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HEALTH AGENCY

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

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This change is made in conjunction with Feb 2008 TOM, Change No. 167, and Feb 2008 TPM, Change No. 153.

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

**CHANGE 123  
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**REMOVE PAGE(S)**

**CHAPTER 3**

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pages 3 and 4

## **SUMMARY OF CHANGES**

### **CHAPTER 3**

1. Section 1. This change removes the cross reference to Chapter 5, Section 4 Individual Consideration Cases. EFFECTIVE DATE: 02/19/2016.

### **CHAPTER 5**

2. Section 3. This change exempts Puerto Rico from the Ambulance Fee Schedule (except for ground ambulance). EFFECTIVE DATE: As Stated in the Issuance.
3. Section 4. This change deletes Individual Consideration Cases. EFFECTIVE DATE: As Stated in the Issuance.

### **CHAPTER 7**

4. Section 2. This change clarifies coverage of programs called Intensive Outpatient Programs that are provided by TRICARE authorized freestanding or hospital-based PHP programs. EFFECTIVE DATE: For S9480, 01/01/2000, For H0015, 01/01/2001.
5. Section 3. This change clarifies coverage of programs called Intensive Outpatient Programs that are provided by TRICARE authorized freestanding or hospital-based PHP programs. EFFECTIVE DATE: For S9480, 01/01/2000, For H0015 01/01/2001.

### **CHAPTER 13**

6. Section 2. This change clarifies coverage of programs called Intensive Outpatient Programs that are provided by TRICARE authorized freestanding or hospital-based PHP programs. EFFECTIVE DATE: 05/01/2009.



## Reimbursement Of Individual Health Care Professionals And Other Non-Institutional Health Care Providers

Issue Date:  
Authority:

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### 1.0 GENERAL

**1.1** TRICARE reimbursement of a non-network individual health care professional or other non-institutional health care provider shall be determined under the allowable charge method specified in [Chapter 1, Section 7](#) and [Chapter 5, Section 1](#). For network providers, the contractor is free to negotiate rates that would be less than the rates established under the allowable charge methodology.

**1.2** Unless otherwise stated in the TRICARE Policy Manual (TPM), inpatient or outpatient services rendered by all individual professional providers and suppliers must be billed on the Centers for Medicare and Medicaid Services (CMS) 1500 [Claim Form](#), except as indicated in [paragraphs 1.4](#) and [1.5](#). This requirement also applies to individual professional providers employed by or under contract to an institution. When inpatient services are rendered by a provider employed by or under contract to a participating institution, the services must be billed on a participating basis.

**1.3** Contractors are not required to individually certify the professional providers employed by or under contract to an institutional provider billing for their services under the institution's federal tax number since these providers are not recognized as authorized TRICARE providers because of their "contracted" status ([32 CFR 199.6\(c\)\(1\)](#)). However, reimbursement for services of institutional-based professional providers is limited to the services of those providers that would otherwise meet the qualifications of individual professional providers except that they are either employed by or under contract to an institutional provider. Institutional-based professional services are subject to the allowable charge methodology; see [32 CFR 199.14\(j\)](#). For TRICARE Encounter Data (TED)/TRICARE Encounter Provider (TEPRV) reporting, refer to the TRICARE Systems Manual (TSM), [Chapter 2](#).

**1.4** Some institutions are required to include the institutional-based professional charges on the CMS 1450 UB-04 claim form. The contractor's system must recognize these charges as noncovered institutional charges when the CMS 1450 UB-04 indicates professional component charges using Value Code "05" (see the CMS 1450 UB-04 Instructions Manual, Form Locator (FL) 39 - 41). Value code "05" indicates that the charges are included on the CMS 1450 UB-04 and will also be billed separately on the CMS 1500 [Claim Form](#). The CMS 1450 UB-04 may be used by institutional providers and Home Health Care (HHC) Agencies to bill for professional services. The CMS 1450 UB-04 must include all the required information needed to process the professional services and reimburse the services using the allowable charge payment methodology, to include any negotiated rates. The contractors shall contact any HHC Agency that has requested to bill for

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professional services on the CMS 1450 UB-04 to assist them with the proper billing requirements, e.g., Current Procedural Terminology, 4th Edition (CPT-4) procedure codes, name of the actual provider, etc.

