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

DEFENSE
HEALTH AGENCY

MB&RS

CHANGE 122
6010.58-M
JANUARY 12, 2016

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

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: **UPDATES TO OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)**

CONREQ: 17405

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates the OPPS chapter in the reimbursement manual by removing outdated and duplicate information, providing links to the Medicare web site where appropriate, and simplifying the quarterly update process for OPPS.

EFFECTIVE DATE: February 12, 2016.

IMPLEMENTATION DATE: February 12, 2016.

FAZZINI.ANN.NOREEN.1199802271

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: 2016.01.08 14:02:20 -07'00'

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

ATTACHMENT(S): **76 PAGE(S)**
DISTRIBUTION: **6010.58-M**

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

CHANGE 122
6010.58-M
JANUARY 12, 2016

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 1	
Section 16, pages 1 through 5	Section 16, pages 1 through 5
CHAPTER 13	
Table of Contents, pages 1 and 2	Table of Contents, page 1
Section 1, pages 1 through 13	Section 1, pages 1 through 11
Section 2, pages 1 through 33	Section 2, pages 1 through 12
Section 3, pages 1 through 55	Section 3, pages 1 through 42
Section 4, pages 1 through 3	Section 4, pages 1 through 3
Addendum B, page 1	Addendum B, page 1
Addendum C, pages 1 and 2	Addendum C, page 1

Chapter 1 Section 16

Surgery

Issue Date: August 26, 1985
Authority: 32 CFR 199.4(c)(2)(i), (c)(2)(ii), (c)(3)(i), (c)(3)(iii), and (c)(3)(iv)

1.0 APPLICABILITY

Paragraphs 3.1 through 3.7 apply to reimbursement of services provided by network and non-network providers. Paragraphs 3.8 and 3.9 apply only to non-network providers.

2.0 ISSUE

How is surgery to be reimbursed?

3.0 POLICY

3.1 Multiple Surgery And Discounting Reimbursement

3.1.1 The following rules are to be followed whenever there is a terminated procedure or more than one surgical procedure performed during the same operative or outpatient session. This applies to those facilities that are exempt from the hospital Outpatient Prospective Payment System (OPPS) and for claims submitted by individual professional providers for services rendered on or after May 1, 2009 (implementation of OPPS):

3.1.1.1 Discounting for Multiple Procedures

3.1.1.1.1 When more than one surgical procedure code subject to discounting (see Chapter 13, Section 3) is performed during a single operative or outpatient session, TRICARE will reimburse the full payment and the beneficiary will pay the cost-share/copayment for the procedure having the highest payment rate. Beginning January 1, 2015, Medicare introduced comprehensive Ambulatory Payment Classifications (APCs) under the OPPS. Surgical procedures considered part of comprehensive APCs (Status Indicator (SI) of **J1**) provided in facilities exempt from OPPS are also subject to discounting for multiple procedures under this paragraph, in addition to those procedures listed in Chapter 13, Section 3, paragraphs 3.1.5.2.

3.1.1.1.2 Fifty percent (50%) of the usual payment amount and beneficiary copayment/cost-share amount will be paid for all other procedures subject to discounting (see Chapter 13, Section 3) performed during the same operative or outpatient session to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

- The reduced payment would apply only to the surgical procedure with the lower

payment rate.

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

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) Current Procedural Terminology (CPT) guide.

3.1.1.2 Discounting for Bilateral Procedures

Note: Bilateral codes can be surgical and non-surgical.

3.1.1.2.1 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).

3.1.1.2.2 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.

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

3.1.1.2.4 The above 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.

3.1.1.3 Modifiers for Discounting Terminated Surgical Procedures

3.1.1.3.1 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.

3.1.1.3.2 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 Ambulatory Surgery Center (ASC) tier rate, the 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.

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.

3.9 In-Office Surgery

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

3.10 On May 1, 2009 (implementation of OPPS), surgical procedures will be discounted in accordance with the provisions outlined in Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3. Multiple discounting will not be applied to the following CPT[1] procedure codes for venipucture, fetal monitoring and collection of blood specimens; 36400-36416, 36591, 36592, 59020, 59025, 59050, and 59051.

- END -

[1] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

Chapter 13

Outpatient Prospective Payment System (OPPS)-Ambulatory Payment Classification (APC)

Section/Addendum	Subject/Addendum Title
1	General
2	Billing And Coding Of Services Under Ambulatory Payment Classifications (APC) Groups
	Figure 13.2-1 PHP As Of CY 2015
	Figure 13.2-2 Reporting Of Partial Hospitalization Services Spanning Two Or More Dates - HIPAA 837 Format
	Figure 13.2-3 Reporting Of Partial Hospitalization Services Spanning Two Or More Dates - CMS 1450 Format
3	Prospective Payment Methodology
	Figure 13.3-1 Discounting Formulas For Bilateral Procedures
	Figure 13.3-2 Application of Discounting Formulas
	Figure 13.3-3 TTPA Adjustment Percentages For 10 Visit APC Codes
	Figure 13.3-4 Devices For Which The FB Modifier Must Be Reported With The Procedure When Furnished Without Cost Or At Full Credit For A Replacement Device
	Figure 13.3-5 Adjustments To APCs In Cases Of Devices Reported Without Cost Or For Which Full Credit Is Received For CY 2009
	Figure 13.3-6 Proportional Payment For "T" Line Items
4	Claims Submission And Processing Requirements
5	Medical Review And Allowable Charge Review Under the Outpatient Prospective Payment System (OPPS)
A	Development Schedule For TRICARE Outpatient Code Editor (OCE)/Ambulatory Payment Classification (APC) Quarterly Update
B	Outpatient Prospective Payment System (OPPS) Outpatient Code Editor (OCE) Notification Process For Quarterly Updates
C	Approval Of OPPS - Outpatient Code Editor (OCE)/APC And No Government Pay List (NGPL) Quarterly Update Process

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 adopted 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).

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 OPPS. 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 OPPS.

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 OPPS, 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 OPPS, 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 See Chapter 8, Section 2, paragraph 4.3.13.5.10 for outpatient services provided to SNF patients.

3.4 Applicability and Scope of Coverage

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

3.4.1 Provider Categories

3.4.1.1 Providers Included In OPPS

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 OPPS unless specifically excluded under this chapter. The marketing contractor will have responsibility for educating providers to bill under the OPPS 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 OPPS 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 OPPS

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. See 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
- Community Mental Health Centers (CMHCs)

Note: CMHC PHPs have been excluded from provider authorization and payment under the OPPS 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 OPPS 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. Beginning January 1, 2014, most laboratory tests will be packaged under OPPS. See Section 4, paragraph 3.6

3.4.2.1.11 Take home surgical dressings.

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

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

- Payment may not be made for items furnished by a supplier of medical equipment and supplies unless the supplier obtains a supplier number. However, since there is no reason to split a claim for DME payment under TRICARE, a separate supplier number will not be required for a hospital to receive reimbursement for DME.

