



DEFENSE
HEALTH AGENCY

MB&RS

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

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

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

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SUMMARY OF CHANGES

CHAPTER 6

1. Section 8. This is a routine update correcting the fixed cost outlier threshold from \$20,763 to \$20,758 based on the Medicare correction file. EFFECTIVE DATE: 10/01/2015.

CHAPTER 7

2. Section 1. This is a routine update of the deflator factor (DF) for the 12 months ended 09/30/2015. EFFECTIVE DATE: 10/01/2014.

CHAPTER 9

3. Section 1. This change updates the Ambulatory Surgery Centers reimbursement system for 2016. EFFECTIVE DATE: 11/01/2015.

CHAPTER 12

4. Section 1. This change updates the HHA PPS for CY 2016. EFFECTIVE DATE: 01/01/2016.
5. Section 4. This change updates the cross-references to Addendum L and M.. EFFECTIVE DATE: 01/01/2016.
6. Section 6. This change updates the HHA PPS for CY 2016. EFFECTIVE DATE: 01/01/2016.
7. Addendum L (CY 2013). This change deletes the Home Health Agency Prospective Payment System (HHA PPS) reimbursement rates for CY 2013. EFFECTIVE DATE: 01/01/13.
8. Addendum L (CY 2015). This change replaces a missing table in the reimbursement rates for CY 2015. EFFECTIVE DATE: 01/01/15.
9. Addendum L (CY 2016). This change adds the reimbursement rates for CY 2016, including certain provisions mandated by the Patient Protection and Affordable Care Act (PPACA). EFFECTIVE DATE: 01/01/2016.
10. Addendum M (CY 2013). This change deletes the Annual (HHA PPS) Wage Index Updates, Addendum M Calendar Year (CY) 2013. EFFECTIVE DATE: 01/01/2013.
11. Addendum M (CY 2015). This change adds the Annual HHA PPS Wage Index Updates to Addendum M CY 2015-CY 2016. EFFECTIVE DATE: 01/01/2016.

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SUMMARY OF CHANGES (Continued)

CHAPTER 13

12. Section 2. This change updates the Outpatient Prospective Payment System for CY 2016.
EFFECTIVE DATE: 01/01/2016.
13. Section 3. This change updates the Outpatient Prospective Payment System for CY 2016.
EFFECTIVE DATE: 01/01/2016.
14. Section 4. This change updates the Outpatient Prospective Payment System for CY 2016.
EFFECTIVE DATE: 01/01/2016.

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

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

3.2.6.4 Cost Outliers

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

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

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

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

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

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

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

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

3.2.6.4.1.4 The CCR for admissions occurring on or after October 1, 2013, is 0.2778. The CCR for admissions occurring on or after October 1, 2014, is 0.2726. **The CCR for admissions occurring on or after October 1, 2015, is 0.2631.**

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Chapter 6, Section 8

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

3.2.6.4.1.5 The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2014 is 0.920, for FY 2015 is 0.922, and for FY 2016 is 0.921.

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

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

3.2.6.4.4 For FY 2016, a TRICARE fixed loss cost-outlier threshold is set at **\$20,758**. Effective October 1, 2015, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of **\$20,758** (also wage-adjusted).

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

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

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

3.2.6.5 Burn Outliers

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

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

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

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

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

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Chapter 7, Section 1

Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

3.6.1.2 The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE mental health discharges and the base period. The base period amount, however, cannot exceed the cap described in this section. Once a statistically valid rate is established based on a year in which the hospital or unit had at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem.

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

3.6.1.2.2 Percent of change and Deflator Factor (DF).

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 2013	243.52%	3.4352
September 30, 2014	258.27%	3.5827
September 30, 2015	279.73%	3.7973

3.6.2 New Hospitals and Units

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

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

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

3.6.3 Request for a Review of Higher or Lower Volume Classification

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

3.7 Payment for Hospital Based Professional Services

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

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

3.8 Leave Days

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

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

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

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

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

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

3.9.4 Sole Community Hospital (SCH). Admission prior to January 1, 2014, (the effective date of the SCH reimbursement methodology described in [Chapter 14, Section 1](#)), any hospital which has

2.1.5.3.2 Discounting for Bilateral Procedures

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

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

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

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

2.1.5.3.3 Modifiers for Discounting Terminated Surgical Procedures

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

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

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

2.1.5.3.4 Unbundling of Procedures

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

2.1.5.3.5 Incidental Procedures

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

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

2.1.6 Updating Payment Rates

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

- The rates were updated by 0.9% effective November 1, 2013.
- The rates were updated by 1.2% effective November 1, 2014.
- The rates were updated by 1.2% effective November 1, 2015.

