



DEFENSE  
HEALTH AGENCY

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**CHANGE 115  
6010.58-M  
AUGUST 24, 2015**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008**

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

**CHANGE TITLE: REIMBURSEMENT AND CODING 15-001**

**CONREQ: 17372**

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

**SUMMARY OF CHANGE(S): See pages 3 and 4.**

**EFFECTIVE DATE: See pages 3 and 4.**

**IMPLEMENTATION DATE: September 24, 2015.**

**This change is made in conjunction with Feb 2008 TPM, Change No. 140 and Feb 2008 TSM, Change No. 76.**

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Date: 2015.08.20 15:49:16 -06'00'

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**ATTACHMENT(S): 156 PAGE(S)  
DISTRIBUTION: 6010.58-M**

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

**REMOVE PAGE(S)**

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## **SUMMARY OF CHANGES**

### **CHAPTER 1**

1. Section 14. This change adds clarifying language on Paramedic Intercept and Joint Responses. EFFECTIVE DATE: 08/24/2015.

### **CHAPTER 2**

2. Addendum A . This change corrects a formatting error in the Cost-Shares chart for Routine Eye Exams. EFFECTIVE DATE: 02/15/2015.

### **CHAPTER 6**

3. Section 3.
  - a. This change adds criteria to allow coverage of acute care transfer payment to Critical Access Hospitals. EFFECTIVE DATE: 12/01/2009.
  - b. This change clarifies the method of pricing of claims from inpatient acute care hospitals. EFFECTIVE DATE: 10/01/2014.

### **CHAPTER 7**

4. Section 1. This change updates the Deflator Factors for FY 2012-2014. EFFECTIVE DATE: 10/01/2014.
5. Addendum B. This change corrects a typographical error in the date range for FY 2015 for Mental Health Reimbursement. EFFECTIVE DATE: 10/01/2015.
6. Addendum D (FY 2014). This change adds new RTCs for FY 2014 and 2015 for Mental Health Reimbursement. EFFECTIVE DATES: 03/26/2014, 06/04/2014, 10/01/2014, and 10/10/2014.
7. Addendum D (FY 2015). This change adds new RTCs for FY 2014 and 2015 for Mental Health Reimbursement. EFFECTIVE DATES: 03/26/2014, 06/04/2014, 10/01/2014, and 10/10/2014.

### **CHAPTER 10**

8. Addendum A. This change updates the 2015 Birthing Center Rate Non-Professional Component for April 1, 2015 to March 31, 2016. EFFECTIVE DATE: 04/01/2015.

**SUMMARY OF CHANGES (Continued)**

**CHAPTER 13**

9. Section 1. This change updates the status indicator of "X" as no longer active. EFFECTIVE DATE: 01/01/2015.
10. Section 2. This change updates the status indicator of "X" as no longer active. EFFECTIVE DATE: 01/01/2015.
11. Section 3. This change updates the status indicator of "X" as no longer active and adds new status indicator "J1." EFFECTIVE DATE: 01/01/2015.

## Ambulance Services

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(d\)\(3\)\(v\)](#), [32 CFR 199.14\(j\)\(1\)\(i\)\(A\)](#), and 10 USC 1079(h)(1)

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### 1.0 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 **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

### 2.0 ISSUE

How are ambulance services to be reimbursed?

### 3.0 POLICY

**3.1** For coverage policy on ambulance services, refer to the TRICARE Policy Manual (TPM), [Chapter 8, Section 1.1](#).

**3.1.1** In contractor service areas where suppliers routinely bill a mileage charge for ambulance services in addition to a base rate, an additional payment based on prevailing mileage charges may be allowed. Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her destination. It is presumed that all unloaded mileage costs are taken into account when a supplier establishes its basic charge for ambulance services and its rate for loaded mileage.

**3.1.2** When there are both Basic Life Support (BLS) and Advanced Life Support (ALS) ambulances furnishing services in a state, separate prevailing profiles are to be developed for each type.

**3.1.3** BLS vs. ALS. There are situations when an advanced life support ambulance is provided but, based on hindsight, it appears that a BLS would have sufficed. In such cases, the question is whether ALS should be billed (since it was provided) or whether BLS should be billed (since that was the minimum service that would have met the patient's needs).

**3.1.4** In localities which offer only ALS ambulance service, the type of vehicle used, rather than the level of service, is normally the primary factor in determining TRICARE payments. Therefore, ALS may be billed for all transports if only ALS is offered in the locality. However, if the provider has established a different pattern of billing for the level of service provided, then the contractor may recognize the difference and allow payment to be based upon the level of services rendered rather than the type of vehicle and crew. In other words, in an all ALS environment where the provider has

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established different billing patterns based on the level of care (e.g., emergency vs. non-emergency), the contractor may allow one amount for emergency and another for non-emergency.

**3.1.5** If the company has only ALS vehicles but BLS and ALS vehicles operate in the locality, then it is the level of service required which will determine the amount allowed by TRICARE. Thus, even though the provider transported via ALS, it may be paid ALS or BLS rates, based on the following:

- If local ordinances or regulations mandate ALS as the minimum standard of patient transportation, then ALS reimbursement will be made.
- If the ALS was the only vehicle available, then the transfer may be reimbursed at the ALS level at the discretion of the contractor.
- If the company receives a call and dispatches ALS, although BLS was available, then BLS will be paid if the patient's condition was such that BLS would have sufficed. There must be justification on the claim supporting the use of the ALS ambulance in those areas where both ALS and BLS ambulances are available and no state or local ordinances are in effect mandating ALS as the minimum standard transport.

**3.1.6** Information will be shared among the Managed Care Support Contractors (MCSCs) regarding local and state ordinances/laws affecting payment of advanced life support ambulance transfers within their respective jurisdictional areas/regions, the sharing of this information among MCSCs should allow for the accurate processing and payment of beneficiaries traveling outside their contract areas.

**3.1.7** For ambulance transportation to or from a Skilled Nursing Facility (SNF), the provisions in [Chapter 8, Section 2, paragraph 4.3.13.5](#) will apply to determine if ambulance costs are included in the SNF Prospective Payment System (PPS) rate.

## **3.2 Reimbursement**

For ambulance services provided on or after October 1, 2013, TRICARE adopts Medicare's Ambulance Fee Schedule (AFS) as the TRICARE CHAMPUS Maximum Allowable Charge (CMAC) for ambulance services, in accordance with [32 CFR 199.14\(j\)\(1\)\(i\)\(A\)](#). TRICARE will follow Medicare Claims Processing Manual, Chapter 15, and reimbursement shall be based on Medicare's AFS, **except as provided under [paragraph 3.2.1](#) during TRICARE's transition to the fully phased-in Medicare AFS.** The AFS is provided on the Centers for Medicare and Medicaid Services (CMS) web site at <http://www.cms.gov/medicare/medicare-fee-for-service-payment/ambulancefeeschedule/index.html?redirect=/ambulancefeeschedule>.

### **3.2.1 TRICARE Transition to Medicare AFS for Air Ambulance Services**

**3.2.1.1** Air ambulance service from October 1, 2013 through September 30, 2014 shall be paid in accordance with [Chapter 5, Section 1](#).

**3.2.1.2** Contractors shall establish a base year rate for purposes of calculating reimbursement rates during the transition to reimbursement based on Medicare's AFS, applicable to air ambulance services on or after October 1, 2014. The base year rate, calculated by state, shall be either 1) the

dead by an individual authorized by the State to make such pronouncements. Figure 1.14-2 shows the TRICARE payment determination for various air ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary. If the flight is aborted for other reasons, such as bad weather, the TRICARE payment determination is based on whether the beneficiary was onboard the air ambulance.

**FIGURE 1.14-2 AIR AMBULANCE SCENARIOS IN WHICH THE BENEFICIARY DIES**

TIME OF DEATH PRONOUNCEMENT	TRICARE PAYMENT DETERMINATION
Prior to takeoff to point-of-pickup with notice to dispatcher and time to abort the flight.	None. <b>Note:</b> This scenario includes situations in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off.
After takeoff to point-of-pickup, but before beneficiary is loaded.	Appropriate air base rate with no mileage or rural adjustment; use the <b>QL</b> modifier when submitting the claim.
After the beneficiary is loaded onboard, but prior to or upon arrival at the receiving facility.	As if the beneficiary had not died.

**3.2.7 Air Ambulance Transport Cancelled Due to Weather or Other Circumstances Beyond the Pilots Control**

Figure 1.14-3 shows the TRICARE payment determination for various air ambulance scenarios in which the flight is aborted due to bad weather, or other circumstances beyond the pilot's control.

**FIGURE 1.14-3 AIR AMBULANCE SCENARIOS IN WHICH THE FLIGHT IS ABORTED**

ABORTED FLIGHT SCENARIO	TRICARE PAYMENT DETERMINATION
Any time before the beneficiary is loaded onboard (i.e., prior to or after take-off to point-of-pickup).	None.
Transport after the beneficiary is loaded onboard.	Appropriate air base rate, mileage, and rural adjustment.

**3.2.8 Multiple Patient Ambulance Transport**

**3.2.8.1** If two patients are transported to the same destination simultaneously, for each TRICARE beneficiary, TRICARE will allow 75% of the payment allowance for the base rate applicable to the level of care furnished to that beneficiary plus 50% of the total mileage payment allowance for the entire trip. The **GM** modifier will be used for reporting multiple patients on one ambulance trip.

**3.2.8.2** If three or more patients are transported to the same destination simultaneously, then the payment allowance for the TRICARE beneficiary (or each of them) is equal to 60% of the base rate applicable to the level of care furnished to the beneficiary. However, a single payment allowance for mileage will be prorated by the number of patients onboard. This policy applies to both ground and air transports.

**3.2.9 Special Payment Limitations**

If the determination is made that transport by air ambulance was necessary, but ground ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for ground transport, if less costly. If the air transport was medically appropriate

(that is, ground transportation was contraindicated, and the beneficiary required air transport to a hospital), but the beneficiary could have been treated at a nearer hospital than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.

**3.3** No separate charge is allowed for personnel manning the ALS. ALS personnel costs are included in the base and mileage charges with the exception of paramedic ALS intercept services (PI) (see paragraph 3.4).

### **3.4 Paramedic Intercept (PI)**

**3.4.1** PI services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only BLS level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or Intravenous (IV) therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient. This tiered approach to life saving is cost effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. These PI services may be payable separate from the ambulance transport, subject to the requirements specified below:

- Furnished in a rural area;
- Furnished under a contract with one or more volunteer ambulance services; and
- Medically necessary based on the condition of the beneficiary receiving the ambulance service.

**3.4.1.1** In addition, the volunteer ambulance service involved must:

- Meet the program's certification requirements for furnishing ambulance services;
- Furnish services only at the BLS level at the time of the intercept; and
- Be prohibited by State law from billing anyone for any service.

**3.4.1.2** The entity furnishing the ALS PI service must:

- Meet the program's certification requirements for furnishing ALS services, and
- Bill all recipients who receive ALS PI services from the entity, regardless of whether or not those recipients are TRICARE beneficiaries.

**3.4.2** For the purposes of the PI benefit, a rural area is an area that is designated as rural by a State law or regulation or any area outside of a Metropolitan Statistical Area or in New England, outside a New England County Metropolitan Area as defined by the Office of Management and Budget. The current list of these areas is periodically published in the Federal Register.

### **3.5 Joint Response (BLS/ALS)**

**3.5.1** In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, PI services, etc.), the BLS supplier may bill TRICARE the ALS rate provided that a written agreement between the BLS and ALS entities exists prior to submitting the TRICARE claim. Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by the TRICARE contractor.

**3.5.2** TRICARE does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment may be made. In this situation, the ALS entity's services are not covered, and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

**3.6** The cost-sharing of ambulance services and supplies will be in accordance with the status of the patient at the time the covered services and supplies are rendered ([32 CFR 199.4\(a\)\(4\)](#)).

**3.6.1** Ambulance transfers from a beneficiary's place of residence, accident scene, or other location to a civilian hospital, Military Treatment Facility (MTF), Veterans Affairs (VA) hospital, or SNF will be cost-shared on an outpatient basis. Transfers from a hospital or SNF to a patient's residence will also be considered an outpatient service for reimbursement under the program. A separate cost-share does not apply to ambulance transfers to or from a SNF, if the costs for ambulance transfer are included in the SNF PPS rate (see [Chapter 8, Section 2, paragraph 4.3.13.5](#)).

**3.6.2** Ambulance transfers between hospitals (acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals) and SNFs will be cost-shared on an inpatient basis.

**3.6.3** Under the above provisions, for ambulance transfers between hospitals, a nonparticipating provider may bill the beneficiary the lower of the provider's billed charge or 115% of the TRICARE allowable charge.

**3.6.4** Transfers to a MTF, VA hospital, or SNF after treatment at, or admission to, an emergency room or civilian hospital will be cost-shared on an inpatient basis, if ordered by either civilian or military personnel.

**3.6.5** Medically necessary ambulance transfers from an Emergency Room (ER) to a hospital more capable of providing the required level of care will also be cost-shared on an inpatient basis. This is consistent with current policy of cost-sharing ER services as inpatient when an immediate inpatient admission for acute care follows the outpatient ER treatment.

**3.6.6** Cost-share amounts for ambulance services are included in [Chapter 2, Section 1](#).

## **4.0 POLICY CONSIDERATIONS**

### **4.1 Ambulance Membership Programs**

**4.1.1** Ambulance membership programs typically charge an annual fee for a subscription to an ambulance service. The ambulance provider agrees to accept assignment on all benefits from third

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party payers for medically necessary services. By paying the annual fee, the covered family members pay no additional fees (including third party cost-shares and deductibles) to the ambulance service.

**4.1.2** When a beneficiary pays premiums to a pre-paid ambulance plan, the premiums are considered to fulfill the beneficiary's cost-share and deductible requirements. Under this arrangement, the ambulance membership program becomes analogous to a limited supplemental plan.

**4.2** When an ambulance company bills a flat fee for ambulance transport within its service area, reimbursement will be at the lesser of the billed amount (flat fee) or the statewide prevailing for Healthcare Common Procedure Coding System (HCPCS) codes A0426 through A0429 subject to applicable beneficiary cost-sharing.

**4.3** The TRICARE national allowable charge system used to reimburse professional services does not apply to ambulance claims. The above reimbursement guidelines are to be used by the contractors.

**4.4** Itemization requirements are dictated by the particular HCPCS codes used in filing an ambulance claim.

- END -

## Benefits And Beneficiary Payments Under The TRICARE Program

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Beneficiary copayments (i.e., beneficiary payments expressed as a specified amount) and enrollment fees may be updated for inflation annually (cumulative effect applied and rounded to the nearest whole dollar) by the national Urban Consumer Price Index (CPI-U) medical index (the medical component of the CPI-U). Beneficiary cost-shares (i.e., beneficiary payments expressed as a percentage of the provider’s fee) will not be similarly updated.

These charts are not intended to be a comprehensive listing of all services covered under TRICARE. All care is subject to review for medical necessity and appropriateness:

### 1.0 TRICARE PRIME PROGRAM ANNUAL ENROLLMENT FEES

Does not apply to the TRICARE Extra Program (also see [paragraph 5.0](#), “Point of Service (POS) Option”):

TRICARE PRIME PROGRAM			
EFFECTIVE DATE OF FEES	ACTIVE DUTY FAMILY MEMBERS (ADFM)s		RETIREES, THEIR FAMILY MEMBERS, ELIGIBLE FORMER SPOUSES, & SURVIVORS
	E1 - E4	E5 & ABOVE	
FY 1996 - FY 2011	None	None	\$230 per Retiree or Family Member \$460 Maximum per Family
FY 2012	None	None	\$260 per Retiree or Family Member \$520 Maximum per Family
FY 2013	None	None	\$269.28 per Retiree or Family Member \$538.56 Maximum per Family
FY 2014	None	None	\$273.84 per Retiree or Family Member \$547.68 Maximum per Family
FY 2015	None	None	\$277.92 per Retiree or Family Member \$555.84 Maximum per Family
<b>FY 2016 - Present</b>	<b>None</b>	<b>None</b>	<b>\$282.60 per Retiree or Family Member</b> <b>\$565.20 Maximum per Family</b>

**EXCEPTIONS:**

1. Effective March 26, 1998, the enrollment fee is waived for those beneficiaries who are eligible for Medicare on the basis of disability or end stage renal disease and who maintain enrollment in Part B of Medicare.
2. Effective Fiscal Year (FY) 2012, beneficiaries who are (1) survivors of active duty deceased sponsors, or (2) medically retired Uniformed Services members and their dependents, shall have their Prime enrollment fees frozen at the rate in effect when classified and enrolled in a fee paying Prime plan. (This does not include TRICARE Young Adult (TYA) plans). Beneficiaries in these two categories who were enrolled in FY 2011 will continue paying the FY 2011 rate. The beneficiaries who become eligible in either category and enroll during FY 2012, or in any future fiscal year, shall have their fee frozen at the rate in effect at the time of enrollment in Prime. The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime. The fee for the dependent(s) of a medically retired Uniformed Services member shall not change if the dependent(s) is later re-classified a survivor.

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**2.0 TRICARE STANDARD AND EXTRA PROGRAM ANNUAL FISCAL YEAR DEDUCTIBLE**

Applies to all outpatient services, does not apply to the TRICARE Prime Program (also see [paragraph 5.0](#), "POS Option"):

TRICARE STANDARD AND EXTRA PROGRAM		
ADFMs		RETIRES, THEIR FAMILY MEMBERS, & SURVIVORS
E1 - E4	E5 & ABOVE	
\$50 per Individual \$100 Maximum per Family	\$150 per Individual \$300 Maximum per Family	\$150 per Individual \$300 Maximum per Family

**3.0 OUTPATIENT SERVICES**

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 1)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	ADFMS		RETIRES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
<b>INDIVIDUAL PROVIDER SERVICES</b> Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; medical supplies used within the office including casts, dressings, and splints.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit.	<b>ADFMs:</b> Cost-share--15% of the fee negotiated by the contractor.  <b>Retirees, their Family Members, &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>ADFMs:</b> Cost-share--20% of the allowable charge.  <b>Retirees, their Family Members, &amp; Survivors:</b> Cost-share--25% of the allowable charge.
<b>OUTPATIENT HOSPITAL DEPARTMENTS</b> Clinics visits; therapy visits; medical supplies; consultations; treatment room; etc. <b>Note:</b> Use other parts of this table for cost-sharing of ASC services, ER services, DME, etc.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit.  No separate copayment/cost-share for separately billed professional charges.		
<b>ANCILLARY SERVICES</b> Refer to Section 1 for specific services considered as ancillary services.	\$0 copayment per visit.	\$0 copayment per visit.	No copayment (see Note 2).		
<b>OTHER RADIOLOGY SERVICES</b> Not considered as ancillary services.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit.		