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

3.4.2.1.14 Services and procedures designated as requiring inpatient care.

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

- Ambulance services
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech-Language Pathology (SLP)

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

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 OPPS (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 OPPS. Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients who have profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

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

3.4.2.3.2.1 Surgical procedures.

Note: All hospital based ASC claims that are submitted to be paid under OPPS 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 for those services that are beyond the scope of SNF comprehensive care plans. See Chapter 8, Section 2, paragraph 4.3.13.5.10 for outpatient services provided to SNF patients.

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 OPPS.

3.4.2.3.2.13 Acquisition costs for allogenic stem cell transportation.

3.4.2.3.2.14 Autologous stem cell processing and harvesting procedures.

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 OPPS.

3.5.2 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. The fundamental criteria for grouping procedures/services are: resource homogeneity; clinical homogeneity; provider concentration; and frequency of service. See the TRICARE OPPS Final Rule for descriptions (73 FR 74945).

3.6 Basic Reimbursement Methodology

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

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

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

3.6.3 Each APC weight represents the median hospital cost of the services included in the APC relative to the median hospital cost of services included in the hospital clinic visits APC. APC weights are scaled to the hospital clinic visits APC because it is one of the most frequently performed services in the outpatient setting.

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

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

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

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

Note: The ASC cost-sharing provision (i.e., assessment of a single copayment for both the professional and facility charge for a Prime beneficiary) will be adopted as long as it is administratively feasible. This will not apply to Extra and Standard beneficiaries since their cost-sharing is based on a percentage of the total bill. The copayment is based on site of service, except for venipuncture and fetal monitoring. Reference Chapter 2, Section 1, paragraphs 1.2.4.5 and 1.2.4.7.

3.6.8 Reimbursement hierarchy for procedures paid outside the OPPS. For information related to the CMAC Facility Pricing Hierarchy, see Chapter 5, Section 3, paragraph 3.7.2.4.

3.6.9 Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service defined as a service typically reported with multiple HCPCS codes. See Section 2 for additional information.

3.6.10 Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim are packaged into the payment for the primary service. See Section 2 for additional information.

3.7 Outpatient Code Editor (OCE)

3.7.1 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 and data files, along with installation and user manuals, will be delivered electronically 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.

3.7.2 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.

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

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

3.8 PRICER Program

3.8.1 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 **J1**, **S**, **T**, **V**, or **X**)[1] reported off of the hospital outpatient claim. The PRICER will also apply discounting for multiple surgical procedures performed during a single operative session and outlier payments for extraordinarily expensive cases. 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 OPPS quarterly effective dates (i.e., January 1, April 1, July 1, and October 1 of each calendar year) but prior to 21 days from receipt of either the OPPS OCE or PRICER update cartridge may be considered excluded claims as defined by the TRICARE Operations Manual (TOM), Chapter 1, Section 3, paragraph 1.5.2.

3.8.2 The contractors shall provide 3M with those pricing files to maintain and update the TRICARE OPPS PRICER within five weeks prior to the quarterly update. For example, statewide prevailings for services that do not have a CMAC 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.

3.9 Geographical Wage Adjustments

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

3.10 Provider-Based Status for Payment Under OPPS

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

3.11 Implementing Instructions

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

[1] Effective January 1, 2015, SI of **X** is no longer recognized.

implementing instructions within Chapter 13:

IMPLEMENTING INSTRUCTIONS/SERVICES	
POLICIES	
General Overview	Section 1
Billing and Coding of Services under APC Groups	Section 2
Reimbursement Methodology	Section 3
Claims Submission and Processing Requirements	Section 4
Medical Review Under the Hospital OPPS	Section 5
ADDENDA	
Development Schedule for TRICARE OCE/APC - Quarterly Update	Addendum A
OPPS OCE Notification Process for Quarterly Updates	Addendum B
Approval Of OPPS - OCE/APC And NGPL Quarterly Update Process	Addendum C

3.12 OPPS Data Elements Available On DHA's Web Site

The OPPS data elements are available on DHA's OPPS web site at http://www.health.mil/rates.

4.0 EFFECTIVE DATE

May 1, 2009.

- END -

Chapter 13 Section 2

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.

- 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.
- Certain laboratory services.

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).

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.

3.2.2.2.1 Special transitional pass-through payments (additional payments) made for at least 2 years, but not more than three years for the following drugs and biologicals:

- Current orphan drugs, as designated under section 526 of the Federal Food, Drugs, and Cosmetic Act;
- Current drugs and biological agents used for treatment of cancer;
- Current radiopharmaceutical drugs and biological products; and
- New drugs and biologic agents in instances where the item was not being paid as a hospital outpatient service as of December 31, 1996, and where the cost of the item is "not insignificant" in relation to the hospital OPPS payment amount.

Note: The process to apply for transitional pass-through payment for eligible drugs and biological agents can be found on the Centers for Medicare and Medicaid Services (CMS) web site: http://www.cms.hhs.gov. The TRICARE contractors will not be required to review applications for pass through payment.

3.2.2.2.2 Separate APC payment for drugs and radiopharmaceuticals for which the median cost per line exceeds an amount determined each year by Medicare, and published in the Medicare final rule ($95 for CY 2015), with the exception of injectable and oral forms of antiemetics.

3.2.2.2.3 Separately payable radiopharmaceuticals, drugs and biologicals classified as "specified covered outpatient drugs" for which payment was made on a pass-through basis on or before December 31, 2002, and a separate APC exists.

3.2.2.2.4 Separate payment for new drugs and biologicals that have assigned Healthcare Common Procedure Coding System (HCPCS) codes, but that do not have a reference Average Wholesale Price (AWP), approval for pass-through payment or hospital claims data.

3.2.2.2.5 Drugs and biologicals that have not been eligible for pass-through status but have been receiving nonpass-through payments since implementation of the Medicare OPPS.

3.2.2.2.6 Separate payment for new drugs, biologicals and radiopharmaceuticals enabling hospitals to begin billing for drugs and biologicals that are newly approved by the U.S. Food and Drug Administration (FDA), and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup.

3.2.2.2.7 Special APC groups that have been created to accommodate payment for new technologies. The drugs, biologicals and pharmaceuticals that are incorporated into these new technology APCs are paid separately from, and in addition to, the procedure or treatment with which they are associated yet are not eligible for transitional pass-through payment. Payment of new technology APCs is available only if the service meets the requirements of 32 CFR 199.4.

3.2.2.2.8 New drugs, biologicals, and devices which qualify for separate payment under OPPS, but have not yet been assigned to a transitional APC (i.e., assigned to a temporary APC for separate payment of an expensive drug or device) will be reimbursed under TRICARE standard allowable charge methodology. This allowable charge payment will continue until a transitional APC has

been assigned (i.e., until CMS has had the opportunity to assign the new drug, biological or device to a temporary APC for separate payment).

Note: The contractors will not be held accountable for the development of transitional APC payments for new drugs, biologicals or devices.

3.2.2.3 Corneal tissue acquisition costs.

- Corneal tissue acquisition costs not packaged into the payment rate for corneal transplant surgical procedures.
- Separate payment will be made based on the hospital's reasonable costs incurred to acquire corneal tissue.
- Corneal acquisition costs must be submitted using HCPCS code V2785 (Processing, Preserving and Transporting Corneal Tissue), indicating the acquisition cost rather than the hospital's charge on the bill.