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

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

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

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

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

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

Chapter 12

Home Health Care (HHC)

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2	Home Health Care (HHC) - Benefits And Conditions For Coverage Figure 12.2-1 Copayments/Cost-Shares For Services Reimbursed Outside The HHA PPS When Receiving Home Health Services Under A POC
3	Home Health Benefit Coverage And Reimbursement - Assessment Process
4	Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology Figure 12.4-1 Calculating Domain Scores From Response Values Figure 12.4-2 Clinical Severity Domain Figure 12.4-3 Functional Status Domain Figure 12.4-4 Service Utilization Domain Figure 12.4-5 HHRG To HIPPS Code Crosswalk Figure 12.4-6 New HIPPS Code Structure Under HH PPS Case-Mix Refinement Figure 12.4-7 Scoring Matrix For Constructing HIPPS Code Figure 12.4-8 Case-Mix Adjustment Variables And Scores For Episodes Ending Before January 1, 2012 Figure 12.4-9 Case-Mix Adjustment Variables And Scores For Episodes Ending On Or After January 1, 2012 Figure 12.4-10 Relative Weights For NRS - Six-Group Approach Figure 12.4-11 NRS Case-Mix Adjustment Variables And Scores Figure 12.4-12 Format For Treatment Authorization Code Figure 12.4-13 Converting Point Values To Letter Codes Figure 12.4-14 Example Of A Treatment Authorization Code Figure 12.4-15 Calculation Of National 60-day Episode Payment Amounts Figure 12.4-16 Standardization For Case-Mix And Wage Index Figure 12.4-17 Per Visit Payment Amounts For Low-Utilization Payment Adjustments
5	Home Health Benefit Coverage And Reimbursement - Primary Provider Status And Episodes Of Care
6	Home Health Benefit Coverage And Reimbursement - Claims And Billing Submission Under HHA PPS
7	Home Health Benefit Coverage And Reimbursement - Pricer Requirements And Logic
8	Home Health Benefit Coverage And Reimbursement - Medical Review Requirements
A	Definitions And Acronym Table

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Chapter 12, Home Health Care (HHC)

Section/Addendum	Subject/Addendum Title
B	Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes
C	Home Health Consolidated Billing Code List - Therapy Codes
D	Home Health Certification And Plan Of Care (POC)
E	Primary Components Of A Home Care Patient Assessment
F	Outcome And Assessment Information Set (OASIS-B1)
G	Outcome and Assessment Information Set (OASIS) Items Used For Assessments Of 60-Day Episodes
H	Diagnosis Codes For Home Health Resource Group (HHRG) Assignment
I	Home Health Resource Group (HHRG) Worksheet Figure 12.I-1 HHRG For Episodes Beginning On Or After January 1, 2008 Figure 12.I-2 Abbreviated OASIS Questions
J	Health Insurance Prospective Payment System (HIPPS) Tables For Pricer
K	Home Assessment Validation and Entry (HAVEN) Reference Manual
L (CY 2014)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2014 Figure 12.L.2014-1 2013 Estimated Average Payment Per Episode Figure 12.L.2014-2 CY 2014 National 60-Day Episode Payment Amounts Figure 12.L.2014-3 CY 2014 National Per-Visit Payment Amounts Figure 12.L.2014-4 CY 2014 NRS Conversion Factor Figure 12.L.2014-5 CY 2014 NRS Payment Amounts Figure 12.L.2014-6 CY 2014 Payment Amounts For Services Provided In A Rural Area, Before Case-Mix Adjustment And Wage Index Adjustment Figure 12.L.2014-7 CY 2014 Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment Figure 12.L.2014-8 CY 2014 NRS Conversion Factor For Beneficiaries Who Reside In A Rural Area Figure 12.L.2014-9 CY 2014 Relative Weights For The Six-Severity NRS System For Beneficiaries Residing In A Rural Area
L (CY 2015)	Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015 Figure 12.L.2015-1 CY 2015 National Standardized 60-Day Episode Payment Amounts Figure 12.L.2015-2 CY 2015 National Per-Visit Payment Amounts For HHAs Figure 12.L.2015-3 CY 2015 NRS Conversion Factor Figure 12.L.2015-4 CY 2015 NRS Payment Amounts Figure 12.L.2015-5 CY 2015 Payment Amounts For 60-Day Episodes For Services Provided In A Rural Area Figure 12.L.2015-6 CY 2015 Per-Visit Amounts For Services Provided In A Rural Area Figure 12.L.2015-7 CY 2015 NRS Conversion Factor For Services Provided In A Rural Area