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**3.0 OUTPATIENT SERVICES (CONTINUED)**

<b>BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)</b>					
<b>TRICARE BENEFITS</b>	<b>TRICARE PRIME PROGRAM (SEE NOTE 1)</b>			<b>TRICARE EXTRA PROGRAM</b>	<b>TRICARE STANDARD PROGRAM</b>
<b>TYPE OF SERVICE</b>	<b>ADFMS</b>		<b>RETIREES, THEIR FAMILY MEMBERS, &amp; SURVIVORS</b>		
	<b>E1 - E4</b>	<b>E5 &amp; ABOVE</b>			
<b>ROUTINE PAP SMEARS</b> Frequency to depend on physician recommendations based on the published guidelines of the American Academy of Obstetrics and Gynecology (see Note 1).	No copayment.	No copayment.	No copayment.	\$0 cost-share.	\$0 cost-share.
<b>AMBULANCE SERVICES</b> When medically necessary as defined in the TRICARE Policy Manual (TPM) and the service is a covered benefit.	\$0 copayment per visit.	\$0 copayment per visit.	\$20 copayment per occurrence.	<b>ADFMs:</b> Cost-share--15% of the fee negotiated by contractor.	<b>ADFMs:</b> Cost-share--20% of the allowable charge.
<b>EMERGENCY SERVICES</b> Emergency and urgently needed care obtained on an outpatient basis, both network and non-network, and in and out of the Region.	\$0 copayment per visit.	\$0 copayment per visit.	\$30 copayment per emergency room visit.	<b>Retirees, their Family Members, &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>Retirees, their Family Members, &amp; Survivors:</b> Cost-share--25% of the allowable charge.
<b>DME, HEARING AIDS FOR ADFMs, AND MEDICAL SUPPLIES PRESCRIBED BY AN AUTHORIZED PROVIDER WHICH ARE COVERED BENEFITS</b> (If dispensed for use outside of the office or after the home visit.)	\$0 copayment per visit.	\$0 copayment per visit.	Cost-share - 20% of the fee negotiated by the contractor.		

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**3.0 OUTPATIENT SERVICES (CONTINUED)**

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 1)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
<p><b>HOME HEALTH CARE</b> Part-time or intermittent skilled nursing and home health aide services, physical, speech, &amp; occupational therapy, medical social services, routine and non-routine medical services. <b>Note:</b> DME, osteoporosis drugs, pneumococcal pneumonia, influenza virus and hepatitis B vaccines, oral cancer drugs, antiemetic drugs, orthotics, prosthetics, enteral and parenteral nutritional therapy and drugs/biologicals administered by other than oral methods are services that can be paid in addition to the prospective payment amount subject to applicable copayment/ cost-sharing and deductible amounts.</p>	\$0 copayment.	\$0 copayment.	\$0 copayment.	\$0 cost-share.	\$0 cost-share.
<p><b>HOSPICE CARE</b> <b>Note:</b> A separate cost-share may be (optional) collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.</p>					
<p><b>WELL CHILD CARE</b> Up to the age of six.</p>	\$0 copayment per visit.	\$0 copayment per visit.	\$0 copayment per visit.		

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Benefits And Beneficiary Payments Under The TRICARE Program

**3.0 OUTPATIENT SERVICES (CONTINUED)**

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 1)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
<b>FAMILY HEALTH SERVICES</b> Family planning. The exclusions listed in the TPM will apply.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit (see Note 1).	<b>ADFMs:</b> Cost-share--15% of the fee negotiated by contractor.	<b>ADFMs:</b> Cost-share--20% of the allowable charge.
<b>OUTPATIENT MENTAL HEALTH TO INCLUDE HOME</b> One hour of therapy, no more than two times each week (when medically necessary).	\$0 copayment per visit.	\$0 copayment per visit.	\$25 copayment for individual visits.  \$17 copayment for group visits.	<b>Retirees, their Family Members, &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>Retirees, their Family Members, &amp; Survivors:</b> Cost-share--25% of the allowable charge.
<b>AMBULATORY SURGERY (same day)</b> Authorized hospital-based or freestanding Ambulatory Surgical Center (ASC) that is TRICARE certified.	\$0 copayment per visit.	\$0 copayment per visit.	\$25 copayment.	<b>ADFMs:</b> Cost-share--\$25. for ASC.	<b>ADFMs:</b> \$25.
<b>ALL SURGICAL PROCEDURES REGARDLESS OF WHERE THEY ARE PERFORMED</b> With the exclusion of those surgical procedures referenced <a href="#">Section 1, paragraphs 1.2.4.5 and 1.2.4.7.</a>				<b>Retirees, their Family Members, &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>Retirees, their Family Members, &amp; Survivors:</b> Lesser of 25% of group rate or 25% of billed charge.
<b>BIRTHING CENTER</b> Prenatal care, outpatient delivery, and postnatal care provided by TRICARE authorized birthing center.					

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

**3.0 OUTPATIENT SERVICES (CONTINUED)**

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION) (SEE NOTE 3)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 1)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
TYPE OF SERVICE					
<p><b>IMMUNIZATIONS</b> Immunizations required for active duty family members whose sponsors have permanent change of station orders to overseas locations. <b>Note:</b> Immunizations provided in accordance with TPM, <a href="#">Chapter 7, Sections 2.1, 2.2, and 2.5</a> are also covered as a clinical preventive service (see below).</p>	\$0 copayment per visit.	\$0 copayment per visit.	N/A	<p><b>ADFMs:</b> \$0 cost-share.</p> <p><b>Retirees, their Family Members, &amp; Survivors:</b> N/A</p>	<p><b>ADFMs:</b> \$0 cost-share.</p> <p><b>Retirees, their Family Members, &amp; Survivors:</b> N/A</p>
<p><b>EYE EXAMINATIONS (See Note 4)</b> One routine examination per year for family members of active duty sponsors. <b>Note:</b> Routine eye examinations once every two years provided in accordance with TPM, <a href="#">Chapter 7, Section 2.2</a>, are covered as a clinical preventive service (see below) for Prime enrollees.</p>	\$0 copayment per visit.	\$0 copayment per visit.	N/A	<p><b>ADFMs:</b> Cost-share--15% of the fee negotiated by the contractor.</p> <p><b>Retirees, their Family Members, &amp; Survivors:</b> N/A</p>	<p><b>ADFMs:</b> Cost-share--20% of the allowable charge.</p> <p><b>Retirees, their Family Members, &amp; Survivors:</b> N/A.</p>
<p><b>CLINICAL PREVENTIVE SERVICES</b> Includes those services listed in the TPM, <a href="#">Chapter 7, Sections 2.1, 2.2, and 2.5</a>.</p>	\$0 copayment.	\$0 copayment.	\$0 copayment.	<p><b>ADFMs:</b> Cost-share--15% of the fee negotiated by contractor.</p> <p><b>Retirees, their Family Members, &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor (see Note 1).</p>	<p><b>ADFMs:</b> Cost-share--20% of the allowable charge.</p> <p><b>Retirees, their Family Members, &amp; Survivors:</b> Cost-share--25% of the allowable charge (see Note 1).</p>

## Hospital Reimbursement - TRICARE DRG-Based Payment System (Basis Of Payment)

Issue Date: October 8, 1987

Authority: [32 CFR 199.14\(a\)\(1\)](#)

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### 1.0 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 **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

### 2.0 ISSUE

What is the basis of payment for the TRICARE DRG-based payment system?

### 3.0 POLICY

#### 3.1 Hospital Billing

Under the TRICARE DRG-based payment system, hospitals are required to submit claims in accordance with [32 CFR 199.7\(b\)](#). The contractor will assign the appropriate DRG to the claim based on the information contained on the claim.

**3.1.1** Hospital participation. As noted previously, all hospitals which participate in Medicare are required to participate on all inpatient claims.

**3.1.2** Late charges. Any late charges received by the contractor for a claim which has been processed under the TRICARE DRG-based payment system are to be processed as an adjustment. Generally, late charges will not result in any additional payment, but they could affect payment by changing the DRG assigned to the claim or by causing the claim to qualify as an outlier, or they could affect the amount of the beneficiary's cost-share.

**3.1.3** Beneficiary-submitted claims. If a beneficiary submits a claim which is determined to be subject to the TRICARE DRG-based payment system (or for services from an exempt hospital which is Medicare-participating), whether for inpatient services or for related professional services rendered by a hospital-based professional, the claim is to be returned (uncontrolled) with the notation that all inpatient hospital claims must be submitted by the provider.

**3.1.4** Effective July 11, 1995, the physician attestation form that requires doctors to certify the accuracy of all diagnoses and procedures before submitting claims for payment is no longer

required, and instead of requiring a physician to sign an acknowledgement statement every year, a physician need only sign the statement upon receiving admitting privileges at a hospital.

### 3.2 Payment On A Per Discharge Basis

Under the TRICARE DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to TRICARE beneficiaries.

### 3.3 Pricing of Claims

**3.3.1** All final claims with discharge dates of September 30, 2014, or earlier that are reimbursed under the TRICARE DRG-based payment system are to be priced using the rules, weights and rates in effect as of the date of admission, regardless of when the claim is submitted. All final claims with discharge dates of October 1, 2014, or later that are reimbursed under the TRICARE DRG-based payment system are to be priced using the rules, weights and rates in effect as of the date of discharge. **Interim claims with "end date of care" on or after October 1, 2014, shall be priced using the rules, weights and rates in effect as of the "end date of care."** (See the TRICARE Systems Manual (TSM), Chapter 2, Section 5.2.)

**3.3.2** Contractors shall maintain at least three years' weights and rates, including Indirect Medical Education (IDME) adjustment factors, wage indexes, etc., in the contractor's on-line system. If the claim filing deadline has been waived and the date of discharge is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest DRG weights and rates on the contractor's system.

### 3.4 Payment In Full

The DRG-based amount paid for inpatient hospital services is the total TRICARE payment for the inpatient operating costs (as described in this section) incurred in furnishing services covered by the TRICARE. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in [Section 8](#) for short-stay outliers. Thus, certain items related or incidental to the treatment of the patient, but which might not otherwise be covered, are included in the DRG-based payment. For example, patient education services such as nutrition counseling are not covered by TRICARE, but if they are provided incidental to covered services, they are to be considered included in the DRG-based payment. The hospital cannot bill the beneficiary for the services, since they are included in the overall treatment regimen for the admission. At the same time, the contractor is not to reduce the DRG-based payment simply because some non-covered services were rendered.

**3.4.1** Services received from another hospital. In those cases in which the hospital obtains certain services from another hospital (e.g., computerized tomography services) no additional payment is to be made to either hospital for the technical component of the services. The technical component is to be considered part of the DRG-based payment, and it is the discharging hospital's responsibility to make suitable payment arrangements with the other hospital providing services. Of course, the professional component of such services can be billed separately by the second hospital.

**3.4.2** Interim bills for unusually long Lengths-Of-Stay (LOS). Because the DRG-based payment is the full payment for the claim, in most cases interim bills will not be accepted. If an interim bill is

submitted for services subject to the TRICARE DRG-based payment system, it is to be denied. The only exception to this is for certain qualifying outlier cases.

**3.4.2.1** Criteria for qualifying for interim payments. In order to qualify for interim payments the following conditions must be met. If a condition is not met, e.g., the claim is received out of chronological order, the claim is to be denied.

- The patient has been in the hospital at least 60 days.
- Multiple claims for single individuals must be submitted in chronological order.

**3.4.2.2** A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill.

**3.4.2.3** Contractor actions on interim claims. Contractors will process the initial claim as a complete claim and each subsequent claim as an adjustment. However, the interim claims are only a method of facilitating cash flow to providers, and the final bill is still the final accounting on the hospital stay. Therefore, upon receipt of the final bill, the contractor is required to review the entire claim to ensure that it has been correctly paid and to ensure that the cost-share has been correctly determined. See the TSM, [Chapter 2, Section 1.1, paragraph 7.0](#) for TRICARE Encounter Data (TED) record submission requirements for interim hospital billings.

### **3.5 Inpatient Operating Costs**

The TRICARE DRG-based payment system provides a payment amount for inpatient operating costs, including:

**3.5.1** Operating costs for routine services, such as the costs of room, board, therapy services (physical, speech, etc.), and routine nursing services as well as supplies (e.g., pacemakers) necessary for the treatment of the patient;

**3.5.2** Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients (the professional component of these services is not included and can be billed separately);

**3.5.3** Take-home drugs for less than \$40;

**3.5.4** Special care unit operating costs (intensive care type unit services); and

**3.5.5** Malpractice insurance costs related to services furnished to inpatients.

### **3.6 Discharges And Transfers**

#### **3.6.1 Discharges**

Subject to the provisions of [paragraphs 3.6.2](#) and [3.6.3](#), a hospital inpatient is considered discharged from a hospital paid under the TRICARE DRG-based payment system when:

**3.6.1.1** The patient is formally released from the hospital; or

**3.6.1.2** The patient dies in the hospital.

**3.6.1.3** The patient is transferred to a hospital or unit that is excluded from the TRICARE DRG-based payment system under the provisions of [Section 4](#). Such cases can be identified by Form Locator (FL) 17 on the CMS 1450 UB-04 claim form. For discharges with an admission date on or after October 1, 1998, such cases shall be processed as a transfer, if the claim contains one of the qualifying DRGs listed in [paragraph 3.6.4](#), and the patient is transferred to one of the settings outlined in [paragraph 3.6.3](#).

### **3.6.2 Acute Care Transfers**

A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this subsection if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital **that** is:

**3.6.2.1** Paid under the TRICARE DRG-based payment system (such instances will result in two or more claims); or

**3.6.2.2** Excluded from being paid under the TRICARE DRG-based payment system because of participation in a statewide cost control program which is exempt from the TRICARE DRG-based payment system under [Section 4](#) (such instances will result in two or more claims); or

**3.6.2.3** Authorized as a Designated Provider (DP) [formerly Uniformed Services Treatment Facilities (USTFs)] or a Department of Veterans Affairs (DVA) hospital.

**3.6.2.4** Excluded from being paid under the TRICARE DRG-based payment system as a Critical Access Hospital (CAH) effective December 1, 2009.

### **3.6.3 Postacute Care Transfers**

A discharge of a hospital inpatient is considered to be a transfer for purposes of this subsection when the patient's discharge is assigned to one of the qualifying DRGs listed in [paragraph 3.6.4](#), and the discharge is made under any of the following circumstances:

**3.6.3.1** To a hospital or distinct part hospital unit excluded from the TRICARE DRG-based payment system as described in [Section 4](#). Claims shall be coded 05, 62, 63, 85, 90, or 91 in FL 17 on the CMS 1450 UB-04 claim form. Effective April 1, 2004, claims shall be coded 65 or 93 in FL 17 for psychiatric hospitals and units.

**3.6.3.2** To a Skilled Nursing Facility (SNF). Claims shall be coded 03 or 83 in FL 17 on the CMS 1450 UB-04 claim form.

**3.6.3.3** To home under a written plan of care for the provision of home health services from a home health agency and those services begin within three days after the date of discharge. Claims shall be coded 06 or 86 in FL 17 on the CMS 1450 UB-04 claim form. Claims coded 06 or 86 with a condition code of 42 or 43 in FL 18 shall be processed as a discharge instead of a transfer.

### **3.6.4 Qualifying DRGs**

The qualifying DRGs, for purposes of [paragraph 3.6.3](#), are listed on either the TRICARE DRG web site at <http://www.tricare.mil/drgrates/> or listed in the applicable addendum for the respective fiscal year. Addendum C reflects the current fiscal year and the two most recent fiscal years.

### **3.6.5 Payment For Discharges**

The hospital discharging an inpatient (under [paragraph 3.6.1](#)) is paid in full in accordance with [paragraph 3.4](#).

### **3.6.6 Payment For Transfers**

**3.6.6.1** General Rule. Except as provided in [paragraphs 3.6.6.2](#) and [3.6.6.5](#), a hospital that transfers an inpatient under circumstances described in [paragraphs 3.6.2](#) or [3.6.3](#), is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the TRICARE DRG-based payment amount that would have been paid if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate DRG rate by the geometric mean LOS for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG amount. For neonatal claims, other than normal newborns, payment is graduated by paying twice the per diem amount for the first day of the stay, and 125% of the per diem rate for each subsequent day, up to the full DRG amount.

**3.6.6.2** Special rule for DRGs 209, 210, and 211 for Fiscal Years (FYs) prior to FY 2006. For fiscal years prior to FY 2006, a hospital that transfers an inpatient under the circumstances described in [paragraph 3.6.3](#) and the transfer is assigned to DRGs 209, 210, and 211 is paid as follows:

**3.6.6.2.1** Fifty percent (50%) of the DRG-based payment amount plus one-half of the per diem payment for the DRG for day one (one-half the usual transfer payment of double the per diem for day one).

**3.6.6.2.2** Fifty percent (50%) of the per diem for each subsequent day up to the full DRG payment.

**3.6.6.3** Special rule for DRGs meeting specific criteria. For discharges occurring on or after October 1, 2005, a hospital that transfers an inpatient under the circumstances described in [paragraph 3.6.3](#) and the transfer is assigned to DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, and 550 shall be paid under the provisions of [paragraphs 3.6.6.2.1](#) and [3.6.6.2.2](#). For all other years, those DRGs subject to the special rule for transfers shall be listed in Addendum C. Addendum C reflects the current fiscal year and the two most recent fiscal years.

#### **3.6.6.4** Outliers.

- A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers as described in [Section 8, paragraph 3.2.6.1](#). For admissions on or after October 1, 1995, when calculating the cost outlier payment, if the LOS exceeds the geometric mean LOS, the cost outlier

threshold shall be limited to the DRG-based payment plus the fixed loss amount. The contractor shall readjudicate claims affected by this change if brought to their attention by any source.

- Refer to <http://www.tricare.mil/drgrates/> for payment details associated with outliers.

**3.6.6.5** Transfer assigned to DRG 601. If a transfer is classified into DRG 601 (Neonate, transferred < 5 days old), the transferring hospital is paid in full. Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.

### **3.7 Leave Of Absence Days**

**3.7.1** General. Normally, a patient will leave a hospital which is subject to the DRG-based payment system only as a result of a discharge or a transfer. However, there are some circumstances where a patient is admitted for care, and for some reason is sent home temporarily before that care is completed. Hospitals may place patients on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples of such situations include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, further treatment is indicated following diagnostic tests but cannot begin immediately, a change in the patient's condition requires that scheduled surgery be delayed for a short time, or test results to confirm the need for surgery are delayed.

**3.7.2** Billing for leave of absence days. In billing for inpatient stays which include a leave of absence, hospitals are to use the actual admission and discharge dates and are to identify all leave of absence days by using revenue code 18X for such days. Contractors are to disallow all leave of absence days. Neither the Program nor the beneficiary may be billed for days of leave.

**3.7.3** DRG-based payments for stays including leave of absence days. Placing a patient on a leave of absence will not result in two DRG-based payments, nor can any payment be made for leave of absence days. Only one claim is to be submitted when the patient is formally discharged (as opposed to being placed on leave of absence), and only one DRG-based payment is to be made. The contractor should ensure that the leave of absence does not result in long-stay outlier days being paid and that it does not increase the beneficiary's cost-share.

