



DEFENSE  
HEALTH AGENCY

**MB&RS**

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS  
16401 EAST CENTRETECH PARKWAY  
AURORA, CO 80011-9066

**CHANGE 117  
6010.58-M  
SEPTEMBER 8, 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 UPDATES 15-001**

**CONREQ: 17452**

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

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

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

**IMPLEMENTATION DATE: October 8, 2015.**

FAZZINI.ANN.NO  
REEN.119980227  
1

Digitally signed by  
FAZZINI.ANN.NOREEN.1199802271  
DN: c=US, o=U.S. Government, ou=DoD,  
ou=PKI, ou=DHA,  
cn=FAZZINI.ANN.NOREEN.1199802271  
Date: 2015.09.02 14:09:37 -08'00'

**Ann N. Fazzini  
Team Chief, Medical Benefits &  
Reimbursement Section (MB&RS)  
Defense Health Agency (DHA)**

**ATTACHMENT(S): 99 PAGE(S)  
DISTRIBUTION: 6010.58-M**

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

**CHANGE 117**  
**6010.58-M**  
**SEPTEMBER 8, 2015**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 11, pages 1, 2, 5, and 6  
Section 16, pages 3 and 4

**CHAPTER 2**

Section 1, pages 3 through 19

**CHAPTER 5**

Section 3, pages 1 through 6

**CHAPTER 6**

Section 2, pages 1 through 4  
Section 3, pages 5 through 7  
Section 8, pages 1, 2, and 7 through 19

**CHAPTER 9**

Section 1, pages 1 through 6

**CHAPTER 12**

Section 4, pages 11 and 12  
Addendum J, page 1  
Addendum M (CY 2015), page 1

**CHAPTER 13**

Section 1, pages 1 through 8 and 11 through 13  
Section 2, pages 1, 2, and 21 through 24  
Section 3, pages 1 - 8, 15 - 22, 33, 34, and 53 - 55

**INSERT PAGE(S)**

Section 11, pages 1, 2, 5, and 6  
Section 16, pages 3 and 4

Section 1, pages 3 through 19

Section 3, pages 1 through 6

Section 2, pages 1 through 4  
Section 3, pages 5 through 7  
Section 8, pages 1, 2, and 7 through 19

Section 1, pages 1 through 6

Section 4, pages 11 and 12  
Addendum J, page 1  
Addendum M (CY 2015), page 1

Section 1, pages 1 through 8 and 11 through 13  
Section 2, pages 1, 2, and 21 through 24  
Section 3, pages 1 - 8, 15 - 22, 33, 34, and 53 - 55

## **SUMMARY OF CHANGES**

### **CHAPTER 1**

1. Section 11. This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.
2. Section 16. This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.

### **CHAPTER 2**

3. Section 1. This change updates the CPT code ranges for ancillary services not subject to copayments. EFFECTIVE DATE: 03/26/1998.

### **CHAPTER 5**

4. Section 3. This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.

### **CHAPTER 6**

5. Section 2. This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.
6. Section 3. This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.
7. Section 8. This change updates websites as a result of the conversion to health.mil. This change also adds the National Operating Standard Costs as a Share of Total Costs for FY2015 for acute care inpatient hospitals and children's hospitals. EFFECTIVE DATE: 10/01/2014.

### **CHAPTER 9**

8. Section 1. This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.

**SUMMARY OF CHANGES (Continued)**

**CHAPTER 12**

9. Section 4. This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.
10. Addendum J. This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.
11. Addendum M (CY 2015). This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.

**CHAPTER 13**

12. Section 1. This change updates websites as a result of the conversion to health.mil. This change revises the statutory authority of 10 USC 1079(j) to 1079(i). This change removed the requirement of contractors to monitor the TRICARE website for the current list of Critical Access Hospitals. EFFECTIVE DATE: As stated in the issuance.
13. Section 2. This change updates websites as a result of the conversion to health.mil. EFFECTIVE DATE: As stated in the issuance.
14. Section 3. This change updates websites as a result of the conversion to health.mil. This change revises the statutory authority of 10 USC 1079(j) to 1079(i). EFFECTIVE DATE: As stated in the issuance.

## Chapter 1

## Section 11

# Claims for Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

Issue Date: December 29, 1982

Authority: [32 CFR 199.4\(d\)\(3\)\(ii\)](#), [\(d\)\(3\)\(iii\)](#), [\(d\)\(3\)\(vii\)](#), and [\(d\)\(3\)\(viii\)](#)

---

### 1.0 APPLICABILITY

This policy is mandatory for reimbursement of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided by either network or non-network providers. Alternative network reimbursement methodologies are also permitted when approved by the **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

### 2.0 ISSUE

How are claims for DMEPOS to be reimbursed?

### 3.0 POLICY

**3.1** Reimbursement for DMEPOS is established by fee schedules. The maximum allowable amount is limited to the lower of the billed charge, the negotiated rate (network providers) or the DMEPOS fee schedule amount.

**3.2** The DMEPOS fee schedule is categorized by state. The allowed amount shall be that which is in effect in the specific geographic location at the time covered services and supplies are provided to a beneficiary. For DMEPOS delivered to the beneficiary's home, the home address is the controlling factor in pricing and the home address shall be used to determine the DMEPOS allowed amount.

**3.3** Payment for an item of Durable Medical Equipment (DME) may also take into consideration:

**3.3.1** The lower of the total rental cost for the period of medical necessity or the reasonable purchase cost; and

**3.3.2** Delivery charge, pick-up charge, shipping and handling charges, and taxes.

**3.4** The fee schedule classifies most DMEPOS into one of six categories.

**3.4.1** Inexpensive or other routinely purchased DME.

**3.4.2** Items requiring frequent and substantial servicing.

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

### Chapter 1, Section 11

#### Claims for Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

---

**3.4.3** Customized items.

**3.4.4** Other prosthetic and orthotic devices.

**3.4.5** Capped rental items.

**3.4.6** Oxygen and oxygen equipment.

**3.5** Inexpensive or routinely purchased DME.

**3.5.1** Payment for this type of equipment is for rental or lump sum purchase. The total payment may not exceed the actual charge of the fee for a purchase.

**3.5.2** Inexpensive DME. This category is defined as equipment whose purchase price does not exceed \$150.

**3.5.3** Other routinely purchased DME. This category consists of equipment that is purchased at least 75% of the time.

**3.5.4** Modifiers used in this category are as follows (not an all-inclusive list):

RR Rental

NU Purchase of new equipment. Only used if new equipment was delivered.

UE Purchase of used equipment. Used equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator).

**3.6** Items requiring frequent and substantial servicing.

**3.6.1** Equipment in this category is paid on a rental basis only. Payment is based on the monthly fee schedule amounts until the medical necessity ends. No payment is made for the purchase of equipment, maintenance and servicing, or for replacement of items in this category.

**3.6.2** Supplies and accessories are not allowed separately.

**3.6.3** For oxygen and oxygen supplies see [Section 12](#) and the TRICARE Policy Manual (TPM), [Chapter 8, Section 10.1](#).

**3.7** Certain customized items.

**3.7.1** The beneficiary's physician must prescribe the customized equipment and provide information regarding the patient's physical and medical status to warrant the need for the equipment.

**3.7.2** See the TPM, [Chapter 9, Section 15.1](#) for further information regarding customization of DME.

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

### Chapter 1, Section 11

#### Claims for Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

---

allowed charge is \$600. The contractor will show the monthly billed charge as \$77 and \$60 as the allowed.

**3.10.4** Notice To Beneficiary. When the contractor makes a determination to rent or purchase, the beneficiary shall be notified of that determination. The beneficiary is not required to follow the contractor's determination. He or she may purchase the equipment even though the contractor has determined that rental is more cost effective. However, payment for the equipment will be based on the contractor's determination. Because of this, the notice should be carefully worded to avoid giving any impression that compliance is mandatory, but should caution the beneficiary concerning the expenses in excess of the allowed amount. Suggested wording is included in [Addendum B](#).

**3.11** Oxygen and oxygen equipment. Oxygen and oxygen equipment is to be reimbursed in accordance with [Section 12](#).

**3.12** Parenteral/enteral nutrition therapy. Parenteral/enteral pumps can be either rented or purchased.

**3.13** Splints and Casts. The reimbursement rates for these items of DMEPOS shall be based on Medicare's pricing.

**3.14** Reimbursement Rates.

**3.14.1** The DMEPOS pricing information is available at <http://www.health.mil/rates> and the claims processors are required to replace the existing pricing with the updated pricing information within 10 calendar days of publication on the internet.

**3.14.2** The pricing for splints and casts is available at <http://www.health.mil/rates> and will be updated annually.

**3.14.3** See the TRICARE Operations Manual (TOM), [Chapter 1, Section 4](#) regarding updating and maintaining TRICARE reimbursement systems.

**3.15** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any TRICARE coverage.

**3.16** Extensive maintenance which, based on manufacturer recommendations, must be performed by authorized technicians is covered as medically necessary. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the beneficiary. Maintenance may be covered for patient owned-DME when such maintenance must be performed by an authorized technician.

**3.17** Replacement and Repair of DMEPOS. The following modifiers are to be used to identify repair and replacement of an item.

**3.17.1** RA - Replacement of an item. The RA modifier on claims denotes instances where an item is furnished as a replacement for the same item which has been lost, stolen, or irreparable damaged.

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

### Chapter 1, Section 11

#### Claims for Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

---

**3.17.2** RB - Replacement of a part of DME furnished as part of a repair. The RB modifier indicates replacement parts of an item furnished as part of the service of repairing the item.

#### **4.0 EXCLUSIONS AND LIMITATIONS**

**4.1** A cost that is non-advantageous to the government shall not be allowed even when the equipment cannot be rented or purchased within a "reasonable distance" of the beneficiary's current address. The charge for delivery and pick up is an allowable part of the cost of an item; consequently, distance does not limit access to equipment.

**4.2** Line-item interest and carrying charges for equipment purchase shall not be allowed. A lump-sum payment for purchase of an item of equipment is the limit of the government cost-share liability. Interest and carrying charges result from an arrangement between the beneficiary and the equipment vendor for prorated payments of the beneficiary's cost-share liability over time.

**4.3** Routine periodic servicing such as testing, cleaning, regulating, and checking that is generally expected to be done by the owner. Normally, the purchasers are given operating manuals that describe the type of service an owner may perform. Payment is not made for repair, maintenance, and replacement of equipment that requires frequent substantial servicing, oxygen equipment, and capped rental items that the patient has not elected to purchase.

#### **5.0 EFFECTIVE DATES**

**5.1** September 1, 2005, for the DMEPOS system.

**5.2** April 1, 2011, for reimbursement of splints and casts.

- END -

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

**3.1.2** Exceptions to the above policy prior to implementation of the hospital OPPS, are:

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

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

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

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

**3.1.5** The OPPS inpatient only list shall apply to OPPS, non-OPPS, and professional providers. Refer to [Chapter 13, Section 5, paragraph 3.2](#). The inpatient only list is available on [the Defense Health Agency's \(DHA's\) web site at <http://www.health.mil/rates>](#).

## **3.2 Multiple Primary Surgeons**

When more than one surgeon acts as a primary surgeon for multiple procedures during the same operative session, the services of each may be covered, subject to the following considerations:

- For co-surgeons (modifier 62), TRICARE pays 125% of the global fee and divides the payment equally between the two surgeons. This means that each surgeon receives 62.5% of the TRICARE allowable charge for each procedure. No payment may be made for an assistant surgeon in such cases.
- For team surgery (modifier 66), payment needs to be determined on a case-by-case basis. Team surgery cases may be seen with organ transplants, separation of siamese twins, severe trauma cases, and cases of a similar nature.
- Payment may not be made to any of the primary surgeons for assisting any of the other primary surgeons.

## **3.3 Assistant Surgeons**

See [Section 17](#).

## **3.4 Pre-Operative Care**

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

examination is performed to assess the beneficiary's suitability for the subsequent surgery.

### 3.5 Post-Operative Care

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

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

### 3.6 Re-Operations For Complications

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

### 3.7 Global Surgery For Major Surgical Procedures

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

### 3.8 Second Opinion

**3.8.1** Claims for patient-initiated, second-physician opinions pertaining to the medical need for surgery or other major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) may be paid. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery or other major nonsurgical diagnostic and therapeutic procedure.

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

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

---

allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CHAMPUS Maximum Allowable Charge (CMAC)). In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

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

#### **1.1.6.4 For Certain Reservists**

The Director, Defense Health Agency (DHA), may waive the individual or family deductible for family members of a Reserve Component (RC) member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a RC member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 United States Code (USC) 101(a)(13). Also, for this purpose a family member is a lawful husband or wife of the member or an eligible child.