**1.5** Professional charges can be billed on a CMS 1450 UB-04, either on the same claim as the facility charges or on a separate claim. If professional charges are submitted on the same CMS 1450 UB-04 claim form as other outpatient facility charges, the contractor may require the provider to submit them on a separate claim form.

## **2.0 ALLOWABLE CHARGE METHOD**

### **2.1 General**

**2.1.1** The TRICARE allowable charge for a service or supply shall be the lowest of the billed charge, the prevailing charge, or the Medicare Economic Index (MEI) adjusted prevailing charge (known as the maximum allowable prevailing charge). The profiled amount (the prevailing charge or the maximum allowable prevailing charge, whichever is lower) to be used is based upon the date of service. Regardless of the profiled amount, no more than the billed amount may ever be allowed.

**Note:** If, under a program approved by the Deputy Director, **Defense Health Agency (DHA)**, a provider has agreed to discount his or her normal billed charges below the profiled amounts, the amount allowed may not be more than the negotiated or discounted charges. When calculating the TRICARE allowable charge, use the discounted charge in place of the provider's actual billed charge unless the discounted amount is above the billed charge. When the discounted amount is above the billed charge, the actual billed charge shall be used.

**2.1.2** The contractor has primary responsibility for determining allowable charges according to the law, the Regulation, and the broad principles and policy guidelines issued.

**2.1.3** Allowable charge determinations made by contractors are not normally reviewed by **DHA** on a case-by-case basis. However, **DHA** will review allowable charge determinations of contractors through profile analysis, sample case review and periodic review of profile development procedures. Therefore, each contractor is to maintain, in accessible form, the following data:

**2.1.3.1** The charge data used to develop prevailing charges. For every prevailing charge, this must include a list identifying each provider whose charges were used in developing the prevailing charge as well as the provider's charges. The list is to be arrayed in ascending order by the amount of the billed charges.

**2.1.3.2** The summary data used to develop prevailing conversion factors. This is to include every prevailing charge (identified by amount, procedures, weighted frequency, and relative value units (RVUs)) which was used in calculating each conversion factor.

## **2.2 Database And Profile Updating**

**Note:** Annual update of state prevailing amounts, reference [Chapter 5, Section 3, paragraph 3.7.5](#).

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**2.2.1** The 80th percentile of charges shall be determined on a date or dates specified by the Deputy Director, **DHA**. Profile update data used shall be charges for services and supplies provided during the 12 month period ending on June 30 prior to the update. Contractors shall maintain two sets of profiles; the current profiles and the previous year's profiles. The contractor will apply profiles based on the date of service. The fee screen year is the calendar year.

**2.2.2** Each contractor shall develop procedures to ensure that the data base used to develop the profile for any procedure contains only charges actually made for that procedure. Thus, edits must be developed which will eliminate charges for individual consideration cases, and charges for multiple surgery, as well as aberrant data resulting from coding errors and other data problems. A description of these procedures is to be available for **DHA** review.

**2.2.3** All charges, except those identified above, made by individual providers for services rendered to TRICARE beneficiaries during the data base period must be included in the data base. The usual (pre-discount) charges of network providers or the contractor's or a subcontractor's private business may be included if the billing arrangement with the provider or other source of data for the data base is such that accurate data for the state will be obtained.

