G](#).

1. Board. Includes use of the partial hospital facilities such as food service, supervised therapeutically constructed recreational and social activities, etc.

2. Patient assessment. Includes the assessment of each individual accepted by the facility, and must, at a minimum, consist of a physical examination; psychiatric examination; psychological assessment; assessment of physiological, biological and cognitive processes; developmental assessment; family history and assessment; social history and assessment; educational or vocational history and assessment; environmental assessment; and

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recreational/activities assessment. Assessments conducted within 30 days prior to admission to a partial program may be used if approved and deemed adequate to permit treatment planning by the partial hospital program.

3. Psychological testing and assessment.

4. Treatment services. All services including routine nursing services, group therapy, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the psychotherapy as indicated in [paragraph III.B.1.](#)). All mental health services must be provided by a authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

5. Ancillary therapies. Includes art, music, dance, occupational, and other such therapies.

6. Overhead and any other services for which the customary practice among similar providers is included as part of the institutional charges.

B. Services which may be billed separately. The following services are not considered as included within the per diem payment amount and may be separately billed when provided by an authorized individual professional provider:

1. Psychotherapy sessions. Professional services provided by an authorized individual professional provider (who is not employed by or under contract with the PHP) for purposes of providing clinical patient care to a patient in the PHP may be cost-shared when billed by the individual professional provider. Any obligation of a professional provider to provide services through employment or contract in a facility or distinct program of a facility would preclude that professional provider from receiving separate TRICARE/CHAMPUS reimbursement on a fee-for-service basis to the extent that those services are covered by the employment or contract arrangement. Psychotherapy services provided outside of the employment/contract arrangement can be reimbursed separately from the PHPs per diem. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family, etc.) per authorized treatment day not to exceed five sessions in any calendar week in any combination of individual and family therapy. Five sessions per week is an absolute limit, and additional sessions are not covered.

NOTE: Group therapy is strictly included in the per diem and cannot be paid separately even if billed by an individual professional provider.

2. Primary/Attending Provider. When a patient is approved for admission to a PHP, the primary or attending provider (if not contracted or employed by the partial program) may provide psychotherapy only when the care is part of the treatment environment which

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is the therapeutic partial program. That is why the patient is there--because that level of care and that program have been determined as medically necessary. The therapy must be adapted toward the events and interactions outlined in the treatment plan and be part of the overall partial treatment plan. Involvement as the primary or attending is allowed and covered only if he is part of the coherent and specific plan of treatment arranged in the partial setting. The treatment program must be under the general direction of the psychiatrist employed by the program to ensure medication and physical needs of the patients are met and the therapist must be part of the treatment team and treatment plan. An attending provider must come to the treatment plan meetings and his/her care must be coordinated with the treatment team and as part of the treatment plan. Care given independent of this is not covered.

3. Non-mental health related medical services. Those services not normally included in the evaluation and assessment of a partial hospitalization patient and not related to care in the PHP. These medical services are those services medically necessary to treat a broken leg, appendicitis, heart attack, etc., which may necessitate emergency transport to a nearby hospital for medical attention. Ambulance services may be cost-shared when billed for by an authorized provider if determined medically necessary for emergency transport.

C. Per diem rate.

For any full day PHP (minimum of six hours), the maximum per diem payment amount is 40% of the average inpatient per diem amount per case paid to both high and low volume psychiatric hospitals and units established under the mental health per diem reimbursement system. The rates shall be updated to the current year using the same factors as used under the TRICARE mental health per diem reimbursement system. A PHP of less than six hours (with a minimum of three hours) will be paid a per diem rate of 75% of the rate for full-day PHP. TRICARE will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half or full day program. See [Chapter 7, Addendum B](#), for the current maximum rate limits which are to be used as is for the full day and half day program.

D. Other requirements.

No payment is due for leave days, for days in which treatment is not provided, for days in which the patient does not keep an appointment, or for days in which the duration of the program services was less than three hours.

- END -

TABLE OF MAXIMUM RATES FOR PARTIAL HOSPITALIZATION PROGRAMS (PHPs) BEFORE MAY 1, 2009 (IMPLEMENTATION OF OPPTS), AND THEREAFTER, FREESTANDING PSYCHIATRIC PHP REIMBURSEMENT (FY 2007 - FY 2009)

UNITED STATES CENSUS REGIONS	FULL-DAY RATE (6 HOURS OR MORE)			HALF-DAY RATE (3-5 HOURS)		
	10/01/06-09/30/07	10/01/07-09/30/08	10/01/08-09/30/09	10/01/06-09/30/07	10/01/07-09/30/08	10/01/08-09/30/09
Northeast:						
New England (ME, NH, VT, MA, RI, CT)	\$275	\$284	\$293	\$207	\$214	\$221
Mid-Atlantic (NY, NJ, PA)	\$298	\$308	\$318	\$224	\$232	\$239
Midwest:						
East North Central (OH, IN, IL, MI, WI)	\$262	\$271	\$280	\$196	\$203	\$209
West North Central (MN, IA, MO, ND, SD, NE, KS)	\$262	\$271	\$280	\$196	\$203	\$209
South:						
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	\$282	\$292	\$301	\$212	\$219	\$226
East South Central (KY, TN, AL, MS)	\$305	\$315	\$325	\$229	\$237	\$245
West South Central (AR, LA, TX, OK)	\$305	\$315	\$325	\$229	\$237	\$245
West:						
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	\$308	\$318	\$328	\$232	\$240	\$248
Pacific (WA, OR, CA, AK, HI)	\$302	\$312	\$322	\$226	\$234	\$241
Puerto Rico	\$196	\$203	\$209	\$148	\$153	\$158
Days of 3 hours or less: no payment authorized.						

NOTE: This table reflects maximum rates.

- END -

CHAPTER 9

AMBULATORY SURGERY CENTERS (ASCs)

SECTION	SUBJECT
1	Ambulatory Surgical Center (ASC) Reimbursement Before May 1, 2009 (Implementation Of OPPS), And Thereafter, Freestanding ASCs, And Non-OPPS Facilities Reimbursement

AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT BEFORE MAY 1, 2009 (IMPLEMENTATION OF OPPTS), AND THEREAFTER, FREESTANDING ASCs, AND NON-OPPS FACILITIES REIMBURSEMENT

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.14\(d\)](#)

I. APPLICABILITY

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

II. ISSUE

Reimbursement of surgical procedures performed in an Ambulatory Surgical Center (ASC) before May 1, 2009 (implementation of TRICARE's Outpatient Prospective Payment System (OPPS)), and thereafter, freestanding ASCs, and other providers who are exempt from the TRICARE OPPTS and provide scheduled ambulatory surgery. For purposes of this section, these facilities are known as non-OPPS facilities. Non-OPPS facilities include any facility not subject to the OPPTS as outlined in [Chapter 13, Section 1, paragraph III.D.1.b](#).

III. BACKGROUND

A. Reimbursement System Before May 1, 2009 (Implementation of TRICARE's OPPTS).

1. General. Ambulatory surgery procedures performed in ASCs will be reimbursed using prospectively determined rates. The rates will be: established on a cost-basis, divided into eleven payment groups representing ranges of costs, and adjusted for area labor costs based on Metropolitan Statistical Areas (MSAs).

2. Applicability.

a. The ambulatory surgery payment system is to be used regardless of where the ambulatory surgery procedures are provided, that is, in a freestanding ASC, in a hospital outpatient department, or in a hospital Emergency Room (ER). No additional benefits are payable outside the ASC payment rate; e.g., revenue codes 0260, 0450, 0510, 0636, etc.