3.2.2.4 Costs for other procedures or services not packaged in the APC payment.

- Blood and blood products, including anti-hemophilic agents.
- Casting, splinting and strapping services.
- Immunosuppressive drugs for patients following organ transplant.
- Certain other high cost drugs that are infrequently administered.

Note: New APC groups have been created for these items and services, which allows separate payment.

3.2.2.5 Reporting Requirements for Device Dependent Procedures.

Hospitals are required to bill all device-dependent procedures using the appropriate C-codes for the devices. Following are provisions related to the required use of C-codes:

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

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

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

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

3.2.2.5.3 Composite APCs provide a single payment when more than one of a specified set of major independent services are provided in a single encounter. When HCPCS codes that meet certain criteria for payment of the composite APC are billed on the same date of service, CMS

makes a single payment for all of the codes as a whole, rather than paying individually for each code. For those services considered to be a TRICARE benefit, TRICARE adopts the composite APC logic as established by Medicare. See the Medicare Claims Processing Manual, Chapter 4, Section 10.2.1 for current composite APC logic. See the TRICARE rates web site at http://www.health.mil/rates for the national unadjusted payment rates for these composite APCs.

3.2.2.5.4 Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim are packaged into payment for the primary service. With some exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service. HCPCS codes assigned to comprehensive APCs are designated with Status Indicator (SI) **J1**. When multiple **J1** services are reported on the same claim, the single payment is based on the rate associated with the highest ranking **J1** service. When certain pairs of **J1** services, or in certain cases a **J1** service and add-on code, are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family. Please see the Medicare Claims Processing Manual, Chapter 4, Section 10.2.3 for detailed logic for comprehensive APCs, including descriptions of those services included in the comprehensive APC payment, and those limited exceptions. For those services considered to be a TRICARE benefit, TRICARE adopts the comprehensive APC logic as established by Medicare. See the TRICARE rates web site at http://www.health.mil/rates for the national unadjusted payment rates for comprehensive APCs.

3.3 Additional Payments Under The OPPS

3.3.1 Certain clinical diagnostic testing (lab work).

3.3.2 Administration of infused drugs.

3.3.3 Therapeutic procedures including resuscitation that are furnished during the course of an emergency visit.

3.3.4 Certain high-cost drugs, such as the expensive “clotbuster” drugs that must be given within a short period of time following a heart attack or stroke.

3.3.5 Cases that fall far outside the normal range of costs. These cases will be eligible for an outlier adjustment.

3.4 Payment For Patients Who Die In The Emergency Department (ED)

3.4.1 If the patient dies in the ED, and the patient’s status is outpatient, the hospital should bill for payment under the OPPS for the services furnished.

3.4.2 If the ED or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient.

- If the patient had been admitted as an inpatient, pay under the hospital DRG-based payment system.

- If the patient was not admitted as an inpatient, pay under the OPPS (an APC-based payment) for the services that were furnished.

- If the patient was not admitted as an inpatient and the procedure designated as an inpatient-only procedure (by OPPS payment SI of **C**) is performed, the hospital should bill for payment under the OPPS for the services that were furnished on that date and should include modifier -CA on the line with the HCPCS code for the inpatient procedure. Payment for all services other than the inpatient procedure designated under OPPS by the SI of **C**, furnished on the same date, is bundled into a single payment under APC 0375.

3.4.3 Billing and Payment Rules for Using Modifier -CA. Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission.

3.4.3.1 All the following conditions must be met in order to receive payment for services billed with modifier -CA:

- The status of the patient is outpatient;

- The patient has an emergent, life-threatening condition;

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

- The patient dies without being admitted as an inpatient.

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

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

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

3.5 Medical Screening Examinations

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

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

3.6 HCPCS/Revenue Coding Required Under OPPS

Hospital Outpatient Departments (HOPDs) should use the CMS 1450 UB-04 Editor as a guide for reporting HCPCS and revenue codes under the OPPS.

3.7 Treatment of Partial Hospitalization Services

Hospital-based Partial Hospitalization Programs (PHPs) (psych and Substance Use Disorder Rehabilitation Facilities (SUDRFs)) will be reimbursed a per diem payment under the OPPS. Freestanding PHPs (psych and SUDRFs) are reimbursed under the existing PHP per diem payment. See Chapter 7. Separate TRICARE certification of hospital-based psychiatric PHPs is not required, making all hospital-based PHPs eligible for payment under TRICARE's OPPS.

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

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

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

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

3.7.3 PHP should be a highly structured and clinically-intensive program, usually lasting most of the day. Since a day of care is the unit that defines the structure and scheduling of partial hospitalization services, a two-tiered payment approach has been retained, one for days with three services (APC 0175) and one for days with four or more services (APC 0176) to provide PHPs scheduling flexibility and to reflect the lower costs of a less intensive day.

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

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

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

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

3.7.3.4.1 Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services. This means that each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

3.7.3.4.2 A complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services or other mental health services outside partial hospitalization is available in the Medicare Claims Processing Manual, Chapter 4, Section 260.1.

3.7.3.4.3 To bill for partial hospitalization services under the hospital OPPS, hospitals are to report partial hospitalization services under bill type 013X, along with Condition Code **41** on the CMS 1450 UB-04 claim form.

3.7.3.4.4 The claim must include a mental health diagnosis and an authorization on file for each day of service. Since there is no HCPCS code that specifies a partial hospitalization related service, partial hospitalizations are identified by means of a particular bill type and condition code (i.e., 13X Type of Bill (TOB) with Condition Code **41**) along with HCPCS codes specifying the individual services that constitute PHPs. In order to be assigned payment under Level II Partial Hospitalization Payment APC (0176) there must be four or more codes from PHP List B of which at least one code must come from PHP List A. In order to be assigned payment under Level I Partial Hospitalization Payment APC (0175) there must be a least three codes from PHP List B of which at least one code must come from PHP List A. List A is a subset of List B and contains only psychotherapy codes, while List B includes all PHP codes. (Refer to PHP Lists A and B in Figure 13.2-1). All other PHP services rendered on the same day will be packaged into the PHP APCs (0175 and 0176). All PHP lines will be denied if there are less than three codes/service appearing on the claim.

FIGURE 13.2-1 PHP AS OF CY 2015

PHP LIST A	PHP LIST B			PHP LIST C*
90832	90785	90845	96119	90785
90834	90791	90846	96120	90833
90837	90792	90847	96129	90836
90845	90832	90865	G0176	90838
90846	90833	96101	G0177	
90847	90834	96102	G0410	
90865	90836	96103	G0411	
G0410	90837	96116		
G0411	90838	96118		

* Add-on codes that are not counted in meeting the numerical requirement for APC assignment.

3.7.3.4.5 In order to assign the partial hospitalization APC to one of the line items the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC. All other partial hospital services on the same day are packaged; (i.e., the SI is changed from **Q** to **N**.) Partial hospitalization services with SI **E** (items or services that are not covered by TRICARE) or **B** (more appropriate code required for TRICARE OPPS) are not packaged and are ignored in the PHP processing. See the Medicare Claims Processing Manual, Chapter 4, Section 260.1 for additional details on PHP claims processing in hospitals subject to OPPS.