### **1.2 TRICARE Prime**

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

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

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

**1.2.4** Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply). **CPT code ranges are given; however, these codes are not all-inclusive. The most up-to-date codes should be utilized to identify services within each category, in accordance with the TOM, Chapter 1, Section 4. Additionally, listing of the code ranges does not imply coverage; the codes just provide the broad range of services that are not subject to copayments under this provision.**

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

---

**1.2.4.1** Diagnostic radiology and ultrasound services included in the CPT<sup>1</sup> procedure code range from 70010-76999, or any other code for associated contrast media;

**1.2.4.2** Diagnostic nuclear medicine services included in the CPT<sup>1</sup> procedure code range from 78012-78999;

**1.2.4.3** Pathology and laboratory services included in the CPT<sup>1</sup> procedure code range from 80047-89398; G0461-G0462 (during 2014); and

**1.2.4.4** Cardiovascular studies included in the CPT<sup>1</sup> procedure code range from 93000-93355.

**1.2.4.5** Venipuncture included in the CPT<sup>1</sup> procedure code range from 36400-36425.

**1.2.4.6** Collection of blood specimens in the CPT<sup>1</sup> procedure codes 36591 and 36592.

**1.2.4.7** Fetal monitoring for CPT<sup>1</sup> procedure codes 59020, 59025, and 59050.

**Note:** Multiple discounting will not be applied to the following CPT<sup>1</sup> procedure codes for venipuncture, fetal monitoring, and collection of blood specimens; 36400-36425, 36591, 36592, 59020, 59025, and 59050.

**1.2.5** POS option. See [Section 3](#).

### **1.3 Basic Program: TRICARE Standard**

#### **1.3.1 Deductible Amount: Outpatient Care**

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

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

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

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

**1.3.1.2.1** Deductible, Individual: Each beneficiary is liable for the first \$150.00 of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

**1.3.1.2.2** Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed \$300.00.

---

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

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

---

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

**1.3.1.4** Allowable Amount Does Not Exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (or \$300.00 if [paragraph 1.3.1.2](#), applies), and no one beneficiary's allowable amounts exceed \$50.00 (or \$150.00 if [paragraph 1.3.1.2](#) applies), neither the family nor the individual deductible will have been met and no TRICARE benefits are payable.

**1.3.1.5** In the case of family members of an active duty member of pay grade E-5 or above, with Persian Gulf conflict service who is, or was, entitled to special pay for hostile fire/imminent danger authorized by 37 USC 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm, the deductible shall be the amount specified in [paragraph 1.3.1.2](#), for care rendered after October 1, 1991.

**Note:** The provisions of [paragraph 1.3.1.5](#), also apply to family members of service members who were killed in the Gulf, or who died subsequent to Gulf service; and to service members who retired prior to October 1, 1991, after having served in the Gulf war, and to their family members.

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

**Note:** This demonstration is effective December 8, 1995, and is in effect until such time as Executive Order 12982 expires. TRICARE eligible beneficiaries other than family members of reservists called to active duty in support of Operation Joint Endeavor are not eligible for participation. This demonstration is limited to the annual TRICARE Standard and Extra deductible; other TRICARE cost-sharing continues to apply. All current TRICARE rules, unless specifically provided otherwise, will continue to apply.

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

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

**1.3.1.7** Adjustment of Excess. Any beneficiary identified under [paragraphs 1.3.1.4](#), [1.3.1.5](#), and [1.3.1.6](#), who paid any deductible in excess of the amounts stipulated is entitled to an adjustment of any amount paid in excess against the annual deductible required under those paragraphs.

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

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

#### **1.3.2 Deductible Amount: Inpatient Care**

None.

#### **1.3.3 Cost-share Amount**

##### **1.3.3.1 Outpatient Care**

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

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

##### **1.3.3.2 Inpatient Care**

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

**FIGURE 2.1-1 UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS**

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

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1

Cost-Shares And Deductibles

**FIGURE 2.1-1 UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS**

| PERIOD   | DAILY CHARGE |
|--|--------------|
| October 1, 2009 - September 30, 2010 (for ADFMs not enrolled in Prime) | \$16.30      |
| October 1, 2010 - September 30, 2011 (for ADFMs not enrolled in Prime) | \$16.85      |
| October 1, 2011 - September 30, 2012 (for ADFMs not enrolled in Prime) | \$17.05      |
| October 1, 2012 - September 30, 2013 (for ADFMs not enrolled in Prime) | \$17.35      |
| October 1, 2013 - September 30, 2014 (for ADFMs not enrolled in Prime) | \$17.65      |
| October 1, 2014 - September 30, 2015 (for ADFMs not enrolled in Prime) | \$17.80      |

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

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

**1.3.3.3 Cost-Shares: Maternity**

**1.3.3.3.1** Determination. Maternity care cost-share shall be determined as follows:

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

**Note 1:** Inpatient cost-share formula applies to prenatal and postnatal care provided in the office of a civilian physician or certified nurse-midwife in connection with maternity care ending in childbirth or termination of pregnancy in, or on the way to, a Military Treatment Facility (MTF) inpatient childbirth unit. ADFMs pay a per diem charge (or a \$25.00 minimum charge) for an admission and there is no separate cost-share for them for separately billed professional charges or prenatal or postnatal care.

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

**1.3.3.3.1.3** Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

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

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

---

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

**1.3.3.3.3** Claims for **pregnancy testing** are cost-shared on an outpatient basis when the delivery is on an inpatient basis.

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

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

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

**1.3.3.3.6.1** In a DRG hospital:

**1.3.3.3.6.1.1** Same newborn date of birth and date of admission:

- For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.
- For newborn family members of other than active duty members, unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of the number of hospital days minus three multiplied by the per diem amount, OR 25% of the total billed charges (less duplicates and DRG non-reimbursables such as hospital-based professional charges).

**1.3.3.3.6.1.2** Different newborn date of birth and date of admission:

- For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.
- For all other beneficiaries, the cost-share is applied to all days in the inpatient stay unless the newborn is deemed enrolled in Prime.

**1.3.3.3.6.2** In DRG exempt hospital:

**1.3.3.3.6.2.1** Same newborn date of birth and date of admission:

- For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.
- For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

---

##### **1.3.3.3.6.2.2** Different newborn date of birth and date of admission:

- For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.
- For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

**1.3.3.3.7** Maternity Related Care. Medically necessary treatment rendered to a pregnant woman for a non-obstetrical medical, anatomical, or physiological illness or condition shall be cost-shared as a part of the maternity episode when:

- The treatment is otherwise allowable as a benefit; and,
- Delay of the treatment until after the conclusion of the pregnancy is medically contraindicated; and,
- The illness or condition is, or increases the likelihood of, a threat to the life of the mother; or,
- The illness or condition will cause, or increase the likelihood of, a stillbirth or newborn injury or illness; or,
- The usual course of treatment must be altered or modified to minimize a defined risk of newborn injury or illness.

#### **1.3.3.4 Cost-Shares: DRG-Based Payment System**

##### **1.3.3.4.1 General**

These special cost-sharing procedures apply only to claims paid under the DRG-based payment system.

##### **1.3.3.4.2 TRICARE Standard**

###### **1.3.3.4.2.1 Cost-shares for ADFMs.**

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

**1.3.3.4.2.1.2** Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission.

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

### Chapter 2, Section 1 Cost-Shares And Deductibles

---

#### **1.3.3.4.2.2** Cost-shares for beneficiaries other than ADFMs.

##### **1.3.3.4.2.2.1** The cost-share will be the lesser of:

**1.3.3.4.2.2.1.1** An amount based on a single, specific per diem amount which will not vary regardless of the DRG involved. The following is the DRG inpatient TRICARE Standard cost-sharing per diems for beneficiaries other than ADFMs.

- For FY 2005, the daily rate is \$512.
- For FY 2006, the daily rate is \$535.
- For FY 2007, the daily rate is capped at the FY 2006 level of \$535, per Section 704 of NDAA FY 2007.
- For FYs 2008, 2009, 2010, and 2011, the daily rate is \$535.
- For FY 2012, the daily rate is \$708.
- For FY 2013, the daily rate is \$698.
- For FY 2014, the daily rate is \$744.
- For FY 2015, the daily rate is \$764.

##### **1.3.3.4.2.2.1.1.1** The per diem amount will be calculated as follows:

- Determine the total allowable DRG-based amounts for services subject to the DRG-based payment system and for beneficiaries other than ADFMs during the same database period used for determining the DRG weights and rates.
- Add in the allowance for Capital and Direct Medical Education (CAP/DME) which have been paid to hospitals during the same database period used for determining the DRG weights and rates.
- Divide this amount by the total number of patient days for these beneficiaries. This amount will be the average cost per day for these beneficiaries.
- Multiply this amount by 0.25. In this way total cost-sharing amounts will continue to be 25% of the allowable amount.
- Determine any cost-sharing amounts which exceed 25% of the billed charge (see [paragraph 1.3.3.4.2.2.1.2](#)) and divide this amount by the total number of patient days in [paragraph 1.3.3.4.2.2.1.1](#)). Add this amount to the amount in [paragraph 1.3.3.4.2.2.1.1](#). This is the per diem cost-share to be used for these beneficiaries.

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

---

**1.3.3.4.2.2.1.1.2** The per diem amount will be required for each actual day of the beneficiary's hospital stay which the DRG-based payment covers except for the day of discharge. When the payment ends on a specific day because eligibility ends on either a long-stay or short-stay outlier day, the last day of eligibility is to be counted for determining the per diem cost-sharing amount. For claims involving a same-day discharge which qualify as an inpatient stay (e.g., the patient was admitted with the expectation of a stay of several days, but died the same day) the cost-share is to be based on a one-day stay. (The number of hospital days must contain one day in this situation.) Where long-stay outlier days are subsequently determined to be not medically necessary by a Peer Review Organization (PRO), no cost-share will be required for those days, since payment for such days will be the beneficiary's responsibility entirely.

**1.3.3.4.2.2.1.2** Twenty-five percent (25%) of the billed charge. The billed charge to be used includes all inpatient institutional line items billed by the hospital minus any duplicate charges and any charges which can be billed separately (e.g., hospital-based professional services, outpatient services, etc.). The net billed charges for the cost-share computation include comfort and convenience items.

**1.3.3.4.2.2.2** Under no circumstances can the cost-share exceed the DRG-based amount.

**1.3.3.4.2.2.3** Where the dates of service span different fiscal years, the per diem cost-share amount for each year is to be applied to the appropriate days of the stay.

#### **1.3.3.4.3 TRICARE Extra**

**1.3.3.4.3.1** Cost-shares for ADFMs. The cost-sharing provisions for ADFMs are the same as those for TRICARE Standard.

**1.3.3.4.3.2** Cost-shares for beneficiaries other than ADFMs. The cost-sharing provisions for beneficiaries other than ADFMs is the same as those for TRICARE Standard, except the per diem copayment is \$250.

#### **1.3.3.4.4 TRICARE Prime**

There is no cost-share for ADFMs. For beneficiaries other than ADFMs, the cost-sharing provision is the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or a per diem rate of \$11, whichever is greater.

#### **1.3.3.4.5 Maternity Services**

See [paragraph 1.3.3.3](#), for the cost-sharing provisions for maternity services.

#### **1.3.3.5 Cost-Shares: Inpatient Mental Health Per Diem Payment System**

**1.3.3.5.1** General. These special cost-sharing procedures apply only to claims paid under the inpatient mental health per diem payment system. For inpatient claims exempt from this system, the procedures in [paragraph 1.3.3.2](#) or [1.3.3.4](#) are to be followed.

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

---

**1.3.3.5.2** Cost-shares for ADFMs. Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission. This \$20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any RTC, any Substance Use Disorder Rehabilitation Facility (SUDRF), and any PHP providing mental health or substance use disorder rehabilitation services. For Prime ADFMs care provided on or after April 1, 2001, cost-share is \$0 per day. See [Addendum A](#) for further information.

**1.3.3.5.3** Cost-shares for beneficiaries other than ADFMs.

**1.3.3.5.3.1** Higher volume hospitals and units. With respect to care paid for on the basis of a hospital specific per diem, the cost-share shall be 25% of the hospital specific per diem amount.

**1.3.3.5.3.2** Lower volume hospitals and units. For care paid for on the basis of a regional per diem, the cost-share shall be the lower of [paragraph 1.3.3.5.3.2.1](#) or [paragraph 1.3.3.5.3.2.2](#):

**1.3.3.5.3.2.1** A fixed daily amount multiplied by the number of covered days. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the inpatient mental health per diem payment system. This fixed daily amount shall be updated annually and published in the **Federal Register** along with the per diems published pursuant to [Chapter 7, Section 1](#). This fixed daily amount will also be furnished to contractors by DHA. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

- Fiscal Year 2000 - \$144 per day.
- Fiscal Year 2001 - \$149 per day.
- Fiscal Year 2002 - \$154 per day.
- Fiscal Year 2003 - \$159 per day.
- Fiscal Year 2004 - \$164 per day.
- Fiscal Year 2005 - \$169 per day.
- Fiscal Year 2006 - \$175 per day.
- Fiscal Year 2007 - \$181 per day.
- Fiscal Year 2008 - \$187 per day.
- Fiscal Year 2009 - \$193 per day.
- Fiscal Year 2010 - \$197 per day.
- Fiscal Year 2011 - \$202 per day.
- Fiscal Year 2012 - \$208 per day.
- Fiscal Year 2013 - \$213 per day.
- Fiscal Year 2014 - \$218 per day.
- Fiscal Year 2015 - \$224 per day.
- Fiscal Year 2016 - \$229 per day.

**1.3.3.5.3.2.2** Twenty-five percent (25%) of the hospital's billed charges (less any duplicates).

**1.3.3.5.4** Claim which spans a period in which two separate per diems exist. A claim subject to the inpatient mental health per diem payment system which spans a period in which two separate per diems exist shall have the cost-share computed on the actual per diem in effect for each day of care.

**1.3.3.5.5** Cost-share whenever leave days are involved. There is no patient cost-share for leave days when such days are included in a hospital stay.