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b. The payment rates established under this system apply only to the facility charges for ambulatory surgery. The facility rate is a standard overhead amount that includes nursing and technician services; use of the facility; drugs including take-home drugs for less than \$40; biologicals; surgical dressings, splints, casts and equipment directly related to provision of the surgical procedure; materials for anesthesia; intraocular lenses (IOLs); and administrative, recordkeeping and housekeeping items and services. The rate does not include items such as physicians' fees (or fees of other professional providers authorized to render the services identified and to bill independently for them); laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure); prosthetic devices (except IOLs); ambulance services; leg, arm, and back braces; artificial limbs; and durable medical equipment for use in the patient's home.

NOTE: A radiology and diagnostic procedure is considered directly related to the performance of the surgical procedure only if it is an inherent part of the surgical procedure, e.g., the CPT code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description (i.e., CPT¹ procedure code 47560).

3. State Waiver. Ambulatory surgery services provided by freestanding ASCs in Maryland are not exempt from this system and are to be reimbursed using the procedures set forth in this section. (See [Chapter 1, Section 24, paragraph III.E.](#) for payment of professional services related to ambulatory surgery.)

4. Ambulatory Surgery Payment Rates.

a. TMA, or its data contractor, will calculate the payment rates and will provide them electronically to the claims processing contractors. The magnetic media will include the locally-adjusted payment rate for each payment group for each MSA and will identify, by procedure code, the procedures in each group and the effective date for each procedure. Additions or deletions to the list of procedures will be given to the contractors as they occur, but the electronic data will be provided only on an annual basis. The MSAs and corresponding wage indexes will be those used by Medicare.

b. In addition to the payment rates, the contractors will be provided a zip code to MSA crosswalk, so that they can determine which payment rate to use for each ambulatory surgery provider. For this purpose the zip code of the facility's physical address (as opposed to its billing address) is to be used. This crosswalk may be updated periodically throughout the year and sent to the contractors.

c. In order to calculate payment rates, only those procedures with at least 25 claims nationwide during the database period will be used.

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d. The rates were initially calculated using the following steps.

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

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

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

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

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

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

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

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

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

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

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

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

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

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5. Payments.

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

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

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

(1) Discounting for Multiple Surgical Procedures.

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

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

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procedure (the procedure for which the greatest amount is allowed) if that can be determined (e.g., the major procedure is on TMA's ambulatory surgery web site or is identified on the claim) and deny the other procedures using EOB message "Requested information not received". If the major procedure cannot be determined, the entire claim is to be denied.

(2) Discounting for Bilateral Procedures.

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

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

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

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

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

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

(3) Modifiers for Discounting Terminated Surgical Procedures.

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

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

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

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

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

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

6. Updating Payment Rates.

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

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

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

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

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

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

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

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

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

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

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

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

D. Claims for Ambulatory Surgery.

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

2. Claim Data.

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

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

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

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

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

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

- END -

FREESTANDING AND HOSPITAL-BASED BIRTHING CENTER REIMBURSEMENT

ISSUE DATE: February 14, 1984

AUTHORITY: [32 CFR 199.6\(b\)\(4\)\(xi\)\(A\)\(3\)](#) and [32 CFR 199.14\(e\)](#)

I. APPLICABILITY

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

II. DESCRIPTION

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

III. POLICY

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

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

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

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

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D. Claims for professional services and tests where the beneficiary has been screened but rejected for admission into the program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, should be priced as individual services and items, subject to current policies for obstetrical care professional services and reported as appropriate CPT¹ procedure code with place of service "25" for birthing center.

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

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

1. The TRICARE maximum allowable all-inclusive rate is equal to the sum of the Class 3 CHAMPUS Maximum Allowable Charge (CMAC) for total obstetrical care for a normal pregnancy and delivery (CPT¹ procedure code 59400) plus the TMA supplied non professional price component amount. TMA will supply each contractor with non professional price components for each state annually to be effective for the forthcoming rate year (see [Chapter 10, Addendum A](#)).

2. The maximum allowable all-inclusive rate shall be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update.

G. Claims processing.

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

2. Claims from birthing centers will be processed as outpatient hospital claims using revenue code 724 and the following CPT¹ procedure code with place of service "25" for birthing center.

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

NOTE: Claims for birthing centers must be submitted on a CMS 1450 UB-04 claim form. Claims not submitted on the appropriate claim form will be denied.

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

H. Excluded services¹ when billed separately.

99071 *Patient education materials*
99078 *Group health education*

- END -

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

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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 OPDS:

- (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 OPPTS (not an all-inclusive list).

(1) Hospital-based full- and half-day PHPs (psych and SUDRFs) which are paid a per diem OPPTS. 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 OPPTS:

(a) Surgical procedures.

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

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

(b) Radiology, including radiation therapy.

(c) Clinic visits.

(d) Emergency department visits.

(e) Diagnostic services and other diagnostic tests.

(f) Surgical pathology.

(g) Cancer chemotherapy.

(h) Implantable medical items.

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

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

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

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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.

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4. The items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median cost for an item or service in the group is more than 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."

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

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

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

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

G. Reimbursement Hierarchy For Procedures Paid Outside The OPPTS.

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

a. The following tables includes the list of rate columns on the CMAC file. The columns are number 1 through 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

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.

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COLUMN	DESCRIPTION
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.

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 OPSS. The OPSS 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 OPSS methodology are exempt from the claims auditing software referenced in [Chapter 1, Section 3](#).

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

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

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

I. PRICER Program.

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

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

2. The contractors shall provide 3M with those pricing files to maintain and update the TRICARE OPSS PRICER within five weeks prior to the quarterly update. For example, statewide 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 OPSS standard payment amounts for labor market differences. Refer to the OPSS Provider File with Wage Indexes on TMA's OPSS home page at <http://www.tricare.mil/opss> for annual OPSS wage index updates. The annual DRG wage index updates will be effective January 1 of each year for the OPSS.

K. Provider-Based Status for Payment Under OPSS.

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

L. Implementing Instructions.

Since this issuance only deals with a general overview of the OPSS reimbursement methodology, the following cross reference is provided to facilitate access to specific

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implementing instructions within [Chapter 13, Section 1](#) through 5:

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

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

The following data elements are available on TMA's OPPTS 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. OPPTS 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 OPPTS.

7. Zip to Wage Index Crosswalk.

IV. EFFECTIVE DATE May 1, 2009.

- END -

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

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

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

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

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

APC	SI	APC TITLE
0039	S	Level I Implantation of Neurostimulator
0040	S	Percutaneous Implantation of Neurostimulator Electrodes
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes
0082	T	Coronary or Non Coronary Atherectomy
0083	T	Coronary or Non Coronary Angioplasty and Percutaneous Valvuloplasty
0084	S	Level I Electrophysiologic Procedures
0085	T	Level II Electrophysiologic Procedures
0086	T	Level III Electrophysiologic Procedures
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes
0090	T	Insertion/Replacement of Pacemaker Pulse Generator
0104	T	Transcatheter Placement of Intracoronary Stents
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes
0107	T	Insertion of Cardioverter-Defibrillator
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads
0115	T	Cannula/Access Device Procedures
0202	T	Level VII Female Reproductive Procedures
0222	S	Level II Implantation of Neurostimulator
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve
0227	T	Implantation of Drug Infusion Device
0229	T	Transcatheter Placement of Intravascular Shunts
0259	T	Level VII ENT Procedures
0293	T	Level V Anterior Segment Eye Procedures
0315	S	Level III Implantation of Neurostimulator
0384	T	GI Procedures with Stents
0385	S	Level I Prosthetic Urological Procedures
0386	S	Level II Prosthetic Urological Procedures
0418	T	Insertion of Left Ventricular Pacing Elect.
0425	T	Level II Arthroplasty or Implementation with Prosthesis
0427	T	Level II Tube or Catheter Changes or Repositioning
0622	T	Level II Vascular Access Procedures

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

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

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

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

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

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

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

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

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

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

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(d) Imaging supervision and interpretation services.