**3.7.4** Services received while on leave of absence. The technical component of laboratory tests obtained while on a leave of absence would be included in the DRG-based payment to the hospital. The professional component is to be cost-shared as inpatient. Tests performed in a physician's office or independent laboratory are also included in the DRG-based payment.

**3.7.5** Patient dies while on leave of absence. If patient should die while on leave of absence, the date the patient left the hospital shall be treated as the date of discharge.

### **3.8 Area Wage Indexes**

The labor-related portion of the ASA will be adjusted to account for the differences in wages among geographic areas and will correspond to the labor market areas used in the Medicare PPS, and the actual indexes used will be those used in the Medicare PPS. The wage index used is to be the one for the hospital's actual address--not for the hospital's billing address.

### **3.9 Redesignation Of Certain Hospitals To Other Wage Index Areas**

TRICARE is simply following this statutory requirement for the Medicare Prospective Payment System (PPS), and the Centers for Medicare and Medicaid Services (CMS) determines the areas affected and wage indexes used.

**3.9.1** Admissions occurring on or after October 1, 1988. A hospital located in a rural county adjacent to one or more urban areas shall be treated as being located in the urban area to which the greatest number of workers commute. The area wage index for the urban area shall be used for the rural county.

**3.9.2** Admissions occurring on or after April 1, 1990. In order to correct inequities resulting from application of the rules in [paragraph 3.9.1](#), CMS modified the rules for those rural hospitals deemed to be urban. TRICARE has also adopted these changes. Some of these hospitals continue to use the urban area wage index, others use a wage index computed specifically for the rural county, and others use the statewide rural wage index.

**3.9.3** Admissions occurring on or after October 1, 1991. Public Law 101-239 created the Medicare Geographic Classification Review Board (MGCRB) to reclassify individual hospitals to different wage index areas based on requests from the hospitals. These reclassifications are intended to eliminate the continuing inequities caused by the reclassification actions described in [paragraphs 3.9.1](#) and [3.9.2](#). TRICARE has adopted these hospital-specific reclassifications effective for admissions occurring on or after October 1, 1991.

**3.9.4** Admissions occurring on or after October 1, 1997. The wage index for an urban hospital may not be lower than the statewide area rural wage index.

### **3.10 Admissions Occurring On Or After October 1, 2004**

TRICARE has adopted the revisions CMS has made to the labor market areas and the wage index changes outlined in CMS' August 11, 2004, Final Rule, including the out-commuting wage index adjustment.

**3.11** Refer to [DHA's DRG home page at <http://www.tricare.mil/drgrates/>](#) for annual DRG wage index updates.

- END -



## Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

Issue Date: November 28, 1988

Authority: [32 CFR 199.14\(a\)](#)

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### 1.0 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 **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

### 2.0 ISSUE

How is the TRICARE inpatient mental health per diem payment system to be used in determining reimbursement for psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the Diagnosis Related Groups (DRG)-based payment system?

### 3.0 POLICY

#### 3.1 Inpatient Mental Health Per Diem Payment System

The inpatient mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the DRG-based payment system. The system uses two sets of per diems. One set of per diems applies to psychiatric hospitals and psychiatric units of general acute hospitals that have a relatively high number (25 or more per federal fiscal year) of TRICARE mental health discharges. For higher volume hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to psychiatric hospitals and units with a relatively low number (less than 25 per federal fiscal year) of TRICARE mental health discharges. For higher volume providers, the contractors are to maintain files which will identify when a provider becomes a high volume provider; the federal fiscal year when the provider had 25 or more TRICARE mental health discharges; the calculation of each provider's high volume rate; and the current high volume rate for the provider. For lower volume hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and Indirect Medical Education (IDME) costs and additional pass-through payments for direct medical education costs.

#### 3.2 Applicability of the Inpatient Mental Health Per Diem Payment System

**3.2.1** Facilities. The inpatient mental health per diem payment system applies to services covered that are provided in a Medicare DRG-exempt psychiatric hospitals and a Medicare DRG-

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exempt unit of a hospital. In addition, any psychiatric hospital that does not participate in Medicare, or any hospital that has a psychiatric unit that has not been so designated for exemption from Medicare DRG because the hospital does not participate in Medicare, must be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the inpatient mental health per diem payment system upon demonstrating that it meets the same Medicare criteria. The contractor is responsible for requesting from a hospital that does not participate in Medicare sufficient information from that hospital which will allow it to make a determination as to whether the hospital meets the Medicare criteria in order to designate it as a DRG-exempt hospital or unit. The inpatient mental health per diem payment system does not apply to mental health services provided in non-psychiatric hospitals or non-psychiatric units. Substance use disorder rehabilitation facilities are not reimbursed under the inpatient mental health per diem payment system (see [Section 3](#)).

**3.2.2** DRGs. All psychiatric hospitals' and psychiatric units' covered inpatient claims which are classified into a mental health DRG of 425 - 432 or a substance use disorder DRG of 433, DRGs 521 - 523, and DRGs 900 and 901 shall be subject to the TRICARE inpatient mental health per diem payment system. Effective October 1, 2008, all psychiatric hospitals and psychiatric units covered claims which are classified into a mental health DRG of 880 - 887 or a substance use disorder DRG of 894 - 896, 898, and 899 shall be subject to the TRICARE inpatient mental health per diem system.

**3.2.3** State Waivers. The DRG-based payment system provides for state waivers for states utilizing state developed rates applicable to all payers, i.e., Maryland. Psychiatric hospitals and units in these states, may also qualify for the waiver; however, the per diem may not exceed the cap amount applicable to other higher volume hospitals.

### 3.3 Hospital-Specific Per Diems for Higher Volume Psychiatric Hospitals and Units

**3.3.1** Hospital-Specific Per Diem. A hospital-specific per diem amount shall be calculated for each hospital or unit with a higher volume of TRICARE mental health discharges. The base period per diem amount shall be equal to the hospital's average daily charge for charges allowed by the government in the base period (July 1, 1987 through May 31, 1988). The average daily charge in the base period shall be calculated by reference to all TRICARE claims paid (processed) during the base period. The base period amount, however, may not exceed the cap.

**3.3.2** Cap Amount. The cap amount is established at the 70th percentile.

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
832	October 1, 2005 through September 30, 2006
860	October 1, 2006 through September 30, 2007
889	October 1, 2007 through September 30, 2008
917	October 1, 2008 through September 30, 2009
936	October 1, 2009 through September 30, 2010
960	October 1, 2010 through September 30, 2011
989	October 1, 2011 through September 30, 2012
1,015	October 1, 2012 through September 30, 2013
1,040	October 1, 2013 through September 30, 2014
1,070	October 1, 2014 through September 30, 2015

**3.3.3** Request for Recalculation of Per Diem Amount. Any psychiatric hospital or unit which has determined DHA calculated a hospital-specific per diem which differs by more than five (\$5) dollars from that calculated by the hospital or unit, may apply to the appropriate contractor for a recalculation unless the calculated rate has exceeded the cap amount described in the previous paragraph. The recalculation does not constitute an appeal, as the per diem rates are not appealable. Unless the provider can prove that the contractor calculation is incorrect, the contractor's calculation is final. The burden of proof shall be on the hospital or unit.

### **3.4 Regional Per Diems for Lower Volume Psychiatric Hospitals and Units**

**3.4.1** Regional Per Diem. Hospitals and units with a lower volume of TRICARE patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and IDME. Base period regional per diems shall be calculated based upon all TRICARE/ lower volume hospitals' and units' claims paid (processed) during the base period. Each regional per diem amount shall be the quotient of all covered charges (without consideration of other health insurance payments) divided by all covered days of care, reported on all TRICARE claims from lower volume hospitals and units in the region paid (processed) during the base period, after having been standardized for IDME costs, and area wage indexes. Direct medical education costs shall be subtracted from the calculation. The regions shall be the same as the federal census regions. See [Addendum A](#), for the regional per diems used for hospitals and units with a lower volume of TRICARE patients.

**3.4.2** Adjustments to Regional Per Diem Rates. Two adjustments shall be made to the regional per diem rates when applicable.

**3.4.2.1** Wage Portion or Labor-Related Share. The wage portion or labor-related share is adjusted by the DRG-based area wage adjustment. See [Addendum A](#), for area wage adjustment rates. The calculated adjusted regional per diem is not to be rounded up to the next whole dollar.

**3.4.2.2** IDME Adjustment. The IDME adjustment factors shall be calculated for teaching hospitals in the same manner as in the DRG-based payment system and applied to the applicable regional per diem rate for each day of the admission. For an exempt psychiatric unit in a teaching hospital, there should be a separate IDME adjustment factor for the unit (separate from the rest of the hospital) when medical education applies to the unit.

**3.4.3** Reimbursement of Direct Medical Education Costs. In addition to payments made to lower volume hospitals and units, the government shall annually reimburse hospitals for actual direct medical education costs associated with TRICARE beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the DRG-based payment system.

**Note:** No additional payment is to be made for capital costs. Such costs have been covered in the regional per diem rates which are based on charges.

### **3.5 Base Period and Update Factors**

**3.5.1** Hospital-Specific Per Diem Calculated Using Date of Payment. The base period for calculating the hospital-specific and regional per diems, as described above is federal FY 1988. The base period calculations shall be based on actual claims paid (processed) during the period July 1, 1987 through May 31, 1988, trended forward to September 30, 1988, using a factor of 1.1%.

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### Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

**3.5.2** Hospital-Specific Per Diem Calculated Using Date of Discharge. Upon application by a higher volume hospital or unit to the appropriate contractor, the hospital or unit may have its hospital-specific base period calculations based on TRICARE claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988, if it has generally experienced unusual delays in TRICARE claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least \$5.00 with the revised per diem not exceeding the cap amount. For this purpose, the unusual delays mean that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations (204 days) longer than the national average (94 days). The burden of proof shall be on the hospital.

**3.5.3** Updating Hospital-Specific and Regional Per Diems. Per diems shall be updated by the Medicare update factor. Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each federal fiscal year by the contractors. New hospitals shall be notified by the contractor at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the **Federal Register** prior to the start of that fiscal year. Initiating FY 2007, Medicare has determined a market basket and subsequent update factor specific to psychiatric facilities.

FISCAL YEAR	UPDATE FACTOR
2006	3.8%
2007	3.4%
2008	3.4%
2009	3.2%
2010	2.1%
2011	2.6%
2012	3.0%
2013	2.6%
2014	2.5%
2015	2.9%

### 3.6 Higher Volume Hospitals and Units

#### 3.6.1 Higher Volume of TRICARE Mental Health Discharges and Hospital-Specific Per Diem Calculation

**3.6.1.1** In any federal fiscal year in which a hospital or unit not previously classified as a higher volume hospital or unit has 25 or more TRICARE mental health discharges, that hospital or unit shall be considered to be a higher volume hospital or unit during the next federal fiscal year and all subsequent fiscal years. All other hospitals and units covered by the TRICARE inpatient mental health per diem payment system shall be considered lower volume hospitals and units.

**3.6.1.2** The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE

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### Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

mental health discharges and the base period. The base period amount, however, cannot exceed the cap described in this section. Once a statistically valid rate is established based on a year in which the hospital or unit had at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem.

**3.6.1.2.1** The TRICARE contractor shall be requested at least annually to submit to the DHA Office of Medical Benefits and Reimbursement Branch (MB&RB) a listing of high volume providers.

**3.6.1.2.2** Percent of change and Deflator Factor (DF).

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 2012	235.16%	3.3516
September 30, 2013	243.52%	3.4352
September 30, 2014	258.27%	3.5827

### 3.6.2 New Hospitals and Units

**3.6.2.1** The inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under Tax Equity and Fiscal Responsibility Act (TEFRA) rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are DRG-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE mental health discharges. This provision also applies to the preceding fiscal year (if it had any TRICARE patients during the preceding fiscal year). A retrospective payment shall be required if payments were originally made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the claims processing standards.

**3.6.2.2** By definition, a new hospital is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the Medicare and or TRICARE programs under the present and previous ownership for less than three full years. A change in ownership in itself does not constitute a new hospital.

**3.6.2.3** Such new hospitals must agree not to bill beneficiaries for any additional cost-share beyond that determined initially based on the regional rate.

### 3.6.3 Request for a Review of Higher or Lower Volume Classification

Any hospital or unit which DHA improperly fails to classify as a higher or lower volume hospital or unit may apply to the appropriate contractor for such a classification. The hospital or unit shall have the burden of proof.

### **3.7 Payment for Hospital Based Professional Services**

**3.7.1** Lower Volume Hospitals and Units. Lower volume hospitals and units may not bill separately for hospital based professional services; payment for those services is included in the per diems.

**3.7.2** Higher Volume Hospitals and Units. Higher volume hospitals and units, whether they billed separately for hospital based professional services or included those services in the hospital's or unit's charges, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to the appropriate contractor notice of its request to change its billing procedures for hospital-based professional services.

### **3.8 Leave Days**

**3.8.1** No Payment. The government shall not pay (including holding charges) for days where the patient is absent on leave (including therapeutic absences) from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement.

**3.8.2** Does Not Constitute a Discharge/Do Not Count Toward Day Limit. The government shall not count a patient's departure for a leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital.

### **3.9 Exemptions from the TRICARE Inpatient Mental Health Per Diem Payment System**

**3.9.1** Providers Subject to the DRG-Based Payment System. Providers of inpatient care which are neither psychiatric hospitals nor psychiatric units as described earlier, or which otherwise qualify under that discussion, are exempt from the inpatient mental health per diem payment system.

**3.9.2** Services Which Group into Mental Health DRG. Admissions to psychiatric hospitals and units for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424 prior to October 1, 2008, or services which group into DRG 876 on or after October 1, 2008) are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

**3.9.3** Non-Mental Health Procedures. Admissions for non-mental health procedures that group into non-mental health DRG, in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

**3.9.4** Sole Community Hospital (SCH). Admission prior to January 1, 2014, (the effective date of the SCH reimbursement methodology described in [Chapter 14, Section 1](#)), any hospital which has qualified for special treatment under the Medicare Prospective Payment System (PPS) as a SCH and has not given up that classification is exempt. For additional information on SCHs, refer to [Chapter 14, Section 1](#).

**3.9.5** Hospital Outside the 50 States, the District of Columbia, or Puerto Rico. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia, or Puerto Rico.

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**3.9.6** Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the DRG-based payment system or the inpatient mental health per diem payment system shall be determined on the basis of billed charges or set rates.

- END -



Chapter 7

Addendum B

Table Of Maximum Rates For Freestanding Psychiatric Partial Hospitalization Programs (PHPs) Reimbursement - FY 2013 - FY 2015

UNITED STATES CENSUS REGIONS	FULL-DAY RATE (6 HOURS OR MORE)			HALF-DAY RATE (3-5 HOURS)		
	10/01/12-09/30/13	10/01/13-09/30/14	10/01/14-09/30/15	10/01/12-09/30/13	10/01/13-09/30/14	10/01/14-09/30/15
<b>NORTHEAST:</b>						
New England (ME, NH, VT, MA, RI, CT)	\$323	\$331	\$341	\$242	\$248	\$256
Mid-Atlantic (NY, NJ, PA)	\$352	\$361	\$371	\$264	\$271	\$278
<b>MIDWEST:</b>						
East North Central (OH, IN, IL, MI, WI)	\$310	\$318	\$327	\$233	\$239	\$245
West North Central (MN, IA, MO, ND, SD, NE, KS)	\$310	\$318	\$327	\$233	\$239	\$245
<b>SOUTH:</b>						
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	\$331	\$339	\$349	\$248	\$254	\$262
East South Central (KY, TN, AL, MS)	\$359	\$368	\$379	\$269	\$276	\$284
West South Central (AR, LA, TX, OK)	\$359	\$368	\$379	\$269	\$276	\$284
<b>WEST:</b>						
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	\$362	\$371	\$382	\$272	\$278	\$287
Pacific (WA, OR, CA, AK, HI)	\$356	\$365	\$376	\$267	\$274	\$282
Puerto Rico	\$231	\$237	\$244	\$173	\$178	\$183
<b>Days of three hours or less: no payment authorized.</b>						

**Note:** This table reflects maximum rates.

- END -



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FACILITY	TRICARE RATE
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	485.00
<b>NEVADA</b>	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	843.00
<b>NEW MEXICO</b>	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	356.00
<div style="display: inline-block; width: 10px; height: 10px; background-color: black; margin-right: 5px;"></div> Youth and Family Centered Services of New Mexico, Inc dba Desert Hills 5310 Sequoia NW Albuquerque, NM 87120 EIN: 74-2753620	777.00
<b>NORTH CAROLINA</b>	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 56-1317433	517.00
<b>OHIO</b>	
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 EIN: 62-1658523	445.00
<b>PENNSYLVANIA</b>	
KidsPeace National Centers 5300 KidsPeace Drive Orefield, PA 18069 EIN: 23-2654908	591.00
<b>SOUTH CAROLINA</b>	
ABS LINCSC, Inc dba Palmetto Pines Behavioral Health 225 Midland Parkway Summerville, SC 29485 EIN: 57-0840074	668.00

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FACILITY	TRICARE RATE
Chestnut Hill Mental Health Center, Inc dba SpringBrook Behavioral Health System 1 Havenwood Lane Travelers Rest, SC 29690 EIN: 57-0693272	520.00
New Hope Carolinas, Inc 101 Sedgewood Drive Rock Hill, SC 29732 EIN: 57-1099555	444.00
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	484.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	808.00
<b>TENNESSEE</b>	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	502.00
Village Behavioral Health dba The Village 2431 Jones Bend Road Louisville, TN 37777 EIN: 27-0788813	421.00
<b>TEXAS</b>	
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	775.00
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	843.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	704.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	791.00
<b>UTAH</b>	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	500.00
UHS of Provo Canyon, Inc / Provo Canyon School 1350 East 750 North Orem, UT 84097 EIN: 23-3044423	500.00
UHS of Timpanogos Center of Change 1790 N. State Street Orem, UT 84057 EIN: 20-3687800	627.00
<b>VIRGINIA</b>	
Cumberland Hospital for Children and Adolescents dba Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 EIN 02-0567575	827.00
Hallmark Youthcare - Richmond 12800 West Creek Parkway Richmond, VA 23238 EIN: 58-2156548	838.00
Harbor Point Behavioral Health Center 301 Fort Lane Portsmouth, VA 23704 EIN: 54-1465094	704.00
The James Barry Robinson Institute dba The Barry Robinson Center 443 Kempsville Road Norfolk, VA 23502 EIN: 54-1038721	815.00
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	496.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
North Spring Behavioral Healthcare 42009 Victory Lane Leesburg, VA 20176 EIN: 20-1215130	531.00
The Pines Residential Treatment Center - Kempsville 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	704.00
Poplar Springs West HHC Poplar Springs, Inc 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	812.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	551.00
<b>WASHINGTON</b>	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	700.00

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Chapter 7

Addendum D (FY 2015)

**TRICARE-Authorized Residential Treatment Centers (RTCs) -  
FY 2015**

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The rates in this Addendum will be used for payment of claims for services rendered on or after October 1, 2014. The rates were adjusted by the lesser of the FY 2015 Medicare update factor (2.9%) or the amount that brought the rate up to the new cap amount of \$868.