**2.2.4** Except when an error has occurred, updated actual prevailings are not to be lower than the previous year's actual prevailings. However, if for two consecutive years the rates are lower than the established profiles, then, in the second year, the rates will be lowered to the higher of the two profiles which are below the established profile. However, if the updated prevailing charge is lower, contractors are to continue using the previous actual prevailing charge. When the updated prevailing charge is 25% or more lower than the previous prevailing charge, the contractor is to review the development of both profiles. If no errors are found, the new profile is to be increased to the level of the previous profile. If the previous profile is higher due to an error in its calculation, the updated profile will be used. The same rules apply to conversion factors when the updated conversion factor is less than the previous one. However, in all cases an actual profile on a procedure takes precedence over an allowance based on a conversion factor.

**2.2.4.1** When the current allowance based on a conversion factor is less than the previous allowance based on an actual profile, the previous profile amount is to be used.

**2.2.4.2** When the current allowance based on an actual profile is less than the previous allowance based on a conversion factor, the actual profile is to be used.

**Note:** This provision does not apply to those instances where profiles are initially developed for a distinct class of provider which was previously included with providers having higher profiles.

**2.2.5** Once the contractor has completed the update of its profiles, further revisions in the profiles will not be permitted, except to correct erroneous calculations or to establish profiles for new services. If the contractor finds it necessary to correct profiles or to establish a profile fee for a new procedure, the action will be thoroughly documented and retained in accessible form for not less than the retention period for the claims processed during the active life of that profile.

## 2.3 Prevailing Charges

**2.3.1** Prevailing charges are those charges which fall within the range of charges that are most frequently used in a state for a particular procedure or service.

**2.3.2** Unless the Deputy Director, **DHA**, has made a specific exception, prevailing profiles must be developed on a statewide basis. Localities within states are not to be used, nor are prevailing profiles to be developed for any area larger than individual states.

**2.3.3** Prevailing profiles also are to be developed on a nonspecialty basis. Of course, types of service are to be differentiated. For example, for a given surgical procedure the surgeon, assistant surgeon, and the anesthesiologist would all be reimbursed based on different profiles. However, reimbursement for the actual surgery would be based on only one profile, regardless of whether the surgery was performed by a specialist or a general surgeon. An exception to this rule is that when services are performed by different classes of providers; e.g., a physician vis-a-vis a non-physician, separate profiles are to be developed for each class of provider. For example, there are three distinct classes of providers who render similar psychiatric services; psychiatrists, psychologists and others (medical social workers (MSWs), marriage and family counselors, pastoral counselors, mental health counselors, etc.). Moreover, two distinct classes of providers render obstetrical services; physicians and nurse midwives. Separate profiles are to be developed for each of the classes. Since a physician can render more comprehensive services than non-physicians (and likewise for psychologists as opposed to MSWs) the profile for the lesser-qualified class of provider should never be higher than that for a higher-qualified class of provider. For example, in cases in which psychologists' profiles are higher than psychiatrists', the psychologists' profiles should be lowered to that of the psychiatrists' profiles.

**2.3.4** When there are two or more procedures which are identical except for the amount of time involved (e.g., CPT<sup>1</sup> procedure codes 90843 and 90844), the contractor is to ensure that the profile for the shorter procedure does not exceed the profile for the longer procedure. In those cases in which it does, the contractor is to reduce the profile for the shorter procedure to that of the longer procedure (see [Chapter 5, Section 3](#)).

## 2.4 Conversion Factors

### 2.4.1 General

Submitted charges must be compared with the applicable prevailing charge to determine the allowable charge for the service. If there is insufficient actual charge data to determine the prevailing charge in the state for a service, the contractor shall calculate a prevailing charge by multiplying the appropriate prevailing charge conversion factor by the appropriate RVUs.

**2.4.1.1** Conversion factors are to be developed for broad types of services. As a minimum, the types of service shall include medicine, surgery, anesthesia, radiology, and pathology. In addition, separate conversion factors must be developed for each class of provider which can provide a

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particular type of service. For example, there should be three medicine conversion factors - one for physicians, one for psychologists, and one for other non-physician providers.