**1.3.3.5.6** Claims for services that are provided during an inpatient admission which are not included in the per diem rate are to be cost-shared as an inpatient claim if the contractor cannot determine where the service was rendered and the status of the patient when the service was provided. The contractor would need to examine the claim for place of service and type of service to determine if the care was rendered in the hospital while the beneficiary was an inpatient of the hospital. This would include non-mental health claims and mental health claims submitted by individual professional providers rendering medically necessary services during the inpatient admission.

### **1.3.3.6 Cost-Shares: Partial Hospitalization**

Cost-sharing for partial hospitalization is on an inpatient basis. The inpatient cost-share also applies to the associated psychotherapy billed separately by the individual professional provider. These providers will have to identify on the claim form that the psychotherapy is related to a partial hospitalization stay so the proper inpatient cost-sharing can be applied. Effective for care on or after October 1, 1995, the cost-share for ADFMs for inpatient mental health services is \$20 per day for each day of the inpatient admission. For care provided on or after April 1, 2001, the cost-share for ADFMs enrolled in Prime for inpatient mental health services is \$0. For retirees and their family members, the cost-share is 25% of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for ADFMs is to be taken from the PHP claim.

### **1.3.3.7 Cost-Shares: Ambulatory Surgery**

**1.3.3.7.1** Non-Prime ADFMs or Authorized NATO Beneficiary. For all services reimbursed as ambulatory surgery, the cost-share will be \$25 and will be assessed on the facility claim. No cost-share is to be deducted from a claim for professional services related to ambulatory surgery. This applies whether the services are provided in a freestanding ASC, a hospital outpatient department or a hospital emergency room. So long as at least one procedure on the claim is reimbursed as ambulatory surgery, the claim is to be cost-shared as ambulatory surgery as required by this section.

**1.3.3.7.2** Other Beneficiaries. Since the cost-share for other beneficiaries is based on a percentage rather than a set amount, it is to be taken from all ambulatory surgery claims. For professional services, the cost-share is 25% of the allowed amount. For the facility claim, the cost-share is the lesser of:

**1.3.3.7.2.1** Twenty-five percent (25%) of the applicable group payment rate (see [Chapter 9, Section 1](#)); or

**1.3.3.7.2.2** Twenty-five percent (25%) of the billed charges; or

**1.3.3.7.2.3** Twenty-five percent (25%) of the allowed amount as determined by the contractor.

**1.3.3.7.2.4** The special cost-sharing provisions for beneficiaries other than ADFMs will ensure that these beneficiaries are not disadvantaged by these procedures. In most cases, 25% of the

group payment rate will be less, but because there is some variation within each group, 25% of billed charges could be less in some cases. This will ensure that the beneficiaries get the benefit of the group payment rates when they are more advantageous, but they will never be disadvantaged by them. If there is no group payment rate for a procedure, the cost-share will simply be 25% of the allowed amount.

### **1.3.3.8 Cost-Shares and Deductible: Former Spouses**

**1.3.3.8.1** Deductible. In accordance with the FY 1991 Appropriations and Authorization Acts, Sections 8064 and 712 respectively, beginning April 1, 1991, an eligible former spouse is responsible for payment of the first one hundred and fifty dollars (\$150.00) of the reasonable costs/charges for otherwise covered outpatient services and/or supplies provided in any one fiscal year. Although the law defines former spouses as family members of the member or former member, there is no legal familial relationship between the former spouse and the member or former member. Moreover, any TRICARE-eligible children of the former spouse will be included in the member's or former member's family deductible. Therefore, the former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of that of any TRICARE-eligible children. In other words, a former spouse must independently meet the \$150.00 deductible in any fiscal year.

**1.3.3.8.2** Cost-Share. An eligible former spouse is responsible for payment of cost-sharing amounts identical to those required for beneficiaries other than ADFMs.

### **1.3.3.9 Cost-Share Amount: Under Discounted Rate Agreements**

Under managed care, where there is a negotiated (discounted) rate agreed to by the network provider, the cost-share shall be based on the following:

**1.3.3.9.1** For non-institutional providers providing outpatient care, and for institution-based professional providers rendering both inpatient and outpatient care; the cost-share (20% for outpatient care to ADFMs, 25% for care to all others) shall be applied to (after duplicates and noncovered charges are eliminated), the lowest of the billed charge, the prevailing charge, the maximum allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge.

**1.3.3.9.2** For institutional providers subject to the DRG-based reimbursement methodology, the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

- The single, specific per diem supplied by DHA after the application of the agreed upon discount rate; OR,
- Twenty-five percent (25%) of the billed charge.

**1.3.3.9.3** For institutional providers subject to the Mental Health Per Diem Payment System (high volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be 25% of the hospital per diem amount after it has been adjusted by the discount.

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

---

**1.3.3.9.4** For institutional providers subject to the Mental Health per diem payment system (low volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

- The fixed daily amount supplied by DHA after the application of the agreed upon discount rate; OR,
- Twenty-five percent (25%) of the billed charge.

**1.3.3.9.5** For RTCs, the cost-share for other than ADFMs shall be 25% of the TRICARE rate after it has been adjusted by the discount.

**1.3.3.9.6** For institutions and for institutional services being reimbursed on the basis of the TRICARE-determined reasonable costs, the cost-share for beneficiaries other than ADFMs shall be 25% of the allowable billed charges after it has been adjusted by the discount.

**Note:** For all inpatient care for ADFMs, the cost-share shall continue to be either the daily charge or \$25 per stay, whichever is higher. There is no change to the requirement for the ADFM's cost-share to be applied to the institutional charges for inpatient services. If the contractor learns that the participating provider has billed a beneficiary for a greater cost-share amount, based on the provider's usual billed charges, the contractor shall notify the provider that such an action is a violation of the provider's signed agreement. (Also see [paragraph 1.3.3.4.](#)) For Prime ADFMs, the cost-share is \$0 for care provided on or after April 1, 2001.

#### **1.3.3.10 Preventive Services**

**1.3.3.10.1** Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TRICARE Policy Manual (TPM), [Chapter 7, Sections 2.1 and 2.5](#):

**1.3.3.10.1.1** Colorectal cancer screening.

**1.3.3.10.1.2** Breast cancer screening.

**1.3.3.10.1.3** Cervical cancer screening.

**1.3.3.10.1.4** Prostate cancer screening.

**1.3.3.10.1.5** Immunizations.

**1.3.3.10.1.6** Well-child visits for children under six years of age.

**1.3.3.10.1.7** Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in [paragraphs 1.3.3.10.1.1 through 1.3.3.10.1.5](#). If one or more of the procedure codes described in the TPM, [Chapter 7, Section 2.1](#) for those preventive services listed in [paragraphs 1.3.3.10.1.1 through 1.3.3.10.1.5](#) is billed on a claim, then the cost-share is waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit are subject to appropriate cost-sharing and deductibles.

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

---

**1.3.3.10.2** A beneficiary is not required to pay any portion of the cost of these preventive services even if the beneficiary has not satisfied the deductible for that year.

**1.3.3.10.3** This waiver does not apply to any TRICARE beneficiary who is a Medicare-eligible beneficiary.

**1.3.3.10.4** Appropriate cost-sharing and deductibles will apply for all other preventive services under TRICARE Standard. See [Chapter 7, Sections 2.1](#) and [2.5](#).

**1.3.3.10.5** The contractor shall process claims for reimbursement of copayments paid for those services exempted from copayments rendered from October 14, 2008 through the implementation date of this change as prescribed in the Underpayments provisions in the TOM. Contractors will add a message to the EOB to advise the provider that this is a retroactive adjustment to the copayment to alert the provider regarding a refund to the beneficiary of the copayment amount.

#### **1.4 TRICARE Extra**

**1.4.1** For Extra deductibles and cost-shares, see [Addendum A](#).

**1.4.2** If non-enrolled TRICARE beneficiary receives care from a network provider out of the region of residence, and if the beneficiary has not met the fiscal year catastrophic cap, the beneficiary shall pay the Extra cost-share to the provider. The contractor for the beneficiary's residence shall process the claim under TRICARE Extra claims processing procedures if the TRICARE Encounter Provider Record (TEPRV) shows the provider to be contracted.

#### **1.4.3 Preventive Services**

**1.4.3.1** Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TPM, [Chapter 7, Sections 2.1](#) and [2.5](#):

**1.4.3.1.1** Colorectal cancer screening.

**1.4.3.1.2** Breast cancer screening.

**1.4.3.1.3** Cervical cancer screening.

**1.4.3.1.4** Prostate cancer screening.

**1.4.3.1.5** Immunizations.

**1.4.3.1.6** Well-child visits for children under six years of age.

**1.4.3.1.7** Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in [paragraphs 1.4.3.1.1](#) through [1.4.3.1.5](#). If one or more of the procedure codes described in the TPM, [Chapter 7, Section 2.1](#) for those preventive services listed in [paragraphs 1.4.3.1.1](#) through [1.4.3.1.5](#) is billed on a claim, then the cost-share is waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit are subject to appropriate cost-sharing and deductibles.

**1.4.3.2** A beneficiary is not required to pay any portion of the cost of these preventive services even if the beneficiary has not satisfied the deductible for that year.

**1.4.3.3** This waiver does not apply to any TRICARE beneficiary who is a Medicare-eligible beneficiary.

**1.4.3.4** Appropriate cost-sharing and deductibles will apply for all other preventive services under TRICARE Standard. See [Chapter 7, Sections 2.1](#) and [2.5](#).

**1.4.3.5** The contractor shall process claims for reimbursement of copayments paid for those services exempted from copayments rendered from October 14, 2008 through the implementation date of this change as prescribed in the Underpayments provisions in the TOM. Contractors shall add a message to the EOB to advise the provider that this is a retroactive adjustment to the copayment to alert the provider regarding a refund to the beneficiary of the copayment amount.

## **1.5 Cost-Shares: Ambulance Services**

**1.5.1** For the basis of payment of ambulance services, see [Chapter 1, Section 14](#).

**1.5.2** Outpatient. The following are beneficiary copayment/cost-sharing requirements for medically necessary ambulance services when paid on an outpatient basis:

### **1.5.2.1 TRICARE Prime**

**1.5.2.1.1** For care provided prior to April 1, 2001, for ADFMs in pay grades E-1 through E-4, \$10. For care provided on or after April 1, 2001, for ADFMs in pay grades E-1 through E-4, \$0. See [Addendum A](#) for further information.

**1.5.2.1.2** For care provided prior to April 1, 2001, for ADFMs in pay grades E-5 and above, \$15. For care provided on or after April 1, 2001, for ADFMs in pay grades E-5 and above, \$0. See [Addendum A](#) for further information.

**1.5.2.1.3** For retirees and their family members, \$20.

### **1.5.2.2 TRICARE Extra**

**1.5.2.2.1** A cost-share of 15% of the fee negotiated by the contractor for ADFMs.

**1.5.2.2.2** A cost-share of 20% of the fee negotiated by the contractor for retirees, their family members, and survivors.

### **1.5.2.3 TRICARE Standard**

**1.5.2.3.1** A cost-share of 20% of the allowable charge for ADFMs.

**1.5.2.3.2** A cost-share of 25% of the allowable charge for retirees, their family members, and survivors.

#### **1.5.2.4 Inpatient: Non-Network Providers**

**1.5.2.4.1** ADFMs. No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

**1.5.2.4.2** Other Beneficiary. The cost-share applicable to inpatient care for beneficiaries other than ADFMs is 25% of the allowable amount.

#### **1.5.2.5 Exceptions**

##### **1.5.2.5.1 Inpatient Cost-share Applicable To Each Separate Admission**

A separate cost-share amount is applicable to each separate beneficiary for each inpatient admission EXCEPT:

**1.5.2.5.1.1** Any admission which is not more than 60 days from the date of the last inpatient discharge shall be treated as one inpatient confinement with the last admission for cost-share amount determination.

**1.5.2.5.1.2** Certain heart and lung hospitals are excepted from cost-share requirements. See [Chapter 1, Section 27](#), entitled "Legal Obligation To Pay".

##### **1.5.2.5.2 Inpatient Cost-Share: Maternity Care**

See [paragraph 1.3.3.3](#). All admissions related to a single maternity episode shall be considered one confinement regardless of the number of days between admissions. For ADFMs, the cost-share will be applied to the first institutional claim received.

##### **1.5.2.5.3 Special Cost-Share Provisions**

**1.5.2.5.3.1** For services provided prior to International Classification of Diseases, 10th Revision (ICD-10) implementation. Effective October 1, 1987, the inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories cannot exceed that which would have been imposed if the service were subject to the DRG-based payment system. This will not affect ADFMs. For all other beneficiaries, the cost-share shall be the lesser of:

- That calculated according to [paragraph 1.3.3.2.2](#); or
- That calculated according to [paragraph 1.3.3.4.2](#).

###### **1.5.2.5.3.1.1 Child Bone Marrow Transplant (BMT)**

All services related to discharges involving BMT for a beneficiary less than 18 years old with International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) principal or secondary diagnosis code V42.8 and ICD-9-CM procedure codes 41.0 through 41.04, 41.06, and 41.91.

###### **1.5.2.5.3.1.2 Child Human Immunodeficiency Virus (HIV) Seropositivity**

All services related to discharges involving HIV seropositive beneficiary less than

18 years old with ICD-9-CM principal or secondary diagnosis codes 042, 079.53, and 795.71.

#### **1.5.2.5.3.1.3 Child Cystic Fibrosis**

All services related to discharges involving beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis code 277.0 (cystic fibrosis).