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

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

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

3.7.3.4.9 Dates of service per revenue code line for partial hospitalization claims that span two or more dates. Each service (revenue code) provided must be repeated as a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date." Following are examples of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

FIGURE 13.2-2 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - HIPAA 837 FORMAT

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

FIGURE 13.2-3 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - CMS 1450 FORMAT

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

Note: Each line item on the CMS 1450 UB-04 Claim Form must be submitted with a specific date of service to avoid claim denial. The header dates of service on the CMS 1450 UB-04 may span, as long as all lines include specific dates of service within the span on the header.

3.7.4 Reimbursement for a day of outpatient mental health services in a non-PHP program (i.e., those mental health services that are not accompanied with a Condition Code **41**) will be capped at the partial hospital per diem rate. The payments for all of the designated Mental Health (MH) services will be totaled with the same date of service. If the sum of the payments for the individual MH services standard APC rules, for which there is an authorization on file, exceeds the Level II Partial Hospitalization APC (0176), a special MH services composite payment APC (APC 0034) will be assigned to one of the line items that represent MH services. All other MH services will be

packaged. The MH services composite payment APC amount is the same as the Level II Partial Hospitalization APC per diem rate. MH services with SI **E** or **B** are not included in payments that are totaled and are not assigned the daily mental health composited APC amount.

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

3.8 Payment Policy for Observation Services

3.8.1 Beginning January 1, 2014, in certain circumstances when observation care is billed in conjunction with a clinical visit, high level Type **A** ED visit (level 4 or 5), high level type **B** ED visit (level 5), critical care services, or a direct referral as an integral part of a patients extended encounter of care, payment may be made for the entire encounter through APC 8009. APCs 8002 and 8003 were deleted as of January 1, 2014. See the Medicare Claims Processing Manual, Chapter 4, Sections 10.2.1, 290.5.1. and 290.5.2 for observation stays for non-maternity conditions.

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 OPPS 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 OPPS web site at http://www.health.mil/rates specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. The list is updated quarterly and reflects CMS changes. 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 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.

3.9.3 There are three exceptions to the policy of not paying for outpatient services furnished on the same day with an "inpatient-only" service that would be paid under the OPPS if the inpatient service had not been furnished:

3.9.3.1 For outpatients who undergo inpatient-only procedures on an emergency basis and who expire before they can be admitted to the hospital, a specified APC payment is made to the provider as reimbursement for all services on that day. The presence of modifier -CA on the inpatient-only procedure line assigns the specified payment APC and associated status and payment indicators to the line. The packaging flag is turned on for all other lines on that day. Payment is only allowed for one procedure with modifier -CA. If multiple inpatient-only procedures are submitted with the modifier -CA, only one procedure is paid and all others are packaged. If multiple units are submitted on a payable inpatient-only procedure line, the OCE resets the service units to 1. If modifier -CA is submitted with an inpatient-only procedure for a patient who did not expire (patient status code is not 20), the claim is suspended for data validation.

3.9.3.2 Inpatient-only procedures that are on the separate-procedure list are bypassed when performed incidental to a surgical procedure with SI of **T**. The line(s) with the inpatient-separate procedure is denied and the claim is processed according to usual OPPS rules.

3.9.3.3 Inpatient-only procedures are allowed on outpatient claims for Supplemental Health Care Program (SHCP) beneficiaries. If a line item with an inpatient-only procedure (SI = **C**) is reported, the inpatient-only logic is bypassed for the day and all procedures with SI = **C** on the same date of service have their SI changed to **T** (and assigned to APC T9999).

3.10 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.

3.11 Billing for Wound Care Services

3.11.1 A list of CPT codes are classified as "sometimes therapy" services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care is located at http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html.

3.11.2 Hospitals would receive separate payment under the OPPS when they bill for wound care services listed as "sometimes therapy" codes that are furnished to hospital outpatients by individuals independent of a therapy plan of care.

3.11.3 When these services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, **GP** for Physical Therapy (PT), **GO** for Occupational Therapy (OT), and **GN** for Speech-Language Pathology (SLP)) or report their charges under a therapy revenue code (that is, 0420, 0430, or 0440) or both, to receive payment under the professional fee schedule.

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

3.11.5 See the Medicare Claims Processing Manual, Chapter 4, Section 200.9 for more information on "sometimes therapy" codes.

4.0 EFFECTIVE DATE

May 1, 2009.

- END -

Chapter 13 Section 3

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. Medicare establishes the relative APC weights; these are updated on a quarterly basis. See the Medicare Claims Processing Manual, Chapter 4, Section 10.3 for a description of APC weights.

3.1.1.1 Revenue center changes that contain items integral to performing the procedure or visit are used to calculate the per-procedure or per-visit costs. Medicare publishes a list of packaged revenue codes every year within the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) Final Rule. These rules are available here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html.

3.1.1.1.1 Some instructions have been issued that require that specific revenue codes be billed with certain Healthcare Common Procedure Coding System (HCPCS) codes, such as specific revenue codes that must be used when billing for devices that qualify for pass-through payments.

Note: Refer to the TRICARE Systems Manual (TSM), Chapter 2, Addendum N, for reporting requirements.

3.1.1.1.2 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.

3.1.1.2 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.

3.1.1.3 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.

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

3.1.1.5 The median cost is calculated for each APC.

3.1.1.6 Relative payment rates are established by CMS, are utilized by DHA, and are listed on DHA's OPPS web site at http://www.health.mil/rates. See the Medicare Claims Processing Manual, Chapter 4, Section 10.3 for more information on how the rates are derived.

3.1.1.7 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 Conversion Factor Update

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

3.1.2.2 The conversion factor is also subject to adjustments for wage index budget neutrality, differences in estimated pass-through payments, and outlier payments. The conversion factor is published in the annual CMS OPPS Final Rule.

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.

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 prevailings) 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 OPPS.

3.1.3.7 **H** to indicate pass-through device categories and 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 non-implantable biologicals, including therapeutic radiopharmaceuticals that are paid in separate APCs under the OPPS.

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 OPPS.

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**[1]. 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 OPPS composite specific payment criteria. Payment is packaged into single payment for specific combinations of service. In all circumstances, payment is made through a separate APC payment for those services.

---

[1] Effective January 1, 2015, SI of X is no longer recognized.

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 OPPS, but to which the multiple procedure reduction does not apply.

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[2].

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 and 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:

---

[2] Effective January 1, 2015, SI of **X** is no longer recognized.

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.

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 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 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 x 0.20 = $70 cost-share

  $350 - $70 = $280 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 OPPS 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 OPPS Provider File with Wage Indexes on DHA's OPPS 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 Adjustments under OPPS

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.

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

3.1.5.1.5.3 Multiply the applicable wage index determined under paragraph 3.1.5.1.5.2 by the amount under paragraph 3.1.5.1.5.1 that represents the labor-related portion of the national unadjusted payment rate.

3.1.5.1.5.4 Calculate 40% (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product in paragraph 3.1.5.1.5.3. The result is the wage index adjusted payment rate for the relevant wage index area.