**2.4.1.2** Conversion factors are used to derive "approximate" prevailing charges. Since prevailing charges based on conversion factors are estimates of actual (but unknown) "average" charges, their reliability is only as good as the known, but often limited, data. Contractors must exercise extreme care in developing conversion factors. When beneficiaries, physicians, and suppliers inquire regarding reimbursement based on the use of a conversion factor, the contractor shall use its best judgment based on the data available to it (including information the physician or supplier may furnish) to resolve the issue.

**2.4.1.3** In those cases in which a profile has been increased to the previous year's level, the contractor shall also use the higher previous amount in calculating a conversion factor. A conversion factor is simply a mathematical representation of what is currently being paid for similar services, and thus it should be based on the profiles actually in use.

**2.4.2 Relative Value Scales**

Relative value scales developed or adopted by the contractor shall be carefully reviewed and validated before they are used. The contractor is responsible for ensuring that a relative value scale which is used to estimate prevailing charges accurately reflects charge patterns in the area serviced by the contractor. When a conversion factor results in an obviously incorrect amount (either high or low), the contractor is to make an adjustment in its relative value scale which will correct the error. Such corrections are to be reviewed in subsequent profile updates to ensure they are accurate.

**2.4.3 Calculation Of Prevailing Charge Conversion Factors**

**2.4.3.1** Prevailing charge conversion factors used with relative value scales to fill gaps in contractor prevailing charge screens shall be calculated from the following formula:

- C/F = Prevailing charge conversion factor.
- CHG = The fully adjusted prevailing charge for a procedure.
- SVC = The number of times the procedure was performed by all physicians in the state.
- RVU = The RVU assigned to the procedure.
- SUM OF SVC = The total number of times all procedures for which actual prevailing charges have been established and were performed in the state.

$$C/F = \frac{\text{CHG} \times \text{SVC} + \text{CHG} \times \text{SVC} + \dots + \text{CHG} \times \text{SVC}}{\text{Sum of SVC}}$$

**Example:** Compute a prevailing charge conversion factor on the basis of known prevailing charges within the same type of service.

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PROCEDURE	FREQUENCY	ACTUAL CHARGE	RELATIVE VALUE
1	30	\$5.00	1
2	70	12.00	2
3	50	35.00	5
4	40	20.00	3
5	<u>60</u>	8.00	1.5
	250		

**2.4.3.2 Method**

- For each procedure, divide the prevailing charge by the relative value and multiply the result by the frequency of that procedure in the charge history.
- Add all the results of these computations.
- Divide the result by the sum of all the frequencies.

**2.4.3.3 Solution**

$$\frac{(5 \times 30)}{1} + \frac{(12 \times 70)}{2} + \frac{(35 \times 50)}{5} + \frac{(20 \times 40)}{3} = \frac{(8 \times 60)}{1.5} =$$


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250

$$\frac{(5 \times 30)}{1} + \frac{(6 \times 70)}{2} + \frac{(7 \times 50)}{5} + \frac{(6.67 \times 40)}{3} = \frac{(5.33 \times 60)}{1.5} =$$


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250

$$150 + 420 + 350 + 266.8 + 319.8 =$$


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250

$$\frac{1506.6}{250} = \$6.03$$

**2.4.3.4** The conversion factors calculated for any profile year shall reflect prevailing charges calculated on the basis of charge data for the applicable profile year. Also, prevailing charges established through the use of a relative value scale and conversion factors, in effect, consist of two components. Consequently, the conversion factors used must be recalculated when there is an extensive change in the RVUs assigned to procedures (as may occur if the contractor begins to use a different or updated relative value scale but not if the unit value of a single procedure is changed) in order to ensure that the change(s) in unit values do not change resultant conversion factors.

**2.4.3.5** Since conversion factors are a calculated amount and will only be used when multiplied by a relative value, conversion factors are to be rounded only to the nearest whole cent. It will not be acceptable to round to the nearest dollar or tenth dollar (dime).