This listing is for RTC per diem rates only. It does not reflect a facility's current status as a TRICARE-authorized RTC. Information regarding a facility's current status as an authorized provider can be obtained from the appropriate contractor.

FACILITY	TRICARE RATE
<b>ALASKA</b>	
DeBarr Residential Treatment Center Frontline Hospital, LLC 1500 DeBarr Circle Anchorage, AK 99508 EIN: 72-1539254	868.00
<b>ARIZONA</b>	
Southwest Children's Health Services dba Parc Place 2190 North Grace Blvd Chandler, AZ 85225 EIN: 86-0768611	467.00
<b>ARKANSAS</b>	
BHC Pinnacle Pointe Hospital 11501 Financial Center Parkway Little Rock, AR 72211 EIN: 62-1658502	863.00
Habilitation Center, Inc. dba Millcreek of Arkansas 1810 Industrial Drive Fordyce, AR 71742 EIN: 74-2474097	546.00
<b>COLORADO</b>	
CBR Youth Connect 28071 Hwy 109 La Junta, CO 81050 EIN: 84-0500375	799.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
PSI Cedar Springs Hospital, Inc. Cedar Springs Behavioral Health Systems, Inc 2135 Southgate Road Colorado Springs, CO 80906 EIN: 74-3081810	868.00
<b>FLORIDA</b>	
LaAmistad Behavioral Health Services 1650 Park Avenue North Maitland, FL 32751 EIN: 58-1791069	824.00
Manatee Palms Youth Service 4480 51st Street West Bradenton, FL 34210 EIN: 65-0816927	773.00
The National Deaf Academy, LLC RTC 19650 Hwy 441 Mt. Dora, FL 32757 EIN 59-3653865	868.00
University Behavioral, LLC dba University Behavioral Center 2500 Discovery Drive Orlando, FL 32826 EIN: 20-5202458	741.00
<b>GEORGIA</b>	
Coastal Harbor Treatment Center UHS of Savannah, LLC 1150 Cornell Avenue Savannah, GA 31406 EIN: 20-0931196	480.00
Ramsey Youth Services of Georgia, Inc dba Macon Behavioral Health System 3500 Riverside Drive Macon, GA 31210 EIN: 35-2174803	565.00
UHS of Laurel Heights, LP Laurel Heights Hospital 934 Briarcliff Road NE Atlanta, GA 30306 EIN: 23-3045288	828.00
Youth Villages, Inc 4685 Dorsett Shoals Road Douglasville, GA 30135 EIN: 58-1716970	868.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
<b>HAWAII</b>	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	868.00
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	838.00
<b>IDAHO</b>	
Eastern Idaho Regional Medical Center - Behavioral Health Center 2280 E 25th Street Idaho Falls, ID 83404 EIN: 82-0436622	395.00
<b>ILLINOIS</b>	
Timberline Knolls TK Behavioral, LLC 40 Timberline Drive Lemont, IL 60439 EIN: 32-0383042	868.00
<b>INDIANA</b>	
Michiana Behavioral Health Center HHC Indiana, Inc 1800 North Oak Road Plymouth, IN 46563 EIN: 20-0768028	490.00
Valle Vista Hospital, LLC Valle Vista Health System 898 East Main Street Greenwood, IN 46143 EIN: 62-1740366	519.00
<b>KANSAS</b>	
KVC Hospitals, Inc Prairie Ridge Psychiatric Hospital 4300 Brenner Drive Kansas City, KS 66104 EIN: 27-1672159	520.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
<b>KENTUCKY</b>	
Spring Meadows Center dba Spring Meadows 330 Hope Street Mount Washington, KY 40047 EIN: 61-0597273	624.00
Ten Broeck Hospital -- Dupont TBD Acquisition, LLC Louisville, KY 40207 EIN: 20-5048087	734.00
Ten Broeck Hospital -- Louisville KMI Acquisition, LLC 8521 LaGrange Road Louisville, KY 40242 EIN: 20-5048153	780.00
United Healthcare of Hardin, Inc dba Lincoln Trail Behavioral Health System 3909 South Wilson Road Radcliff, KY 40160 EIN: 62-1244469	656.00
<b>MARYLAND</b>	
Adventist Healthcare Inc dba Adventist Behavior Health 14901 Broschart Road Rockville, MD 20850 EIN: 52-1532556	451.00
<b>MISSISSIPPI</b>	
Millcreek of Pontotoc Psychiatric RTC 1814 Hwy 15 North Pontotoc, MS 38863 EIN: 64-0568382	428.00
<b>MISSOURI</b>	
Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 EIN: 44-0545808	374.00
Heartland Behavioral Health Services, Inc Great Plains Hospital, Inc 1500 W. Asland Nevada, MO 64772 EIN: 43-1328523	457.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
Lakeland Regional Hospital Lakeland Hospital Acquisition Corporation 440 South Market Avenue Springfield, MO 65806 EIN: 58-2291915	469.00
<b>MONTANA</b>	
Acadia Montana 55 Basin Creek Road Butte, MT 59701 EIN: 62-1681724	586.00
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	500.00
<b>NEVADA</b>	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	868.00
<b>NEW MEXICO</b>	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	367.00
Youth and Family Centered Services of New Mexico, Inc dba Desert Hills 5310 Sequoia NW Albuquerque, NM 87120 EIN: 74-2753620	800.00
<b>NORTH CAROLINA</b>	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 56-1317433	532.00
<b>OHIO</b>	
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 EIN: 62-1658523	458.00

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FACILITY	TRICARE RATE
<b>PENNSYLVANIA</b>	
KidsPeace National Centers 5300 KidsPeace Drive Orefield, PA 18069 EIN: 23-2654908	609.00
<b>SOUTH CAROLINA</b>	
ABS LINC SC, Inc dba Palmetto Pines Behavioral Health 225 Midland Parkway Summerville, SC 29485 EIN: 57-0840074	688.00
Chestnut Hill Mental Health Center, Inc. dba SpringBrook Behavioral Health System 1 Havenwood Lane Travelers Rest, SC 29690 EIN: 57-0693272	536.00
New Hope Carolinas, Inc 101 Sedgewood Drive Rock Hill, SC 29732 EIN: 57-1099555	457.00
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	499.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	832.00
<b>TENNESSEE</b>	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	517.00
Village Behavioral Health dba The Village 2431 Jones Bend Road Louisville, TN 37777 EIN: 27-0788813	434.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
<b>TEXAS</b>	
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	798.00
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	868.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	725.00
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	814.00
<b>UTAH</b>	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	515.00
UHS of Provo Canyon, Inc / Provo Canyon School 1350 East 750 North Orem, UT 84097 EIN: 23-3044423	515.00
UHS of Timpanogos Center of Change 1790 N. State Street Orem, UT 84057 EIN: 20-3687800	646.00
<b>VIRGINIA</b>	
Cumberland Hospital for Children and Adolescents dba Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 EIN 02-0567575	851.00
Hallmark Youthcare - Richmond 12800 West Creek Parkway Richmond, VA 23238 EIN: 58-2156548	863.00

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<b>FACILITY</b>	<b>TRICARE RATE</b>
Harbor Point Behavioral Health Center 301 Fort Lane Portsmouth, VA 23704 EIN: 54-1465094	725.00
The James Barry Robinson Institute dba The Barry Robinson Center 443 Kempsville Road Norfolk, VA 23502 EIN: 54-1038721	839.00
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	511.00
North Spring Behavioral Healthcare 42009 Victory Lane Leesburg, VA 20176 EIN: 20-1215130	547.00
The Pines Residential Treatment Center - Kempsville 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	725.00
Poplar Springs West HHC Poplar Springs, Inc 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	836.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	567.00
<b>WASHINGTON</b>	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	721.00

- END -

## Chapter 10

### Birthing Centers

Section/Addendum	Subject/Addendum Title
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1	Freestanding And Hospital-Based Birthing Center Reimbursement
A	Birthing Center Rate Non-Professional Component
	Figure 10.A-1 2013 Rate Year
	Figure 10.A-2 2014 Rate Year
	Figure 10.A-3 2015 Rate Year



## Birthing Center Rate Non-Professional Component

**FIGURE 10.A-1 2013 RATE YEAR**

These state specific non-professional component amounts are to be used in creating the maximum allowable all-inclusive TRICARE-authorized birthing center prices during the 2013 rate year (i.e., April 1, 2013 - March 31, 2014). The all-inclusive prices are to be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update. (See [Section 1](#), for instruction for the use of these amounts.)

2013 RATE YEAR			
TRICARE-AUTHORIZED BIRTHING CENTER PROVIDER			
NON-PROFESSIONAL COMPONENT FOR ALL-INCLUSIVE PRICING FORMULA			
Alabama	\$3,750.53	Montana	\$2,570.16
Alaska	\$5,047.14	Nebraska	\$1,849.71
Arizona	\$2,769.84	Nevada	\$5,759.87
Arkansas	\$6,131.49	New Hampshire	\$3,462.94
California	\$5,011.25	New Jersey	\$5,642.83
Colorado	\$4,237.23	New Mexico	\$2,739.12
Connecticut	\$5,631.04	New York	\$1,939.82
Delaware	\$4,065.23	North Carolina	\$3,856.23
District of Columbia	\$5,661.24	North Dakota	\$2,260.90
Florida	\$4,621.59	Ohio	\$4,576.99
Georgia	\$3,578.92	Oklahoma	\$4,298.70
Hawaii	\$2,794.97	Oregon	\$2,777.44
Idaho	\$3,227.67	Pennsylvania	\$4,347.28
Illinois	\$3,650.89	Puerto Rico	\$923.34
Indiana	\$3,788.51	Rhode Island	\$4,617.08
Iowa	\$3,136.80	South Carolina	\$4,185.61
Kansas	\$4,419.96	South Dakota	\$2,150.38
Kentucky	\$2,510.71	Tennessee	\$3,147.23
Louisiana	\$3,129.91	Texas	\$3,723.08
Maine	\$3,085.36	Utah	\$2,000.52
Maryland	\$3,031.72	Vermont	\$3,074.79
Massachusetts	\$3,789.41	Virginia	\$3,055.29
Michigan	\$3,335.42	Washington	\$3,662.91
Minnesota	\$3,510.95	West Virginia	\$2,232.88
Mississippi	\$4,119.31	Wisconsin	\$2,673.76
Missouri	\$3,438.78	Wyoming	\$4,110.73

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## Chapter 10, Addendum A

## Birthing Center Rate Non-Professional Component

**FIGURE 10.A-2 2014 RATE YEAR**

These state specific non-professional component amounts are to be used in creating the maximum allowable all-inclusive TRICARE-authorized birthing center prices during the 2014 rate year (i.e., April 1, 2014 - March 31, 2015). The all-inclusive prices are to be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update. (See [Section 1](#), for instruction for the use of these amounts.)

<b>2014 RATE YEAR</b>			
<b>TRICARE-AUTHORIZED BIRTHING CENTER PROVIDER</b>			
<b>NON-PROFESSIONAL COMPONENT FOR ALL-INCLUSIVE PRICING FORMULA</b>			
Alabama	\$3,943.57	Montana	\$2,825.76
Alaska	\$4,738.77	Nebraska	\$2,753.94
Arizona	\$3,052.20	Nevada	\$6,480.08
Arkansas	\$6,631.38	New Hampshire	\$3,699.49
California	\$5,182.11	New Jersey	\$5,132.04
Colorado	\$4,135.18	New Mexico	\$3,132.48
Connecticut	\$5,822.35	New York	\$2,091.82
Delaware	\$4,271.51	North Carolina	\$3,765.73
District of Columbia	\$5,975.75	North Dakota	\$2,158.93
Florida	\$4,839.45	Ohio	\$4,783.74
Georgia	\$3,605.80	Oklahoma	\$4,410.60
Hawaii	\$3,327.54	Oregon	\$2,561.25
Idaho	\$3,614.03	Pennsylvania	\$4,654.12
Illinois	\$3,897.92	Puerto Rico	\$823.70
Indiana	\$4,351.17	Rhode Island	\$4,234.96
Iowa	\$3,465.01	South Carolina	\$4,523.20
Kansas	\$5,083.33	South Dakota	\$2,303.51
Kentucky	\$3,023.32	Tennessee	\$3,223.01
Louisiana	\$3,205.11	Texas	\$4,250.31
Maine	\$3,619.29	Utah	\$2,105.72
Maryland	\$2,904.13	Vermont	\$3,547.13
Massachusetts	\$4,235.09	Virginia	\$3,188.26
Michigan	\$3,450.38	Washington	\$3,500.41
Minnesota	\$4,009.48	West Virginia	\$2,742.66
Mississippi	\$4,617.02	Wisconsin	\$2,736.70
Missouri	\$3,821.02	Wyoming	\$4,159.73

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Birthing Center Rate Non-Professional Component

**FIGURE 10.A-3 2015 RATE YEAR**

These state specific non-professional component amounts are to be used in creating the maximum allowable all-inclusive TRICARE-authorized birthing center prices during the 2015 rate year (i.e., April 1, 2015 - March 31, 2016). The all-inclusive prices are to be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update. (See [Section 1](#), for instruction for the use of these amounts.)

<b>2015 RATE YEAR</b>			
<b>TRICARE-AUTHORIZED BIRTHING CENTER PROVIDER</b>			
<b>NON-PROFESSIONAL COMPONENT FOR ALL-INCLUSIVE PRICING FORMULA</b>			
Alabama	\$4,174.51	Montana	\$2,808.87
Alaska	\$5,763.04	Nebraska	\$3,698.43
Arizona	\$3,134.13	Nevada	\$6,947.53
Arkansas	\$6,787.90	New Hampshire	\$4,142.02
California	\$5,265.59	New Jersey	\$5,746.23
Colorado	\$4,313.85	New Mexico	\$3,794.83
Connecticut	\$5,978.47	New York	\$2,295.37
Delaware	\$4,504.27	North Carolina	\$4,016.23
District of Columbia	\$7,138.74	North Dakota	\$2,325.70
Florida	\$5,117.97	Ohio	\$4,946.59
Georgia	\$4,661.69	Oklahoma	\$4,502.55
Hawaii	\$3,598.03	Oregon	\$2,594.82
Idaho	\$3,697.99	Pennsylvania	\$4,339.23
Illinois	\$4,090.83	Puerto Rico	\$941.01
Indiana	\$4,496.27	Rhode Island	\$3,966.18
Iowa	\$3,598.49	South Carolina	\$4,453.79
Kansas	\$5,231.14	South Dakota	\$2,309.43
Kentucky	\$2,892.84	Tennessee	\$3,302.13
Louisiana	\$3,286.34	Texas	\$4,150.62
Maine	\$3,958.73	Utah	\$2,178.34
Maryland	\$2,976.79	Vermont	\$3,724.89
Massachusetts	\$4,381.90	Virginia	\$3,243.43
Michigan	\$3,569.90	Washington	\$3,524.92
Minnesota	\$3,875.64	West Virginia	\$2,836.54
Mississippi	\$4,916.55	Wisconsin	\$3,039.69
Missouri	\$3,843.29	Wyoming	\$4,398.81

- END -



## Chapter 13

## Section 1

### General

Issue Date: July 27, 2005

Authority: 10 USC 1079(j)(2) and 10 USC 1079(h)

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#### 1.0 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 **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

#### 2.0 ISSUE

A general overview of the coverage and reimbursement of hospital outpatient services.

#### 3.0 POLICY

##### 3.1 Statutory Background

**3.1.1** Under 10 United States Code (USC) 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE shall, by regulation, be established "to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare." Similarly, under 10 USC 1079(h), the amount to be paid to health care professionals and other non-institutional health care providers "shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules used by Medicare." Based on these statutory provisions, TRICARE will adopt Medicare's prospective payment system for reimbursement of hospital outpatient services currently in effect for the Medicare program as required under the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), which provided comprehensive provisions for establishment of a hospital Outpatient Prospective Payment System (OPPS). The Act required development of a classification system for covered outpatient services that consisted of groups arranged so that the services within each group were comparable clinically and with respect to the use of resources. The Act described the method for determining the Medicare payment amount and the beneficiary coinsurance amount for services covered under the OPPS. This included the formula for calculating the conversion factor and data requirements for establishing relative payment weights.

**3.1.2** Centers for Medicare and Medicaid Services (CMS) published a proposed rule in the **Federal Register** (FR) on September 8, 1998 (63 FR 47552) setting forth the proposed PPS for hospital outpatient services. On June 30, 1999, a correction notice was published (64 FR 35258) to

correct a number of technical and typographical errors contained in the September 8, 1998 Proposed Rule.

**3.1.3** Subsequent to publication of the proposed rule, the Balanced Budget Refinement Act (BBRA) of 1999, enacted on November 29, 1999, made major changes that affected the proposed OPSS. The following BBRA 1999 provisions were implemented in a Final Rule (65 FR 18434) published on April 7, 2000:

**3.1.3.1** Made adjustments for covered services whose costs exceeded a given threshold (i.e., an outlier payment).

**3.1.3.2** Established transitional pass-through payments for certain medical devices, drugs, and biologicals.

**3.1.3.3** Placed limitations on judicial review for determining outlier payments and the determination of additional payments for certain medical devices, drugs, and biologicals.

**3.1.3.4** Included as covered outpatient services implantable prosthetics and Durable Medical Equipment (DME) and diagnostic x-ray, laboratory, and other tests associated with those implantable items.

**3.1.3.5** Limited the variation of costs of services within each payment classification group by providing that the highest median cost for an item or service within the group cannot be more than two times greater than the lowest median cost for an item or service within the group (referred to as the "two times rule"). An exception to this requirement may be made in unusual cases, such as low volume items and services, but may not be made in the case of a drug or biological that has been designated as an orphan drug under Section 526 of the Federal Food, Drug and Cosmetic Act.

**3.1.3.6** Required at least annual review of the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, the addition of new services, new cost data, and other relevant information or factors.

**3.1.3.7** Established transitional corridors that would limit payment reductions under the hospital OPSS.

**3.1.3.8** Established hold harmless provisions for rural and cancer hospitals.

## **3.2 Participation Requirement**

In order to be an authorized provider under the TRICARE OPSS, an institutional provider must be a participating provider for all claims in accordance with [32 CFR 199.6\(a\)\(8\)](#).