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	Figure 12.L.2016-1 CY 2016 National Standardized 60-Day Episode Payment Amounts
	Figure 12.L.2016-2 CY 2016 National Per-Visit Payment Amounts For HHAs
	Figure 12.L.2016-3 CY 2016 NRS Conversion Factor
	Figure 12.L.2016-4 CY 2016 Relative Weights For The Six-Severity NRS System
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N	Diagnoses Associated With Each Of The Diagnostic Categories Used In Case-Mix Scoring
O	Diagnoses Included In The Diagnostic Categories Used For The Non-Routine Supplies (NRS) Case-Mix Adjustment Model
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	Figure 12.Q-1 Request for Anticipated Payment (RAP) - Non-Transfer Situation
	Figure 12.Q-2 RAP - Non-Transfer Situation With Line Item Service Added
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	Figure 12.Q-7 Claim - Transfer Situation - Beneficiary Transfers To Your HHA
	Figure 12.Q-8 Claim - Significant Change in Condition (SCIC) Situation
	Figure 12.Q-9 Claim - No-RAP-Low Utilization Payment Adjustment (LUPA) Claim
	Figure 12.Q-10 Claim Adjustment
	Figure 12.Q-11 Claim - Cancellation
R	Input/Output Record Layout
S	Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008

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 Chapter 12, Section 1
 Home Health Benefit Coverage And Reimbursement - General Overview

3.2.7 Implementing Instructions

Since this issuance only deals with a general overview of the HHC benefit and reimbursement methodology, the following cross-reference is provided to facilitate access to specific implementing instructions within Chapter 12:

IMPLEMENTING INSTRUCTIONS	
POLICIES	
General Overview	Section 1
Benefits and Conditions for Coverage	Section 2
Assessment Process	Section 3
Reimbursement Methodology	Section 4
Primary Provider Status and Episodes of Care	Section 5
Claims and Billing Submission Under HHA PPS	Section 6
Pricer Requirements and Logic	Section 7
Medical Review Requirements	Section 8
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Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes	Addendum B
Home Health Consolidated Billing Code List - Therapy Codes	Addendum C
CMS Form 485 - Home Health Certification And Plan Of Care Data Elements	Addendum D
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Outcome and Assessment Information Set (OASIS-B1)	Addendum F
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Calendar Year 2014	Addendum L (CY 2014)
Calendar Year 2015	Addendum L (CY 2015)
Calendar Year 2016	Addendum L (CY 2015)
Annual HHA PPS Wage Index Updates	
Calendar Year 2014	Addendum M (CY 2014)
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Diagnoses Associated with Diagnostic Categories Used in Case-Mix Scoring	Addendum N

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IMPLEMENTING INSTRUCTIONS (CONTINUED)

Diagnoses Included with Diagnostic Categories for Non-Routine Supplies (NRS) Case-Mix Adjustment Model	Addendum O
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Chapter 12, Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

FIGURE 12.4-15 CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNTS

ADJUSTMENTS:	
1. Average cost per episode for NRS included in the home health benefit and reported as costs on the cost report	\$43.54
2. Average payment per episode for NRS possibly unbundled and billed separately for Part B	\$6.08
3. Average payment per episode for Part B therapies	\$17.76
4. Average payment per episode for OASIS one time adjustment for form changes	\$5.50
5. Average payment per episode for ongoing OASIS adjustment costs	\$4.32
Total Non-Standardized Prospective Payment Amount for 60-day Episode for FY 2001 Plus Medical Supplies, Part B Therapies and OASIS	\$2,416.01

3.8.1.3 The adjusted non-standardized prospective payment amount per 60-day episode for FY 2001 was adjusted as follows in [Figure 12.4-16](#) for case-mix, budget neutrality and outliers in the establishment of a final standardized and budget neutral payment amount per 60-day episode for FY 2001.