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## **2.5 Procedure Codes**

The CPT<sup>2</sup> Coding System includes Level I: CPT Codes and Level II: Alpha Character and DHA approved codes for retail and Mail Order Pharmacy (MOP). (Reference the TSM, [Chapter 2, Addendum E.](#))

**2.6** Professional surgical procedures will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under the Outpatient Prospective Payment System (OPPS) for services rendered on or after May 1, 2009 (implementation of OPPS). Refer to [Chapter 1, Section 16, paragraphs 3.1.1.1 through 3.1.1.3](#) and [Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3](#) for further detail.

**2.7** Professional procedures which are terminated or are bilateral will be subject to discounting based on modifier guideline requirements as prescribed under the OPPS for services rendered on or after May 1, 2009 (implementation of OPPS). Refer to [Chapter 1, Section 16, paragraphs 3.1.1.1 through 3.1.1.3](#) and [Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3](#) for further detail.

## **2.8 Prevention Of Gross Dollar Errors**

Parameters Consistent With Private Business. The contractor shall establish procedures for the review and authorization of payment for all claims exceeding a predetermined dollar amount. These authorization schedules shall be consistent with the contractor's private business standards.

**2.9** Industry standard modifiers and condition codes may be billed on 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 claims.

## **3.0 CHAMPUS MAXIMUM ALLOWABLE CHARGE (CMAC) SYSTEM**

### **3.1 General**

The CMAC system is effective for all services. The zip code where the service was rendered determines the locality code to be used in determining the allowable charge under CMAC. In most instances the zip code used to determine locality code will be the zip code of the provider's office. For processing an adjustment, the zip code which was used to process the initial claim must be used to determine the locality for the allowable charge calculation for the adjustment. Adjustments shall be processed using the appropriate rate based on the date of service. Post office box zip codes are acceptable only for Puerto Rico and for providers whose major specialty is anesthesiology, radiology or pathology (see [Chapter 5, Section 3](#)).

### **3.2 Locality Code**

For TED reporting, the locality code used in the reimbursement of the procedure code is to be reported for each payment record line item, i.e., on each line item where payment is based on a CMAC, the locality shall be reported. Any adjustment to a claim originally paid under CMAC without

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a locality code, shall include the locality code that it was priced on at the time of the initial payment. The locality code reported on the initial claim shall be used to process any future adjustments of that claim unless one of the conditions listed below occurs:

- The adjustment is changing the type of pricing from CMAC to a different payment method, in which case the locality code should be blank filled, or;
- The initial claim was priced incorrectly because of using a wrong locality code, in which case the correct locality code should be used.

#### **4.0 BALANCE BILLING LIMITATION FOR NON-PARTICIPATING PROVIDERS**

##### **4.1 General**

Non-participating providers may not balance bill the beneficiary more than 115% of the allowable charge.

**Note:** When the billed amount is less than 115% of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit is to be applied to each line item on a claim.

**Example 1:** No Other Health Insurance (OHI)

Billed charge	\$500
Allowable charge	\$200
Amount billed to beneficiary (115% of \$200)	\$230

**Example 2:** OHI

Billed charge	\$500
Allowable charge	\$200
Amount paid by OHI to the beneficiary	\$200
Amount billable to beneficiary (115% of \$200)	\$230

**Note:** When payment is made by OHI, this payment does not affect the amount billable to the beneficiary by the non-participating provider except, when it can be determined, that the OHI limits the amount that can be billed to the beneficiary by the provider.