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

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

Example: A surgical procedure with an APC payment rate of $300 is performed in the outpatient department of a hospital located in Heartland, USA. The cost-sharing amount for the standard ADFM is $60.80 (i.e., 20% of the wage-adjusted APC amount for the procedure). The hospital inpatient DRG wage index value for hospitals located in Heartland, USA, is 1.0234. The labor-related portion of the payment rate is $180 ($300 x 60%), and the nonlabor-related portion of the payment rate is $120 ($300 x 40%). It is assumed that the beneficiary deductible has been met.

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

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

  = ($180 x 1.0234) = $184.21 + $120 = $304.21

- Cost-share for standard ADFM (rounded to nearest cent):

  = ($304.21 x 0.20) = $60.84

- Subtract the standard ADFM cost-share from the wage-adjusted rate to get the final TRICARE payment:

  = ($304.21 - $60.84) = $243.37

3.1.5.2 Discounting of Surgical and Terminating Procedures

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

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

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

3.1.5.2.1.3 Fifty percent (50%) of the usual PPS payment amount and beneficiary copayment/ cost-share amount would be paid for all other procedures performed during the same operative session to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

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

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

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

- Modifier -73 (Discontinued Outpatient Procedure Prior to Anesthesia Administration) would identify a procedure that is terminated after the patient has been prepared for surgery, including sedation when provided, and taken to the room where the procedure is to be performed, but before anesthesia is induced (for example, local, regional block(s), or general anesthesia).
- Modifier -52 (Reduced Services) would be used to indicate a procedure that did not require anesthesia, but was terminated after the patient had been prepared for the procedure, including sedation when provided, and taken to the room where the procedure is to be performed.

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

- Modifier -74 (Discontinued Procedure) would be used to indicate that a surgical procedure was started but discontinued after the induction of anesthesia (for example, local, regional block, or general anesthesia), or after the procedure was

started (incision made, intubation begun, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient.

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

3.1.5.3 Discounting for Bilateral Procedures

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

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

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

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

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

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

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

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

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

FIGURE 13.3-1 DISCOUNTING FORMULAS FOR BILATERAL PROCEDURES

DISCOUNTING FORMULA NUMBER	FORMULAS
1	1.0
2	(1.0 + D (U - 1))/U
3	T/U
4	(1 + D)/U
Where:	**D = discounting fraction (currently 0.5)** **U = number of units** **T = terminated procedure discount (currently 0.5)**

FIGURE 13.3-1 DISCOUNTING FORMULAS FOR BILATERAL PROCEDURES (CONTINUED)

DISCOUNTING FORMULA NUMBER	FORMULAS
5	D
8	2.0
9	2D/U
Where:	**D = discounting fraction (currently 0.5)** **U = number of units** **T = terminated procedure discount (currently 0.5)**

3.1.5.3.7 Figure 13.3-2 summarizes the application of above discounting formulas:

FIGURE 13.3-2 APPLICATION OF DISCOUNTING FORMULAS

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

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

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

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

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

[3] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

3.1.5.5 Outlier Payments

An additional payment is provided for outpatient services for which a hospital's charges, adjusted to cost, exceed the sum of the wage-adjusted APC rate plus a fixed dollar threshold and a fixed multiple of the wage-adjusted APC rate. Only line item services with SIs of **J1**, **P**, **R**, **S**, **T**, **V**, or **X**[4] will be eligible for outlier payment under OPPS. No outlier payments will be calculated for line item services with SIs of **G**, **H**, **K**, **N**, and **U**, with the exception of blood and blood products.

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

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

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

3.1.5.5.4 Outlier payments are not subject to cost-sharing.

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

3.1.5.5.6 Example of outlier payment calculation.

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

Step 1: Identify all APCs on the claim.

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

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

[4] Effective January 1, 2015, SI of **X** is no longer recognized.

HCPCS CODE	SI	APC	SERVICE	WAGE-ADJUSTED APC PAYMENT RATE	RATIO OF APC TO TOTAL PAYMENT
93041	S	0099	Electrocardiogram	$24.79	0.0401275

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

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

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

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

Step 5: Calculate the total charges for each OPPS service (APC) and reduce them to costs by applying the statewide Cost-To-Charge Ratio (CCR). Statewide CCRs are based on the geographical Core Based Statistical Area (CBSA) (two digit = rural, five digit = urban). Assume that the outpatient CCR is 31.4%.

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

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

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

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

The total outlier payment on the claim was: **$1,746.50**.

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 **J1**, **P**, **S**, **T**, **V**, and **X**[5]), 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 13.3-3 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 13.3-3 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%

[5] Effective January 1, 2015, SI of **X** is no longer recognized.

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 Director, DHA, 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 30), shall be granted a Transitional TMCPA in addition to the TTPAs for the first four years of the OPPS implementation. At the end of the first year of OPPS implementation, i.e., April 30, 2010, the total TRICARE OPPS 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 OPPS payment levels are reached; (i.e., 15% year two, 10% year three, and 5% year four). The adjustment will be applied to the total year OPPS payment amount received by the hospital for all active duty members and all TRICARE beneficiaries (including ADDs, retirees and their family members, 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 OPPS year. In year five, the OPPS 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 OPPS payments of $1.5 million or more for care of ADSMs and ADDs during the previous OPPS 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 OPPS year. Each year, subsequent adjustments will be issued to the qualifying hospitals for the prior OPPS 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 OPPS year, a qualifying hospital's total TRICARE OPPS payments will be increased by 15%. The hospital will also receive an additional adjustment for the first OPPS 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 Section G of the contract. The voucher shall be sent electronically to the DHA CRM Office and to 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 OPPS years and the current OPPS 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 Director, DHA, 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 Director, DHA, 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 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 Section G of the contract. The voucher shall be sent electronically to the DHA CRM Office and to 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.

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 Director, DHA, 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 Director, DHA, 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 Section G of the contract. The voucher shall be sent electronically to 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 Director, DHA, 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 OPPS 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 OPPS 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 OPPS costs and the OPPS 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 OPPS was implemented.

Note: Orphan drugs will be paid separately at the Average Sales Price (ASP) + 6%, which represents a combined payment for acquisition and overhead costs associated with furnishing

these products. Orphan drugs will no longer be paid based on the use of drugs because all orphan drugs, both single-indication and multi-indication, will be paid under the same methodology. The TRICARE contractors will not be required to calculate orphan drug payments.

3.2.1.2 Current Cancer Therapy Drugs, Biologicals, and Brachytherapy

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

3.2.1.3 Current Radiopharmaceutical Drugs and Biological Products

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

3.2.1.4 New Medical Devices, Drugs, and Biologicals

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

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

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

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

3.2.3.1 All non-pass-through diagnostic radiopharmaceuticals are packaged.

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

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

3.2.3.4 Offset Calculations.

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

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

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

3.2.4 Transitional Pass-Through Device Categories

3.2.4.1 Excluded Medical Devices

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

3.2.4.2 Included Medical Devices

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

- Prosthetic implants (other than dental) that replace all or part of an internal body organ.
- Implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

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

3.2.4.3 Pass-Through Payment Criteria for Devices

Pass-through payments will be made for new or innovative medical devices. Medicare establishes the list of devices eligible for pass-through payments at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html.

3.2.4.4 Duration of Transitional Pass-Through Payments

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

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

3.2.5 General Coding and Billing Instructions and Explanations

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

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

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

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

3.2.5.2 Kits. Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, codes for such kits have not been established. However, hospitals are free to purchase and use such kits.