**1.5.2.5.3.2** For services provided on or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**. Effective October 1, 1987, the inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories cannot exceed that which would have been imposed if the service were subject to the DRG-based payment system. This will not affect ADFMs. For all other beneficiaries, the cost-share shall be the lesser of:

- That calculated according to [paragraph 1.3.3.2.2](#); or
- That calculated according to [paragraph 1.3.3.4.2](#).

#### **1.5.2.5.3.2.1 Child BMT**

All services related to discharges involving BMT for a beneficiary less than 18 years old with International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) principal or secondary diagnosis code Z94.81 and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) procedure codes 30230G0-30263Y0 through 30230X0-30263X0 and 079T3ZZ-07DS3ZZ.

#### **1.5.2.5.3.2.2 HIV Seropositivity**

All services related to discharges involving HIV seropositive beneficiary less than 18 years old with ICD-10-CM principal or secondary diagnosis codes B20, B97.35, and R75.

#### **1.5.2.5.3.2.3 Child Cystic Fibrosis**

All services related to discharges involving beneficiary less than 18 years old with ICD-10-CM principal or secondary diagnosis code E84 (cystic fibrosis).

#### **1.5.2.5.4 Cost-Sharing for Family Members of a Member who Dies While on Active Duty**

Those in Transitional Survivor status, are not distinguished from other ADFMs for cost-sharing purposes. After the Transitional Survivor status ends, eligible TRICARE beneficiaries may be placed in Survivor status and will be responsible for retiree cost-shares. See the Transitional Survivor Status policy in the TPM, [Chapter 10, Section 7.1](#).

### **1.6 Catastrophic Loss Protection**

See [Section 2](#).

- END -



## CHAMPUS Maximum Allowable Charges (CMAC)

Issue Date: March 3, 1992

Authority: [32 CFR 199.14](#)

---

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

### 3.0 POLICY

**3.1** On September 6, 1991, the Final Rule was published in the Federal Register implementing the provisions of the Defense Appropriations Act for Fiscal Year (FY) 1991, Public Law (PL) 101-511, Section 8012, which limits payments to physicians and other individual health care providers.

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

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

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

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

Chapter 5, Section 3

CHAMPUS Maximum Allowable Charges (CMAC)

---

**3.2.3** The zip code/Medicare locality file has a file layout as follows:

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

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

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

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

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

**3.3** Categories of care not subject to the National Allowable Charge System.

**3.3.1** Pricing for certain categories of health care shall remain the responsibility of the contractor. The following categories will continue to be priced under current contractor procedures:

- Routine Dental (American Dental Association (ADA codes)
- Ambulance

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

### Chapter 5, Section 3

#### CHAMPUS Maximum Allowable Charges (CMAC)

---

**Note:** Effective for services provided on or after October 1, 2013, TRICARE adopts Medicare's Ambulance Fee Schedule (AFS) as the TRICARE CMAC for ambulance services, in accordance with [32 CFR 199.14\(j\)\(1\)\(i\)\(A\)](#). See [Chapter 1, Section 14](#). The AFS reimbursement methodology does not apply to the TRICARE Overseas Program (TOP), except for Puerto Rico.

### 3.4 Bundled Codes

**3.4.1** Bundled codes are codes for which payment is included in the payment for another service under the Physician Fee Schedule or CMAC, for professional services.

**3.4.2** There are a number of services/supplies that are covered under TRICARE and that have Healthcare Common Procedure Coding System (HCPCS) codes, but they are services for which TRICARE bundles payment into the payment for other related services. If contractors receive a claim that is solely for a service or supply that must be bundled, the claim for payment shall be denied by the contractor. Separate payment is never made for routinely bundled services and supplies. A listing of these "bundled" codes will be maintained on [DHA's Rates and Reimbursement web site \(http://www.health.mil/rates\)](#) and updated each year in conjunction with the annual CMAC update.

**3.5** The CMAC applies to all 50 states, Puerto Rico, and the Philippines. Further information regarding the reimbursement of professional services in the Philippines, see the TRICARE Operations Manual (TOM), [Chapter 24, Section 9](#). Guam and the U.S. Virgin Islands are to still be paid as billed for professional services.

**3.6** Updates to the CMACs shall occur annually and quarterly when needed. The annual update usually takes place February 1. However, circumstances may cause the updates to be delayed. MCSCs shall be notified when the annual update is delayed.

**3.7** Provisions which affect the TRICARE allowable charge payment methodology.

**3.7.1** Reductions in maximum allowable payments to Medicare levels.

#### 3.7.2 Site of Service

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

##### 3.7.2.1 Categories

- Category 1: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and Certified Nurse Midwives (CNMs) provided in a facility including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered), Residential Treatment Centers (RTCs), ambulances, hospices, MTFs, psychiatric facilities, Community Mental Health Centers (CMHCs), Skilled Nursing Facilities

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

### Chapter 5, Section 3

#### CHAMPUS Maximum Allowable Charges (CMAC)

(SNFs), Ambulatory Surgical Centers (ASCs), etc.

- Category 2: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and CNMs provided in a non-facility including provider offices, home settings, and all other non-facility settings. The non-facility CMAC rate applies to Occupational Therapy (OT), Physical Therapy (PT), or Speech Therapy (ST) regardless of the setting.
- Category 3: Services, of all other providers not found in Category 1, provided in a facility including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered), RTCs, ambulances, hospices, MTFs, psychiatric facilities, CMHCs, SNFs, ASCs, etc.
- Category 4: Services, of all other providers not found in Category 2, provided in a non-facility including provider offices, home settings, and all other non-facility settings.

#### 3.7.2.2 Linking The Site Of Service With The Payment Category

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

#### 3.7.2.3 Payment Of 0510 And 0760 Series Revenue Codes

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

#### 3.7.2.4 Reimbursement Hierarchy For Procedures Paid Outside The OPPS

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

**3.7.2.4.1.1** 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 |

**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.**

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

Chapter 5, Section 3

CHAMPUS Maximum Allowable Charges (CMAC)

| COLUMN | DESCRIPTION                                   |
|--------|---|
| 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.**

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

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

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

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

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

**3.7.3** Multiple Surgery Discounting. Professional surgical procedures which are reimbursed under the CMAC payment methodology will be subject to the same multiple surgery guidelines and modifier requirement as prescribed under the OPSS for services rendered on or after May 1, 2009 (implementation of OPSS). Refer to [Chapter 1, Section 16, paragraphs 3.1.1.1 through 3.1.1.3](#) and [Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3](#) for further detail.

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

**3.7.5** Annual Update of State Prevailing Amounts. Effective with the 2012 CMAC update, for professional services and items of DMEPOS for which there is no CMAC fee schedule amount or DMEPOS fee schedule amount (i.e., reimbursement is made by creating state prevailing rates), the contractor shall perform annual updates of the state prevailing amounts.

**3.7.5.1** The contractor shall use the charges for claims for services that were provided on July 1 and ending on June 30. The updated amounts shall be implemented with the CMAC file, which normally occurs in February. For example, the annual update to state prevailings for 2012, shall be established using claims data from July 1, 2010, through June 30, 2011, and shall be implemented with the 2012 CMAC update, and continue with subsequent CMAC updates.

**3.7.5.2** Contractors shall create a state prevailing annual report as described in the Contract Data Requirements List (CDRL) DD Form 1423.

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

Chapter 5, Section 3

CHAMPUS Maximum Allowable Charges (CMAC)

---

**3.7.6** Effective for services provided on or after October 1, 2011, the payment for CNMs is to be made at 100 percent of the physician provider class. For services provided prior to October 1, 2011, CNMs are paid at the non-physician provider class.

- END -

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

Issue Date: October 8, 1987

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

---

### 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 DRG-based payment system to be used in determining inpatient reimbursement for hospitals?

### 3.0 POLICY

#### 3.1 Scope

The TRICARE DRG-based payment system applies only to hospitals. Under the TRICARE DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively determined rates and applied on a per discharge basis using DRGs. DRG payments will include an allowance for Indirect Medical Education (IDME) costs. Additional payments will be made for capital costs, direct medical education costs and outlier cases. Under the TRICARE DRG-based payment system, a hospital may keep the difference between its prospective payment rate and its operating costs incurred in furnishing inpatient services, and is at risk for operating costs that exceed its payment rate.

#### 3.2 Modeled On Medicare's Prospective Payment System (PPS)

The TRICARE DRG-based payment system is modeled on the Medicare PPS. Although many of the procedures in the TRICARE DRG-based payment system are similar or identical to the procedures in the Medicare PPS, the actual payment amounts, DRG weights, and certain procedures are different. This is necessary because of the differences in the two programs, especially in the beneficiary population. While the vast majority of Medicare beneficiaries are over age 65, TRICARE beneficiaries are considerably younger and generally healthier. Moreover, some services, notably obstetric and pediatric services, which are nearly absent from Medicare claims comprise a large part of TRICARE services.

### 3.2.1 DRGs Used

With some exceptions, the TRICARE DRG-based payment system uses the same DRGs used in the current Medicare Grouper. Although claims may be grouped into either DRG 469, Principal diagnosis invalid as discharge diagnosis, or DRG 470, Ungroupable, claims in these DRGs must be denied without development. Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.health.mil/rates>.

- EXCEPTION 1. Beginning with admissions occurring on or after October 1, 1988, the TRICARE system has replaced DRG 435 (Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment Without Complications or Comorbidity) with two age-based DRGs. Any claim which groups into DRG 435 shall be grouped by the contractor into either DRG 900 (where the beneficiary is 21 years old or younger) or DRG 901 (where the beneficiary is over 21 years old). This grouping by the contractor shall be based on the patient's age, as shown on the claim, on the date of admission. Effective for admissions on or after October 1, 2001, DRG 435 has been replaced by DRG 523. Any claim which groups into DRG 523, shall be grouped by the contractor into either DRG 900 or 901 as specified above. Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.health.mil/rates>.
- EXCEPTION 2. For admissions occurring on or after April 1, 1989, the TRICARE DRG-based payment system uses Pediatric Modified-DRGs (PM-DRGs) for all neonatal claims except those classified to DRGs 103, 391, 480, 495, 512, and 513. The PM-DRGs are DRGs 600 - 636. Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.health.mil/rates>.

### 3.2.2 Assignment Of Discharges To DRGs

DHA uses a "Grouper" program to classify specific hospital discharges within DRGs so that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge. The TRICARE Grouper is developed by Health Information Systems, 3M Health Care, and is based on the Centers for Medicare and Medicaid Services (CMS) Grouper, but it also incorporates the PM-DRGs and DRGs 900 and 901.

**3.2.2.1** The Medicare Code Editor (or other similar editor programs) is an integral part of the CMS Grouper and serves two functions. It helps to ensure that the claim discharge data is accurate and complete, so that it can be correctly grouped into a DRG. It also "edits" the claims data to identify cases which may not meet certain coverage requirements or which might involve inappropriate services. Contractors are not required to use any "Editor" program, but it is recommended since the first function will facilitate claims processing, and the second function may be useful in assessing coverage under TRICARE.

**3.2.2.2** The classification of a particular discharge is based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status. (Contractors are required to use the expanded diagnosis and procedure code fields.) For neonatal claims (other than normal newborns), it also is based on the newborn's birth weight, surgery, and the presence of multiple, major and other problems which exist at birth. For services

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

### Chapter 6, Section 2

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

---

provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, the birth weight is to be indicated through use of a fifth digit on the neonatal International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code. For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, the birth weight is to be indicated through use of a sixth digit on the neonatal ICD-10-CM diagnosis code.

**3.2.2.2.1** In situations where the narrative diagnosis on the DRG claim does not correspond to the numerical diagnosis code, the contractor shall give precedence to the narrative and revise the numerical code accordingly. Contractors are not required to make this comparison on every claim. Precedence should be given to the narrative code in those cases where a difference is identified as the result of editing, prepayment review, or other action that would identify a discrepancy. If an adjustment is subsequently necessary because the numerical code was, in fact, correct, the adjustment should be submitted under a Record Processing Mode (RPM) a reason for adjustment code indicating that there was no contractor error.

**3.2.2.2.2** It is the hospital's responsibility to submit the information necessary for the contractor to assign a discharge to a DRG.

**3.2.2.2.3** When the discharge data is inadequate (i.e., the contractor is unable to assign a DRG based on the submitted data), the contractor is to develop the claim for the additional information.

**3.2.2.2.4** In some cases the "admitting diagnosis" may be different from the principal diagnosis. Although the admitting diagnosis is not required to assign a DRG to a claim, it may be needed to determine if a Non-Availability Statement (NAS) is required (see the TRICARE Policy Manual (TPM), [Chapter 1, Section 6.1](#)).

**3.2.2.2.5** For neonatal claims only (other than normal newborns), the following rules apply.

- If a neonate (patient age 0 - 28 days at admission) is premature, the appropriate prematurity diagnosis code must be used as a principal or secondary diagnosis.
- Where a prematurity diagnosis code is used, a fifth digit value of 0 through 9 must be used in the principal or secondary diagnosis to specify the birth weight. If no fifth digit is used, the Grouper will ignore that diagnosis code and the claim will be denied.
- If a neonate is not premature, a prematurity diagnosis code must not be used. The Grouper will automatically assign a birth weight of "> 2,499 grams" and assign the appropriate PM-DRG. If the birth weight is less than 2,500 grams, the birth weight must be provided in the "remarks" section of the CMS 1450 UB-04.
- If there is more than one birth weight on the claim, the Grouper will assign the claim to the "ungroupable" DRG, and the claim will be denied.
- All claims for beneficiaries less than 29 days old upon admission (other than normal newborns) will be assigned to a PM-DRG, except those classified to DRGs 103, 480, 495, 512, and 513. Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.health.mil/rates>.