## **3.3 Unbundling Provisions**

As a prelude to implementation of the OPSS, Omnibus Budget Reconciliation Act (OBRA) of 1996 prohibited payment for nonphysician services furnished to hospital patients (inpatients and outpatients), unless the services were furnished either directly or under arrangement with the hospital except for services of Physician Assistants (PAs), Nurse Practitioners (NPs), and Clinical Nurse Specialists (CNSs). This facilitated the payment of services included within the scope of each

Ambulatory Payment Classification (APC). The Act provided for the imposition of civil money penalties not to exceed \$2,000, and a possible exclusion from participation in Medicare, Medicaid and other federal health care programs for any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service that violates the requirement for billing subject to the following exceptions:

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

**3.3.2** SNF Consolidated Billing (CB) requirements do not apply to the following exceptionally intensive hospital outpatient services:

- Cardiac catheterization;
- Computerized Axial Tomography (CAT) scans;
- Magnetic Resonance Imagings (MRIs);
- Ambulatory surgery involving the use of an Operating Room (OR);
- Emergency Room (ER) services;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

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

### **3.4 Applicability and Scope of Coverage**

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

#### **3.4.1 Provider Categories**

##### **3.4.1.1 Providers Included In OPPTS**

**3.4.1.1.1** All hospitals participating in the Medicare program, except for those excluded under [paragraph 3.4.1.2](#).

**3.4.1.1.2** Hospital-based Partial Hospitalization Programs (PHPs) **before November 30, 2009**, that are subject to the more restrictive TRICARE authorization requirements under [32 CFR 199.6\(b\)\(4\)\(xii\)](#). Following are the specific requirements for authorization and payment under the Program:

**3.4.1.1.2.1** Be certified pursuant to TRICARE certification standards.

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

**3.4.1.1.2.3** Currently accredited by the Joint Commission under the current edition of the **Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Development Disabilities Services**.

**3.4.1.1.2.4** Has a written participation agreement with TRICARE.

**3.4.1.1.3** Hospital-based PHPs on or after November 30, 2009, shall no longer require separate TRICARE certification. Authorization of a hospital by TRICARE is sufficient for its PHP to be an authorized TRICARE provider.

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

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

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

TRICARE delayed implementation of its OPSS for small rural hospitals with 100 or fewer beds and rural SCHs with 100 or fewer beds until January 1, 2010.

#### **3.4.1.2 Providers Excluded From OPSS**

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

**3.4.1.2.2** Certain hospitals in Maryland that qualify for payment under the state's cost containment waiver.

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

**3.4.1.2.4** Hospitals located outside one of the 50 states, the District of Columbia, and Puerto Rico.

**3.4.1.2.5** Specialty care providers to include:

- Cancer and children's hospitals
- Freestanding Ambulatory Surgery Centers (ASCs)
- Freestanding PHPs that offer psych and substance use treatments, and Substance Use Disorder Rehabilitation Facilities (SUDRFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)

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- Home Health Agencies (HHAs)
- Hospice programs
- Community Mental Health Centers (CMHCs)

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

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

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

- Freestanding Birthing Centers
- Department of Veterans Affairs (DVA) Hospitals
- Freestanding End Stage Renal Disease (ESRD) Facilities
- SNFs
- Residential Treatment Centers (RTCs)

### 3.4.2 Scope of Services

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

**3.4.2.1.1** Physician services.

**3.4.2.1.2** NP and CNS services.

**3.4.2.1.3** Physician Assistant (PA) services.

**3.4.2.1.4** Certified Nurse-Midwife (CNM) services.

**3.4.2.1.5** Services of qualified psychologists.

**3.4.2.1.6** Clinical Social Worker (CSW) services.

**3.4.2.1.7** Services of an anesthetist.

**3.4.2.1.8** Screening and diagnostic mammographies.

**3.4.2.1.9** Influenza and pneumococcal pneumonia vaccines.

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

**3.4.2.1.10** Clinical diagnostic laboratory services.

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**3.4.2.1.11** Take home surgical dressings.

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

- An item such as crutches or a walker that is given to the patient to take home, but that may also be used while the patient is at the hospital, would be paid for under the hospital OPPS.
- Payment may not be made for items furnished by a supplier of medical equipment and supplies unless the supplier obtains a supplier number. However, since there is no reason to split a claim for DME payment under TRICARE, a separate supplier number will not be required for a hospital to receive reimbursement for DME.

**3.4.2.1.13** 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.

**3.4.2.1.14** Services and procedures designated as requiring inpatient care.

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

- Ambulance services
- Physical therapy
- Occupational therapy
- Speech-language pathology

**Note:** The above services are subject to the CMAC or other TRICARE recognized reimbursement methodology (e.g., statewide prevalings).

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

**3.4.2.2** Costs excluded under the hospital OPPS:

**3.4.2.2.1** Direct cost of medical education activities.

**3.4.2.2.2** Costs of approved nursing and allied health education programs.

**3.4.2.2.3** Costs associated with interns and residents not in approved teaching programs.

**3.4.2.2.4** Costs of teaching physicians.

**3.4.2.2.5** Costs of anesthesia services furnished to hospital outpatients by qualified non-physician anesthetists (Certified Registered Nurse Anesthetists (CRNAs) and Anesthesiologists’ Assistants (AAs)) employed by the hospital or obtained under arrangements, for hospitals.

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**3.4.2.2.6** Bad debts for uncollectible and coinsurance amounts.

**3.4.2.2.7** Organ acquisition costs.

**3.4.2.2.8** Corneal tissue acquisition costs incurred by hospitals that are paid on a reasonable cost basis.

**3.4.2.3** Services included in payment under the OPSS (not an all-inclusive list).

**3.4.2.3.1** Hospital-based full- and half-day PHPs (psych and SUDRFs) which are paid a per diem OPSS. 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.

**3.4.2.3.2** All hospital outpatient services, except those that are identified as excluded. The following are services that are included in OPSS:

**3.4.2.3.2.1** Surgical procedures.

**Note:** Hospital-based ASC procedures will be included in the OPSS/APC system even though they are currently paid under the ASC grouper system. The new OPSS/APC system covers procedures on the ASC list when they are performed in a HOPD, 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 OPSS 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.

**3.4.2.3.2.2** Radiology, including radiation therapy.

**3.4.2.3.2.3** Clinic visits.

**3.4.2.3.2.4** Emergency Department (ED) visits.

**3.4.2.3.2.5** Diagnostic services and other diagnostic tests.

**3.4.2.3.2.6** Surgical pathology.

**3.4.2.3.2.7** Cancer chemotherapy.

**3.4.2.3.2.8** Implantable medical items.

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

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

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

**3.4.2.3.2.9** 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:

- Cardiac catheterization;
- CAT scans;
- MRIs;
- Ambulatory surgery involving the use of an OR;
- ER services;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

**3.4.2.3.2.10** Certain preventive services furnished to healthy persons, such as colorectal cancer screening.

**3.4.2.3.2.11** Acute dialysis (e.g., dialysis for poisoning).

**3.4.2.3.2.12** ESRD Services. Since TRICARE does not have an ESRD composite rate, ESRD services are included in TRICARE's OPSS.

### **3.5 Description of APC Groups**

**3.5.1** 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.

**3.5.2** Grouping of Procedures/Services Under APC System.

**3.5.2.1** 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.

**3.5.2.2** Fundamental criteria for grouping procedures/services under the APC system:

- Resource Homogeneity. The amount and type of facility resources (e.g., OR 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.

- **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.
- **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.
- **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.

### **3.6 Basic Reimbursement Methodology**

**3.6.1** 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.

**3.6.2** 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:

- New temporary technology APCs for certain approved services that are structured based on cost rather than clinical homogeneity.
- Separate APCs for certain medical devices, drugs, biologicals, radiopharmaceuticals and devices of brachytherapy under transitional pass-through provisions.

**3.6.3** 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.

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

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

**3.6.6** 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.

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

**Note:** The ASC cost-sharing provision (i.e., assessment of a single copayment for both the professional and facility charge for a Prime beneficiary) will be adopted as long as it is administratively feasible. This will not apply to Extra and Standard beneficiaries since their cost-sharing is based on a percentage of the total bill. The copayment is based on site of service, except for Current Procedural Terminology (CPT)<sup>1</sup>/HCPCS 36400-36416, 36591, 36592, 59020, 59025, and 59050, for venipuncture and fetal monitoring. Reference [Chapter 2, Section 1, paragraphs 1.2.4.5 and 1.2.4.7](#).

### **3.7 Reimbursement Hierarchy For Procedures Paid Outside The OPSS.**

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

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

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

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

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

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

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

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

### **3.8 Outpatient Code Editor (OCE)**

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

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

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

**3.8.4** 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.

### **3.9 PRICER Program**

**3.9.1** 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**)<sup>2</sup> reported off of the hospital outpatient claim. The PRICER will also apply discounting for multiple surgical procedures performed during a

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<sup>2</sup> Effective January 1, 2015, SI of **X** is no longer recognized.

single operative session and outlier payments for extraordinarily expensive cases. DHA 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 TRICARE Operations Manual (TOM), [Chapter 1, Section 3, paragraph 1.5.2](#).

**3.9.2** 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 (until implementation of Ambulance Fee Schedule (AFS)/ TRICARE CMAC as describe in [Chapter 1, Section 14](#)) 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.

### 3.10 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 DHA'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.

### 3.11 Provider-Based Status for Payment Under OPSS

An OPD, 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.

### 3.12 Implementing Instructions

Since this issuance only deals with a general overview of the OPSS reimbursement methodology, the following cross-reference is provided to facilitate access to specific implementing instructions within Chapter 13:

IMPLEMENTING INSTRUCTIONS/SERVICES	
<b>POLICIES</b>	
General Overview	Section 1
Billing and Coding of Services under APC Groups	<a href="#">Section 2</a>
Reimbursement Methodology	<a href="#">Section 3</a>
Claims Submission and Processing Requirements	<a href="#">Section 4</a>
Medical Review Under the Hospital OPSS	<a href="#">Section 5</a>

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Chapter 13, Section 1

### General

#### IMPLEMENTING INSTRUCTIONS/SERVICES (CONTINUED)

##### ADDENDA

Development Schedule for TRICARE OCE/APC - Quarterly Update	<a href="#">Addendum A</a>
OPPS OCE Notification Process for Quarterly Updates	<a href="#">Addendum B</a>
Approval Of OPPS - OCE/APC And NGPL Quarterly Update Process	<a href="#">Addendum C</a>

### 3.13 OPPS Data Elements Available On **DHA's** Web Site

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

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

### 4.0 EFFECTIVE DATE

May 1, 2009.

- END -



## Billing And Coding Of Services Under Ambulatory Payment Classifications (APC) Groups

Issue Date: July 27, 2005

Authority: 10 USC 1079(j)(2) and 10 USC 1079(h)

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### 1.0 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 **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

### 2.0 ISSUE

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

### 3.0 POLICY

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

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

### 3.2 Packaging of Services Under APC Groups

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

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

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### Chapter 13, Section 2

#### Billing And Coding Of Services Under Ambulatory Payment Classifications (APC) Groups

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

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

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

**3.2.2.1.1** For the drugs paid under the OPPS, hospitals can bill both for the drug and for the administration of the drug.

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

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

**3.2.2.2** Separate payment of drugs, biologicals and devices outside the APC amounts of the services to which they are normally associated.

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**3.2.2.5.2.3** Following are the device-dependent APCs for CY 2009:

**FIGURE 13.2-1 CALENDAR YEAR (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
<b>0168</b>	<b>T</b>	<b>Level II Urethral Procedures</b>
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
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

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**3.2.2.6** 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.

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

- 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.
- 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**<sup>1</sup>, in which case it would be paid separately.
- 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.
- 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.

**3.2.2.6.2** Categories of ancillary and supportive services for which the packaging status is changed for CY 2008 are as follows:

**3.2.2.6.2.1** Guidance services.

**3.2.2.6.2.2** Imaging processing services.

**3.2.2.6.2.3** Intraoperative services.

**3.2.2.6.2.4** Imaging supervision and interpretation services.

- Certain imaging supervision and interpretation services are always packaged.
- 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.

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

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

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<sup>1</sup> Effective January 1, 2015, SI of **X** is no longer recognized.

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##### **3.2.2.6.2.7** Observation services.

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

**3.2.2.6.2.7.2** 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.

**3.2.2.6.2.7.3** 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.

**3.2.2.6.2.7.4** 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:

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

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

**3.2.2.6.2.7.6** 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 imagining supervision and interpretation services. Therefore, while Current Procedural Terminology (CPT)<sup>2</sup> 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.

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

**3.2.2.6.3.1** 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.

**3.2.2.6.3.1.1** Composite APC for LDR Prostate Brachytherapy (APC 8001).

- 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 CPT<sup>3</sup> codes 55875 and 77778 as component services provided during the same hospital encounter.
- CPT<sup>3</sup> 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 CPT<sup>3</sup> 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.
- These two CPT<sup>3</sup> codes will be assigned SI **Q3** to identify their status as potentially payable through a composite APC.

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

**3.2.2.6.3.1.2.1** 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 claim with the same date of service. The five CPT 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)
<b>GROUP A</b>			
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

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**3.8.1.2.2** 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.

**3.8.1.2.3** 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	<ol style="list-style-type: none"> <li>Eight or more units of HCPCS code G0378 are billed— On the same day as HCPCS code G0379; or On the same day or the day after CPT* codes 99205 or 99215; and</li> <li>There is no service with SI=<b>T</b> on the claim on the same date of service or one day earlier than G0378.</li> </ol>
8003	Level II Extended Assessment and Management Composite	<ol style="list-style-type: none"> <li>Eight 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</li> <li>There is no service with SI=<b>T</b> on the claim on the same date of service or one day earlier than G0378.</li> </ol>

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**3.8.1.2.4** 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.

**3.8.1.3** 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.

**3.8.1.4** Direct Admission to Observation Care Using G0379.

**3.8.1.4.1** 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.

**3.8.1.4.2** Payment for direct admission to observation will be made either:

**3.8.1.4.2.1** Separately as low level hospital clinic visit under APC 604;

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**3.8.1.4.2.2** Packaged into payment for composite APC 8002 (Level I Prolonged Assessment and Management Composite); or

**3.8.1.4.2.3** Packaged into payment for other separately payable services provided in the same encounter.

**3.8.1.4.3** Criteria for payment of HCPCS code G0379 under either APC 8002 or APC 0604 include:

**3.8.1.4.3.1** 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.

**3.8.1.4.3.2** 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.

**3.8.1.4.3.3** If either of the above criteria (i.e., [paragraphs 3.8.1.4.3.1](#) or [3.8.1.4.3.2](#)) 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.

**3.8.1.4.3.4** 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.

**3.8.1.4.3.5** 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.

### **3.8.2 Observations For Maternity Conditions**

**3.8.2.1** 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:

**3.8.2.1.1** The maternity observation claim must have a maternity diagnosis as Principal Diagnosis (PDX) or Reason Visit Diagnosis (VRDX). Refer to **DHA's** OPSS web site (<http://www.tricare.mil/opps>) for the listing of maternity diagnoses.

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

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

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

**3.8.2.3** 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.

**3.8.2.4** 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.

### 3.9 Inpatient Only Procedures

**3.9.1** The inpatient list on DHA's OPSS web site at <http://www.tricare.mil/opss> 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 12, Section 5](#) for appeal procedures.

**3.9.2** 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 OPSS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.
- It has been determined that the procedure is being performed in multiple hospitals on an outpatient basis.

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

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

**3.9.5** 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.

**3.9.5.1** 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.

**3.9.5.2** Such patients would typically receive services such as those provided during a high-level emergency visit, appropriate diagnostic testing (X-ray, Computerized Tomography (CT) scan,

Electrocardiogram (EKG), and so forth) and administration of intravenous fluids and medication prior to the surgical procedure.

**3.9.5.3** 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.

**3.9.5.4** 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.

### **3.10 APC For Vaginal Hysterectomy**

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

### **3.11 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.

### **3.12 Special Billing/Codings Requirements as of January 1, 2008**

#### **3.12.1 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 CPT<sup>4</sup> code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT<sup>4</sup> code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)) to report cardiac rehabilitation services.

**3.12.1.1** 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.

**3.12.1.2** 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.

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**3.12.2 Billing for Wound Care Services**

**3.12.2.1** Following CPT<sup>5</sup> 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:

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

**3.12.2.2** Hospitals would receive separate payment under the OPSS when they bill for wound care services described by CPT<sup>5</sup> codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by individuals independent of a therapy plan of care.

**3.12.2.3** 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.

**3.12.2.4** 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.

**3.12.2.5** Revised the list of therapy revenue codes effective January 1, 2008, that may be reported with CPT<sup>5</sup> 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.

**3.12.3 Billing for Bone Marrow and Stem Cell Processing Services**

**3.12.3.1** 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.

**3.12.3.2** Hospital are required to bill the appropriate CPT<sup>5</sup> codes, specifically 38207 through 38215, in order to report bone marrow and stem cell processing services under OPSS.

**FIGURE 13.2-10 BILLING FOR BONE MARROW AND STEM CELL PROCESSING SERVICES**

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

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**3.12.3.3** For CY 2008, CPT<sup>6</sup> 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, CPT<sup>6</sup> 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**.

**3.12.4 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 CPT<sup>6</sup> codes 33240 or 33249, as appropriate, along with the applicable device C codes, for payment under the OPPS.

**3.12.5 Payment for Brachytherapy Sources**

**3.12.5.1** 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.

**3.12.5.2** 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.

**3.12.5.3** 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.

**3.12.5.4** 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 13.2-11 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

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**FIGURE 13.2-16 NEW DRUG ADMINISTRATION CPT CODES EFFECTIVE IN CY 2009**

APC	HCPCS* CODE	LONG DESCRIPTOR
436	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.
	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
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).

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**FIGURE 13.2-16 NEW DRUG ADMINISTRATION CPT CODES EFFECTIVE IN CY 2009**

APC	HCPCS* CODE	LONG DESCRIPTOR
0438	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.
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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**3.12.9 Billing for Cardiac Echocardiography Services**

**3.12.9.1 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 CPT<sup>7</sup> code(s) (93303-93350).

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## Prospective Payment Methodology

Issue Date: July 27, 2005

Authority: 10 USC 1079(h) and (j)(2)

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### 1.0 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 **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

### 2.0 ISSUE

To describe the payment methodology for hospital outpatient services.

### 3.0 POLICY

#### 3.1 Basic Methodology for Determining Prospective Payment Rates for Outpatient Services

##### 3.1.1 Setting of Payment Rates

The prospective payment rate for each Ambulatory Payment Classification (APC) is calculated by multiplying the APC's relative weight by the conversion factor.

##### 3.1.2 Recalibration of Group Weights and Conversion Factor

###### 3.1.2.1 Relative Weights for Services Furnished on a Calendar Year (CY) Basis

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

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

**3.1.2.1.2.1** The statewide Cost-to-Charge Ratio (CCR) is identified for each hospital's cost center ("statewide CCRs") and applied based on the from date on the claim.