1 Certain imaging supervision and interpretation services are always packaged.

2 Others are packaged when the service appears on the same claim with a procedural HCPCS code that has been assigned SI T. These codes are T packaged codes.

(e) Diagnostic radiopharmaceuticals. Beginning in January 2008, claims for nuclear medicine procedures must contain a code for a diagnostic radiopharmaceutical to be processed to payment.

(f) Contrast media. New Level II HCPCS C-codes have been created for reporting echocardiography services with contrast beginning in CY 2008.

(g) Observation services.

1 CMS created two composite APCs, APCs 8002 and 8003, for Extended Assessment and Management of which observation care is a component.

2 When eight hours or more of observation care is provided in conjunction with direct admission to observation or a high level clinical or Emergency Department (ED) visit or critical care services, then payment may be made for the extended encounter of care.

3 When the criteria for payment of either composite APC 8002 or 8003 are met, then the costs associated with HCPCS code G0378 are attributed to the total cost of the composite APC. When the criteria are not met, the costs of observation care are packaged with the costs of the separately payable independent services on the claim, usually the clinic or ED visit.

4 Separate payment under APC 0604 would apply for HCPCS code G0379 when the criteria for payment of this service through composite APC 8002 are not met. Following are the criteria for payment under APC 0604:

a Both HCPCS codes G0378 and G0379 are reported with the same date of service.

b No service with SI of T or V or critical care APC 0617 is provided on the same date of service as HCPCS code G0379.

c If either of the above criteria is not met, HCPCS code G0379 is assigned SI N and its payment is packaged into the payment for other separately payable services provided in the same encounter.

5 These Extended Assessment and Management composite APCs may be paid regardless of diagnosis, when the observation care is unrelated to a surgical procedure.

6 The OCE logic will handle the assignment of these composite APCs for payment.

NOTE: A hierarchy of categories has been created that determines which category each code appropriately falls into. This hierarchy is organized from the most clinically specific to the most general type of category. The hierarchy of categories is as follows: guidance services; image processing services; intraoperative services; and imaging supervision and interpretation services. Therefore, while CPT¹ code 93325 may logically be grouped with either image processing services or intraoperative services, it is treated as an image processing service because that group is more clinically specific and precedes intraoperative services in the hierarchy. It was not necessary to include diagnostic radiopharmaceuticals, contrast media or observation categories in this list because those services generally map to only one of those categories.

(3) Composite APCs provide a single payment when more than one of a specified set of major independent services are provided in a single encounter.

(a) Effective for services furnished on or after January 1, 2008, low dose rate prostate brachytherapy and cardiac electrophysiology evaluation and ablation will be paid using composite APCs when the claim contains the specified combination of services. This established an encounter based APC for each of these sets of services that would provide a single payment for certain common combinations of component services that were reported on the same date of service.

1 Composite APC for LDR Prostate Brachytherapy (APC 8001).

a A composite APC 8001, titled "LDR Prostate Brachytherapy Composite," has been created that will provide one bundled payment for LDR prostate brachytherapy when the hospital bills both CPT¹ codes 55875 and 77778 as component services provided during the same hospital encounter.

b CPT¹ code 55875 will continue to be paid through APC 0163 (Transperineal placement of needles or catheters in prostate for interstitial radioelement application, with and without cystoscopy) and CPT¹ code 77778 will continue to be paid through APC 0651 (Intrastitial radiation source application; complex) when the services are individually furnished other than on the same date of service in the same facility.

c These two CPT¹ codes will be assigned SI Q3 to identify their status as potentially payable through a composite APC.

2 Composite APC for Cardiac Electrophysiologic Evaluation and Ablation (APC 8000).

a Another composite APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite) was also established in CY 2008 that will pay for a composite service made up of any number of services in Groups A and B in Figure 13-2-2 when at least one code from Group A and at least one code from Group B appear on the same

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

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

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

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

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

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

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

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

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

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

- 8004 (Ultrasound Composite)
- 8005 (CT and CTA without Contrast Composite)
- 8006 (CT and CT with Contrast Composite)
- 8007 (MRI and MRA without Contrast Composite)
- 8008 (MRI an MRA with Contrast Composite)

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

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

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

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

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

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

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

FAMILY 1 - ULTRASOUND (US)	
APC 8004 (COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$188
76604	US exam, chest.
76700	US exam, abdom, complete
76705	Echo exam of abdomen.
76770	US exam abdo back wall, comp.
76775	US exam abdo back wall, lim.
76776	US exam k transpl w/Doppler
76831	Echo exam, uterus.
76856	US exam, pelvic, complete.
76870	US exam, scrotum.
FAMILY 2 - CT AND CTA WITH AND WITHOUT CONTRAST	
APC 8005 (WITHOUT CONTRAST COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$406
0067T	CT colonography; dex
70450	CT head/brain w/o dye.
70480	CT orbit/ear/fossa w/o dye.
70486	CT maxillofacial w/o dye.
70490	CT soft tissue neck w/o dye.
71250	CT thorax w/o dye.
72125	CT neck spine w/o dye.
72128	CT chest spine w/o dye.
72131	CT lumbar spine w/o dye.
72192	CT pelvis w/o dye.
73200	CT upper extremity w/o dye.
73700	CT lower extremity w/o dey.
APC 8006 (WITH CONTRAST COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$621
70487	CT maxillofacial w/dye.
70460	CT head/brain w/dye.
70470	CT head/brain w/o & w/dye.
70481	CT orbit/ear/fossa w/dye.
70482	CT orbit/ear/fossa w/o & w/dye.
70488	CT maxillofacial w/o & w/dye.
70491	CT soft tissue neck w/dye.
70492	CT sft tsue nck w/o & w/dye.
70496	CT angiography, head.
70498	CT angiography, neck.
71260	CT thorax w/dye.
71270	CT thorax w/o & w/dye.

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

71275	CT angiography, chest.
72126	CT neck spine w/dye.
72127	CT neck spine w/o & w/dye.
72129	CT chest spine w/dye.
72130	CT chest spine w/o & w/dye.
72132	CT lumbar spine w/dye.
72133	CT lumbar spine w/o & w/dye.
72191	CT angiograph pelv w/o & w/dye.
72193	CT pelvis w/dye.
72194	CT pelvis w/o & w/dye.
73201	CT upper extremity w/dye.
73202	CT upper extremity w/o & w/dye.
73206	CT angio up extrm w/o & w/dye.
73701	CT lower extremity w/dye.
73702	CT lwr extremity w/o & w/dye.
73706	CT angio lwr extr w/o & w/dye.
74160	CT abdomen w/dye.
74170	CT abdomen w/o & w/dye.
74175	CT angio abdomen w/o & w/dye.
75635	CT angio abdominal arteries.
FAMILY 3 – MRI AND MRA WITH AND WITHOUT CONTRAST	
APC 8007 (WITHOUT CONTRAST COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$695
70336	Magnetic image, jaw joint.
70540	MRI orbit/face/neck w/o dye.
70544	MR angiography head w/o dye.
70547	MR angiography neck w/o dye.
70551	MRI brain w/o dye.
70554	FMRI brain by tech.
71550	MRI chest w/o dye.
72141	MRI neck spine w/o dye.
72146	MRI chest spine w/o dye.
72148	MRI Lumbar spine w/o dye.
72195	MRI Pelvis w/o dye.
73218	MRI Upper extremity w/o dye.
73221	MRI joint up extremity w/o dye.
73718	MRI lower extremity w/o dye.
73721	MRI jnt of lwr extre w/0 dye.
74181	MRI abdomen w/o dye.
75557	Cardiac mri for morph.