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

### Chapter 6, Section 2

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

---

**3.2.2.3** Each discharge will be assigned to only one DRG (related, except as provided in [paragraphs 3.2.2.4](#) and [3.2.2.5](#), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

**3.2.2.4** When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the contractor is to develop the claim to assure that the data are not the result of miscoding by either the contractor or the hospital. Where the procedure and medical condition are supported by the services and the procedure is unrelated to the principal diagnosis, the claim will be assigned to the DRG, Unrelated OR Procedure.

**3.2.2.5** When the discharge data submitted by a hospital result in assignment of a DRG which may need to be reviewed for coverage (e.g., abortion without dilation and curettage, which does not meet the TRICARE requirements for coverage), the contractor is to review the claim to determine if other diagnoses or procedures which were rendered concurrently are covered. If other covered services were rendered, the contractor shall change the principal diagnosis to the most logical alternative covered diagnosis, delete the abortion diagnosis and procedure from the claim so that it does not result in a more complex DRG, and regroup the claim.

**Example:** If a claim is grouped into the DRG for an abortion and the abortion is not covered, but a tubal ligation was performed concurrently, the contractor should change the principal diagnosis to that for the tubal and delete the abortion from the procedures performed. If no covered services were rendered, the claim must be denied, and all related ancillary and professional services which are submitted separately must also be denied.

**3.2.2.5.1** Contractors are not normally required to review all diagnoses and procedures to determine their coverage. Contractors are required to develop for medical necessity only if the principal diagnosis is generally not covered but potentially could be. Deletion of a diagnosis and/or procedure is required only when the principal diagnosis or procedure is not covered.

**3.2.2.5.2** The only exception to the above paragraph is for abortions. Since abortions are statutorily excluded from coverage in most cases, the contractor is to ensure that payment is not affected by a noncovered abortion diagnosis or procedure whether it is principal or secondary. In all cases where payment would be affected, the abortion data is to be deleted from the claim.

### 3.3 Beneficiary Eligibility

#### 3.3.1 Change Of Eligibility Status

**3.3.1.1** Payment when eligibility changes. If a beneficiary is eligible for TRICARE coverage during any part of his/her inpatient confinement, except for the following cases, the claim shall be processed as if the beneficiary was eligible for the entire stay.

**3.3.1.1.1** Claims which qualify for the long-stay or short-stay outlier payment. The long-stay outlier was eliminated for all cases, except neonates and children's hospitals, for admissions occurring on or after October 1, 1997. The long-stay outlier was eliminated for neonates and children's hospitals for admissions occurring on or after October 1, 1998. See [paragraph 3.3.1.3](#).

### 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.health.mil/rates> 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.health.mil/rates> 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.health.mil/rates>.

### **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.health.mil/rates> for annual DRG wage index updates.

- END -



## Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment Amounts)

Issue Date: October 8, 1987  
Authority: [32 CFR 199.14\(a\)\(1\)](#)

---

### 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 are the adjustments to the TRICARE DRG-based payment amounts?

### 3.0 POLICY

#### 3.1 Adjustments to the DRG-Based Payment Amounts

There are several adjustments to the basic DRG-based amounts (the weight multiplied by the Adjusted Standardized Amount (ASA) which can be made.

#### 3.2 Specific Adjustments

##### 3.2.1 Capital Costs

TRICARE will reimburse hospitals for their capital costs as reported annually to the contractor (see below). Payment for capital costs will be made annually. See [Chapter 3, Section 2](#) for the procedures for paying capital costs.

**3.2.1.1** For October 1, 2003, through present, TRICARE will reimburse 100% of capital-related costs.

**3.2.1.2** Allowable capital costs are those specified in Medicare Regulation Section 413.130 of Title 42 CFR.

**3.2.1.3** To obtain the total allowable capital costs from the Medicare cost reports as of October 1992, the contractor shall add the figures from Worksheet D, Part 1, Columns 3 and 6, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, and line 33, to the figures from Worksheet D, Part II, Columns 1 and 2, lines 37-63.

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System  
(Adjustments To Payment Amounts)

---

**3.2.1.4** The instructions outlined in [paragraph 3.2.1.3](#) are effective for initial and amended requests received on or after October 1, 1998.

**3.2.1.5** To obtain the total allowable capital costs from the Medicare cost reports as of **May 1, 2010**, the contractor shall add the figures from Worksheet D, Part I, Column 3, lines 30-33, **lines 34 and 35 if the cost report reflects intensive care unit costs**, and **line 43**, to the figures from Worksheet D, Part II, Column 1, lines 50-76 and 88-93.

**3.2.1.6** The instructions outlined in [paragraph 3.2.1.5](#), are effective for initial and amended requests received on or after **May 1, 2010**.

**3.2.1.7** Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Section 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

**3.2.1.7.1** The capital-related equipment is leased or rented by the provider;

**3.2.1.7.2** The capital-related equipment is located on the provider's premises; and

**3.2.1.7.3** The capital-related portion of the charge is separately specified in the charge to the provider.

**3.2.2 Direct Medical Education Costs**

TRICARE will reimburse hospitals their actual direct medical education costs as reported annually to the contractor (see below). Such direct medical education costs must be for a teaching program approved under Medicare Regulation Section 413.85. Payment for direct medical education costs will be made annually and will be calculated using the same steps required for calculating capital payments below. Allowable direct medical education costs are those specified in Medicare Regulation Section 413.85. See [Chapter 3, Section 2](#) for the procedures for paying direct medical education costs.

**3.2.2.1** Direct medical education costs generally include:

**3.2.2.1.1** Formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution.

**3.2.2.1.2** Nursing schools.

**3.2.2.1.3** Medical education of paraprofessionals (e.g., radiological technicians).

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System  
(Adjustments To Payment Amounts)

---

**3.2.4.3.2.2** The contractor shall process amended payment requests based on changes in the Medicare cost-report as a result of desk reviews, audits and appeals. An adjustment will not be processed unless there are changes to items 6 through 10 on the initial CAP/DME reimbursement request. The contractor will not process amended requests for days only.

**3.2.4.3.2.3** The contractor shall verify the number of TRICARE and active duty inpatient days with its data. If the contractor's data represents a greater number of days than submitted on the hospital's request, payment shall be based on the contractor's data. If the hospital's request represents a greater number of days than the contractor's data, the contractor shall notify the hospital of the discrepancy and inform them payment will be based on the number of days it has on file unless they can provide documentation substantiating the additional days. The notification to the hospital must be made within 10 working days of identification of the discrepancy and include the inpatient day verification report.

**3.2.4.3.2.4** The contractor shall wait until the end of the following month to hear from the hospital. If the hospital does not respond, the contractor shall make payment based on its totals.

**3.2.4.3.2.5** The contractor shall verify the accuracy of the financial amounts listed for CAP/DME with the applicable pages of the amended Medicare cost report. If the financial amounts do not match, the contractor shall reimburse the hospital based on the figures in the cost-report and notify the hospital of the same.

**3.2.4.3.2.6** The contractor must make the CAP/DME payment to the hospital within 30 days of the amended request unless notification has been sent to the hospital regarding a discrepancy in the number of days as outlined in [paragraph 3.2.4.3.2.2](#).

**3.2.4.3.2.7** The TRICARE/CHAMPUS contractor shall be responsible for proactively researching the Medicare web site (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/index.html>) to identify hospitals in their region that submitted amended Medicare cost reports, obtaining copies of the amended cost reports from hospitals that failed to submit them to the TRICARE contractor as required, recalculating the CAP/DME costs based on the revised cost report data, and initiating a collection action or notifying the hospital if an underpayment was identified based on the results of recalculation. The CMS post the Hospital Cost Report files 30 days after the end of each quarter.

**3.2.4.3.2.8** The contractor shall complete the "Annual Capital and Direct Medical Education Report" as described in the Contract Data Requirements List (CDRL) DD Form 1423, and submit the information to the Contractor Officer (CO) and Contracting Officer's Representative (COR) identifying the hospitals that submitted amended Medicare cost reports directly to the TRICARE contractor and those hospitals which the TRICARE contractor identified on the CMS web site.

**3.2.4.3.2.9** For a period of one year following the report period, the "Quarterly Capital and Direct Medical Education Over and Under Payment Report" as described in the CDRL, DD Form 1423, shall be updated on a calendar quarterly basis to reflect collections that are received, or underpayments refunded at the hospital's request, after the end of the previous calendar year report. The quarterly reports shall pertain only to cases initiated in the calendar year being reported.

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

### Chapter 6, Section 8

#### Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment Amounts)

---

**3.2.4.4** Negotiated Rates. If a contract between the Managed Care Support (MCS) prime contractor and a subcontractor or institutional network provider does not specifically state the negotiated rate includes all costs that would otherwise be eligible for additional payment, such as CAP/DME, the MCS prime contractor is responsible for reimbursing these costs to the subcontractors and institutional network providers if a request for reimbursement is made.

**3.2.4.5** CAP/DME costs for children's hospitals. Amounts for CAP/DME are included in both the hospital-specific and the national children's hospital differentials (see below). The amounts are based on national average costs. No separate or additional payment is allowed.

**3.2.4.6** CAP/DME costs under TRICARE for Life (TFL). TRICARE will make no payments for CAP/DME costs for any claims on which Medicare makes payment. These costs are included in the Medicare payment. TRICARE CAP/DME cost payments will be made only on claims on which TRICARE is the primary payer (e.g., claims for stays beyond 150 days), and in those cases payment will be made following the procedures described above.

### **3.2.5 Children's Hospital Differential**

#### **3.2.5.1 General**

All DRG-based payments to children's hospitals for admissions occurring on or after April 1, 1989, are to be increased by adding the applicable children's hospital differential to the appropriate ASA prior to multiplying by the DRG weight.

#### **3.2.5.2 Qualifying for the Children's Hospital Differential**

In order to qualify for a children's hospital differential adjustment, the hospital must be exempt from the Medicare Prospective Payment System (PPS) as a children's hospital. If the hospital is not Medicare-participating, it must meet the criteria in [32 CFR 199.6\(b\)\(4\)\(i\)](#). In addition, more than half of its inpatients must be individuals under the age of 18.

#### **3.2.5.3 Calculation of the Children's Hospital Differentials**

They will be calculated so that they are "revenue neutral" for children's hospitals; that is, for Fiscal Year (FY) 1988 overall TRICARE payments to children's hospitals under the DRG-based payment system would have been equal to those under the old payment system. To accomplish this, DHA (the Office of Program Development) calculated separate ASAs for children's hospitals. Normally in calculating ASAs, DHA reduces the adjusted charges according to the Medicare Cost-to-Charge Ratio (CCR) (0.66 during FY 1988). However, in recognition of the higher costs of children's hospitals, we do not use this step in calculating the children's hospital differentials. We subtract the appropriate ASA from the children's hospital ASAs, and these amounts are the children's hospital differentials. The differentials will not be subject to annual inflation updates nor will they be recalculated except as provided below.

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System  
(Adjustments To Payment Amounts)

---

**3.2.5.4 Differential Amounts**

**3.2.5.4.1** Admissions prior to April 1, 1992. High volume children's hospitals (those children's hospitals with 50 or more TRICARE discharges during FY 1988) have a hospital-specific differential for a three year transition period ending April 1, 1992. All other children's hospitals use national differentials. There are two national differentials--one for large urban areas and one for other urban areas.

**3.2.5.4.1.1** Calculation of the national children's hospital differentials. These differentials are calculated using the procedures described in [paragraph 3.2.5.3](#), but based on a database of only low-volume children's hospitals. They were calculated initially using a database of claims processed from July 1, 1987, through June 30, 1988 and updated to FY 1988 using the hospital market basket. They were subsequently finalized based on claims processed from April 1, 1989, through March 31, 1990.

**3.2.5.4.1.2** Calculation of the hospital-specific differentials for high-volume children's hospitals. The hospital-specific differentials were calculated using the same procedures used for calculating the national differentials, except that the database used was limited to claims from the specific high-volume children's hospital.

**3.2.5.4.1.3** Administrative corrections. Any children's hospital that believed **DHA** erroneously failed to classify the hospital as a high-volume hospital or correctly calculate (in the case of a high-volume hospital) the hospital's differential could obtain administrative corrections by submitting appropriate documentation to **DHA**. The corrected differential was effective retroactively to April 1, 1989, so this process included adjustments, by the contractor, to any previously processed claims which were processed using an incorrect differential.

**3.2.5.4.2** Admissions on or after April 1, 1992. These claims are reimbursed using a single set of differentials which do not distinguish high-volume and low-volume children's hospitals. The differentials are:

|                   |            |
|-------------------|------------|
| Large Urban Areas |            |
| Labor portion     | \$1,945.99 |
| Non-labor portion | + 689.42   |
|                   | <hr/>      |
|                   | \$2,635.41 |
| Other Areas       |            |
| Labor portion     | \$1,483.21 |
| Non-labor portion | 525.47     |
|                   | <hr/>      |
|                   | \$2,008.68 |

**3.2.5.4.3** Admissions on or after October 1, 2004. Children's hospitals located in other areas shall receive the same differential payment as large urban area hospitals.