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

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

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

**FIGURE 13.3-1 LIST OF REVENUE CENTERS PACKAGED INTO MAJOR HCPCS CODES WHEN APPEARING IN THE SAME CLAIM**

REVENUE CODE	DESCRIPTION
0250	Pharmacy, Drugs Requiring Specific Identification, General Class
0251	Generic
0252	Nongeneric
0253	Take Home Drugs
0254	Pharmacy Incident to Other Diagnostic
0255	Pharmacy Incident to Radiology
0257	Nonprescription Drugs
0258	IV Solutions
0259	Other Pharmacy
0260	IV Therapy, General Class
0262	IV Therapy/Pharmacy Services
0263	Supply/Delivery
0264	IV Therapy/Supplies
0269	Other IV Therapy
0270	M&S Supplies
0271	Nonsterile Supplies
0272	Sterile Supplies
0273	Take Home supplies
0275	Pacemaker Drug
0276	Intraocular Lens Source Drug
0277	Oxygen Take Home
0278	Other Implants
0279	Other M&S Supplies
0280	Oncology
0289	Other Oncology
0370	General Classification
0371	Anesthesia Incident to Radiology
0372	Anesthesia Incident to Other Diagnostic Services
0374	Acupuncture
0379	Other Anesthesia
0390	Blood Storage and Processing

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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
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

**3.1.2.1.2.4.1** 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 in [Figure 13.3-1](#), refer to the TRICARE Systems Manual (TSM), [Chapter 2, Addendum N](#), for reporting requirements.

**3.1.2.1.2.4.2** 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.

**3.1.2.1.2.5** 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.

**3.1.2.1.2.6** 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.

**3.1.2.1.2.7** Each procedure or visit cost is mapped to its assigned APC.

**3.1.2.1.2.8** The median cost is calculated for each APC.

**3.1.2.1.2.9** 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 DHA's OPPS web site at <http://www.tricare.mil/opps>.

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

### **3.1.2.2 Conversion Factor Update**

**3.1.2.2.1** The conversion factor is updated annually by the hospital inpatient market basket percentage increase applicable to hospital discharges.

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

**3.1.2.2.3** 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.

### **3.1.3 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:

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

**3.1.3.2 B** to indicate more appropriate code required for TRICARE OPPS.

**3.1.3.3 C** to indicate inpatient services that are not paid under the OPPS.

**3.1.3.4 E** to indicate items or services are not covered by TRICARE.

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**3.1.3.5 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.

**3.1.3.6 G** to indicate drug/biological pass-through that are paid in separate APCs under the OPSS.

**3.1.3.7 H** to indicate pass-through device categories and radiopharmaceutical agents allowed on a cost basis.

**3.1.3.8 J1** to indicate hospital outpatient department services paid through a comprehensive APC.

**3.1.3.9 K** to indicate non-pass-through drugs and biologicals that are paid in separate APCs under the OPSS.

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

**3.1.3.11 P** to indicate services that are paid only in Partial Hospitalization Programs (PHPs).

**3.1.3.12 Q** to indicate packaged services subject to separate payment under OPSS.

**3.1.3.13 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**<sup>1</sup>. In all other circumstances, payment is made through a separate APC payment.

**3.1.3.14 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.

**3.1.3.15 Q3** to indicate composite APC payment based on OPSS 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.

**3.1.3.16 R** to indicate separate APC payment for blood and blood products.

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

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<sup>1</sup> Effective January 1, 2015, SI of **X** is no longer recognized.

**3.1.3.18 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.

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

**3.1.3.20 V** to indicate medical visits (including clinic or Emergency Department (ED) visits) for which payment is allowed under the hospital OPPS.

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

**3.1.3.22 X** to indicate an ancillary service for which payment is allowed under the hospital OPPS<sup>2</sup>.

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

**3.1.3.24 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 DHA's OPPS web site at <http://www.tricare.mil/opps>.

### 3.1.4 Calculating TRICARE Payment Amount

**3.1.4.1** 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 DHA's OPPS web site at <http://www.tricare.mil/opps> for national APC payment rates.)

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

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

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

**3.1.4.4.1** 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 DHA's OPPS home page at <http://www.tricare.mil/opps> for annual Diagnosis Related Group (DRG) wage indexes used in the payment of hospital outpatient claims, effective January 1 of each year.)

**3.1.4.4.2** 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 with 100 or more beds. Effective January 1, 2010, the OPPS rural adjustment will apply to all SCHs in rural areas.

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<sup>2</sup> Effective January 1, 2015, SI of X is no longer recognized.

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**3.1.4.4.3** Determine any outlier amounts and add them to the sum of either [paragraph 3.1.4.4.1](#) or [3.1.4.4.2](#).

**3.1.4.4.4** 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 Hospital Outpatient Departments (HOPDs) and Ambulatory Surgery Centers (ASCs).

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

**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.

- Adjusted APC payment rate: \$400.
- Subtract any applicable deductible:  $\$400 - \$0 = \$400$
- Subtract the Prime ADFM copayment from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

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

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

**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.

- Adjusted APC payment rate: \$400.
- Subtract any applicable deductible:  $\$400 - \$0 = \$400$
- Subtract the Prime retiree family member copayment from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

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

- 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).

**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.

- Adjusted APC payment rate: \$400.
- Subtract any applicable deductible:  $\$400 - \$50 = \$350$
- 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.

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

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

- 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.

### 3.1.5 Adjustments to APC Payment Amounts

#### 3.1.5.1 Adjustment for Area Wage Differences

**3.1.5.1.1** 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 **G, H, K, R, and U**. The hospital DRG wage index will be used given the inseparable, subordinate status of the outpatient department within the hospital.

**3.1.5.1.2** 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 [DHA's OPSS home page at http://www.tricare.mil/opps](http://www.tricare.mil/opps)).

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

**3.1.5.1.4** 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%).

#### 3.1.5.1.5 Steps in Applying Wage Adjusts under OPSS

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

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**3.1.5.1.5.2** Determine the wage index in which the hospital is located and identify the wage index level that applies to the specific hospital.

**3.1.5.1.5.3** Multiply the applicable wage index determined under [paragraphs 3.1.5.1.5.2](#) and [3.1.5.1.5.3](#) by the amount under [paragraph 3.1.5.1.5.1](#) that represents the labor-related portion of the national unadjusted payment rate.

**3.1.5.1.5.4** Calculate 40% (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product in [paragraph 3.1.5.1.5.4](#). The result is the wage index adjusted payment rate for the relevant wage index area.

**3.1.5.1.5.5** 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.

**3.1.5.1.5.6** 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.

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

- Wage-Adjusted Payment Rate (rounded to nearest cent):  
$$= (\$180 \times 1.0234) = \$184.21 + \$120 = \$304.21$$
- Cost-share for standard retiree family member (rounded to nearest cent):  
$$= (\$304.21 \times .20) = \$60.84$$
- Subtract the standard retiree family member cost-share from the wage-adjusted rate to get the final TRICARE payment:  
$$= (\$304.21 - \$60.84) = \$243.37$$

#### **3.1.5.2 Discounting of Surgical and Terminating Procedures**

**3.1.5.2.1** 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.

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

**3.1.5.2.1.2** 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.

**3.1.5.2.1.3** 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.

- The reduced payment would apply only to the surgical procedure with the lower payment rate.
- The reduced payment for multiple procedures would apply to both the beneficiary copayment/cost-share and the TRICARE payment.

**3.1.5.2.2** Hospitals are required to use modifiers on bills to indicate procedures that are terminated before completion.

**3.1.5.2.2.1** 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.

- 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).
- 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.

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

- 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.
- 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.

**3.1.5.3 Discounting for Bilateral Procedures**

**3.1.5.3.1** Following are the different categories/classifications of bilateral procedure:

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

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

**3.1.5.3.1.3** 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)).

**3.1.5.3.2** 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.

**3.1.5.3.3** 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.

**3.1.5.3.4** The discounting factor for bilateral procedures is the same as the discounting factor for multiple type **T** procedures.

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

**3.1.5.3.6** Following are the different discount formulas that can be applied to a line item:

**FIGURE 13.3-2 DISCOUNTING FORMULAS FOR BILATERAL PROCEDURES**

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

**3.1.5.3.7** Figure 13.3-3 summarizes the application of above discounting formulas:

**FIGURE 13.3-3 APPLICATION OF DISCOUNTING FORMULAS**

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

For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (T) any applicable offset, will be applied prior to selecting the T procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first before the terminated procedure discount.  
 \*If not terminated, non-type T Conditional bilateral procedures with modifier 50 will be assigned discount formula #8. Non-type T Independent bilateral procedures with modifier 50 will be assigned to formula #8.  
 \*\*If modifier 50 is present on a independent or conditional bilateral line that has a composite APC or a separately paid STVX/T-packaged procedure, the modifier is ignored in assigning the discount formula.

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

**3.1.5.3.8** 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.

**3.1.5.4** Multiple discounting will not be applied to the following CPT<sup>3</sup> codes for venipuncture, fetal monitoring and collection of blood specimens: 36400 - 36416, 36591, 36592, 59020, 59025, and 59050-59051.

**3.1.5.5 Outlier Payments**

An additional payment is provided for outpatient services for which a hospital's charges, adjusted to cost, exceed the sum of the wage-adjusted APC rate plus a fixed dollar threshold and a fixed multiple of the wage-adjusted APC rate. Only line item services with SIs of **P, R, S, T, V, or X**<sup>4</sup> will be eligible for outlier payment under OPPS. No outlier payments will be calculated for line item services with SIs of **G, H, K, N, and U**, with the exception of blood and blood products.

**3.1.5.5.1** 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

<sup>3</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

<sup>4</sup> Effective January 1, 2015, SI of X is no longer recognized.

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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.

**3.1.5.5.2** 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.

**3.1.5.5.3** 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.

**3.1.5.5.4** Outlier payments are not subject to cost-sharing.

**3.1.5.5.5** TTPAs and TMCPAs shall not be included in cost outlier calculations.

**3.1.5.5.6** 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

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

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

**Step 5:** Calculate the total charges for each OPPS service (APC) and reduce them to costs by applying the statewide CCR. Statewide CCRs are based on the geographical Core Based Statistical Area (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 INDEX APC RATE)	COSTS IN EXCESS OF MULTIPLIER THRESHOLD	OUTLIER PAYMENT COSTS OF WAGE-ADJUSTED APC - (1.75 X WAGE-ADJUSTED APC RATE) X 0.50
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: **\$1,746.50.**

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**3.1.5.6** 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**<sup>5</sup>), excluding drugs, biologicals and services paid under the pass-through payment policy (SIs of **G** and **H**).

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

**3.1.5.6.2** The adjustment is budget neutral and will be applied before calculating outliers and copayments/cost-sharing.

#### **3.1.5.7 Temporary Transitional Payment Adjustments (TTPAs)**

**3.1.5.7.1** 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 a four year period. The four year transition will set higher payment percentages for the 10 APC codes 604-609 and 613-616 during the first year, with reductions in each of the transition years. For non-network hospitals, the adjustment will cover a three year period, with reductions in each of the transition years for the same 10 APC codes. [Figure 13.3-4](#) provides the TTPA percentage adjustments for the 10 visit APC codes for network and non-network hospitals. An applicable Explanation of Benefits (EOB) message will be applied.

**3.1.5.7.2** 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%

#### **3.1.5.8 Temporary Military Contingency Payment Adjustments (TMCPAs)**

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

##### **3.1.5.8.1 Transitional TMCPAs**

In view of the ongoing military operations in Afghanistan and Iraq, the **DHA** 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 effective May 1, 2009, network hospitals that have received OPPS payments of \$1.5 million or more for care provided to ADSMs and ADDs during an OPPS year (May 1 through April

<sup>5</sup> Effective January 1, 2015, SI of **X** is no longer recognized.

30), shall be granted a Transitional TMCPA in addition to the TTPAs for the first four years of the OPSS implementation. At the end of the first year of OPSS implementation, i.e., April 30, 2010, the total TRICARE OPSS payments for each one of these qualifying hospitals will be increased by 20%. 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 OPSS payment levels are reached; (i.e., 15% year two, 10% year three, and 5% year four). The adjustment will be applied to the total year OPSS 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. These year-end adjustments will be paid approximately four months following the end of the OPSS year. In year five, the OPSS payments will be at established APC levels.

**3.1.5.8.1.1** DHA will run a query of claims history to determine which network hospitals qualify for Transitional TMCPAs at year end; i.e., those network hospitals receiving OPSS payments of \$1.5 million or more for care of ADSMs and ADDs during the previous OPSS year (May 1 through April 30).

**3.1.5.8.1.2** These queries will be run in subsequent Transitional TMCPA years to determine those network hospitals qualifying for Transitional TMCPAs.

**3.1.5.8.1.3** The year end adjustment will be paid approximately four months following the end of the OPSS year. Each year, subsequent adjustments will be issued to the qualifying hospitals for the prior OPSS year to ensure claims that were not Processed To Completion (PTC) the previous year are adjusted. This adjustment payment is separate from the applicable TMCPA percentage in effect during the current transitional year.

**Example:** At the end of the second OPSS year, a qualifying hospital's total TRICARE OPSS payments will be increased by 15%. The hospital will also receive an additional adjustment for the first OPSS year for those claims that were not PTC and included in the prior year's payment. This subsequent adjustment would be paid at the first year's TMCPA percentage of 20%.

**3.1.5.8.1.4** The DHA Medical Benefits and Reimbursement Branch (MB&RB) shall verify the accuracy of the Transitional TMCPA amounts and provide the contractor's with a copy of the report noting which hospitals in their region qualify for the Transitional TMCPAs and the amounts to pay. MB&RB shall also provide a copy of the report to Contract Resource Management (CRM).

**3.1.5.8.1.5** The contractors shall submit the Transitional TMCPAs amounts on a voucher 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](mailto:RM.Invoices@tma.osd.mil) at the DHA CRM Office and to [OPSS.MBRB@tma.osd.mil](mailto:OPSS.MBRB@tma.osd.mil) at the MB&RB before releasing payments. The vouchers should contain the following information: hospital name, address, Medicare number or provider number, Tax Identification Number (TIN), and the amount to be paid. Listings shall separate payments for prior OPSS years and the current OPSS year.

**3.1.5.8.1.6** CRM shall send an approval to the contractors to issue Transitional TMCPA payments out of the non-financially underwritten bank account based on fund availability.

**3.1.5.8.1.7** Hospitals that previously qualified for Transitional TMCPAs but subsequently fell below \$1.5 million revenue threshold would no longer be eligible for the adjustment. However, if a subsequent adjustment for the prior OPSS year results in a hospital exceeding the \$1.5 million revenue threshold, the hospital shall receive the Transitional TMCPA for the prior year.

**3.1.5.8.1.8** 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%.

### **3.1.5.8.2 General TMCPAs**

The **DHA** Director, or designee at any time after OPSS implementation, 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 **DHA** Director may approve a General 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 received for services provided to TRICARE ADSMs and ADDs must have been at least 10% of the hospital's total outpatient revenue received during the previous OPSS year (May 1 through April 30) or the number of OPSS visits by ADSMs and ADDs during that same 12-month period must have been at least 50,000. Billed charges will not be used as the basis for determining a hospital's eligibility for a General TMCPA.

#### **3.1.5.8.2.1 General TMCPA Process for the First OPSS Year (May 1, 2009 through April 30, 2010); Second OPSS Year (May 1, 2010 through April 30, 2011); and Third OPSS Year (May 1, 2011 through April 30, 2012)**

**3.1.5.8.2.1.1** 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.

**3.1.5.8.2.1.2** In analyzing and recommending the appropriate year end percentage adjustment, the DTRO will ensure the General TMCPA adjustment does not exceed 95% of the amount that would have been paid prior to implementation of OPSS. Although, the maximum amount that a hospital can receive is 95% of the pre-OPSS amount, this does not infer the hospital is entitled to receive the full 95%. It is the DTRO's discretion on what percentage adjustment is appropriate to ensure access to care (ATC) in a facility requesting a General TMCPA. This applies to TRICARE beneficiaries when TRICARE is the primary payer. The contractors shall provide the history of pre-OPSS payments for the analysis to the DTRO.

**3.1.5.8.2.1.3** Total TRICARE OPSS payments (including the TTPAs) and Transitional TMCPA's, if applicable, of the qualifying hospital will be increased by the Director, **DHA**, or designee, approved adjustment percentage by way of an additional payment after the end of the OPSS year (May 1 through April 30). At the end of the second and third OPSS years, subsequent adjustments will be issued to the qualifying hospitals for the first and second OPSS years to ensure claims that were not

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PTC the previous year are adjusted. This adjustment payment is separate from the applicable General TMCPA percentage approved for the current OPPS year.

**Example:** Assume a hospital was approved for a General TMCPA of 5% for the first year of OPPS and a General TMCPA of 8% for the second year of OPPS. At the end of the second year, the hospital will receive an adjustment of 5% for the first OPPS year for those claims that were not PTC and included in the prior year's payment. The General TMCPA is applied to the total OPPS payment amount at year end.

**3.1.5.8.2.1.4** 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 OPPS year end adjustment to total OPPS payments.

**3.1.5.8.2.1.5** The hospital's request for a General TMCPA for the first OPPS year (May 1, 2009 through April 30, 2010); second OPPS year (May 1, 2010 through April 30, 2011); and third OPPS year (May 1, 2011 through April 30, 2012) shall include the data requirements in [paragraph 3.1.5.8.2.2](#), and a full 12 months of claims payment data from the OPPS year the General TMCPA is requested.

**3.1.5.8.2.1.6** The DHA MB&RB shall verify the accuracy of the General TMCPA amounts and provide the contractor's with a copy of the report noting which hospitals in their region qualify for the General TMCPAs and the amounts to pay. MB&RB shall also provide a copy of the report to CRM.

**3.1.5.8.2.1.7** The contractor shall submit the General TMCPA amounts on a voucher in accordance with the requirements of the TOM, [Chapter 3, Section 4](#). The voucher shall be sent electronically to [RM.Invoices@tma.osd.mil](mailto:RM.Invoices@tma.osd.mil) at the DHA CRM Office and to [OPPS.MBRB@tma.osd.mil](mailto:OPPS.MBRB@tma.osd.mil) at the MB&RB before releasing payments. The vouchers should contain the following information: hospital name, address, Medicare number or provider number, TIN, and the amount to be paid. Listings shall separate payments for prior OPPS years and the current OPPS year. Additional vouchers shall be submitted, as needed, for voided/staledated checks and/or for reissued or adjusted payments.

**3.1.5.8.2.1.8** CRM shall send an approval to the contractors to issue General TMCPA payments out of the non-financially underwritten bank account based on fund availability.

**3.1.5.8.2.2 Annual Data Requirements for General TMCPAs for the First OPPS Year (May 1, 2009 through April 30, 2010); Second OPPS Year (May 1, 2010 through April 30, 2011); and Third OPPS Year (May 1, 2011 through April 30, 2012)**

Hospital required data submissions to the contractor for review and consideration:

**3.1.5.8.2.2.1** The hospital's percent of outpatient revenue derived from ADSM plus ADD OPPS visits; i.e., the outpatient revenue from TRICARE ADSM plus ADD visits divided by total outpatient revenue (TRICARE and non-TRICARE) derived from all other third party payers and private pay during the previous OPPS year; i.e., May 1 through April 30. Reference [paragraph 3.1.5.8.2](#).