FIGURE 12.4-16 STANDARDIZATION FOR CASE-MIX AND WAGE INDEX

NON-STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS	STANDARDIZATION FACTOR FOR WAGE INDEX AND CASE-MIX	BUDGET NEUTRALITY FACTOR	OUTLIER ADJUSTMENT FACTOR	STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS
\$2,416.01	0.96184	0.88423	1.05	\$2,115.30

3.8.1.3.1 The above 60-day episode payment calculations were derived using base-year costs and utilization rates and subsequently adjusted by annual inflationary update factors, the last three iterations of which can be found in [Addendums L \(CY 2014\)](#), [L \(CY 2015\)](#), and [L \(CY 2016\)](#).

3.8.1.3.2 The standardized prospective payment amount per 60-day EOC is case-mix and wage-adjusted in determining payment to a specific HHA for a specific beneficiary. The wage adjustment is made to the labor portion (0.77668) of the standardized prospective payment amount after being multiplied by the beneficiary's designated HHRG case-mix weight. For example, a HHA serves a TRICARE beneficiary in Denver, CO. The HHA determines the patient is in HHRG C2F1S2 with a case-mix weight of 1.8496. The following steps are used in calculating the case-mix and wage-adjusted 60-day episode payment amount:

Step 1: Multiply the standard 60-day prospective payment amount by the applicable case-mix weight.

$$(1.8496 \times \$2,115.30) = \$3,912.46$$

Step 2: Divide the case-mix adjustment episode payment into its labor and non-labor portions.

$$\text{Labor Portion} = (0.77668 \times \$3,912.46) = \$3,038.73$$

$$\text{Non-Labor Portion} = (0.22332 \times \$3,912.46) = \$873.73$$

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Step 3: Adjust the labor portion by multiplying by the wage index factor for Denver, CO.

$$(1.0190 \times \$3,038.73) = \$3,096.47$$

Step 4: Add the wage-adjusted labor portion to the non-labor portion to calculate the total case-mix and wage-adjusted episode payment.

$$(\$873.73 + \$3,096.47) = \mathbf{\$3,970.20}$$

3.8.1.4 Since the initial methodology used in calculating the case-mix and wage-adjusted 60-day episode payment amounts has not changed, the above example is still applicable using the updated wage indices and 60-day episode payment amounts (both the all-inclusive payment amount and per-discipline payment amount) contained in [Addendums L \(CY 2014\)](#), [L \(CY 2015\)](#), [L \(CY 2016\)](#), [M \(CY 2014\)](#), and [M \(CY 2015 - CY 2016\)](#).

3.8.1.5 Annual Updating of HHA PPS Rates and Wage Indexes.

3.8.1.5.1 In subsequent fiscal years, HHA PPS rates (i.e., both the national 60-day episode amount and per-visit rates) will be increased by the applicable home health market basket index change.

3.8.1.5.2 Three iterations of these rates will be maintained in [Addendums L \(CY 2014\)](#), [L \(CY 2015\)](#), and [L \(CY 2016\)](#). These rate adjustments are also integral data elements used in updating the Pricer.

3.8.1.5.3 Three iterations of wage indexes will also be maintained in [Addendums M \(CY 2014\)](#) and [M \(CY 2015 - CY 2016\)](#), for computation of individual HHA payment amounts. These hospital wage indexes will lag behind by a full year in their application.

3.8.2 Calculation of Reduced Payments

Under certain circumstances, payment will be less than the full 60-day episode rate to accommodate changes of events during the beneficiary's care. The start and end dates of each event will be used in the apportionment of the full-episode rate. These reduced payment amounts are referred to as: 1) PEP adjustments; 2) SCIC adjustments; 3) LUPAs; and 4) therapy threshold adjustments. Each of these payment reduction methodologies will be discussed in greater detail below.

Note: Since the basic methodology used in calculating HHA PPS adjustments (i.e., payment reductions for PEPs, SCICs, LUPAs, and therapy thresholds) has not changed, the following examples are still applicable using the updated wage indices and 60-day episode payment amounts in [Addendums L \(CY 2014\)](#), [L \(CY 2015\)](#), [L \(CY 2016\)](#), [M \(CY 2014\)](#), and [M \(CY 2015 - CY 2016\)](#).