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

7559	Cardiac mri w/stress img.
C8901	MRA w/o cont. abd.
C8904	MRI w/o cont. breast, uni.
C8907	MRI w/o cont. breast, bi.
C8910	MRA w/o cont. chest
C8913	MRA w/o cont. lwr ext.
C8919	MRA w/o cont. pelvis.
APC 8008 (WITH CONTRAST COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$968
70549	Mr angiograph neck w/o & w/dye.
70542	MRI orbit/face/neck w/dye.
70543	MRI orbit/fac/nck w/o & w/dye.
70545	MR angiography head w/dye.
70546	MR angiograph head w/o & w/dye.
70548	MR angiography neck w/dye.
70552	MRI brain w/dye.
70553	MRI brain w/o & w/dye.
71551	MRI chest w/dye.
71552	MRI chest w/o & w/dye.
72142	MRI neck spine w/dye.
72147	MRI chest spine w/dye.
72149	MRI lumbar spine w/dye.
72156	MRI neck spine w/o & w/dye.
72157	MRI chest spine w/o & w/dye.
72158	MRI lumbar spine w/o & w/dye.
72196	MRI pelvis w/dye.
72197	MRI pelvis w/o & w/dye.
73219	MRI upper extremity w/dye.
73220	MRI upper extremity w/o & w/dye.
73222	MRI joint upr extreme w/dye.
73223	MRI joint upr extr w/o & w/dye.
73719	MRI lower extremity w/dye.
73720	MRI lwr extremity w/o & w/dye.
73722	MRI joint of lwr extr w/dye.
73723	MRI joint lwr extr w/o & w/dye.
74182	MRI abdomen w/dye.
74183	MRI abdomen w/o & w/dye.
75561	Cardiac mri for morph w/dye.
75563	Cardiac mri w/stress img & dye.
C8900	MRA w/cont, abd.

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

C8902	MRA w/o fol w/cont, abd.
C8903	MRI w/cont, breast, uni.
C8905	MRI w/o fol w/cont, brst, un.
C8906	MRI w/cont, breast, bi.
C8908	MRI w/o fol w/cont, breast.
C8909	MRA w/cont, chest.
C8911	MRA w/o fol w/cont, chest.
C8912	MRA w/cont, lwr ext.
C8914	MRA w/o fol w/cont, lwr ext.
C8918	MRA w/cont, pelvis.
C8920	MRA w/o fol w/cont, pelvis

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

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

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

COMPOSITE APC	COMPOSITE APC TITLE	CRITERIA FOR COMPOSITE PAYMENT
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT* code 93619 or 93620 and at least one unit of CPT* code 93650, 93651, or 93652 on the same date of service.
8001	Low Dose Rate Prostate Brachytherapy Composite	One or more units of CPT* codes 55875 and 77778 on the same date of service.
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed— <ul style="list-style-type: none"> • On the same day as HCPCS code G0379; or • On the same day or the day after CPT* codes 99205 or 99215 and; 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed on the same date of service or the date of service after CPT* 99284, 99285, or 99291 and; 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378.
0034	Mental Health Services Composite	Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0173.

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C. Additional Payments Under The OPSS.

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

D. Payment For Patients Who Die In The ED.

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

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(3) A procedure on the inpatient list (designated by payment SI of C) is performed on an emergency basis to resuscitate or stabilize the patient; and

(4) The patient dies without being admitted as an inpatient.

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

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

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

E. Medical Screening Examinations.

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

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

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

G. Treatment of Partial Hospitalization Services. Effective on May 1, 2009 (implementation of OPSS), hospital-based Partial Hospitalization Programs (PHPs) (psych and Substance Use Disorder Rehabilitation Facilities (SUDRFs)) will be reimbursed a national per diem APC payment under the OPSS. Freestanding PHPs (psych and SUDRFs) will continue to be reimbursed under the existing PHP per diem payment.

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

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

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

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

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

4. PHP should be a highly structured and clinically-intensive program, usually lasting most of the day. Since a day of care is the unit that defines the structure and scheduling of partial hospitalization services, a two-tiered payment approach has been retained, one for days with three services (APC 0172) and one for days with four or more services (APC 0173) to provide PHPs scheduling flexibility to ensure that patients receive at least 20 hours of therapeutic services per week and to reflect the lower costs of a less intensive day.

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

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

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

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

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

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

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

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

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

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

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

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

⁵ HCPCS Level I/CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

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

(3) To bill for partial hospitalization services under the hospital OPPS, hospitals are to use the above HCPCS and revenue codes and are to report partial hospitalization services under bill type 013X, along with condition code 41 on the CMS 1450 UB-04 claim form.

(4) The claim must include a mental health diagnosis and an authorization on file for each day of service. Since there is no HCPCS code that specifies a partial hospitalization related service, partial hospitalizations are identified by means of a particular bill type and condition code (i.e., 13X TOB with Condition Code 41) along with HCPCS codes specifying the individual services that constitute PHPs. In order to be assigned payment under Level II Partial Hospitalization Payment APC (0173) there must be four or more codes

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from PHP List B of which at least one code must come from PHP List A. In order to be assigned payment under Level I Partial Hospitalization Payment APC (0172) there must be a least three codes from PHP List B of which at least one code must come from PHP List A. List A is a subset of List B and contains only psychotherapy codes, while List B includes all PHP codes. (Refer to PHP Lists A and B in Figure 13-2-6). All other PHP services rendered on the same day will be packaged into the PHP APCs (0172 and 0173). All PHP lines will be denied if there are less than three codes/service appearing on the claim.

FIGURE 13-2-6 PHP FOR CY 2008

PHP LIST A	PHP LIST B	
90818	90801	90846
90819	90902	90847
90821	90816	90865
90822	90817	96101
90826	90818	96102
90827	90819	96103
90828	90821	96116
90829	90822	96118
90845	90823	96119
90846	90824	96120
90847	90826	G0129
90865	90827	G0176
G0410	90828	G0177
G0411	90829	G0410
	90845	G0411

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

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

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

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

(9) Dates of service per revenue code line for partial hospitalization claims that span two or more dates. Each service (revenue code) provided must be repeated as a

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separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date." Following are examples of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

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

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

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

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

NOTE: All line items on the CMS 1450 UB-04 claim form must be submitted with a specific date of service. The header date of the CMS 1450 UB-04 claim form may span dates of services. However, each line item date of service must fall within the span date billed or the claim will be denied.

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

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

H. Payment Policy For Observation Services.

1. Observations For Non-Maternity Conditions.

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

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

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

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

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

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

COMPOSITE APC	COMPOSITE APC TITLE	CRITERIA FOR COMPOSITE PAYMENT
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed— <ul style="list-style-type: none"> • On the same day as HCPCS code G0379; or • On the same day or the day after CPT* codes 99205 or 88215; and 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378.
8003	Level II Extended Assessment and Management Composite	1) 8 or more units of HCPCS code G0378 are billed on the same date of service or the date of service after CPT* codes 99284, 99285, or 99291; and 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378.

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(4) The beneficiary must also be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

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

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d. Direct Admission to Observation Care Using G0379.

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

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

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

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

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

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

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

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

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

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

(e) If the composite is not applicable, payment for HCPCS code G0379 may be made under APC 0604. In general, this would occur when the units of observation reported under HCPCS code G0378 are less than eight and no services with a SI of T or V or Critical Care (APC 0617) were provided on the same day of service as HCPCS code G0379.

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2. Observations For Maternity Conditions.

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

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

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

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

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

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

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

FIGURE 13-2-10 REQUIRED DIAGNOSES FOR MATERNITY

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care:		
0 unspecified as to episode of care or not applicable		
1 delivered, with or without mention of antepartum condition		
2 delivered, with mention of postpartum complication		
3 antepartum condition or complication		
4 postpartum condition or complication		
V22	Normal pregnancy	
V22.0	Supervision of normal first pregnancy	
V22.1	Supervision of other normal pregnancy	
V22.2	Pregnant state, incidental	
V23	Supervision of high-risk pregnancy	
V23.0	Pregnancy with history of infertility	
V23.1	Pregnancy with history of trophoblastic disease	
V23.2	Pregnancy with history of abortion	
V23.3	Grand multiparity	
V23.4	Pregnancy with other poor obstetric history	
V23.41	Pregnancy with history of pre-term labor	
V23.49	Pregnancy with other poor obstetric history	

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

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

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

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

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

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

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

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

l. Inpatient Only Procedures.