### **3.2.5.5 Hold Harmless Provision**

At such time as the weights initially assigned to neonatal DRGs are recalibrated based on a sufficient volume of TRICARE claims records, DHA will recalculate children's hospital differentials and appropriate retrospective and prospective adjustments will be made. To the extent possible, the recalculation will also include reestimated values of other factors (including, but not limited to, direct and Indirect Medical Education (IDME) and capital costs) for which more accurate data become available. This will probably occur about one year after implementation of the neonatal DRGs, and it will not require any actions by the contractors.

### **3.2.6 Outliers**

#### **3.2.6.1 General**

TRICARE will adjust the DRG-based payment to a hospital for atypical cases. These outliers are those cases that have either an unusually short Length-Of-Stay (LOS) or involve extraordinarily high costs when compared to most discharges classified in the same DRG. Recognition of these outliers is particularly important, since the number of TRICARE cases in many hospitals is relatively small, and there may not be an opportunity to "average out" DRG-based payments over a number of claims. Contractors will not be required to document or verify the medical necessity of outliers prior to payment, since outlier review will be part of the admission and quality review system. However, in determining additional cost outlier payments on all claims qualifying as a cost outlier, the contractor must identify and reduce the billed charge for any non-covered items such as comfort and convenience items (line N), as well as any duplicate charges (line X) and services which can be separately billed (line 7) such as professional fees, outpatient services, and solid organ transplant acquisition costs. Comfort and convenience items are defined as those optional items which the patient may elect at an additional charge (i.e., television, guest trays, beautician services, etc.), but are not medically necessary in the treatment of a patient's condition.

#### **3.2.6.2 Provider Reporting of Outliers**

The provider is to identify outliers on the CMS 1450 UB-04, Form Locator (FL) 24 - 30. Code 60 is to be used to report LOS outliers, and code 66 is to be used to signify that a cost outlier is not being requested. If a claim qualifies as a cost outlier and code 66 is not entered in the appropriate FL (i.e., it is blank or code 61), the contractor is to accept this as a request for cost outlier payment by the hospital.

#### **3.2.6.3 Short-Stay Outliers**

The TRICARE DRG-based payment system uses short-stay outliers and are reimbursed using a per diem amount. All short-stay outliers must be identified by the contractor when the claims are processed, and necessary adjustments to the payment amounts must be made automatically.

- Any discharge which has a LOS less than or equal to the greater of 1 or 1.94 standard deviations below the arithmetic mean LOS for that DRG shall be classified as a short-stay outlier. In determining the actual short-stay threshold, the calculation will be

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System  
(Adjustments To Payment Amounts)

---

rounded down to the nearest whole number, and any stay equal to or less than the short-stay threshold will be considered a short-stay outlier.

- Short-stay outliers will be reimbursed at 200% of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the wage-adjusted DRG amount divided by the arithmetic mean LOS for the DRG. The per diem rate is to be calculated before the DRG-based amount is adjusted for IDME. Cost outlier payments shall be paid on short stay outlier cases that qualify as a cost outlier.
- Any stay which qualifies as a short-stay outlier (a transfer cannot qualify as a short-stay outlier), even if payment is limited to the normal DRG amount, is to be considered and reported on the payment records as a short-stay outlier. This will ensure that outlier data is accurate and will prevent the beneficiary from paying an excessive cost-share in certain circumstances.

**3.2.6.4 Cost Outliers**

**3.2.6.4.1** Any discharge which has standardized costs that exceed the thresholds outlined below, will be classified as a cost outlier.

**3.2.6.4.1.1** For admissions occurring prior to October 1, 1997, the standardized costs will be calculated by first subtracting the noncovered charges, multiplying the total charges (less lines 7, N, and X) by the CCR and adjusting this amount for IDME costs by dividing the amount by one plus the hospital's IDME adjustment factor. For admissions occurring on or after October 1, 1997, the costs for IDME are no longer standardized.

**3.2.6.4.1.2** Cost outliers will be reimbursed the DRG-based amount plus 80% effective October 1, 1994 of the standardized costs exceeding the threshold.

**3.2.6.4.1.3** For admissions occurring on or after October 1, 1997, the following steps shall be followed when calculating cost outlier payments for all cases other than neonates and children's hospitals:

$$\text{Standard Cost} = (\text{Billed Charges} \times \text{CCR})$$

$$\text{Outlier Payment} = 80\% \text{ of } (\text{Standard Cost} - \text{Threshold})$$

$$\text{Total Payments} = \text{Outlier Payments} + (\text{DRG Base Rate} \times (1 + (\text{IDME})))$$

**Note:** Noncovered charges should continue to be subtracted from the billed charges prior to multiplying the billed charges by the CCR.

**3.2.6.4.1.4** The CCR for admissions occurring on or after October 1, 2012, is 0.2979. The CCR for admissions occurring on or after October 1, 2013, is 0.2778. **The CCR for admissions occurring on or after October 1, 2014, is 0.2726.**

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System  
(Adjustments To Payment Amounts)

**3.2.6.4.1.5** The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2013 is 0.920, for FY 2014 is 0.920, and for FY 2015 is 0.922.

**3.2.6.4.2** For FY 2013, a TRICARE fixed loss cost-outlier threshold is set at \$20,075. Effective October 1, 2012, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$20,075 (also wage-adjusted).

**3.2.6.4.3** For FY 2014, a TRICARE fixed loss cost-outlier threshold is set at \$20,008. Effective October 1, 2013, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$20,008 (also wage-adjusted).

**3.2.6.4.4** For FY 2015, a TRICARE fixed loss cost-outlier threshold is set at \$22,705. Effective October 1, 2014, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$22,705 (also wage-adjusted).

**3.2.6.4.5** The cost-outlier threshold shall be calculated as follows:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + (DRG Base Payment (wage-adjusted) x (1 + IDME))}

**Example:** Using FY 1999 figures {[10,129 x ((0.7110 x Applicable wage index) + 0.2890) x 0.913] + (DRG Based Payment (wage-adjusted) x (1 + IDME))}

**3.2.6.5 Burn Outliers**

**3.2.6.5.1** Burn outliers generally will be subject to the same outlier policies applicable to the TRICARE DRG-based payment system except as indicated below. For admissions prior to October 1, 1998, there are six DRGs related to burn cases. They are:

- 456 - Burns, transferred to another acute care facility
- 457 - Extensive burns w/o O.R. procedure
- 458 - Non-extensive burns with skin graft
- 459 - Non-extensive burns with wound debridement or other O.R. procedure
- 460 - Non-extensive burns w/o O.R. procedure
- 472 - Extensive burns with O.R. procedure

**3.2.6.5.2** Effective for admissions on or after October 1, 1998, the above listed DRGs are no longer valid.

**3.2.6.5.3** For admissions on or after October 1, 1998, there are eight DRGs related to burn cases. They are:

- 504 - Extensive 3rd degree burn w skin graft
- 505 - Extensive 3rd degree burn w/o skin graft
- 506 - Full thick burn w sk graft or inhal inj w cc or sig tr

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System  
(Adjustments To Payment Amounts)

---

- 507 - Full thick burn w sk graft or inhal inj w/o cc or sig tr
- 508 - Full thick burn w/o sk graft or inhal inj w cc or sig tr
- 509 - Full thick burn w/o sk graft or inhal inj w/o cc or sig tr
- 510 - Non-extensive burns w cc or significant trauma
- 511 - Non-extensive burns w/o cc or significant trauma

**3.2.6.5.3.1** Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.health.mil/rates>.

**3.2.6.5.3.2** For burn cases with admissions occurring prior to October 1, 1988, there are no special procedures. The marginal cost factor for outliers for all such cases will be 60%.

**3.2.6.5.3.3** Burn cases which qualify as short-stay outliers, regardless of the date of admission, will be reimbursed according to the procedures for short-stay outliers.

**3.2.6.5.3.4** Burn cases with admissions occurring on or after October 1, 1988, which qualify as cost outliers will be reimbursed using a marginal cost factor of 90%.

**3.2.6.5.3.5** For a burn outlier in a children's hospital, the appropriate children's hospital outlier threshold is to be used (see below), but the marginal cost factor is to be either 60% or 90% according to the criteria above.

### **3.2.6.6 Children's Hospital Outliers**

The following special provisions apply to cost outliers.

**3.2.6.6.1** The threshold shall be the same as that applied to other hospitals.

**3.2.6.6.2** Effective October 1, 2012, the standardized costs are calculated using a CCR of 0.3231. Effective October 1, 2013, the standardized costs are calculated using a CCR of 0.3012. Effective October 1, 2014, the standardized costs are calculated using a CCR of 0.2939. (This is equivalent to the Medicare CCR increased to account for CAP/DME costs.)

**3.2.6.6.3** The marginal cost factor shall be 80%.

**3.2.6.6.4** For admissions occurring during FY 2013, the marginal cost factor shall be adjusted by 1.03. For admissions occurring during FY 2014, the marginal cost factor shall be adjusted by 1.10. For admissions occurring during FY 2015, the marginal cost factor shall be adjusted by 1.18.

**3.2.6.6.5** The NOSCASTC for calculating the cost-outlier threshold for FY 2012 is 0.919. The NOSCASTC for calculating the cost-outlier threshold for FY 2013 is 0.920. The NOSCASTC for calculating the cost-outlier threshold for FY 2014 is 0.920. The NOSCASTC for calculating the cost-outlier threshold for FY 2015 is 0.922.

**3.2.6.6.6** The following calculation shall be used in determining cost outlier payments for children's hospitals and neonates:

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System  
(Adjustments To Payment Amounts)

---

**Step 1:** Computation of Standardized Costs:

Billed Charges x CCR

(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the CCR.)

**Step 2:** Determination of Cost-Outlier Threshold:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + [DRG Based Payment (wage-adjusted) x (1 + IDME)]}

**Step 3:** Determination of Cost Outlier Payment

{[(Standardized costs - Cost-Outlier Threshold) x Marginal Cost Factor] x Adjustment Factor}

**Step 4:** Total Payments = Outlier Payments + [DRG Base Rate x (1 + IDME)]

**3.2.6.7 Neonatal Outliers**

Neonatal outliers in hospitals subject to the TRICARE DRG-based payment system (other than children's hospitals) shall be determined under the same rules applicable to children's hospitals, except that the standardized costs for cost outliers shall be calculated using the CCR of 0.64. Effective for admissions occurring on or after October 1, 2005, and subsequent years, the CCR used to calculate cost outliers for neonates in acute care hospitals shall be reduced to the same CCR used for all other acute care hospitals.

**3.2.7 IDME adjustment**

**3.2.7.1 General**

The DRG-based payments for any hospital which has a teaching program approved under Medicare Regulation Section 413.85, Title 42 CFR shall be adjusted to account for IDME costs. The adjustment factor used shall be the one in effect on the date of discharge (see below). The adjustment will be made by multiplying the total DRG-based amount by 1.0 plus a hospital-specific factor equal to:

$$1.04 \times \left[ \left( 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

- For admissions occurring during FYs 2008 and subsequent years, the same formula shall be used except the first number shall be 1.02.

### **3.2.7.2 Number of Interns and Residents**

TRICARE will use the number of interns and residents from CMS most recently available Provider Specific File.

### **3.2.7.3 Number of Beds**

TRICARE will use the number of beds from CMS' most recently available Provider Specific File.

### **3.2.7.4 Updates of IDME Factors**

**3.2.7.4.1** TRICARE will use the ratio of interns and residents to beds from CMS' most recently available Provider Specific File to update the IDME adjustment factors. The ratio will be provided to the contractors to update each hospital's IDME adjustment factor at the same time as the annual DRG update. The updated factors provided with the annual DRG update shall be applied to claims with a date of discharge on or after October 1 of each year.

**3.2.7.4.2** Other updates of IDME factors. It is the contractor's responsibility to update the IDME factor if a hospital provides information (for the same base periods) which indicates that the IDME factor provided by TRICARE with the DRG update is incorrect or needs to be updated. An IDME factor is updated based on the hospital submitting CMS Worksheet showing the number of interns, residents, and beds. The effective date of these other updates shall be the date payment is made to the hospital (check issued) for its CAP/DME costs, but in no case can it be later than 30 days after the hospital submits the appropriate worksheet or information. The contractor shall notify **DHA** of such IDME updates.

**3.2.7.4.3** This alternative updating method shall only apply to those hospitals subject to the Medicare PPS as they are the only ones included in the Provider Specific File.

### **3.2.7.5 Adjustment for Children's Hospitals**

An IDME adjustment factor will be applied to each payment to qualifying children's hospitals. The factors for children's hospitals will be calculated using the same formula as for other hospitals. The initial factor will be based on the number of interns and residents and hospital bed size as reported by the hospital to the contractor. If the hospital provides the data to the contractor after payments have been made, the contractor will not make any retroactive adjustments to previously paid claims, but the amounts will be reconciled during the "hold harmless" process. At the end of its fiscal year, a children's hospital may request that its adjustment factor be updated by providing the contractor with the necessary information regarding its number of interns and residents and beds. The number of interns, residents, and beds must conform to the requirements above. The contractor is required to update the factor within 30 days of receipt of the request from the hospital, and the effective date shall conform to the policy contained above.