3.8.2.1 PEP Adjustment

The PEP adjustment is used to accommodate payment for EOCs less than 60 days resulting from one of the following intervening events: 1) beneficiary elected a transfer prior to the end of the 60-day EOC; or 2) beneficiary discharged after meeting all treatment goals in the original POC and subsequently readmitted to the same HHA before the end of the 60-day EOC. The PEP

adjustment is based on the span of days over which the beneficiary received treatment prior to the intervening event; i.e., the days, including the start-of-care date/first billable service date through and including the last billable service date, before the intervening event. The original POC must be terminated with no anticipated need for additional home health services. A new 60-day EOC would have to be initiated upon return to a HHA, requiring a physician's recertification of the POC, a new OASIS assessment, and authorization by the contractor. The PEP adjustment is calculated by multiplying the proportion of the 60-day episode during which the beneficiary was receiving care prior to the intervening event by the beneficiary's assigned 60-day episode payment. The PEP adjustment is only applicable for beneficiaries having more than four billable home health visits. Transfers of beneficiaries between HHAs of common ownership are only applicable when the agencies are located in different metropolitan statistical areas. Also, PEP adjustments do not apply in situations where a patient dies during a 60-day EOC. Full episode payments are made in these particular cases. For example, a beneficiary assigned to HHRG C2F1S2 and receiving care in Denver, CO was discharged from a HHA on Day 28 of a 60-day EOC and subsequently returned to the same HHA on Day 40. However, the first billable visit (i.e., a physician ordered visit under a new POC) did not occur until Day 42. The beneficiary met the requirements for a PEP adjustment, in that the treatment goals of the original POC were accomplished and there was no anticipated need for home care during the balance of the 60-day episode. Since the last visit was furnished on Day 28 of the initial 60-day episode, the PEP adjustment would be equal to the assigned 60-day episode payment times 28/60, representing the proportion of the 60 days that the patient was in treatment. Day 42 of the original episode becomes Day 1 of the new certified 60-day episode. The following steps are used in calculating the PEP adjustment:

Step 1: Calculate the proportion of the 60 days that the beneficiary was under treatment.

$$(28/60) = 0.4667$$

Step 2: Multiply the beneficiary assigned 60-day episode payment amount by the proportion of days that the beneficiary was under treatment.

$$(\$3,970.20 \times 0.4667) = \mathbf{\$1,852.90}$$

3.8.2.2 SCIC Payment Adjustment

For Episodes Beginning On Or After January 1, 2008. The refined HH PPS no longer contains a policy to allow for adjustments reflecting SCICs. Episodes paid under the refined HH PPS will be paid based on a single HIPPS code. Claims submitted with additional HIPPS codes reflecting SCICs will be returned to the provider; i.e., claims for episodes beginning on or after January 1, 2008, that contain more than one revenue code 0023 line.

3.8.2.3 LUPA

3.8.2.3.1 For Episodes Beginning Prior To January 1, 2008

3.8.2.3.1.1 The LUPA reduces the 60-day episode payments, or PEP amounts, for those beneficiaries receiving less than five home health visits during a 60-day EOC. Payment for low-utilization episodes are made on a per-visit basis using the cost-per-visit rates by discipline calculated in [Figure 12.4-1](#) plus additional amounts for: 1) NRS paid under a home health POC; 2) NRS possibly unbundled to Part B; 3) per-visit ongoing OASIS reporting adjustment; and 4) one-time OASIS scheduling implementation change. These cost-per-visit rates are standardized for

wage index and adjusted for outliers to come up with final wage standardized and budget neutral per-visit payment amounts for 60-day episodes as reflected in [Figure 12.4-17](#).