1. The inpatient list on TMA's OPPS web site at <http://www.tricare.mil/opps> specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. Denial of payment for procedures on the inpatient only list are appealable under the Appeal of Factual (Non-Medical Necessity) Determinations. Refer to the TRICARE Operations Manual (TOM), [Chapter 13, Section 5](#) for appeal procedures.

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

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

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

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

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

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

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

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

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

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

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

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

J. APC For Vaginal Hysterectomy.

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

K. Billing of Condition Codes Under OPPS.

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

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

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

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

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

2. Billing for Wound Care Services.

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

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

b. Hospitals would receive separate payment under the OPPS when they bill for wound care services described by CPT³ codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by individuals independent of a therapy plan of care.

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

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

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

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

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

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

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

HCPCS CODE	CPT ⁴ CODE
G0265	38207
G0266	38208, 38209
G0267	38210, 38211, 38212, 38213, 38214, 38215

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

4. Billing for Implantable Cardioverter Defibrillators (ICDs).

Effective January 1, 2008, the four Level II HCPCS codes (G0297, G0298, G0299, and G0300) for ICD insertion procedures will be deleted. Hospitals are required to bill the appropriate CPT codes, specifically CPT⁴ codes 33240 or 33249, as appropriate, along with

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the applicable device C codes, for payment under the OPPS.

5. Payment for Brachytherapy Sources.

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

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

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

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

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

CPT/ HCPCS	LONG DESCRIPTOR	SI	APC
A9257	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	U	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	U	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	U	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	U	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	U	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	U	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium- 103, greater than 2.2 mCi (NIST), per source	U	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	U	2636
C2638	Brachytherapy source, stranded, Iodine-125, per source	U	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	U	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	U	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	U	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	U	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	U	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	U	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	U	2699

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6. Billing for Drugs, Biologicals, and Radiopharmaceuticals.

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

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

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

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

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

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

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

2008 HCPCS	2008 SHORT DESCRIPTOR	2008 SI	2008 APC
A9501	Tc99m tebroxmine	N	
A9509	I 123 sodium iodide, dx	N	
A9569	Technetium TC-99m auto WBC	N	
A9570	Indium In-111 auto wbc	N	
A9571	Indium In-111 auto platelet	N	
A9576	Inj prohance multipack	N	
A9577	Inj multihance	N	
A9578	Inj multihance multipack	N	
C9237	Injection, lanreotide acetate	K	9237
C9238	Inj. Levetiracetam	K	9238
C9239	Inj. Temsirolimus	G	1168
C9240	Injection, ixabepilone	K	9240
C9354	Veritas collagen matrix, cm2	G	9354
C9355	Neuromatrix nerve, cuff, cm	G	9355
J0400	Aripiprazole injections	K	1165
J1573	Hepagam B intravenous, inj	K	1138
J2724	Protein C concentrate	K	1139
J92266	Supprelin LA implant	K	1142

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

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

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

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

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

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

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

h. Correct Reporting of Units for Drugs.

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

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

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

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

7. Payment for Therapeutic Radiopharmaceuticals.

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

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

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

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

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

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

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

8. Drug Administration.

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

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

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

APC	HCPCS ¹ CODE	LONG DESCRIPTOR
0436	90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid).
	90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in additions to code for primary procedure).
	90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).
	90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).
	96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure).
	96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).
	96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code primary procedure).
	96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
	96379	Unlisted therapeutic prophylactic, or diagnostic intravenous or intr-arterial injection or infusion.
	95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection.
	95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections.
	95145	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom.
	95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses).
	95170	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses).
96549	Unlisted chemotherapy procedure.	
0437	96367	Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure).
	96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
	96373	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra arterial.

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

APC	HCPCS ¹ CODE	LONG DESCRIPTOR
437	96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.
	96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure).
	95144	Profession services for the supervision of preparation and provision of antigens for allergen immunotherapy, single does vial(s) (specify number of vials).
	95148	Profession services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms.
	96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic.
	96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic.
	96405	Chemotherapy administration; intralesional, up to and including 7 lesions.
	96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure).
0438	96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hours.
	96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s).
	95146	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms.
	95147	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms
	96406	Chemotherapy administration; intralesional, more than 7 lesions.
	96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure).
	96417	Chemotherapy administration; intravenous, push technique, each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure).
	96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure).
0439	96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); Initial, up to 1 hour.
	95149	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms.
	96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug.
	96420	Chemotherapy administration, intra-arterial' push technique.
	96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial).
	96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents.

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

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

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9. Billing for Cardiac Echocardiography Services.

a. Cardiac Echocardiography Without Contrast. Hospitals are instructed to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT⁵ code(s) (93303-93350).

b. Cardiac Echocardiograph With Contrast.

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

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

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

HCPCS	LONG DESCRIPTOR
C8921	Transthoracic echocardiography with contrast for congenital cardiac anomalies; complete
C8922	Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study

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

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

IV. EFFECTIVE DATE May 1, 2009.

- END -

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

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

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

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

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

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

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

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

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

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

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

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

b. Conversion Factor Update.

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

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

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

3. Payment Status Indicators (SIs).

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

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

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- b. **B** to indicate more appropriate code required for TRICARE OPPS.
 - c. **C** to indicate inpatient services that are not paid under the OPPS.
 - d. **E** to indicate items or services are not covered by TRICARE.
 - e. **F** to indicate acquisition of corneal tissue, which is paid on an allowable charge basis (i.e., paid based on the CMAC reimbursement system or statewide prevalings) and certain Certified Registered Nurse Anesthetist (CRNA) services and hepatitis B vaccines that are paid on an allowable charge basis.
 - f. **G** to indicate drug/biological pass-through that are paid in separate APCs under the OPPS.
 - g. **H** to indicate pass-through device categories and radiopharmaceutical agents allowed on a cost basis.
 - h. **K** to indicate non-pass-through drugs and biologicals that are paid in separate APCs under the OPPS.
 - i. **N** to indicate services that are incidental, with payment packaged into another service or APC group.
 - j. **P** to indicate services that are paid only in Partial Hospitalization Programs (PHPs).
 - k. **Q** to indicate packaged services subject to separate payment under OPPS.
 - l. **Q1** to indicate packaged APC payment if billed on the same date of service as a HCPCS code assigned SI of **S, T, V, and X**. In all other circumstances, payment is made through a separate APC payment.
 - m. **Q2** to indicate APC payment if billed on the same date of service as a HCPCS code assigned SI of **T**. In all other circumstances, payment is made through a separate APC payment.
 - n. **Q3** to indicate composite APC payment based on OPPS composite specific payment criteria. Payment is packaged into single payment for specific combinations of service. In all circumstances, payment is made through a separate APC payment for those services.
- NOTE: HCPCS codes with SI of **Q** are either separately payable or packaged depending on the specific circumstances of their billing. Outpatient Code Editor (OCE) claims processing logic will be applied to codes assigned SI of **Q** in order to determine if the service will be packaged or separately payable.
- o. **R** to indicate separate APC payment for blood and blood products.

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

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

r. **U** to indicate separate APC payment for brachytherapy sources.

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

t. **W** to indicate invalid HCPCS or invalid revenue code with blank HCPCS.

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

v. **Z** to indicate valid revenue code with blank HCPCS and no other SI assigned.

w. **TB** to indicate TRICARE reimbursement not allowed for CPT/HCPCS code submitted.