**3.2.7.5.1** Beginning in August 1998, and each subsequent year, the contractor shall send a notice to each children's hospital in its Region, who have not provided the contractor with updated

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System  
(Adjustments To Payment Amounts)

---

information on its number of interns, residents and beds since the previous October 1 and advise them to provide the updated information by October 1 of that same year.

**3.2.7.5.2** The contractors shall send the number of interns, residents, and beds and the updated ratios for children's hospitals to **DHA**, Medical Benefits and Reimbursement **Section (MB&RS)**, or designee, by April 1 of each year to be used in **DHA's** annual DRG update calculations. These updated amounts will be included in the files for the October DRG update.

**3.2.7.6 TRICARE for Life (TFL)**

No adjustment for IDME costs is to be made on any TFL claim on which Medicare has made any payment. If TRICARE is the primary payer (e.g., claims for stays beyond 150 days) payments are to be adjusted for IDME in accordance with the provisions of this section.

**3.2.8 Present On Admission (POA) Indicators and Hospital Acquired Conditions (HACs)**

**3.2.8.1** Effective for admissions on or after October 1, 2009:

**3.2.8.1.1** For services provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation:

**3.2.8.1.1.1** Those inpatient acute care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a POA indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. Providers shall report POA indicators to TRICARE in the same manner they report to the CMS, and in accordance with the UB-04 Data Specifications Manual, and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-9-CM Official Guidelines for Coding and Reporting.

**3.2.8.1.1.2** There are five POA indicator reporting options, as defined by the ICD-9-CM Official Coding Guidelines for Coding and Reporting:

- Y = Indicates that the condition was present on admission.
- W = Affirms that the provider has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.
- N = Indicates that the condition was not present on admission.
- U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
- 1 = (Definition prior to FY 2011.) Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.

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

### Chapter 6, Section 8

#### Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment Amounts)

---

- 1 = (Definition for FY 2011 and subsequent years.) Unreported/not used. Exempt from POA reporting.  
(This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.)

**3.2.8.1.2** For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation:

**3.2.8.1.2.1** Those inpatient acute care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a POA indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. Providers shall report POA indicators to TRICARE in the same manner they report to the CMS, and in accordance with the UB-04 Data Specifications Manual, and ICD-10-CM Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-10-CM Official Guidelines for Coding and Reporting.

**3.2.8.1.2.2** There are five POA indicator reporting options, as defined by the ICD-10-CM Official Coding Guidelines for Coding and Reporting:

- Y = Indicates that the condition was present on admission.
- W = Affirms that the provider has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.
- N = Indicates that the condition was not present on admission.
- U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
- 1 = (Definition prior to FY 2011.) Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-10-CM diagnosis codes is available in the ICD-10-CM Official Coding Guidelines.
- 1 = (Definition for FY 2011 and subsequent years.) Unreported/not used. Exempt from POA reporting. (This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.)

**3.2.8.2** HACs. TRICARE shall adopt those HACs adopted by CMS. The HACs, and their respective diagnosis codes, are posted at <http://www.health.mil/rates>.

**3.2.8.3** Provider responsibilities and reporting requirements. For non-exempt providers, issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System  
(Adjustments To Payment Amounts)

---

**3.2.8.4** The TRICARE/CHAMPUS contractor shall accept, validate, retain, pass, and store the POA indicator.

**3.2.8.5** Exempt providers.

**3.2.8.5.1** The following hospitals are exempt from POA reports for TRICARE:

- Critical Access Hospitals (CAHs)
- Long-Term Care (LTC) Hospitals
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children's Inpatient Hospitals
- Inpatient Rehabilitation Hospitals
- Psychiatric Hospitals and Psychiatric Units
- Department of Veterans Affairs (DVA) Hospitals

**3.2.8.5.2** Contractors shall identify claims from those hospitals that are exempt from POA reporting, and shall take the actions necessary to be sure that the TRICARE grouper software does not apply HAC logic to the claim.

**3.2.8.6** The DRG payment is considered payment in full, and the hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complications or charges because the DRG was demoted to a lesser-severity level.

**3.2.8.7** Effective October 1, 2009, claims will be denied if a non-exempt hospital does not report a valid POA indicator for each diagnosis on the claim.

**3.2.8.8 Replacement Devices**

**3.2.8.8.1** TRICARE is not responsible for the full cost of a replaced device if a hospital receives a partial or full credit, either due to a recall or service during the warranty period. Reimbursement in cases in which an implanted device is replaced shall be made:

- At reduced or no cost to the hospital; or
- With partial or full credit for the removed device.

**3.2.8.8.2** The following condition codes 49 and 50 allow TRICARE to identify and track claims billed for replacement devices:

- Condition Code 49. Product replacement within product lifecycle. Condition code 49 is used to describe replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly - warranty.
- Condition Code 50. Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly. Condition code 50 is used to describe that the manufacturer or the U.S. Food and

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

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment)

---

Drug Administration (FDA) has identified the product for recall and, therefore, replacement.

**3.2.8.8.3** When a hospital receives a credit for a replaced device that is 50% or greater than the cost of the device, hospitals are required to bill the amount of the credit in the amount portion for value code **FD**.

**3.2.8.8.4** Beginning with admissions on or after October 1, 2009, the contractor shall reduce hospital reimbursement for those DRGs subject to the replacement device policy, by the full or partial credit a provider received for a replaced device. The specific DRGs subject to the replacement device policy will be posted on TRICARE's DRG web page at <http://www.health.mil/rates>. As necessary, the DRGs subject to the replacement device policy will be updated as part of the annual DRG update.

**3.2.8.8.5** Hospitals must use the combination of condition code 49 or 50, along with value code **FD** to correctly bill for a replacement device that was provided with a credit or no cost. The condition code 49 or 50 will identify a replacement device while value code **FD** will communicate to TRICARE the amount of the credit, or cost reduction, received by the hospital for the replaced device.

**3.2.8.8.6** The contractor shall deduct the partial/full credit amount, reported in the amount for value code **FD** from the final DRG reimbursement when the assigned DRG is one of the DRGs subject to the replacement device policy.

**3.2.8.8.7** Once a DRG rate is determined, any full/partial credit amount is deducted from the DRG reimbursement rate. The beneficiary copayment/cost-share is then determined based on the reduced rate.

- END -



## Ambulatory Surgical Center (ASC) Reimbursement

Issue Date: August 26, 1985  
Authority: [32 CFR 199.14\(d\)](#)

---

### 1.0 APPLICABILITY

**1.1** The policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

**1.2** Reimbursement of surgical procedures performed in an ASC prior to the implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of TRICARE's Outpatient Prospective Payment System (OPPS), and thereafter, freestanding ASCs, and other providers who are exempt from the TRICARE OPPS and provide scheduled ambulatory surgery. For purposes of this section, these facilities are known as non-OPPS facilities. Non-OPPS facilities include any facility not subject to the OPPS as outlined in [Chapter 13, Section 1, paragraph 3.4.1.2](#).

### 2.0 BACKGROUND

#### 2.1 Reimbursement System Prior to Implementation of Reasonable Cost Method for CAHs and Implementation of TRICARE's OPPS

##### 2.1.1 General

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

##### 2.1.2 Applicability

**2.1.2.1** The ambulatory surgery payment system is to be used regardless of where the ambulatory surgery procedures are provided, that is, in a freestanding ASC, in a Hospital Outpatient Department (HOPD), or in a hospital Emergency Room (ER). No additional benefits are payable outside the ASC payment rate; e.g., revenue codes 260, 450, 510, 636, etc.

**2.1.2.2** The payment rates established under this system apply only to the facility charges for ambulatory surgery. The facility rate is a standard overhead amount that includes nursing and technician services; use of the facility; drugs including take-home drugs for less than \$40; biologicals; surgical dressings, splints, casts and equipment directly related to provision of the

surgical procedure; materials for anesthesia; Intraocular Lenses (IOLs); and administrative, recordkeeping and housekeeping items and services. The rate does not include items such as physicians' fees (or fees of other professional providers authorized to render the services and to bill independently for them); laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure); prosthetic devices (except IOLs); ambulance services; leg, arm, and back braces; artificial limbs; and Durable Medical Equipment (DME) for use in the patient's home.

**Note:** A radiology and diagnostic procedure is considered directly related to the performance of the surgical procedure only if it is an inherent part of the surgical procedure, e.g., the Common Procedure Terminology (CPT) code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description (i.e., CPT<sup>1</sup> procedure code 47560).

### 2.1.3 State Waiver

Ambulatory surgery services provided by freestanding ASCs in Maryland are not exempt from this system and are to be reimbursed using the procedures set forth in this section. (See [Chapter 1, Section 24, paragraph 2.5](#) for payment of professional services related to ambulatory surgery.)

### 2.1.4 Ambulatory Surgery Payment Rates

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

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

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

**2.1.4.4** The rates were initially calculated using the following steps.

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

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

---

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

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

### Chapter 9, Section 1

#### Ambulatory Surgical Center (ASC) Reimbursement

---

- Applying the Cost-to-Charge Ratio (CCR) using the Medicare CCR for freestanding ASCs for TRICARE ASCs.
- Calculating a median cost for each procedure; and
- Updating to the year for which the payment rates were in effect by the Consumer Price Index-Urban (CPI-U).

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

**2.1.4.4.3** The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

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

- Calculating a volume-weighted ratio of TRICARE payment rates to Medicare payment rates for those procedures with sufficient data;
- Applying the ratio to the Medicare payment rate for each procedure; and
- Assigning the procedure to the appropriate payment group.

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

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

## **2.1.5 Payments**

### **2.1.5.1 General**

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

### 2.1.5.2 Procedures Which Do Not Have An Ambulatory Surgery Rate and Are Provided by an ASC

Only those procedures that have an ambulatory surgery rate listed on DHA's ambulatory surgery web site (<http://www.health.mil/rates>) are to be reimbursed under this reimbursement process. If a claim is received from an ASC for a procedure which is not listed on DHA's ambulatory web site, the facility charges are to be reimbursed using the process in [paragraph 2.2](#).

### 2.1.5.3 Multiple and Terminated Procedures

The following rules are to be followed whenever there is a terminated surgical procedure or more than one procedure is included on an ambulatory surgery claim. The claim for professional services, regardless of what type of ambulatory surgery facility provided the services and regardless of what procedures were provided, is to be reimbursed according to the multiple surgery guidelines in [Chapter 1, Section 16, paragraphs 3.1.1.1 through 3.1.1.3](#).

#### 2.1.5.3.1 Discounting for Multiple Surgical Procedures

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

**2.1.5.3.1.2** If the claim includes procedures listed on DHA's ambulatory surgery web site as well as procedures not listed on DHA's ambulatory surgery web site, the following rule is to be followed.

- Each service is to be reimbursed according to the method appropriate to it. That is, the allowable amount for procedures listed on DHA's ambulatory surgery web site is to be based on the appropriate group payment amount while the allowable amount for procedures not listed on DHA's ambulatory surgery web site is to be based on the process in [paragraph 2.2](#). Regardless of the method used for determining the reimbursement for each procedure, only one procedure (the procedure which allows the greatest payment) is to be reimbursed at 100%. All other procedures are to be reimbursed at 50%. If the contractor is unable to determine the charges for each procedure (i.e., a single billed charge is made for all procedures), the contractor is to develop the claim for the charges using the steps contained in the TRICARE Operations Manual (TOM). If development does not result in usable charge data, the contractor is to reimburse the major procedure (the procedure for which the greatest amount is allowed) if that can be determined (e.g., the major procedure is on DHA's ambulatory surgery web site or is identified on the claim) and deny the other procedures using Explanation of Benefits (EOB) message "Requested information not received". If the major procedure cannot be determined, the entire claim is to be denied.

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

### **2.1.5.3.2 Discounting for Bilateral Procedures**

**2.1.5.3.2.1** Following are the different categories/classifications of bilateral procedures:

- Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).
- Inherent bilateral (i.e., procedure in and of itself is bilateral).
- Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures).

**2.1.5.3.2.2** Terminated bilateral procedures or terminated procedures with units greater than one should not occur. Line items with terminated bilateral procedures or terminated procedures with units greater than one are denied.

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

### **2.1.5.3.3 Modifiers for Discounting Terminated Surgical Procedures**

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

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

- Modifiers 52 and 73 are used to identify a surgical procedure that is terminated prior to the delivery of anesthesia and is reimbursed at 50% of the allowable; i.e., the ASC tier rate, the Ambulatory Payment Classification (APC) allowable amount for OPPS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.
- Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100% of the appropriated allowable amounts referenced above.

### **2.1.5.3.4 Unbundling of Procedures**

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

### **2.1.5.3.5 Incidental Procedures**

The rules for reimbursing incidental procedures as contained in [Chapter 1, Section 3](#), are to be applied to ambulatory surgery procedures reimbursed under the rules set forth in this

section. That is, no reimbursement is to be made for incidental procedures performed in conjunction with other procedures which are not classified as incidental. This limitation applies to payments for facility claims as well as to professional services.

### 2.1.6 Updating Payment Rates

The rates will be updated annually by **DHA** by the same update factor as is used in the Medicare annual updates for ASC payments.

- The rates were updated by 1.3% effective November 1, 2012.
- The rates were updated by 0.9% effective November 1, 2013.
- The rates were updated by 1.2% effective November 1, 2014.

## 2.2 Reimbursement for Procedures Not Listed On **DHA's** Ambulatory Surgery Web Site

Ambulatory surgery procedures that are not listed on **DHA's** ambulatory surgery web site, and are performed in either a freestanding ASC may be cost-shared, but only if doing so results in no additional costs to the program.