**Example 3:** Provider Refuses To File Claim Or Has Charged An Administrative Fee

Billed charge	\$100.00
CMAC	\$110.00
Allowed amount	\$100.00
10% abatement (\$100 x 0.10)	\$10.00
Adjusted allowed amount (\$100 - \$10)	\$90.00

## Chapter 5

### Allowable Charges

Section/Addendum	Subject/Addendum Title
1	Providers
2	Locality-Based Reimbursement Rate Waiver
3	CHAMPUS Maximum Allowable Charges (CMAC)
4	Payment For Professional/Technical Components Of Diagnostic Services



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## Chapter 5, Section 3

### CHAMPUS Maximum Allowable Charges (CMAC)

**Note:** Effective for services provided on or after October 1, 2013, TRICARE adopts Medicare's Ambulance Fee Schedule (AFS) as the TRICARE CMAC for ambulance services, in accordance with 32 CFR 199.14(j)(1)(i)(A). See Chapter 1, Section 14. The AFS reimbursement methodology applies only to ground ambulance services in Puerto Rico. The AFS does not apply to air ambulance transport (aeromedical evacuations) covered under the TRICARE Overseas Program (TOP), including Puerto Rico.

### 3.4 Bundled Codes

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

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

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

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

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

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

### 3.7.2 Site of Service

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

#### 3.7.2.1 Categories

- Category 1: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and Certified Nurse Midwives (CNMs) provided in a facility including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered),

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Residential Treatment Centers (RTCs), ambulances, hospices, MTFs, psychiatric facilities, Community Mental Health Centers (CMHCs), Skilled Nursing Facilities (SNFs), Ambulatory Surgical Centers (ASCs), etc.

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

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

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

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

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

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

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

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

COLUMN	DESCRIPTION
1	Non-facility CMAC for physician/LLP class
2	Facility CMAC for physician/LLP class
3	Non-facility CMAC for non-physician class

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

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

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

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

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

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

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

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

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

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

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

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

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Chapter 5, Section 3

CHAMPUS Maximum Allowable Charges (CMAC)

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

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

- END -

## Payment For Professional/Technical Components Of Diagnostic Services

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)\(ix\)](#) and [\(c\)\(2\)\(x\)](#)

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### 1.0 APPLICABILITY

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

### 2.0 ISSUE

How are professional and technical components of diagnostic services to be reimbursed?

### 3.0 POLICY

**3.1** Frequently, charges for diagnostic services are split between the professional (physician) and the technical (equipment) components. Wherever possible, separate allowable charges are developed for each component. When a bill is received for the total service, the total allowable charge is to be used in the processing of the claim.

**3.2** Under the national allowable charge system, the Maximum Allowable Charge file provides the contractor with a complete allowable charge or with separate allowable charges for professional and technical components.

**3.3** For diagnostic procedures that are still priced using area prevailing allowable charges, the contractor is to establish professional and technical components from the billed charges for the service as identified on the claims.

**3.4** Clinical diagnostic lab tests furnished by Critical Access Hospitals (CAHs), are reimbursed under the reasonable cost method, reference [Chapter 15, Section 1](#).

- END -



treatment plan. An attending provider must come to the treatment plan meetings and his/her care must be coordinated with the treatment team and as part of the treatment plan. Care given independent of this is not covered.

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

### **2.3 Per Diem Rate**

For any full-day PHP (minimum of six hours), the maximum per diem payment amount is 40% of the average inpatient per diem amount per case paid to both high and low volume psychiatric hospitals and units established under the mental health per diem reimbursement system. The rates shall be updated to the current year using the same factors as used under the TRICARE mental health per diem reimbursement system. A PHP of less than six hours (with a minimum of three hours) will be paid a per diem rate of 75% of the rate for full-day PHP. TRICARE will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half- or full-day program. See the DHA web site at <http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement>, for the current maximum rate limits which are to be used as is for the full-day and half-day program.

### **2.4 Other Requirements**

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

### **2.5 CAHs**

Effective December 1, 2009, PHPs in CAHs shall be reimbursed under the reasonable cost method, reference [Chapter 15, Section 1](#).