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

4. Calculating TRICARE Payment Amount.

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

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

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

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

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

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(2) **Effective January 1, 2010, multiply** the wage adjusted APC payment rate by the OPPS rural adjustment (1.071) if the provider is a Sole Community Hospital (SCH) in a rural area.

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

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

e. Examples of TRICARE payments under 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Adjustments to APC Payment Amounts.

a. Adjustment for Area Wage Differences.

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

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

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

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

(5) Steps in Applying Wage Adjusts under OPPS.

(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.

(c) Multiply the applicable wage index determined under [paragraph III.A.5.a.\(5\)\(b\)](#) and (c) by the amount under [paragraph III.A.5.a.\(5\)\(a\)](#) 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 [paragraph III.A.5.a.\(5\)\(d\)](#). 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):

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

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

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

b. Discounting of Surgical and Terminating Procedures.

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

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

(b) When more than one procedure with payment SI 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.

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

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

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

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

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

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

c. Discounting for Bilateral Procedures.

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

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

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

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

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

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

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

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

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

FIGURE 13-3-2 DISCOUNTING FORMULAS FOR BILATERAL PROCEDURES

DISCOUNTING FORMULA NUMBER	FORMULAS
1	1.0
2	$(1.0 + D (U - 1))/U$
3	T/U
4	$(1 + D)/U$
5	D
6	TD/U
7	$D (1 + D)/U$
8	2.0
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

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

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

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

e. Outlier Payments.

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

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

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

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

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

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

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(6) Example of outlier payment calculation.

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

STEP 1: Identify all APCs on the claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

g. Temporary Transitional Payment Adjustments (TTPAs).

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

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a four year period. The four year transition will set higher payment percentages for the 10 APC codes 604-609 and 613-616 during the first year, with reductions in each of the transition years. For non-network hospitals, the adjustment will cover a three year period, with reductions in each of the transition years for the same 10 APC codes. Figure 13-3-4 provides the TTPA percentage adjustments for the 10 visit APC codes for network and non-network hospitals.

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

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

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

h. Temporary Military Contingency Payment Adjustments (TMCPAs).

Under the authority of the last paragraph of 32 CFR 199.14(a)(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 **within three months** after the end of the year; i.e., **15 months** after implementation of OPPS **to ensure that the adjustment is based on a full 12 months of claims history** (May 1, 2009 through April 30, 2010). Second and subsequent year adjustments (assuming a hospital continues to meet the \$1.5 million threshold) will be reduced by 5% per year until the OPPS payment levels are reached; (i.e., 15% year two, 10% year three, and 5% year four). **In year five, the outpatient payments will be at established APC levels.** The adjustment will be applied to the total year OPPS payment amount received by the hospital for all active duty members and all TRICARE beneficiaries (including ADDs, retirees and their family members **but excluding TRICARE For Life (TFL) beneficiaries**) for whom TRICARE is primary payer.

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

during a one-year period - 12 months from implementation of TRICARE's OPSS (May 1, 2009).

(b) The query will run within three months after the year end date to ensure a full 12 months of claims history/payment on which to base the Transitional TMCPAs.

(c) The Transitional TMCPAs will be year-end adjusted based on vouchers submitted by the MCSCs in accordance with the requirements of the TRICARE Operations Manual (TOM), Chapter 3, Section 4. The voucher shall be sent electronically to RM.Invoices@tma.osd.mil at the TMA Contract Resource Management (CRM) Office for approval before releasing the checks. The vouchers received should contain the following information: hospital name, address, tax identification number, and calculations used for amount to be paid.

(d) These queries will be run in subsequent Transitional TMCPA years (i.e., within three months after each of the remaining transitional years) to determine those network hospitals qualifying for Transitional TMCPAs.

(e) Hospitals that previously qualified for Transitional TMCPAs but subsequently fell below \$1.5 million revenue threshold would no longer be eligible for the adjustment.

(f) New hospitals that meet the \$1.5 million revenue threshold would be eligible for the Transitional TMCPA percentage adjustment in effect during the transitional year in which the revenue threshold was met.

EXAMPLE: A hospital that meets the \$1.5 million revenue threshold in year three of the transition but failed to meet it in year one and two, would receive a percentage adjustment of 10%.

(2) General TMCPAs. The TMA Director, or designee at any time after OPSS 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 for a hospital to be considered for a General TMCPA, the hospital's outpatient revenue from TRICARE ADSMs and ADDs must have been at least 10% of the hospital's total outpatient revenue during the 12-month period ending three months prior to the date of the TMCPA application, or the number of outpatient visits by ADSMs and ADDs during that same 12-month period must have been at least 50,000.

(a) General TMCPA Process.

1 The Director, TRICARE Regional Office (DTRO), shall conduct a thorough analysis and recommend the appropriate year end adjustment to total OPSS payments for a network hospital qualifying for a General TMCPA.

2 General TMCPA payments cannot result in a hospital receiving under OPSS (including basic OPSS, Transitional TTPA, Transitional TMCPA, and General TMCPA payments) more than 95% of the amount that it would have received under TRICARE pre-OPSS payment policies. This applies to TRICARE beneficiaries when TRICARE is the primary payer.

3 Total TRICARE OPSS payments (including the TTPAs) of the qualifying hospital will be increased by the Director TMA's, or designee's, approved adjustment percentage by way of an additional payment within three months after the end of the year; i.e., 15 months after implementation of OPSS to ensure that the adjustment is based on a full 12 months of claims history (May 1, 2009 through April 30, 2010). For subsequent years, if a hospital continues to meet the qualifying criteria for a General TMCPA, an additional payment will be made 15 months after the end of each year.

4 General TMCPAs will be reviewed and approved on an annual basis; i.e., General TMCPAs will have to be evaluated on a yearly basis by the DTRO in order to determine if the hospital continues to serve a disproportionate share of ADSMs and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities. This will include a recommendation for the appropriate year end adjustment to total OPSS payments.

5 The hospital's initial and all subsequent requests for a General TMCPA shall include the data requirements in [paragraph III.A.5.h.\(2\)\(b\)](#), and a full 12 months of claims payment data. If the initial request is approved by the TMA Director, or designee, and the hospital wants to ensure the adjustments continue in subsequent years (based on meeting the qualifying criteria in [paragraph III.A.5.h.\(2\)](#)), they must submit their request to the MCSC three months prior to the termination date of the current TMCPA, i.e., nine months after the approval date, to allow sufficient time for review and approval.

6 The General TMCPAs will be year-end adjusted based on vouchers submitted by the MCSCs in accordance with requirements of the TOM, [Chapter 3, Section 4](#). The vouchers shall be sent electronically to RM.Invoices@tma.osd.mil at the TMA CRM Office for approval before releasing the checks. The vouchers received should contain the following information: hospital name, address, tax identification number, and calculations used for amount to be paid.

(b) Annual Data Requirements for General TMCPAs. Hospital required data submissions to the Managed Care Support Contractor (MCSC) for review and consideration:

1 The hospital's percent of revenue derived from ADSM plus ADD outpatient visits (e.g., Emergency Room (ER) and Hospital Outpatient Department (HOPD)); i.e., the revenue from TRICARE ADSM plus ADD visits divided by total outpatient revenue during the 12-month period ending three months prior to the date of the TMCPA application.

2 The number of outpatient visits by ADSMs and ADDs during the 12-month period ending three months prior to the date of the TMCPA application.

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

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

5 The hospital's percent of TRICARE outpatient visits (ER and HOPD); i.e., the TRICARE outpatient visits divided by total outpatient visits **during the 12-month period ending three months prior to the date of the TMCPA application.**

6 The hospital's percent of TRICARE outpatient revenue (ER and HOPD); i.e., the TRICARE outpatient revenue divided by total outpatient revenue **during the 12-month period ending three months prior to the date of the TMCPA application.**

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

(c) 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.h.\(2\)](#), 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.

(d) 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.