## 2.3 Reimbursement System On Or After May 1, 2009 (Implementation Of OPPS)

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

**2.3.2** For ambulatory surgery procedures performed in freestanding ASCs and non-OPPS facilities, the provisions in [paragraph 2.1](#) shall apply, except as follows:

- Contractors will no longer be allowed to group other procedures not listed on **DHA's** ambulatory surgery web site. On May 1, 2009 (implementation of OPPS), these groupers will be end dated. Only ambulatory surgery procedures listed on **DHA's** ambulatory surgery web site are to be grouped.
- Multiple and Terminated Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), the professional services shall be reimbursed according to the multiple surgery guidelines in [Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3](#).
- Discounting for Multiple Surgical Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), discounting for multiple surgical procedures are subject to the provisions in [Chapter 13, Section 3](#).
- Discounting for Bilateral Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), bilateral procedures will be discounted based on the application of discounting formulas appearing in [Chapter 13, Section 3, paragraphs 3.1.5.3.6 and 3.1.5.3.7](#).

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

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

**3.5.1.3** Each HIPPS code represents a distinct payment amount, without any duplication of payment weights across codes.

**3.5.1.4** The new HIPPS coding structure has resulted in 153 case-mix groups represented by the first four positions of the code. Each of these case-mix groups can be combined with a NRS severity level, resulting in 918 HIPPS codes in all (i.e., 153 case-mix times six NRS severity levels). With two values representing supply levels (1-6 in cases where NRS's are not associated with the first four positions of the HIPPS code and **S-X** where they are), there are actually 1836 new HIPPS codes. Refer to the DHA web site (<http://www.health.mil/rates>) for a complete listing of HH PPS case-mix refined HIPPS codes (all five positions) with associated weights.

**3.5.2 Constructing of HIPPS Codes from Grouping Step and Point Scores**

The following scoring matrix (Figure 12.4-7) will be used in construction of the HIPPS code for payment under HH PPS:

**FIGURE 12.4-7 SCORING MATRIX FOR CONSTRUCTING HIPPS CODE**

|   | LEVEL | FIRST & SECOND EPISODES |                      | THIRD + EPISODES    |                      | ALL EPISODES       | HIPPS CODE   |              |                |
|---|-------|-------------------------|----------------------|---------------------|----------------------|--------------------|--------------|--------------|----------------|
|   |       | 0-13 THERAPY VISITS     | 14-19 THERAPY VISITS | 0-13 THERAPY VISITS | 14-19 THERAPY VISITS | 20+ THERAPY VISITS | LEVEL        | HIPPS VALUES | HIPPS POSITION |
| <b>Grouping Step:</b>   |       | <b>1</b>                | <b>2</b>             | <b>3</b>            | <b>4</b>             | <b>5</b>           | <b>Step:</b> | <b>1-5</b>   | <b>1</b>       |
| <b>Clinical Severity Level:</b><br>(by point scores-<br><a href="#">Figure 12.4-8</a> )         | C1    | 0 to 4                  | 0 to 6               | 0 to 2              | 0 to 8               | 0 to 7             | C1           | A            | 2              |
|   | C2    | 5 to 8                  | 7 to 14              | 3 to 5              | 9 to 16              | 8 to 14            | C2           | B            |                |
|   | C3    | 9+                      | 15+                  | 6+                  | 17+                  | 15+                | C3           | C            |                |
| <b>Functional Severity Level:</b><br>(by point scores-<br><a href="#">Figure 12.4-8</a> )       | F1    | 0 to 5                  | 0 to 6               | 0 to 8              | 0 to 7               | 0 to 6             | F1           | F            | 3              |
|   | F2    | 6                       | 7                    | 9                   | 8                    | 7                  | F2           | G            |                |
|   | F3    | 7+                      | 8+                   | 10+                 | 9+                   | 8+                 | F3           | H            |                |
| <b>Services Utilization Level:</b><br>(by number of therapy visits)                             | S1    | 0 to 5                  | 14 to 15             | 0 to 5              | 14 to 15             | 20+ (1 Group)      | S1           | K            | 4              |
|   | S2    | 6                       | 16 to 17             | 6                   | 16 to 17             |                    | S2           | L            |                |
|   | S3    | 7 to 9                  | 18 to 19             | 7 to 9              | 18 to 19             |                    | S3           | M            |                |
|   | S4    | 10                      |                      | 10                  |                      |                    | S4           | N            |                |
|   | S5    | 11 to 13                |                      | 11 to 13            |                      |                    | S5           | P            |                |
| <b>NRS - Supplies Severity Level:</b><br>(by NRS point scores- <a href="#">Figure 12.4-10</a> ) | NRS-1 | 0                       |                      |                     |                      |                    | NRS-1        | S            | 5              |
|   | NRS-2 | 1 to 14                 |                      |                     |                      |                    | NRS-2        | T            |                |
|   | NRS-3 | 15 to 27                |                      |                     |                      |                    | NRS-3        | U            |                |
|   | NRS-4 | 28 to 48                |                      |                     |                      |                    | NRS-4        | V            |                |
|   | NRS-5 | 49 to 98                |                      |                     |                      |                    | NRS-5        | W            |                |
|   | NRS-6 | 99+                     |                      |                     |                      |                    | NRS-6        | X            |                |

**Note:** If an episode has 20 or more visits, the case mix points could come from the second leg if it is an early episode, and from the fourth leg if it is a later episode. The table column headers indicate that these two legs are for 14 or more therapy visits.

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

Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

**3.5.2.1** Case-mix adjustment variables and scores used in constructing HIPPS codes (i.e., point scoring used in [Figure 12.4-6](#) for determining the appropriate HIPPS code for payment).

**3.5.2.1.1** The point scores for clinical and functional severity levels (second and third positions of HIPPS code) are derived from [Figure 12.4-8](#) which gives a description of each diagnosis group followed by four columns representing the four legs of the four-equation model. The diagnoses associated with each of the diagnostic categories in [Figure 12.4-8](#) can be found in [Addendum N](#).

**FIGURE 12.4-8 CASE-MIX ADJUSTMENT VARIABLES AND SCORES FOR EPISODES ENDING BEFORE JANUARY 1, 2012**

|                           | <b>Episode number within sequence of adjacent episodes</b>  | <b>1 or 2</b> | <b>1 or 2</b> | <b>3+</b>   | <b>3+</b>  |
|---------------------------|---|---------------|---------------|-------------|------------|
|                           | <b>Therapy visits</b>   | <b>0-13</b>   | <b>14+</b>    | <b>0-13</b> | <b>14+</b> |
|                           | <b>EQUATION:</b>  | <b>1</b>      | <b>2</b>      | <b>3</b>    | <b>4</b>   |
| <b>CLINICAL DIMENSION</b> |   |               |               |             |            |
| 1                         | Primary or Other Diagnosis = Blindness/Low Vision   | 3             | 3             | 3           | 3          |
| 2                         | Primary or Other Diagnosis = Blood disorders  | 2             | 5             |             |            |
| 3                         | Primary or Other Diagnosis = Cancer, selected benign neoplasms  | 4             | 7             | 3           | 10         |
| 4                         | Primary Diagnosis = Diabetes  | 5             | 12            | 1           | 8          |
| 5                         | Other Diagnosis = Diabetes  | 2             | 4             | 1           | 4          |
| 6                         | Primary or Other Diagnosis = Dysphagia<br><b>AND</b><br>Primary or Other Diagnosis = Neuro 3 - Stroke   | 2             | 6             |             | 6          |
| 7                         | Primary or Other Diagnosis = Dysphagia<br><b>AND</b><br>M0250 (Therapy at home) = 3 (Enteral)   |               | 6             |             |            |
| 8                         | Primary or Other Diagnosis = Gastrointestinal disorders   | 2             | 6             | 1           | 4          |
| 9                         | Primary or Other Diagnosis = Gastrointestinal disorders<br><b>AND</b><br>M0550 (ostomy) = 1 or 2  | 3             |               |             |            |
| 10                        | Primary or Other Diagnosis = Gastrointestinal disorders<br><b>AND</b><br>Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis,<br>OR Neuro 2 - Peripheral neurological disorders, OR Neuro 3 - Stroke, OR<br>Neuro 4 - Multiple Sclerosis |               |               | 2           |            |
| 11                        | Primary or Other Diagnosis = Heart Disease OR Hypertension  | 3             | 7             | 1           | 8          |
| 12                        | Primary Diagnosis = Neuro 1 - Brain disorders and paralysis   | 3             | 8             | 5           | 8          |
| 13                        | Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis<br><b>AND</b><br>M0680 (Toileting) = 2 or more   | 3             | 10            | 3           | 10         |
| 14                        | Primary or Other Diagnosis = Neuro 1 - Brain disorders and paralysis<br>OR Neuro 2 - Peripheral neurological disorders<br><b>AND</b><br>M0650 or M0660 (Dressing upper or lower body) = 1, 2, or 3  | 2             | 4             | 2           | 2          |
| 15                        | Primary or Other Diagnosis = Neuro 3 - Stroke   |               | 1             |             |            |
| 16                        | Primary or Other Diagnosis = Neuro 3 - Stroke<br><b>AND</b><br>M0650 or M0660 (Dressing upper or lower body) = 1, 2, or 3   | 1             | 3             | 2           | 8          |

## Chapter 12

## Addendum J

# Health Insurance Prospective Payment System (HIPPS) Tables For Pricer

---

Refer to the **Defense Health Agency (DHA)** web site (<http://www.health.mil/rates>) for the HIPPS Tables for the Pricer.

- END -



## Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2015

---

In 2013 the Office of Management and Budget (OMB) issued changes in the delineation of Metropolitan Statistical Areas (MSA), Micropolitan Statistical Areas, and Combined Statistical Areas. Centers for Medicare and Medicaid Services (CMS) finalized changes to the wage index based on the revised Core Based Statistical Area (CBSA) delineations for the Calendar Year (CY) 2015 HH PPS wage index. These changes are made to the wage index using a blended wage index for a one-year transition. For each county, a blended wage index is calculated as 50% of the CY 2015 wage index using the current OMB delineations and 50% of the CY 2015 wage index using the revised OMB delineations. Beginning January 1, 2016, the wage index for all HH PPS payments will be fully based on the new OMB delineations.

■ The CY 2015 transitional wage index is available for download at <http://www.health.mil/rates>.

- END -



## Chapter 13

## Section 1

### General

Issue Date: July 27, 2005

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

---

#### 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(i)(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 OPSS.

#### **3.4.1 Provider Categories**

##### **3.4.1.1 Providers Included In OPSS**

**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. **Please reference 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)
- Home Health Agencies (HHAs)
- Hospice programs

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

### Chapter 13, Section 1

#### General

---

- 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.

**3.4.2.1.11** Take home surgical dressings.

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

### Chapter 13, Section 1

#### General

---

**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.

**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.

---

**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

---

<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.health.mil/rates> 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.health.mil/rates>.

- 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(i)(2) and 10 USC 1079(h)

---

### 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.health.mil/rates> 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.

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

### Chapter 13, Section 2

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

---

- 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.

**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—<br/>On the same day as HCPCS code G0379; or<br/>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>                  |

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

**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;

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

### Chapter 13, Section 2

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

---

**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.health.mil/rates>) 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.health.mil/ratespecifies> 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.health.mil/rates> 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.

---

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

## Prospective Payment Methodology

Issue Date: July 27, 2005

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

---

### 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.

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

Chapter 13, Section 3

Prospective Payment Methodology

**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                                     |

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

Chapter 13, Section 3

Prospective Payment Methodology

**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.health.mil/rates>.

**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.

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

### Chapter 13, Section 3

#### Prospective Payment Methodology

---

**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.

---

<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.health.mil/rates>.

### **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.health.mil/rates> 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.health.mil/rates> 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.

---

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

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

### Chapter 13, Section 3

#### Prospective Payment Methodology

---

**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.health.mil/rates>).

**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.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 13, Section 3

Prospective Payment Methodology

**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.

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

### Chapter 13, Section 3

#### Prospective Payment Methodology

---

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 **Section** (MB&RS) 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&RS 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&RS 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 OPPS 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 OPPS 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 OPPS year (May 1 through April 30) or the number of OPPS 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 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)**

**3.1.5.8.2.1.1** The Director, TRICARE Regional Office (DTRO), shall conduct a thorough analysis and recommend the appropriate year end adjustment to total OPPS 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 OPPS. Although, the maximum amount that a hospital can receive is 95% of the pre-OPPS 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-OPPS payments for the analysis to the DTRO.

**3.1.5.8.2.1.3** Total TRICARE OPPS 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 OPPS year (May 1 through April 30). At the end of the second and third OPPS years, subsequent adjustments will be issued to the qualifying hospitals for the first and second OPPS years to ensure claims that were not

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

### Chapter 13, Section 3

#### Prospective Payment Methodology

---

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&RS 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&RS 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&RS 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](#).

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

### Chapter 13, Section 3

#### Prospective Payment Methodology

---

**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&RS for DHA Director review and approval.

---

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

**3.4 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.health.mil/rates> 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.

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

Chapter 13, Section 3

Prospective Payment Methodology

**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.health.mil/rates>;
- 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

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

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

Chapter 13, Section 3

Prospective Payment Methodology

---

non-professional component, will lag two months (i.e., April 1 instead of February 1).

**4.0 EFFECTIVE DATE**

May 1, 2009.

- END -