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

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

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

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

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

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

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

3.2.7 Calculation of Transitional Pass-Through Payment for a Pass-Through Device

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

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

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

Example 1: Transitional Pass-Through Payment Calculation with Offset

Device: (C1884 - Embolization Protective System)

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

Associated procedure: HCPCS Level I[6] code 92982 (APC0083)

Payment rate = $3,289.42

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

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

[6] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

Note: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph 3.2.7.4 for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

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

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

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

TRICARE payment for pass-through device C1884 = $397.94

Beneficiary cost-share liability for APC 0083 = $657.88

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

$2,631.54	TRICARE program payment for HCPCS Level I[7] code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I[7] code 92982
+ 397.94	Transitional pass-through payment for device
$3,687.36	Total amount received by the provider

Example 2: Transitional Pass-Through Payment Calculation without Offset

Device: (C1884 - Embolization Protective System)

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

Associated procedure: HCPCS Level I[7] code 92982 (APC0083)

Payment rate = $3,289.42

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

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

Note: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph 3.2.7.4 for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

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

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

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

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

Beneficiary cost-share liability for APC 0083 = $657.88

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

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

$2,631.54	TRICARE program payment for HCPCS Level I[8] code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I[8] code 92982
+1,500.00	Transitional pass-through payment for device
$4,789.42	Total amount received by the provider

Note: Transitional payments for devices (SI of **H**) are not subject to beneficiary cost-sharing/ copayments.[8]

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

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

(Offset x Discount Rate x Units of Service)

Step 2: Sum the products of Step 1.

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

(Step 2 Amount x Labor % x Wage Index) + Step 2 Amount x Nonlabor %)

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

[(Step 2 Amount x Labor % x Wage Index) + (Step 2 Amount x Nonlabor %) x (Device Units ÷ Offset Procedure Units)]

otherwise

(Step 2 Amount x Labor % x Wage Index) Step 2 Amount x Non-Labor %)

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

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

[Step 4 Amount - (Line Item Charge x State CCR)]

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

(Line Item Device Charge ÷ Sum of Device Charges)

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

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

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

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

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

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

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

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

3.4 Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals

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

3.4.2 Payments for drugs and radiopharmaceuticals are packaged into the APCs with which they are billed if the median cost per day for the drug or radiopharmaceutical is less than the threshold defined by CMS ($95 for CY 2015), and published in the CMS OPPS annual Final Rule. Separate APC payment is established for drugs and radiopharmaceuticals for which the median cost per day exceeds this threshold.

3.4.3 All non-pass-through diagnostic radiopharmaceuticals and contrast agents, regardless of their per day costs are packaged.

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

3.4.4.1 "Specified Covered Outpatient Drugs" Classification

3.4.4.1.1 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.

3.4.4.1.2 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.

3.4.4.2 Payment of Specified Outpatient Drugs, Biological, and Radiopharmaceuticals

3.4.4.2.1 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 OPPS. In the absence of ASP data, the WAC will be used for the product to establish the initial payment rate. If the WAC is also unavailable, then payment will be calculated at 95% of the most recent AWP.

3.4.4.2.2 Since there is no ASP data for separately payable specified radiopharmaceuticals, reimbursement will be based on charges converted to costs.

- Therapeutic radiopharmaceuticals must have a mean per day cost of more than the threshold established by Medicare in the CMS OPPS annual Final Rule 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.

3.4.4.3 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 OPPS (APC Rate). Refer to DHA's OPPS web site at http://www.health.mil/rates for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

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

3.4.5.1 New drugs and biologicals with HCPCS codes, but which do not have pass-through status and are without OPPS hospital claims data, will be paid at ASP + 4% consistent with its final payment methodology for other separately payable non-pass-through drugs and biologicals.

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

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

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

3.4.5.5 In order to determine the packaging status of these items for CY 2008 an estimate of the per day cost of each of these items was calculated by multiplying the payment rate for each product based on ASP + 4%, by a estimated average number of units of each product that would typically be furnished to a patient during one administration in the hospital outpatient setting. Items for which the estimated per day cost is less than or equal to the threshold established by Medicare in the CMS OPPS annual final rule ($95 for CY 2015) will be packaged. For drugs currently covered under the CAP the payment rates calculated under that program that were in effect as of April 1, 2008 will be used for purposes of packaging decisions.

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

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

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

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

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

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

- Hospitals should be instructed to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code C9399, "Unclassified Drug or Biological."
- When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.
- The new drug, biological and/or radiopharmaceutical will be priced at 95% of its AWP from a schedule of allowable charges based on the AWP, and process the claim for payment.

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

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

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

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

3.4.8.2 Any new biologicals without pass-through status that are surgically inserted or implanted will be packaged.

3.4.9 Drugs And Non-Implantable Biologicals With Expiring Pass-Through Status

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

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

3.5 Drug Administration Coding and Payment

3.5.1 HCPCS Level I drug administration codes APC and SI assignments can be found at http://www.health.mil/rates.

3.5.2 Drugs for which the median cost per day is greater than the threshold established by Medicare in the CMS OPPS annual Final Rule ($95 for CY 2015) are paid separately and are not packaged into the payment for the drug administration. Separate payment for drugs with a median cost in excess of the packaging threshold will result in more equitable payment for both the drugs and their administration.

3.6 Coding and Payment Policies for Drugs and Supplies

3.6.1 Drug Coding

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

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

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

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

3.6.2 Payment for the Unused Portion of a Drug

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

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

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

Example 2: An appropriate hospital staff member must administer 30 units of drug X to a patient, and it is not practical to schedule another patient for the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and does not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and OPPS pays for 100 units.

3.6.2.3 Coding for Supplies

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

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

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

3.6.3 Recognition of Multiple HCPCS Codes for Drugs

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

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

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

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

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

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

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

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

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

3.6.5 Correct Reporting of Units for Drugs

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

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

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

3.7 Orphan Drugs

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

- The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan condition(s).
- The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

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

3.7.3 Payment Methodology

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

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

3.8 Vaccines

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

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

3.9 Payment Policy for Radiopharmaceuticals

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

3.9.1 The threshold for the establishment of separate APCs for radiopharmaceuticals is determined by Medicare and published in the CMS OPPS annual Final Rule ($95 for CY 2015).

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

3.9.3 Radiopharmaceuticals will be excluded from receiving outlier payments.

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

3.10 Blood and Blood Products

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

3.10.2 The OPPS provider also should report charges for processing and storage services on a separate line using Revenue Code 0390 (General Classification), 0392 (Blood Processing/Storage),

or 0399 (Blood Processing/Storage; Other Blood Storage and Processing), along with appropriate blood HCPCS code, the number of units transfused, and the Line Item Date Of Service (LIDOS).

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

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

3.10.5 Payment rates for blood and blood products will be determined based on median costs.

3.10.6 Blood clotting factors are paid at ASP + 4%, plus an additional payment for the furnishing fee that is also a part of the payment for blood clotting factors furnished in physician's offices.