FIGURE 12.4-17 PER VISIT PAYMENT AMOUNTS FOR LOW-UTILIZATION PAYMENT ADJUSTMENTS

HOME HEALTH DISCIPLINE TYPE	AVERAGE COST PER VISIT				STANDARDIZATION FACTOR FOR WAGE INDEX	OUTLIER ADJUSTMENT FACTOR	PER VISIT PAYMENT AMOUNTS PER 60-DAY EPISODE FOR FY 2001
	FROM THE PPS AUDIT SAMPLE	FOR NON-ROUTINE MEDICAL SUPPLIES*	FOR ONGOING OASIS ADJUSTMENT COSTS	FOR ONE-TIME OASIS SCHEDULING CHANGE			
Home Health Aide	\$41.75	\$1.94	\$0.12	\$0.21	0.96674	1.05	\$43.37
Medical Social	153.59	1.94	0.12	0.21	0.96674	1.05	153.55
Physical Therapy	104.05	1.94	0.12	0.21	0.96674	1.05	104.74
Skilled Nursing	94.96	1.94	0.12	0.21	0.96674	1.05	95.79
Speech Pathology	113.26	1.94	0.12	0.21	0.96674	1.05	113.81
Occupational Therapy	104.76	1.94	0.12	0.21	0.96674	1.05	105.44

* Combined average cost per-visit amounts for NRS reported as costs on the cost report and those which could have been unbundled and billed separately to Part B.

3.8.2.3.1.2 The per-visit rates per discipline are wage-adjusted but not case-mix adjusted in determining the LUPA. For example, a beneficiary assigned to HHRG C2L1S2 and receiving care in a Denver, CO, HHA has one skilled nursing visit, one physical therapy visit and two home health visits. The per-visit payment amount (obtained from [Figure 12.4-3](#)) is multiplied by the number of visits for each discipline and summed to obtain an unadjusted low-utilization payment amount. This amount is then wage-adjusted to come up with the final LUPA. The following steps are used in calculating the LUPA:

Note: Since the basic methodology used in calculating HHA PPS outliers has not changed, the following example is still applicable using the updated wage indices, 60-day episode payment amounts and Fixed Dollar Loss (FDL) amounts in [Addendums L \(CY 2014\)](#), [L \(CY 2015\)](#), [L \(CY 2016\)](#), [M \(CY 2014\)](#), and [M \(CY 2015 - CY 2016\)](#).

Step 1: Multiple the per-visit rate per discipline by the number of visits and add them together to get the total unadjusted low-utilization payment amount.

Skilled nursing visits	1 x \$95.79	=	\$ 95.79
Physical therapy visits	1 x \$104.74	=	\$104.74
Home health aide visits	2 x \$43.37	=	\$ 86.74
Total unadjusted payment amount			\$287.27

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SUBCATEGORY	STANDARD ABBREVIATION
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

- Required detail: HCPCS code G0151, HCPCS code G0159, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

3.1.2.19.29.2.3 43X - Occupational Therapy (OT) - Services provided by a qualified OT practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities; therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other OT (may include restorative therapy)	OTHER OCCUP THER

- Required detail: HCPCS code G0152, HCPCS code G0160, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

3.1.2.19.29.2.4 44X - Speech-Language Pathology - Charges for services provided to persons with impaired communications skills.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PATH

- Required detail: HCPCS code G0153, HCPCS code G0161, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

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3.1.2.19.29.2.5 55X - Skilled Nursing - Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

- Required detail: HCPCS code G0154 on or before December 31, 2015 and HCPCS code G0299 or G0300 on or after January 1, 2016, HCPCS code G0162, HCPCS code G0163, HCPCS code G0164, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

3.1.2.19.29.2.6 56X - Medical Social Services - Charges for services such as counseling patients, interviewing patients, and interpreting problems of a social situation rendered to patients on any basis.

- Rationale: Necessary for TRICARE home health billing requirements. May be used at other times as required by hospital.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	MED SOCIAL SVS
1 - Visit charge	MED SOC SERV/VISIT
2 - Hourly charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Service	MED SOC SERV/OTHER

- Required detail: HCPCS code G0155, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.

3.1.2.19.29.2.7 57X - Home Health Aide (Home Health) - Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

- Rationale: Necessary for TRICARE home health billing requirements.

SUBCATEGORY	STANDARD ABBREVIATION
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015

(Final payment amounts per 60-day episodes ending on or after January 1, 2015, and before January 1, 2016 - Continuing Calendar Year (CY) update.)

Home Health Agency Prospective Payment System (HHA PPS) - Determination of Standard HHA PPS amounts

Section 1895(b)(3)(B) of the Act, as amended by section 5201 of the Deficit Reduction Act (DRA), requires for Calendar Year (CY) 2015 that the standard prospective payment amount be increased by a factor equal to the applicable Home Health (HH) market basket update for HHAs.