(e) 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.h.\(2\)\(c\)](#). **Non-network TMCPAs will be adjusted on a claim-by-claim basis.**

(4) Application of Cost-Sharing.

- (a) Transitional **and General** TMCPAs are not subject to cost-sharing.
- (b) **Non-network** TMCPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

(5) **Reimbursement of Transitional and General TMCPA costs shall be paid as pass-through costs. The MCSC does not financially underwrite these costs.**

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.

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. **Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2009.**

a. **Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug Competitive Acquisition Program (CAP) at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Social Security Act (SSA) rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug or biological.**

b. **Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug CAP at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Act, rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug and biological.**

c. **The difference between ASP + 4% and ASP + 6%, therefore would be the CY 2009 pass-through payment amount for these drugs and biologicals.**

d. **Considering diagnostic radiopharmaceuticals to be drugs for pass-through purposes which will be reimbursed based on the ASP methodology; i.e., ASP + 6%.**

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e. Therapeutic radiopharmaceuticals with pass-through status in CY 2009 will be paid at hospital charges adjusted to cost, the same payment methodology as other therapeutic radiopharmaceuticals in CY 2009.

f. If a drug or biological that has been granted pass-through status for CY 2009 becomes covered under the Part B drug CAP (if the program is reinstated) the Centers for Medicare and Medicaid Services (CMS) will provide payment for Part B Drugs that are granted pass-through status and are covered under the Part B drug CAP at the Part B drug CAP rate.

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

h. Drugs and biologicals that are continuing pass-through status or have been granted pass-through status as of January 2009 for CY 2009 are displayed in Figure 13-3-5.

FIGURE 13-3-5 DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2009

CY 2008	CY 2009			
HCPCS	HCPCS	SHORT DESCRIPTOR	SI	APC
C9238	J1953	Levetiracetam injection	G	9238
C9239	J9330	Temsirolimus injection	G	1168
C9240*	J9207	Exabepilone injection	G	9240
C9241	J1267	Doripenem injection	G	9241
C9242	J1453	Fosaprepitant injection	G	9242
C9243	J9033	Bendamustine injection	G	9243
C9244	J2785	Injection, regadenoson	G	9244
C9354	C9354	Veritas collagen matrix, cm2	G	9354
C9355	C935	Neuromatrix nerve cuff, cm	G	9355
C9356	C9356	TendoGlide Tendon prot, cm2	G	9356
C9357	Q4114	Integra flowable wound matri	G	1251
C9358	C9358	SurgiMend, 0.5cm2	G	9358
C9359	C9359	Implant, bone void filler	G	9359
J1300	J1300	Eculizumab injection	G	9236
J1571	J1571	Hepagam b im injection	G	0946
J1573	J1573	Hepagam b intravenous, inj	G	1138
J3488*	J3488	Reclast injection	G	0951
J9225*	J9225	Vantas implant	G	1711
J9226	J9226	Supprelin LA implant	G	1142
J9261	J9261	Nelarabine injection	G	0825
Q4097	J1459	Inj IVIG privigen 500 mg	G	1214
	C9245	Injection, romiplostim	G	9245
	C9246	Inj, gadoxetate	G	9246
	C9248	Inj, clevidipine butyrate	G	9248

* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology (prior to January 1, 2009) while identified as pass-through under the OPPS.

4. Reduction of Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals to Offset Costs Packaged Into APC Groups.

a. Prior to CY 2008, certain diagnostic radiopharmaceuticals were paid separately under the OPSS if their mean per day cost were greater than the applicable year's drug packaging threshold.

b. In CY 2008, CMS payment for all non-pass-through diagnostic radiopharmaceuticals were packaged as ancillary and supportive items and service.

c. In CY 2009, continued to package payment for all non-pass-through diagnostic radiopharmaceuticals.

d. For OPSS pass-through purposes, radiopharmaceuticals are considered to be "drugs" where the transitional pass-through for the drugs and biologicals is the difference between the amount paid ASP + 4% or the Part B drug CAP rate and the otherwise applicable OPSS payment amount of ASP + 6%.

e. There is currently one radiopharmaceutical with pass-through status under OPSS.

f. New pass-through diagnostic radiopharmaceuticals with no ASP information or CAP rate will be paid at ASP + 6%, while those without ASP information will be paid based on Wholesale Acquisition Cost (WAC) or, if WAC is not available, based on 95% of the product's most recently published Average Wholesale Price (AWP).

g. Offset Calculations.

(1) An established methodology will be employed to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment (the APC device offset).

(2) New pass-through device categories will be evaluated individually to determine if there are device costs packaged into the associated procedural APC payment rate - suggesting that a device offset amount would be appropriate.

h. Effective April 1, 2009, diagnostic radiopharmaceutical HCPCS code C9247, Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries, has been granted pass-through status under the OPSS and will be assigned SI of G.

(1) Beginning April 1, 2009, payment for HCPCS code C9247 will be made at 106% of ASP if ASP data are submitted by the manufacturer. Otherwise, payment will be made based on the product's WAC. Further if WAC data is not available, payment will be made at 95% of the AWP.

(2) Effective for nuclear medicine services furnished on and after April 1, 2009, when HCPCS code C9247 is billed on the same claims with a nuclear medicine procedure, the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 will be reduced by the corresponding nuclear medicine

procedure's portion of its APC payment (offset amount) associated with diagnostic radiopharmaceutical; i.e., the payment for HCPCS code C9247 will be reduced by the estimated amount of payment that is attributable to the predecessor radiopharmaceutical that is package into payment for the associated nuclear medicine procedure reported on the same claim as HCPCS code C9247.

(3) When C9247 is billed on a claim with one or more nuclear medicine procedures, the OPSS Pricer will identify the offset amount or amounts that apply to the nuclear medicine procedures that are reported on the claim.

(4) Where there is a single nuclear medicine procedure reported on the claim with a single occurrence of C9247, the OPSS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index that applies to the hospital submitting the bill.

(5) Where there are multiple nuclear medicine procedures on the claim with a single occurrence of the pass-through radiopharmaceutical, the OPSS Pricer will select the nuclear medicine procedure with the single highest offset amount, and will adjust the selected offset amount by the wage index of the hospital submitting the claim.

(6) When a claim has more than one occurrence of C9247, the OPSS Pricer will rank potential offset amounts associated with the units of nuclear medicine procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through radiopharmaceutical on the claims and adjust the total offset amount by the wage index of the hospital submitting the claim.

(7) The adjusted offset will be subtracted from the APC payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247.

(8) The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status.

5. 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.

(a) 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.

(b) HCPCS codes that describe devices without pass-through status and that are packaged in kits with other items used in a particular procedure, hospitals may consider all kit costs in their line-item charge for the associated device/device category HCPCS code that is assigned SI of N for packaged payment (i.e., hospitals may report the total charge for the whole kit with the associated device/device category HCPCS code. Payment for device/device category HCPCS codes without pass-through status is packaged into payment for the procedures in which they are used, and these codes are assigned SI of N. In the case of a device kit, should a hospital choose to report the device charge alone under a device/device category HCPCS code with SI of N, the hospital should report charges for other items that may be included in the kit on a separate line on the claim.

(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 APC².

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 I² 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.5.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

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

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

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

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

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

\$2,631.54	TRICARE program payment for HCPCS Level I ³ code 92982 when used with device code C1884	
657.88	Beneficiary coinsurance amount for HCPCS Level I ³ 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 I³ 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.5.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

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

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

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

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

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

STEP 2: Sum the products of Step 1.

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

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

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

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

otherwise

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

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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.

[Step 4 Amount - (Line Item Charge x 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.

(Line Item Device Charge ÷ Sum of Device Charges)

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

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

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

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

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

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

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. Continuing to package payment for all non-pass-through diagnostic radiopharmaceuticals and contrast agents, regardless of their per day costs for CY 2009.