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

3.11.1 Hospitals will be required to append the modifier **FC** to the HCPCS code for the procedure in which the device was inserted on claims when the device that was replaced with partial credit under warranty, recall, or field action is one of the devices in Figure 13.3-4. Hospitals should not append the modifier to the HCPCS procedure code if the device is not listed in Figure 13.3-4.

3.11.2 Claims containing the **FC** modifier will not be accepted unless the modifier is on a procedure code with SI **S**, **T**, **V**, or **X**[10].

3.11.3 If the APC to which the procedure is assigned is one of the APCs listed in Figure 13.3-5, the Pricer will reduce the unadjusted payment rate for the procedure by an amount equal to the percent in Figure 13.3-5 for partial credit device replacement (i.e., 50% of the device offset when both a device code listed in Figure 13.3-4 is present on the claim and the procedure code maps to an APC listed in Figure 13.3-5) multiplied by the unadjusted payment rate.

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

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

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

---

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

[10] Effective January 1, 2015, SI of **X** is no longer recognized.

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

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

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

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

3.12.3 The presence of the modifier **FB** ["Item Provided Without Cost to Provider, Supplier, or Practitioner or Credit Received for Replacement (examples include, but are not limited to devices covered under warranty, replaced due to defect, or provided as free samples)"] would trigger the adjustment in payment if the procedure code to which modifier **FB** was amended appeared in Figure 13.3-4 and was also assigned to one of the APCs listed in Figure 13.3-5. OPPS payments for implantation procedures to which the **FB** modifier is appended are reduced to 100% of the device offset for no-cost/full credit cases.

FIGURE 13.3-4 DEVICES FOR WHICH THE FB MODIFIER MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACEMENT DEVICE

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

FIGURE 13.3-4 DEVICES FOR WHICH THE FB MODIFIER MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACEMENT DEVICE (CONTINUED)

DEVICE HCPCS CODE	DESCRIPTOR
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Pmkr, other than sing/dual
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8600	Implant breast silicone/eq
L8614	Cochlear device/system
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

FIGURE 13.3-5 ADJUSTMENTS TO APCs IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED FOR CY 2009

APC	SI	APC GROUP TITLE	DEVICE OFFSET PERCENTAGE FOR NO-COST/FULL CREDIT CASE	DEVICE OFFSET PERCENTAGE FOR PARTIAL CREDIT CASE
0039	S	Level I Implantation of Neurostimulator	84	42
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	57	29
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluded	62	31
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	72	36
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74	37
0106	T	Insertion/Replacement/Repair of Pacemaker Leads and/or Electrodes	43	21
0107	T	Insertion of Cardioverter-Defibrillator	89	45
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	89	44
0222	T	Level II Implantation of Neurological Device	85	42

FIGURE 13.3-5 ADJUSTMENTS TO APCs IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED FOR CY 2009 (CONTINUED)

APC	SI	APC GROUP TITLE	DEVICE OFFSET PERCENTAGE FOR NO-COST/FULL CREDIT CASE	DEVICE OFFSET PERCENTAGE FOR PARTIAL CREDIT CASE
0225	S	Implantation of Neurostimulator Electrodes, Cranial	62	31
0227	T	Implantation of Drug Infusion Devices	82	41
0229	T	Transcatheter Placement of Intravascular Shunts	84	42
0259	T	Level IV ENT Procedures	88	44
0315	T	Level III Implantation of Neurostimulator	59	29
0385	S	Level I Prosthetic Urological Procedures	69	34
0386	S	Level II Prosthetic Urological Procedures	71	36
0418	T	Insertion of Left Ventricular Pacing Elect	59	29
0425	T	Level II Arthroplasty or Implantation with Prosthesis	46	23
0648	T	Level IV Breast Surgery	77	38
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	76	38
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	71	36
0680	S	Insertion of Patient Activated Event Recorders	71	35
0681	T	Knee Arthroplasty	71	36

3.12.4 If the APC to which the device code (i.e., one of the codes in Figure 13.3-4) is assigned is on the APCs listed in Figure 13.3-5, the unadjusted payment rate for the procedure APC will be reduced by an amount equal to the percent in Figure 13.3-5 times the unadjusted payment rate.

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

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

3.13 Policies Affecting Payment of New Technology Services

3.13.1 A process was developed that recognizes new technologies that do not otherwise meet the definition of current orphan drugs, or current cancer therapy drugs and biologicals and brachytherapy, or current radiopharmaceutical drugs and biologicals products. This process, along

with transitional pass-throughs, provides additional payment for a significant share of new technologies.

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

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

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

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

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

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

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

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

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

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

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

- From $0 to $50 in increments of $10.
- From $50 to $100 in a single $50 increment.
- From $100 through $2,000 in intervals of $100.
- From $2,000 through $6,000 in intervals of $500.

3.13.10 Beneficiary cost-sharing/copayment amounts for items and services in the new technology APC groups are dependent on the eligibility status of the beneficiary at the time the outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra and Standard beneficiary categories). (Refer to Chapter 2, Addendum A for applicable deductible cost-sharing/copayment amounts for outpatient hospital services.)

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

New technology APCs are established by CMS. TRICARE may only reimburse new technology APCs when they meet all other conditions of coverage under the TRICARE program. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

3.14 Coding And Payment Of ED Visits

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

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

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

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

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

3.14.3.3 During the calendar year immediately preceding the calendar year in which a determination under the regulations is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring previously scheduled appointment.

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

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

3.14.6 Hospitals report Type **A** ED visits using CPT[11] codes 99281-99285 and Type **B** ED visits using G0380-G0384.

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

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

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

3.15 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)

[11] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

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.

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 OPPS 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 OPPS 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 13.3-6). The new charge amount will be used in place of the submitted charge amount in the line item outlier calculator.

FIGURE 13.3-6 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 x $20,000 = $12,000.

3.16 TRICARE Specific Procedures/Services

3.16.1 TRICARE specific APCs have been assigned for certain procedures covered by TRICARE but excluded by Medicare.

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 OPPS) until they can be placed into existing or new APC groups.

3.17 Validation Reviews

OPPS 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[12] code 59400 and the state specific non-professional component, will lag two months (i.e., April 1 instead of February 1). See Chapter 10, for information on freestanding birthing centers.

4.0 EFFECTIVE DATE

May 1, 2009.

- END -

[12] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

Chapter 13 Section 4

Claims Submission And Processing Requirements

Issue Date: July 27, 2005
Authority: 10 USC 1079(j)(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

To describe additional claims submission and processing requirements.

3.0 POLICY

Appropriate bill types:

3.1 Bill Types Subject To Outpatient Prospective Payment System (OPPS)

All outpatient hospital bills (bill types 013X with Condition Code 41, 013X without Condition Code 41, 014X for diagnostic services), with the exception of bills from providers excluded under Section 1, paragraph 3.4.1.2.5 will be subject to the OPPS.

3.2 Reporting Requirements

3.2.1 Payment of outpatient hospital claims will be based on the "from" date on the claim.

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

3.2.3 Each line item on the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 Claim Form must be submitted with a specific date of service to avoid claim denial. The header dates of service on the CMS 1450 UB-04 may span, as long as all lines include specific dates of service within the span on the header.

3.3 Procedures for Submitting Late Charges

3.3.1 Hospitals may not submit a late charge bill (frequency 5 in the third position of the bill type) for bill types 013X.