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**3.1.5.8.2.2.2** The number of OPPS visits by ADSMs and ADDs during the previous OPPS year; i.e., May 1 through April 30.

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

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

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

**3.1.5.8.2.3 Annual Contractor Data Review Requirements for the First OPPS Year (May 1, 2009 through April 30, 2010); Second OPPS Year (May 1, 2010 through April 30, 2011); and Third OPPS Year (May 1, 2011 through April 30, 2012)**

**3.1.5.8.2.3.1** Data requirements for evaluation of network adequacy necessary to support military contingency operations:

- Number of available primary care and specialist providers in the network locality;
- Availability (including reassignment) of military providers in the locations or nearby;
- Appropriate mix of primary care and specialists needed to satisfy demand and meet appropriate patient access standards (appointment/waiting time, travel distance, etc.);
- Efforts that have been made to create an adequate network, and
- Other cost effective alternatives and other relevant factors.

**3.1.5.8.2.3.2** If upon initial evaluation, the contractor determines the hospital meets the disproportionate share criteria in [paragraph 3.1.5.8.2](#), 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.

**3.1.5.8.2.4** For the first OPPS year (May 1, 2009 through April 30, 2010); second OPPS year (May 1, 2010 through April 30, 2011); and third OPPS year (May 1, 2011 through April 30, 2012); 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 MB&R to be forwarded to the Director, **DHA**, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RB for **DHA** Director review and approval.

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**3.1.5.8.2.5 General TMCPA Process for OPPS Year Four and Subsequent Years (May 1, 2012 and After)**

**3.1.5.8.2.5.1** The hospital's request for a General TMCPA shall include the data requirements in [paragraphs 3.1.5.8.2.2.1](#) through [3.1.5.8.2.2.4](#).

**3.1.5.8.2.5.2** The MCSC shall conduct an initial evaluation and determine if the requesting hospital meets the disproportionate share criteria in [paragraph 3.1.5.8.2](#), and is essential for continued network adequacy. The request from the hospital for a General TMCPA along with the supporting documentation in [paragraphs 3.1.5.8.2.2.1](#) through [3.1.5.8.2.2.4](#) and [3.1.5.8.2.3](#), shall be submitted to the DTRO for review and determination.

**3.1.5.8.2.5.3** The DTRO shall request DHA MB&RB run a query of claims history to determine if the network hospital qualifies for a General TMCPA, i.e., the hospital's payment-to-cost ratio is less than 1.3 for care provided to ADSMs and ADDs during the previous OPPS year (May 1 through April 30).

**3.1.5.8.2.5.4** The DTRO shall review the supporting documentation and the report from DHA MB&RB, determine if the network hospital qualifies for a General TMCPA. The recommendation for approval of a General TMCPA shall be submitted to the MB&RB to be forwarded to the Director, DHA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RB for DHA Director review and approval.

**3.1.5.8.2.5.5** If a hospital meets the disproportionate share criteria in [paragraph 3.1.5.8.2](#), and is deemed essential for network adequacy to support military contingency operations, the approved hospital's General TMCPA payment will be set so the hospital's payment-to-cost ratio for TRICARE HOPD services does not exceed a ratio of 1.30. A hospital cannot be approved for a General TMCPA payment if it results in the hospital earning more than 30% above its costs for TRICARE beneficiaries.

**3.1.5.8.2.5.6** Total TRICARE OPPS payments (including the TTPAs and the Transitional TMCPA) of the qualifying hospital will be increased by the Director, DHA, or designee, by way of an additional payment after the end of the OPPS year (May 1 through April 30). Subsequent adjustments will be issued to the qualifying hospitals for the prior OPPS year to ensure claims that were not PTC the previous year are adjusted. The adjustment payment is separate from the applicable General TMCPA approved for the current OPPS year.

**3.1.5.8.2.5.7** Upon approval of the General TMCPA request by the DHA Director, MB&RB shall notify the TRO of the approval. The TRO shall notify the Contracting Officer (CO) who shall send a letter to the MCSC notifying them of the approval.

**3.1.5.8.2.5.8** The MCSCs shall submit the General TMCPA amounts on a voucher in accordance with requirements of the TOM, [Chapter 3, Section 4](#). The voucher shall be sent electronically to [RM.Invoices@tma.osd.mil](mailto:RM.Invoices@tma.osd.mil) at the DHA CRM Office before releasing payments. The vouchers should contain the following information: hospital name, address, Medicare number or provider number, TIN, and the amount to be paid. Listings shall separate payments for prior OPPS years and the current OPPS year.

**3.1.5.8.2.5.9** CRM shall send an approval to the contractors to issue General TMCPA payments out of the non-financially underwritten bank account based on fund availability.

**3.1.5.8.2.5.10** General TMCPAs will be reviewed and approved on an annual basis; i.e., they 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.

**3.1.5.8.2.6** **DHA** Director, or designee review.

- The Director, **DHA** or designee is the final approval authority.
- A decision by the Director, **DHA** or designee to adopt, modify, or extend General TMCPAs is not subject to appeal.

### **3.1.5.8.3 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 contractor'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 3.1.5.8.2.3](#). Non-network TMCPAs will be adjusted on a claim-by-claim basis. The associated costs would be underwritten or non-underwritten following the applicable financing rules of the contract.

### **3.1.5.8.4 Application of Cost-Sharing**

**3.1.5.8.4.1** Transitional and General TMCPAs are not subject to cost-sharing.

**3.1.5.8.4.2** Non-network TMCPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

**3.1.5.8.5** Reimbursement of Transitional, General, and Non-Network TMCPA costs shall be paid as pass-through costs. The contractor does not financially underwrite these costs.

### **3.1.5.9 Hold Harmless TRICARE Transitional Outpatient Payments (TTOPs)**

**3.1.5.9.1** Effective January 1, 2010, TRICARE adopted Medicare's hold harmless provision. TRICARE will apply the hold harmless provision to qualifying hospitals as long as the provision remains in effect under Medicare.

**3.1.5.9.1.1** For CYs 2010 and 2011, the hold harmless provision applies to hospitals with 100 or fewer beds and all SCHs regardless of bed size.

**3.1.5.9.1.2** For CY 2012, for the period January 1 through February 29, 2012, the hold harmless provision applies to rural hospitals with 100 or fewer beds and all SCHs regardless of bed size. For the period March 1, through December 31, 2012, the hold harmless provision applies to small rural hospitals with 100 or fewer beds and SCHs with 100 or fewer beds.

**3.1.5.9.2** TTOPs will be made to qualifying hospitals that have OPSS costs that are greater than their TRICARE allowed amounts. The 7.1% increase for SCHs, the TTPAs for ER and clinic visits, Transitional and General TMCPAs, if applicable, will be included in the allowed amounts when determining if a hospital's OPSS costs are greater than their TRICARE allowed amounts.

**3.1.5.9.3** TRICARE will use a method similar to Medicare to reimburse these hospitals their TTOPs. TRICARE will pay qualifying hospitals an amount equal to 85% of the difference between the estimated OPSS costs and the OPSS payment.

**3.1.5.9.4 Process for TTOPs Year One (Effective January 1, 2010, through December 31, 2010) and Subsequent Years**

**3.1.5.9.4.1** DHA will run query reports of claims history to determine which hospitals qualify for TTOPs at year end; i.e., those hospitals whose costs exceeded their allowed amounts during the previous TTOPs year (January 1 through December 31).

**3.1.5.9.4.2** These query reports will be run in subsequent TTOPs years to determine those hospitals qualifying for TTOPs.

**3.1.5.9.4.3** The year end adjustment will be paid approximately six months following the end of the TTOPs year. Each year, subsequent adjustments will be issued to the qualifying hospitals for the prior TTOPs year to ensure claims that were not PTC the previous year are adjusted.

**3.1.5.9.4.4** The DHA MB&RB shall provide the MCSC with a copy of the query report noting which hospitals in their region qualify for the TTOPs and the amounts to pay. A copy of the report shall also be provided to DHA's CRM.

**3.1.5.9.4.5** The contractor shall process the adjustment payments per the instructions in Section G of their contracts under Invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No payments will be sent out without approval from DHA-Aurora (DHA-A), CRM, Budget.

**3.2 Transitional Pass-Through for Innovative Medical Devices, Drugs, and Biologicals**

**3.2.1 Items Subject to Transitional Pass-Through Payments**

**3.2.1.1 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 OPSS 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.

### **3.2.1.2 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.

### **3.2.1.3 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.

### **3.2.1.4 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.

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

- Pass-through device categories are identified by SI of **H**
- Pass-through drugs and biological agents are identified by SI of **G**

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

**3.2.3.1** 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.

**3.2.3.2** 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.

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

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

**3.2.3.5** 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.

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**3.2.3.6** 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.

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

**3.2.3.8** 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	C9355	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.

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

**3.2.4.1** 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.

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

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

**3.2.4.4** 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%.

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

**3.2.4.6** 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).

**3.2.4.7** Offset Calculations.

**3.2.4.7.1** 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).

**3.2.4.7.2** 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.

**3.2.4.8** 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**.

**3.2.4.8.1** 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.

**3.2.4.8.2** 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.

**3.2.4.8.3** 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.

**3.2.4.8.4** 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.

**3.2.4.8.5** 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.

**3.2.4.8.6** 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.

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

**3.2.4.8.8** The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status.

### **3.2.5 Transitional Pass-Through Device Categories**

#### **3.2.5.1 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.

#### **3.2.5.2 Included Medical Devices**

**3.2.5.2.1** The following implantable items may be considered for the transitional pass-through payments:

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

### 3.2.5.3 Pass-Through Payment Criteria for Devices

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

**3.2.5.3.1** 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:

**3.2.5.3.1.1** The device is described by one of the initial categories established and in effect, or

**3.2.5.3.1.2** The device is described by one of the additional categories established and in effect, and

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

**3.2.5.3.2** They have been approved/cleared for use by the U.S. Food and Drug Administration (FDA).

**3.2.5.3.3** 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.

**3.2.5.3.4** 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 HOPD.

**3.2.5.3.4.1** 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.

**3.2.5.3.4.2** 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".

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

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

**3.2.5.3.7** They are not material such as biologicals or synthetics that may be used to replace human skin.

**3.2.5.3.8** No existing or previously existing device category is appropriate for the device.

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

**3.2.5.3.10** 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.

#### **3.2.5.4 Duration of Transitional Pass-Through Payments**

**3.2.5.4.1** 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.

**3.2.5.4.2** 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.

#### **3.2.6 General Coding and Billing Instructions and Explanations**

**3.2.6.1** Devices implanted, removed, and implanted again, not associated with failure (applies to transitional pass-through devices only):

- 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.
- 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.

**3.2.6.2** 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.

**3.2.6.2.1** If the kits contain individual items that separately qualify for transitional pass-through payment, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

**3.2.6.2.2** 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.

**3.2.6.3** 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.

**3.2.6.4** 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.

### **3.2.6.5 Current Device Categories Subject to Pass-Through Payment**

Two device categories were established for pass-through payment as of 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.

### **3.2.7 Reduction of Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups**

**3.2.7.1** 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.

**3.2.7.2** 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.

**3.2.8 Calculation of Transitional Pass-Through Payment for a Pass-Through Device**

**3.2.8.1** 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).

**3.2.8.2** 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).

**3.2.8.3** The offset adjustment is applied only when a pass-through device is billed in addition to the APC.

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

Device: (C1884 - Embolization Protective System)

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

Associated procedure: HCPCS Level I<sup>6</sup> code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (Standard ADFM who has met his/her yearly deductible)

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

**Note:** The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to [paragraph 3.2.8.4](#) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:  $\$1,200 - \$802.06 = \$397.94$

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

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

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

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

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

\$2,631.54 TRICARE program payment for HCPCS Level I<sup>6</sup> code 92982 when used with device code C1884

657.88 Beneficiary coinsurance amount for HCPCS Level I<sup>6</sup> code 92982

+ 397.94 Transitional pass-through payment for device

\$3,687.36 Total amount received by the provider

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**Example 2:** Transitional Pass-Through Payment Calculation without Offset

Device: (C1884 - Embolization Protective System)

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

Associated procedure: HCPCS Level I<sup>7</sup> code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (standard ADFM who has met his/her yearly deductible)

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

**Note:** The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to [paragraph 3.2.8.4](#) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:  $\$1,500 - \$0 = \$1,500$

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

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

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

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

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

\$2,631.54 TRICARE program payment for HCPCS Level I<sup>7</sup> code 92982 when used with device code C1884

657.88 Beneficiary coinsurance amount for HCPCS Level I<sup>7</sup> code 92982

+1,500.00 Transitional pass-through payment for device

\$4,789.42 Total amount received by the provider

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

**3.2.8.4** 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.

(Offset x Discount Rate x Units of Service)

**Step 2:** Sum the products of Step 1.

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

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

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

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

**otherwise**

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

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

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

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

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

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

### 3.3 Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

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

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

**3.3.2** 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:

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

**3.3.3** 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.

**3.4 Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals**

**3.4.1** 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.

**3.4.2** 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.

**3.4.3** 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

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

**3.4.5 Payment For Drugs, Biologicals, And Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged**

**3.4.5.1 “Specified Covered Outpatient Drugs” Classification**

**3.4.5.1.1** 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.

**3.4.5.1.2** 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.

**3.4.5.1.3** 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 drug or biological for which payment was first made on or after January 1, 2003,

under the transitional pass-through payment provision.

- A drug or biological for which a temporary HCPCS code has been assigned.
- Orphan drugs.

### **3.4.5.2 Payment of Specified Outpatient Drugs, Biological, and Radiopharmaceuticals**

**3.4.5.2.1** 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 OPSS. 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.

**3.4.5.2.2** 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 13.2-14](#), for a list of therapeutic radiopharmaceuticals that will continue to be reimbursed under the cost-to-charge methodology up through December 31, 2009.

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

### **3.4.5.3 Designated SI**

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

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

**3.4.6.1** These new drugs and biologicals with HCPCS codes as of January 1, 2008, but which do not have pass-through status and are without OPSS 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.

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

**3.4.6.3** 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 OPSS claims data. If the WAC is also unavailable, payment will be made at 95% of the product's most recent AWP.

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

**3.4.6.5** 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.

**3.4.6.6** 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.

**3.4.7 Drugs and Biologicals Not Eligible for Pass-Through Status and Receiving Separate Non-Pass-Through Payment**

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

- Separately paid since implementation of the OPPS under Medicare, but were not eligible for pass-through status; and
- Historically packaged with the procedures with which they were billed, even though their median cost per day was above the \$60 packaging threshold.

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

**3.4.8 Payment for New Drugs, Biologicals, and Radiopharmaceuticals Before HCPCS Codes Are Assigned**

**3.4.8.1** 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:

- 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."
- When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.
- The new drug, biological and/or radiopharmaceutical will be priced at 95% of its AWP from a schedule of allowable charges based on the AWP, and process the claim for payment.

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

**3.4.8.2** 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.

**3.4.9** 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.

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

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

**3.4.10 Drugs And Non-Implantable Biologicals With Expiring Pass-Through Status**

**3.4.10.1** 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.

**3.4.10.2** 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**.

**3.5 Drug Administration Coding and Payment**

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

**FIGURE 13.3-7 CROSSWALK FROM HCPCS LEVEL I CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs**

HCPCS LEVEL I* CODE	DESCRIPTION	SI	APC
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0116
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0116
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0116
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0116
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0117
96420	Chemotherapy administration, intra-arterial; push technique	S	0116
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0117
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	A	--

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**FIGURE 13.3-7 CROSSWALK FROM HCPCS LEVEL I CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs (CONTINUED)**

HCPCS LEVEL I* CODE	DESCRIPTION	SI	APC
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0117
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0116
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0116
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0116
96521	Refilling and maintenance of portable pump	T	0125
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	T	0125
96523	Irrigation of implanted venous access device for drug delivery systems	N	--
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0116
96549	Unlisted chemotherapy procedure	S	0116

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**3.5.2** 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* 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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**3.5.3** 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.

**3.5.4** HCPCS Level I<sup>8</sup> codes 90772-90774 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

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**3.5.5** 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.

### **3.6 Coding and Payment Policies for Drugs and Supplies**

#### **3.6.1 Drug Coding**

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

**3.6.1.2** 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.

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

**3.6.1.4** 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.

#### **3.6.2 Payment for the Unused Portion of a Drug**

**3.6.2.1** 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.

**3.6.2.2** 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.

### **3.6.2.3 Coding for Supplies**

**3.6.2.3.1** Supplies that are an integral component of a procedure or treatment are not reported with a HCPCS code.

**3.6.2.3.2** 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.

**3.6.2.3.3** 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.

### **3.6.3 Recognition of Multiple HCPCS Codes for Drugs**

**3.6.3.1** Prior to January 1, 2008, the OPSS 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 OPSS assigned a SI **B** indicating that another code existed for OPSS purposes. For example, if drug X has two HCPCS codes, one for a 1 ml dose and another for a 5 ml dose, the OPSS would assign a payable status indicator to the 1 ml dose and SI **B** to the 5 ml dose.

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

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

**3.6.3.4** 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.

### **3.6.4 Correct Reporting of Drugs and Biologicals When Used As Implantable Devices**

**3.6.4.1** 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.

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

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

### **3.6.5 Correct Reporting of Units for Drugs**

**3.6.5.1** 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.

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**3.6.5.2** 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.

**3.6.5.3** 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.

### 3.7 Orphan Drugs

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

- 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).
- 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).

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

### 3.7.3 Payment Methodology

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

**3.7.3.2** 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.

### 3.8 Vaccines

**3.8.1** 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.

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

**3.8.3** See [Figure 13.3-9](#) for vaccine administration codes and SIs.

**FIGURE 13.3-9 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS**

HCPCS LEVEL 1* CODE	DESCRIPTION	SI	APC
G0008	Influenza vaccine administration	S	0350

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**FIGURE 13.3-9 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS (CONTINUED)**

HCPCS LEVEL 1* CODE	DESCRIPTION	SI	APC
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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### 3.9 Payment Policy for Radiopharmaceuticals

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

**3.9.1** The threshold for the establishment of separate APCs for radiopharmaceuticals is \$60.

**3.9.2** 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.

**3.9.3** Radiopharmaceuticals will be excluded from receiving outlier payments.

**3.9.4** 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.”

### 3.10 Blood and Blood Products

**3.10.1** 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.

**3.10.2** 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).

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**3.10.3** 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.

**3.10.4** Payment for the collection, processing, and storage of autologous blood, as described by HCPCS Level I<sup>9</sup> code 86890 and used in transfusion, is made through APC 347 (Level III Transfusion Laboratory Procedures).