### **2.6 Intensive Outpatient Programs (IOPs)**

PHPs may provide services they call "Intensive Outpatient Program", or IOP. PHPs may provide partial hospitalization services, also referred to as IOP, provided less than five days per week, but at least three hours per day but less than six hours per day. Freestanding PHPs providing IOP services may submit reimbursement for Healthcare Common Procedure Coding System (HCPCS) codes S9480 or H0015 to represent these services; the contractor shall reimburse the provider the half-day PHP rate (i.e., three to five hours), in accordance with this section. See the TRICARE Policy Manual (TPM), [Chapter 7, Sections 3.6 and 3.7](#); and the TRICARE Reimbursement Manual (TRM), [Chapter 13, Section 2, paragraph 3.7.3.4](#) for reimbursement in hospital-based PHPs.

- END -



## Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement

Issue Date: June 26, 1995

Authority: [32 CFR 199.14\(a\)\(1\)\(ii\)\(E\)](#) and [\(a\)\(2\)\(ix\)](#)

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### 1.0 APPLICABILITY

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

**1.2** The following reimbursement methodology will be used for payment of all Substance Use Disorder Rehabilitation Facilities (SUDRFs) prior to implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of Outpatient Prospective Payment System (OPPS). Thereafter, this methodology will only be used in the reimbursement of freestanding SUDRFs and other providers who are exempt from the TRICARE OPPS and provide SUDRF services.

### 2.0 ISSUE

Reimbursement of SUDRFs. This includes reimbursement for both inpatient and partial hospitalization for the treatment of substance use disorder rehabilitation care.

### 3.0 POLICY

**3.1** Inpatient SUDRFs. Admissions to authorized SUDRFs are subject to the Diagnosis Related Group (DRG)-based payment system.

**3.2** Partial hospitalization for the treatment of substance use disorders. Substance use disorder rehabilitation partial hospitalization services are reimbursed on the basis of prospectively determined all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, routine nursing services, ancillary services (includes art, music, dance, occupational and other such therapies), psychological testing and assessments, overhead and any other services for the customary practice among similar providers is included as part of the institutional charges. **SUDRFs may provide services they call "Intensive Outpatient Program" or IOP. SUDRFs may provide substance use disorder Partial Hospitalization Program (PHP) services less than five days per week, at least three hours per day but less than six hours per day, with reimbursement occurring at the half-day PHP rate (i.e., three to five hours), in accordance with the Chapter 7, Section 2. See Chapter 7, Section 2, paragraph 2.6 and the TRICARE Policy Manual (TPM), Chapter 7, Section 3.7, paragraph 3.3.1.2.3.**

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Chapter 7, Section 3

Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement

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**3.3** Outpatient professional services will be reimbursed using the appropriate Healthcare Common Procedure Coding System (HCPCS) code or Current Procedural Terminology (CPT) code. Payment is the lesser of the billed charge or the CHAMPUS Maximum Allowable Charge (CMAC).

**3.4** Family therapy provided on an inpatient or outpatient basis will be reimbursed under the CMAC for the procedure code(s) billed.

**3.5** Cost-sharing. The cost-share for Active Duty Dependents (ADDs) for inpatient substance use disorder services is \$20.00 per day for each day of the inpatient admission. The \$20.00 cost-share amount also applies to substance use disorder rehabilitation care provided in a partial hospitalization setting. The inpatient cost-share applies to the associated services billed separately by the individual professional providers. For retirees and their dependents, the cost-share is 25% of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for ADDs is to be taken from the partial hospitalization facility claim.

- END -

### 3.6 HCPCS/Revenue Coding Required Under OPPTS

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

### 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 OPPTS. 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 OPPTS.