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

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

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

3.4 Claim Adjustments

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

3.5 Proper Reporting of Condition Code G0 (Zero)

Hospitals should report Condition Code **G0** when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. Refer to the Medicare Claims Processing Manual, Chapter 4, Section 180.4 for proper reporting of Condition Code **G0**.

3.6 Clinical Diagnostic Laboratory Services Furnished to Outpatients

3.6.1 Prior to January 1, 2014, payment for these services will be made under the CHAMPUS Maximum Allowable Charge (CMAC) System.

3.6.2 Hospitals should report HCPCS codes for clinical diagnostic laboratory services.

3.6.3 Beginning January 1, 2014, most laboratory tests will be packaged under OPPS. Laboratory tests should be reported on TOB 13X. Laboratory tests may be separately paid when billed on TOB 14X in the following circumstances:

3.6.3.1 Non-patient laboratory specimen tests.

3.6.3.2 When the hospital only provides laboratory tests (directly or under arrangement) and patient receives no other hospital outpatient services during the same encounter.

3.6.3.3 When the laboratory test is provided (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services.

3.7 OPPS Modifiers

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

4.0 EFFECTIVE DATE

May 1, 2009.

- END -

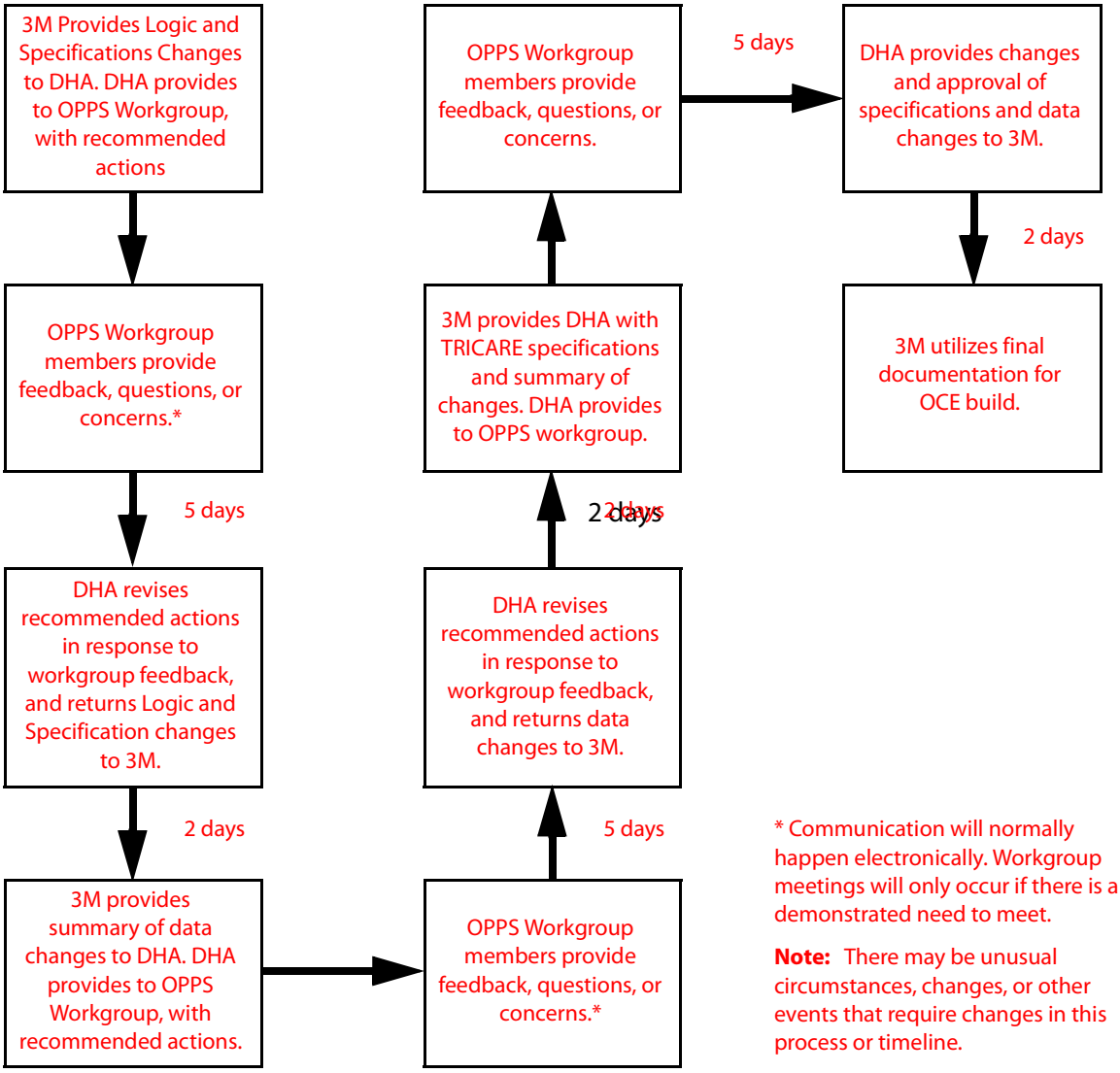
Outpatient Prospective Payment System (OPPS) Outpatient Code Editor (OCE) Notification Process For Quarterly Updates

	MCSC: OCE Version: Summary of Data Changes: OCE/APC Working Specification: Effective Date:
4 days (Checklist)	**Review Updates:** 1. HCPC/CPT Procedure Code Changes • Adds/Deletes procedure code • HCPC Changes - APC, Status Indicator and/or Edit Assignment 2. Diagnosis Code Changes • Adds/Deletes diagnosis • Age/Sex Relations 3. Revenue Codes (Appendix K) • Add Revenue Codes • Revenue Code Status Indicator Changes 4. Government No Pay List Updates 5. HCPC Intersection Report (compare SI differences between CMS and TRICARE) 6. Edit Assignment (applicable TRICARE edits)
	Impacts:
	File format changes (record layout) ☐ Describe:
	New values: ☐ Describe:
	Policy: ☐ Manual: TRM Chapter: Sections:
	Manual: TRM Chapter: Sections:
	Manual: TRM Chapter: Sections:
	Comments:
3 days	Gather feedback for all Primes. • Feedback will be gathered electronically. If deemed necessary by the Government, feedback will be gathered via meeting. • Assigned resource will consolidate feedback using 3M templates
1 day	Provide feedback to 3M. Meet with 3M if the Government deems a meeting necessary. • DHA sends to 3M and copies OCE Quarterly Update Team • Notify DHA of changes impacting TRICARE policy
1 day	Meet with 3M on feedback (maintain open date on Thursdays at 11:00 a.m. EDT/EST or 8:00 a.m. Pacific), if necessary. • Review responses • Address policy impacts (DHA) • Update changes (if needed) • Concur on changes

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

- END -

Approval Of OPPS - Outpatient Code Editor (OCE)/APC And No Government Pay List (NGPL) Quarterly Update Process



* Communication will normally happen electronically. Workgroup meetings will only occur if there is a demonstrated need to meet.

Note: There may be unusual circumstances, changes, or other events that require changes in this process or timeline.

- END -