**3.10.5** 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

<sup>9</sup> HCPCS Level I/CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**FIGURE 13.3-10 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES (CONTINUED)**

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
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

**3.10.6** 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.

### **3.11 Adjustment to Payment in Cases of Devices Replaced with Partial Credit for the Replaced Device**

**3.11.1** 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](#).

**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**<sup>10</sup>.

**3.11.3** 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.

**3.11.4** 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.

### **3.12 Payment When Devices Are Replaced Without Cost or Where Credit for a Replacement Device is Furnished to the Hospital**

**3.12.1** 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.

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

<sup>10</sup> Effective January 1, 2015, SI of **X** is no longer recognized.

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

**3.12.2.2** 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

**3.12.2.3** 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%.

**3.12.3** 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 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 THE FB MODIFIER MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACEMENT DEVICE**

DEVICE HCPCS CODE	DESCRIPTOR
C1721	AICD, dual chamber
C1722	AICS, single chamber
C1728	Cath, brachytx seed adm
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep Dev urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual rate-resp
C1786	Pmkr, single rate-resp
C1789	Prosthesis, breast, imp
C1813	Prostheses, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro, rechg bat sys
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans

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**FIGURE 13.3-11 DEVICES FOR WHICH THE FB MODIFIER MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACEMENT DEVICE (CONTINUED)**

DEVICE HCPCS CODE	DESCRIPTOR
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Pmkr, other than sing/dual
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8600	Implant breast silicone/eq
L8614	Cochlear device/system
L8685	Implt nrostm pls gen sng rec
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 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, Excluded	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/Repair 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	T	Level II Implantation of Neurological Device	85	42
0225	S	Implantation of Neurostimulator Electrodes, Cranial	62	31
0227	T	Implantation of Drug Infusion Devices	82	41

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**FIGURE 13.3-12 ADJUSTMENTS TO APCS IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED FOR CY 2009 (CONTINUED)**

APC	SI	APC GROUP TITLE	DEVICE OFFSET PERCENTAGE FOR NO-COST/FULL CREDIT CASE	DEVICE OFFSET PERCENTAGE FOR PARTIAL CREDIT CASE
0229	T	Transcatheter Placement of Intravascular Shunts	84	42
0259	T	Level IV ENT Procedures	88	44
0315	T	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
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	76	38
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	71	36
0680	S	Insertion of Patient Activated Event Recorders	71	35
0681	T	Knee Arthroplasty	71	36

**3.12.4** 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.

**3.12.5** 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.

**3.12.6** 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.

**3.13 Policies Affecting Payment of New Technology Services**

**3.13.1** 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.

**3.13.2** 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.

**3.13.3** The SI of **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.

**3.13.4** 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.

**3.13.5** 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.

**3.13.6** 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.

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

**3.13.8** 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.

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

**3.13.9.1** 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**).

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

**3.13.9.3** 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:

- From \$0 to \$50 in increments of \$10.
- From \$50 to \$100 in a single \$50 increment.
- From \$100 through \$2,000 in intervals of \$100.

- From \$2,000 through \$6,000 in intervals of \$500.

**3.13.10** 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.)

### **3.13.11 Process and Criteria for Assignment to a New Technology APC Group**

#### **3.13.11.1 Services Paid Under New Technology APCs**

**3.13.11.1.1** Limit eligibility for placement in new technology APCs to complete services and procedures.

**3.13.11.1.2** 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.

**3.13.11.1.3** 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).

- 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.
- 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.

**3.13.11.1.4** 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.

#### **3.13.11.2 Criteria for Determining Whether a Service Will Be Assigned to a New Technology APC**

**3.13.11.2.1** 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.

**3.13.11.2.2** 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.

**3.13.11.2.3** The service does not qualify for an additional payment under the transitional pass-through provisions.

**3.13.11.2.4** 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.

**3.13.11.2.5** The service falls within the scope of TRICARE benefits.

**3.13.11.2.6** 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.

### **3.14 Coding And Payment Of ED Visits**

**3.14.1** 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.”

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

**3.14.3** 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.

**3.14.4** 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:

**3.14.4.1** It is licensed by the State in which it is located under applicable State law as an Emergency Room (ER) or ED;

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**3.14.4.2** 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

**3.14.4.3** 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.

**3.14.5** 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.

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

**FIGURE 13.3-13 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDs**

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0380	Level 1 Hosp Type <b>B</b> Visit	Level 1 hospital ED visit provided in a Type <b>B</b> ED. (The ED must meet at least one of the following requirements: <ol style="list-style-type: none"> <li><b>1.</b> It is licensed by the State in which it is located under applicable State law as an ER or ED;</li> <li><b>2.</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</li> <li><b>3.</b> 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.)</li> </ol>
G0381	Level 2 Hosp Type <b>B</b> Visit	Level 2 hospital ED visit provided in a Type <b>B</b> ED. (The ED must meet at least one of the following requirements: <ol style="list-style-type: none"> <li><b>1.</b> It is licensed by the State in which it is located under applicable State law as an ER or ED;</li> <li><b>2.</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</li> <li><b>3.</b> 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.)</li> </ol>

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**FIGURE 13.3-13 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDs (CONTINUED)**

<b>HCPCS CODE</b>	<b>SHORT DESCRIPTOR</b>	<b>LONG DESCRIPTOR</b>
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: <ol style="list-style-type: none"> <li>1. It is licensed by the State in which it is located under applicable State law as an ER or ED;</li> <li>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</li> <li>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.)</li> </ol>
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: <ol style="list-style-type: none"> <li>1. It is licensed by the State in which it is located under applicable State law as an ER or ED;</li> <li>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</li> <li>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.)</li> </ol>
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: <ol style="list-style-type: none"> <li>1. It is licensed by the State in which it is located under applicable State law as an ER or ED;</li> <li>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</li> <li>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.)</li> </ol>

**3.14.7** 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.

**3.14.8** 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.

**3.14.9** 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.

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**3.14.10** 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.

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

- If critical care is provided without trauma activation, the hospital will bill with either CPT<sup>11</sup> codes 99291 or 99292, receiving payment for APC 0617.
- 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.

**3.14.12** 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)
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam Pt lops
		G0241	Office consultation (Level 1)
		G0271	Confirmatory consultation (Level 1)
		G0264	Assmt otr CHF, CP, asthma
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level 2)
		99212	Office/outpatient visit, est (Level 2)
		99213	Office/outpatient visit, est (Level 3)
		99243	Office consultation (Level 3)
		99242	Office consultation (Level 2)
		99273	Confirmatory consultation (Level 3)
		99272	Confirmatory consultation (Level 2)
		99431	Initial care, normal newborn
		G0246	Follow-up eval of foot pt lop
		G0344	Initial preventive exam

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**FIGURE 13.3-14 ASSIGNMENT OF CPT E/M CODES AND OTHER HCPCS CODES TO NEW VISIT APCs FOR CY 2007 (CONTINUED)**

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 3 Hospital Clinic Visits	0606	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	99204	Confirmatory consultation (Level 1)
		99215	Office/outpatient visit, est (Level 5)
		99245	Office consultation (Level 5)
		99275	Confirmatory consultation (Level 5)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level 5)
		G0175	OPPS service, sched team conf
Level 1 Type A Emergency Visits	0609	99281	Emergency department visit
Level 2 Type A Emergency Visits	0613	99282	Emergency department visit
Level 3 Type A Emergency Visits	0614	99283	Emergency department visit
Level 4 Type A Emergency Visits	0615	99284	Emergency department visit
Level 5 Type A Emergency Visits	0616	99285	Emergency department visit
Critical Care	0617	99291	Critical care, first hour

**3.15 OPPS PRICER**

**3.15.1** Common PRICER software will be provided to the contractor that includes the following data sources:

- National APC amounts
- Payment status by HCPCS code
- Multiple surgical procedure discounts
- Fixed dollar threshold
- Multiplier threshold
- Device offsets
- Other payment systems pricing files (CMAC, DMEPOS, and statewide prevailings)

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

- Units;
- HCPCS/Modifiers;
- APC;
- Status payment indicator;
- Line item date of service;
- Primary diagnosis code; and
- Other necessary OCE output.

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 13, Section 3

#### Prospective Payment Methodology

**3.15.3** The following data elements will be passed into the PRICER by the contractors:

- Wage indexes (same as DRG wage indexes);
- Statewide CCRs as provided in the CMS Final Rule and listed on DHA's OPSS web site at <http://www.tricare.mil/opps>;
- Locality Code: Based on CBSA - two digit = rural and five digit = urban;
- Hospital Type: Rural SCH = 1 and All Others = 0

**3.15.4** The outpatient PRICER will return the line item APC and cost outlier pricing information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary EOB with exception for an electronic 835 transaction. Paper EOB 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.

**3.15.5** 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 **T** lines will be summed and the charges will then be divided up proportionately to the payment rates for each **T** line (refer to [Figure 13.3-15](#)). 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  $\$6,000/\$10,000 \times \$20,000 = \$12,000$ .

### 3.16 TRICARE Specific Procedures/Services

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

**3.16.2** 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.

### 3.17 Validation Reviews

OPSS claims are not subject to validation review.

### **3.18 Hospital-Based Birthing Centers**

Hospital-based birthing centers will be reimbursed the same as freestanding birthing centers except the all inclusive rate consisting of the CMAC for CPT<sup>12</sup> code 59400 and the state specific non-professional component, will lag two months (i.e., April 1 instead of February 1).

### **4.0 EFFECTIVE DATE**

May 1, 2009.

- END -

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<sup>12</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.



## Acronyms And Abbreviations

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AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
AAFES	Army/Air Force Exchange Service
AAMFT	American Association for Marriage and Family Therapy
AAP	American Academy of Pediatrics
AAPC	American Association of Pastoral Counselors
AARF	Account Authorization Request Form
AATD	Access and Authentication Technology Division
ABA	American Banking Association Applied Behavior Analysis
<b>ABAT</b>	<b>Applied Behavior Analysis Technician</b>
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
AC	Active Component
ACA	Affordable Care Act
ACD	Augmentative Communication Devices
ACE	Angiotensin-Converting Enzyme
ACH	Automated Clearing House
ACI	Autologous Chondrocyte Implantation
ACIP	Advisory Committee on Immunization Practices
ACO	Administrative Contracting Officer
ACOG	American College of Obstetricians and Gynecologists
ACOR	Administrative Contracting Officer's Representative
ACP	American College of Physicians
ACS	American Cancer Society
ACSC	Ambulatory Care Sensitive Condition
ACSP	Autism Demonstration Corporate Services Provider
ACTUR	Automated Central Tumor Registry
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

ADAMHA	Alcohol, Drug Abuse, And Mental Health Administration
ADAMHRA	Alcohol, Drug Abuse, And Mental Health Reorganization Act
ADCP	Active Duty Claims Program
ADD	Active Duty Dependent
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADH	Atypical Ductal Hyperplasia
ADL	Activities of Daily Living
ADP	Automated Data Processing
ADSM	Active Duty Service Member
AF	Atrial Fibrillation
AFAP	Attenuated Familial Adenomatous Polyposis
AFB	Air Force Base
AFOSI	Air Force Office of Special Investigations
AFS	Ambulance Fee Schedule
AGR	Active Guard/Reserve
AHA	American Hospital Association
AHCB	American Hippotherapy Certification Board
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIF	Ambulance Inflation Factor
AIIM	Association for Information and Image Management
AIS	Ambulatory Infusion Suite Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALH	Atypical Lobular Hyperplasia
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMCB	American Midwifery Certification Board
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous [Myeloid] Leukemia

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

ANCC	American Nurses Credentialing Center
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Adenomatous Polyposis Coli Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ARB	Angiotensin Receptor Blocker
ARCIS	Archives and Records Centers Information System
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ARVC	Arrhythmogenic Right Ventricular Cardiomyopathy
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ASRM	American Society for Reproductive Medicine
ATA	American Telemedicine Association
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BAA	Business Associate Agreement
BACB	<b>Behavior</b> Analyst Certification Board
BART	BRAC Analysis Large Rearrangement Test
BBA	Balanced Budget Act

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BC	Birth Center
BCaBA	Board Certified Assistant Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst - Doctoral
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BE&SD	Beneficiary Education and Support Division
BH	Behavioral Health
BI	Background Investigation
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPPV	Benign Paroxysmal Positional Vertigo
BRAC	Base Realignment and Closure
BRCA	BReast CAncer (genetic testing)
BRCA1/2	BReast CAncer Gene 1/2
BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BT	Behavior Technician
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&P	Compensation and Pension
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CAD	Coronary Artery Disease

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORE	Committee on Operating Rules for Information Exchange
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CP	Cerebral Palsy
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRP	Canalith Repositioning Procedure
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)

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## Appendix A

### Acronyms And Abbreviations

---

CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTA	Composite Tissue Allotransplantation Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CTLN1	Citrullinemia Type 1
CTX	Corporate Trade Exchange
CUC	Chronic Ulcerative Colitis
<b>CUI</b>	<b>Controlled Unclassified Information</b>
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DBN	DoD Benefits Number
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigative Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDD	Degenerative Disc Disease
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard Disability Evaluation System
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
<b>DHA</b>	<b>Defense Health Agency</b>
DHA-GL	Defense Health Agency-Great Lakes (formerly Military Medical Support Office (MMSO))
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DHS	Department of Homeland Security
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DLI	Donor Lymphocyte Infusion
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMR	Direct Member Reimbursement
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen

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DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty (Band)
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoDM	Department of Defense Manual
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPCLO	Defense Privacy and Civil Liberties Office
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSA	Data Sharing Agreement
DSAA	Data Sharing Agreement Application Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DS Logon	DoD Self-Service Logon
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSMT	Diabetes Self-Management Training

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DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Versatile Disc (formerly Digital Video Disc)
DVD-R	Digital Versatile Disc-Recordable
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EACH	Essential Access Community Hospital
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFD	Energy Flux Density
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

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#### Acronyms And Abbreviations

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EFP	Environment Failure Protection
eFRC	Electronic Federal Records Center
EFT	Electronic Funds Transfer
	Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care
	Extended Care Health Option Home Health Care
EHP	Employee Health Program
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Early Identification
	Enrollment Information for Dental
EIDS	Executive Information and Decision Support
EIIP	External Insulin Infusion Pump
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim
	Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
eMSM	Enhanced Multi-Service Market
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
EOP	Explanation of Payment
ePHI	electronic Protected Health Information
EPO	Erythropoietin
	Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income and Security Act of 1974

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#### Acronyms And Abbreviations

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ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV <sub>1</sub>	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FOUO	For Official Use Only
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSH	Follicle Stimulating Hormone

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Appendix A

Acronyms And Abbreviations

---

FSO	Facility Security Officer
FTC	Federal Trade Commission
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAF	Geographic Adjustment Factor
GAO	General Accounting Office
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHP	Group Health Plan
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
GTMCPA	General Temporary Military Contingency Payment Adjustment
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly HCFA Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDE	Humanitarian Device Exemption
HDGC	Hereditary Diffuse Gastric Cancer

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

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HDL	Hardware Description Language
HDR	High Dose Radiation
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HE ESWT	High Energy Extracorporeal Shock Wave Therapy
HepB-Hib	Hepatitis B and Hemophilus influenza B
HH	Home Health
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
<b>HIT</b>	<b>Health Information Technology</b>
HITECH	Health Information Technology for Economic and Clinical Health
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HSWL	Health, Safety and Work-Life

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HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
I&OD	Infrastructure & Operations Division
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program

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IFC	Interim Final Rule with comment
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHC	Immunohistochemistry
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRF	Inpatient Rehabilitation Facility
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVD	In Vitro Diagnostic Ischemic Vascular Disease
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
LE ESWT	Low Energy Extracorporeal Shock Wave Therapy
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
LIS	Low Income Subsidy
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
LVSD	Left Ventricular Systolic Dysfunction
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MAP	MYH-Associated Polyposis
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHCC	Maryland Health Care Commission
MHO	Medical Holdover

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMPCMHP	Maryland Multi-Payer Patient-Centered Medical Home Program
MMPP	Maryland Multi-Payer Patient
MMR	Mismatch Repair
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPC	Medical Payments Coverage
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
MS	Microsoft® Multiple Sclerosis
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSI	Microsatellite Instability
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MSS	Medical Social Services
MST	Mountain Standard Time

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### Appendix A

#### Acronyms And Abbreviations

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MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
MYH	mutY homolog
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACHA	National Automated Clearing House Association
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCCN	National Comprehensive Cancer Network
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List

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#### Acronyms And Abbreviations

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NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLDA	Nursery and Labor/Delivery Adjustment
NLT	No Later Than
NMA	Non-Medical Attendant
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set

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OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office for Civil Rights Optical Character Recognition
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OIT	Oral Immunotherapy
OLT	Orthotopic Liver Transplantation
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OTCD	Ornithine Transcarbamylase Deficiency
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&CL	Privacy & Civil Liberties [Office]
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide

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PAO <sub>2</sub>	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAS	Privacy Act Statement
PAT	Performance Assessment Tracking
PATH Intl	Professional Association of Therapeutic Horsemanship International
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMH	Patient-Centered Medical Home
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Pelvic Congestion Syndrome Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center

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#### Acronyms And Abbreviations

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PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
PGD	Preimplantation Genetic Diagnosis
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PII	Personally Identifiable Information
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M

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POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPC-PCMH	Physician Practice Connections Patient-Centered Medical Home
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSF	Provider Specific File
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy

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PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QABA	Qualified Applied Behavior Analysis
QASP	Qualified Autism Services Practitioner
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RARC	Remittance Advice Remark Code
RBT	Registered Behavior Technician
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RIA	Radioimmunoassay

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### Acronyms And Abbreviations

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RM	Records Management
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory
	Rough Order of Magnitude
ROMF	Record Object Metadata File
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume
	Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
	<b>Specified Authorization Staff (formerly Service Point of Contact (SPOC))</b>
SAT	Service Assist Team
SAVR	Surgical Aortic Valve Replacement
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information
	Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue

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### Acronyms And Abbreviations

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S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SLP	Speech-Language Pathology
SMC	System Management Center
<b>SME</b>	<b>Subject Matter Expert</b>
SMHC	Supervised Mental Health Counselor
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons System of Records
SORN	System of Records Notice
<b>SP</b>	<b>Special Publication</b>
SPA	Simple Power Analysis
SPC	Special Processing Code
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event

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SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVP	State Vaccine Program State Vaccine Program entity
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
T-3	TRICARE Third Generation
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAH	Total Artificial Heart
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TAVR	Transcatheter Aortic Valve Replacement
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDR	Total Disc Replacement

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#### Acronyms And Abbreviations

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TDRL	Temporary Disability Retired List
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TN	Termination Notice
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office

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TP	Treatment Plan
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter

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TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouses
URL	Universal Resource Locator
US	Ultrasound United States
US-CERT	United States-Computer Emergency Readiness Team
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
<b>USCYBERCOM</b>	<b>United States Cyber Command</b>
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force

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USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
<b>WDR</b>	<b>Written Determination Report</b>
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

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