5. 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 HCPCS 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 + 4% 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 13-2-15](#), for a list of therapeutic radiopharmaceuticals that will continue to be reimbursed under the cost-to-charge methodology up through **December 31, 2009**.

(c) 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/oppo> for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

6. 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 + 4% 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.

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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 **December 31, 2009**.

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 + 4%, 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. **For drugs currently covered under the CAP the payment rates calculated under that program that were in effect as of April 1, 2008 will be used for purposes of packaging decisions.**

7. Drugs and Biologicals Not Eligible for Pass-Through Status and Receiving Separate Non-Pass-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

(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.

8. 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 OPPS:

(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 OPPS update.

9. Package payment for any biological without pass-through status that is surgically inserted or implanted (through a surgical incision or a natural orifice) into the payment for the associated surgical procedure.

a. As a result, HCPCS codes C9352, C9353, and J7348 are packaged and assigned SI of N.

b. Any new biologicals without pass-through status that are surgically inserted or implanted will be packaged beginning in CY 2009.

10. Drugs and non-implantable biologicals with expiring pass-through status

a. CY 2009 payment methodology of packaged or separate payment based on their estimated per day costs, in comparison with the CY 2009 drug packaging threshold.

b. Packaged drugs and biologicals are assigned SI of N and drugs and biologicals that continue to be separately paid as non-pass-through products are assigned SI of K.

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 I¹ CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs

HCPCS LEVEL I ¹ 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
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

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FIGURE 13-3-7 CROSSWALK FROM HCPCS LEVEL I¹ CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs (CONTINUED)

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
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 ¹ 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 I⁵ 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.

3. Recognition of Multiple HCPCS Codes for Drugs.

a. Prior to January 1, 2008, the OPPS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPPS assigned a SI B indicating that another code existed for

OPPS purposes. For example, if drug X has two HCPCS codes, one for a 1 ml dose and another for a 5 ml dose, the OPPS would assign a payable status indicator to the 1 ml dose and SI B to the 5 ml dose.

b. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under OPPS.

c. Beginning January 1, 2008, the OPPS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor.

d. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

4. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices.

a. When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriated HCPCS code for the product.

b. Separate payment will be made for an implanted biological when it has pass-through status.

c. If the implantable device does not have pass-through status it will be packaged into the payment for the associated procedure.

5. Correct Reporting of Units for Drugs.

a. Units of drugs administered to patients should be accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

b. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patients, the units bill should be one. If the description for the drug code is 50 mg, but 200 mg of the drug was administered, the units billed should be four.

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

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).

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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 ¹ 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	--
90468	Immunization admin, under 8 yrs old, with counseling; each additional intranasal or oral	N	--
90471	Immunization admin, one vaccine injection	S	0437
90472	Immunization admin, each additional vaccine injections	S	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 OPSS 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. **SI R was created in CY 2009 to denote blood and blood products.**
2. **The OPSS provider also should report charges for processing and storage services on a separate line using Revenue Code 0390 (General Classification), 0392 (Blood Processing/Storage), or 0399 (Blood Processing/Storage; Other Blood Storage and Processing), along with appropriate blood HCPCS code, the number of units transfused, and the Line Item Date Of Service (LIDOS).**
3. 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.
4. Payment for the collection, processing, and storage of autologous blood, as described by HCPCS Level I⁶ code 86890 and used in transfusion, is made through APC 347 (Level III Transfusion Laboratory Procedures).

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5. 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		R	Whole blood for transfusion	0950
P9011		R	Split unit of blood	0967
P9012		R	Cryoprecipitate each unit	0952
P9016		R	RBC leukocytes reduced	0954
P9017		R	Plasma 1 donor frz w/in 8 hr	9508
P9019		R	Platelets, each unit	0957
P9020		R	Platelet rich plasma unit	0958
P9021		R	Red blood cells unit	0959
P9022		R	Washed red blood cells unit	0960
P9023		R	Frozen plasma, pooled, sd	0949
P9031		R	Platelets leukocytes reduced	1013
P9032		R	Platelets, irradiated	9500
P9033		R	Platelets leukoreduced irradiated	0968
P9034		R	Platelets, pheresis	9507
P9035		R	Platelets pheresis leukoreduced	9501
P9036		R	Platelet pheresis irradiated	9502
P9037		R	Platelet pheresis leukoreduced irradiated	1019
P9038		R	RBC irradiated	9505
P9039		R	RBC deglycerolized	9504
P9040		R	RBC leukoreduced irradiated	0969
P9043		R	Plasma protein fract, 5%, 50 ml	0956
P9044		R	Cryoprecipitate reduced plasma	1009
P9048		R	Granulocytes, pheresis unit	9506
P9051	C1010	R	Blood, L/R, CMV-NEG	1010
P9052	C1011	R	Platelets, HLA-m, L/R, unit	1011
P9053	C1015	R	Plt, pher, L/R, CMV, irradiated	1020
P9054	C1016	R	Blood, L/R, Froz/Degly/Washed	1016
P9055	C1017	R	Plt, Aph/Pher, L/R, CMV-Neg	1017
P9056	C1018	R	Blood, L/R, Irradiated	1018
P9057	C1020	R	RBC, frz/deg/wash, L/R irradiated	1021
P9058	C1021	R	RBC, L/R, CMV-Neg, irradiated	1022
P9059	C1022	R	Plasma, frz within 24 hours	0955
P9060	C9503	R	Fresh frozen plasma, ea unit	9503

6. For CY 2009, blood clotting factors will be paid at ASP + 4%, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DEVICE HCPCS CODE	SHORT DESCRIPTOR
C1721	AICD, dual chamber
C1722	AICS, single chamber
C1728	Cath, brachytx seed adm
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep Dev urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual rate-resp
C1786	Pmkr, single rate-resp
C1789	Prosthesis, breast, imp
C1813	Prostheses, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro, rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Pmkr, other than sing/dual
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8600	Implant breast silicone/eq
L8614	Cochlear device/system

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

DEVICE HCPCS CODE	SHORT DESCRIPTOR
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

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

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

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

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

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

M. Policies Affecting Payment of New Technology Services.

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

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

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

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

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

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

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

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 OPPTS.

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 OPSS 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 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

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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.)
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.)
G0383	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.)

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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
G0384	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.

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 CPT⁷ 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 CPT⁷ 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.

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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
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)
Level 4 Hospital Clinic Visits	0607	M0064	Visit for drug monitoring
		99204	Confirmatory consultation (Level 1)
		99215	Office/outpatient visit, est (Level 5)
		99245	Office consultation (Level 5)
Level 5 Hospital Clinic Visits	0608	99275	Confirmatory consultation (Level 5)
		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

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

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

O. OPPTS PRICER.

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

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

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

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

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

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

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

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

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

4. The outpatient PRICER will return the line item APC and cost outlier pricing information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary 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 OPSS methodology's, e.g., CMAC (SI of A) when applicable.

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

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

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

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

P. TRICARE Specific Procedures/Services.

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

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

Q. Validation Reviews.

OPSS claims are not subject to validation review.

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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 CPT⁸ 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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CHAPTER 13
SECTION 4

CLAIMS SUBMISSION AND PROCESSING REQUIREMENTS

ISSUE DATE: July 27, 2005

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

I. APPLICABILITY

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

II. ISSUE

To describe additional claims submission and processing requirements.

III. POLICY

Appropriate Bill Types:

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

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

B. Reporting Requirements.

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

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

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

3. All line items on the CMS 1450 UB-04 claim form must be submitted with a specific date of service. The header date of the CMS 1450 UB-04 may span dates of services. |

However, each line item date of service must fall within the span date billed or the claim will be denied.

C. Procedures for Submitting Late Charges.

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Clinical Diagnostic Laboratory Services Furnished to Outpatients.

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

G. OPPTS Modifiers.

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

IV. EFFECTIVE DATE May 1, 2009.

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