**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. **PHP programs offering "Intensive Outpatient Therapy" or IOP, provided less than five days per week, at least three hours per day but less than six hours per day, may be appropriate for patients who do not require the more intensive level of care, or for those who have completed a more intense inpatient or partial hospitalization stay.**

**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. **An exception to the requirement for three units for service is made for programs billing with HCPCS codes S9480 or H0015. However, because these codes represent comprehensive programs, they must represent a program providing at a minimum three hours of service per day.**

**3.7.3.4** PHPs may provide IOP services for either psychiatric or substance use disorder treatment. Hospital-based PHPs or SUDRFs may provide partial hospitalization services, also referred to as IOP, provided less than five days per week, at least three hours per day but less than six hours per day. Hospital-based PHPs providing psychiatric or substance use disorder IOP services, may submit reimbursement for one unit of HCPCS codes S9480 or H0015 for each day of service to represent these services. These codes will be assigned to an APC with the same payment rate as APC 0175. Reimbursement is only allowed for hospital-based PHP programs that provide IOP services; reimbursement is not available for hospital-based IOPs that are not PHPs. Also, see the TRICARE Policy Manual (TPM), Chapter 7, Sections 3.6 and 3.7. For hospital-based services rendered in a non-PHP program, see paragraph 3.7.4.

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

**3.7.3.5.1** 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.

**3.7.3.5.2** 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.

**3.7.3.5.3** 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.

**3.7.3.5.4** 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-](#)

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Chapter 13, Section 2

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

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.

**3.7.3.5.5** 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 OPSS) 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 OPSS.

**3.7.3.5.6** 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.

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

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

**3.7.3.5.9** 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 OPSS web site (<http://www.health.mil/rates>) for the listing of maternity diagnoses.

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

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

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

**3.8.2.3** Multiple maternity observations on a claim are paid separately if the required criteria are met for each observation and Condition Code **G0** is present on the claim or modifier 27 is present on additional lines with G0378.

**3.8.2.4** If multiple payable maternity observations are submitted without Condition Code **G0** or modifier 27, the first encountered is paid and additional observations for the same day are denied.

### **3.9 Inpatient Only Procedures**

**3.9.1** The inpatient list on DHA's OPSS web site at <http://www.health.mil/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 OPSS 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 OPSS 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 -

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			Skilled Nursing Facility (SNF)		
			Case-Mix Adjusted Federal Rates		
			FY 2014	8	D (FY2014)
			FY 2015	8	D (FY2015)
			<b>FY 2016</b>	<b>8</b>	<b>D (FY2016)</b>
			Example Of Computation of Adjusted PPS Rates And SNF Payment		
			FY 2014	8	B (FY2014)
			FY 2015	8	B (FY2015)
			<b>FY 2016</b>	<b>8</b>	<b>B (FY2016)</b>
			Fact Sheet Regarding Consolidated Billing and Ambulance Services	8	C
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			Rural Areas (Based On CBSA Labor Market Areas)		
			FY 2014	8	F (FY2014)
			FY 2015	8	F (FY2015)
			<b>FY 2016</b>	<b>8</b>	<b>F (FY2016)</b>
			Urban Areas (Based On CBSA Labor Market Areas)		
			FY 2014	8	E (FY2014)
			FY 2015	8	E (FY2015)
			<b>FY 2016</b>	<b>8</b>	<b>E (FY2016)</b>
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Administration	3	5			
Ambulatory Surgical Center (ASC)	9	1			
Birthing Center (Freestanding and Hospital-Based)	10	1			
Covered Services Provided By Individual Health Care Professionals And Other Non-Institutional Health Care Providers	1	7			
Emergency Inpatient Admissions To Unauthorized Facilities	1	29			
Freestanding Ambulatory Surgical Center (ASC)	9	1			
Freestanding Psychiatric Partial Hospitalization Program (PHP)	7	2			
Hospital	3	2			
In Teaching Setting	1	4			
Individual Health Care Professionals	3	1			
Institutional Health Care Provider	3	2			
Network Provider	1	1			
Non-Institutional Health Care Providers	3	1			
Non-OPPS Facilities	9	1			
Outpatient Services	1	24			
Physician Assistants, Nurse Practitioners, And Certified Psychiatric Nurse Specialists	1	6			
Preferred Provider Organization (PPO)	1	25			
Psychiatric Partial Hospitalization Program (PHP)	7	2			
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Skilled Nursing Facility (SNF)	8	1			
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