Rebasing of 60-Day Episode Payment Amount, National Per-Visit Rates, and the Non-Routine Medical Supplies (NRS) Conversion Factor

For CY 2014, as required by section 3131(a)(1) of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS), in their Final Rule published December 2, 2013, rebased the national, standardized 60-day episode payment amount, the national per-visit rates, and the NRS conversion factor. The rebasing adjustments will occur over the next four years. For CY 2015 the rebasing adjustment is \$80.95.

National 60-Day Episode Payment Amounts - CY 2015

In order to calculate the CY 2015 national standardized 60-day episode, the CY 2014 estimated average payment per 60-day episode of \$2,869.27 is adjusted by the wage index standardization factor, a case-mix budget neutrality factor, the rebasing adjustment, and the home health market basket update, as reflected in [Figure 12.L.2015-1](#).

FIGURE 12.L.2015-1 CY 2015 NATIONAL STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNTS

CY 2014 National Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	CY 2015 National, Standardized 60-Day Episode Payment
\$2,869.27	x 1.0024	x 1.0366	- \$80.95	x 1.021	= \$2,961.38

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Chapter 12, Addendum L (CY 2015)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015

National Per-Visit Amounts Used to Pay Low Utilization Payment Adjustments (LUPAs) and Compute Costs of Outlier - CY 2015

To calculate the CY 2015 national per-visit rates, the 2014 national per-visit rates are adjusted by a wage index budget neutrality factor, and are then increased by the maximum rebasing adjustments described in the December 2, 2013, CMS Final Rule. Finally, the rates are updated by the CY 2015 HH market basket update. National per-visit rates are not subjected to the nominal increase in case-mix. The final updated CY 2015 national per-visit rates per discipline are reflected in [Figure 12.L.2015-2](#):

FIGURE 12.L.2015-2 CY 2015 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS

HH Discipline Type	CY 2014 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	CY 2015 Per-Visit Payment
HH Aide	\$54.84	x 1.0012	+ \$1.79	x 1.021	\$57.89
Medical Social Services (MSS)	194.12	x 1.0012	+ 6.34	x 1.021	204.91
Occupational Therapy (OT)	133.30	x 1.0012	+ 4.35	x 1.021	140.70
Physical Therapy (PT)	132.40	x 1.0012	+ 4.32	x 1.021	139.75
Skilled Nursing (SN)	121.10	x 1.0012	+ 3.96	x 1.021	127.83
Speech-Language Pathology (SLP)	143.88	x 1.0012	+ 4.70	x 1.021	151.88

Payment of LUPA Episodes

For CY 2014 and years following, as described in the December 2, 2013, CMS Final Rule, the per-visit payment amount for the first SN, PT, and SLP visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes is multiplied by the LUPA add-on factors, which are: 1.8451 for SN; 1.6700 for PT; and 1.6266 for SLP.

NRS Conversion Factor Update

Payments for the NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. For CY 2015, the 2014 NRS conversion factor was adjusted using the 2.82 rebasing adjustment factor, as described in the December 2, 2013, CMS Final Rule, and then updated by the CY 2015 HH market basket. See [Figure 12.L.2015-3](#).

FIGURE 12.L.2015-3 CY 2015 NRS CONVERSION FACTOR

CY 2014 NRS Conversion Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	CY 2015 NRS Conversion Factor
\$53.65	x 0.9718	x 1.021	= \$53.23

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Chapter 12, Addendum L (CY 2015)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015

The payment amounts, using the above computed CY 2015 NRS conversion factor (\$53.23), for the various severity levels based on the updated conversion factor are calculated in [Figure 12.L.2015-4](#).

FIGURE 12.L.2015-4 CY 2015 NRS PAYMENT AMOUNTS

Severity Level	Points (Scoring)	Relative Weight	CY 2015 NRS Payment Amounts
1	0	0.2698	\$14.36
2	1 to 14	0.9742	51.86
3	15 to 27	2.6712	142.19
4	28 to 48	3.9686	211.25
5	49 to 98	6.1198	325.76
6	99+	10.5254	560.27

Labor And Non-Labor Percentages

For CY 2015, the labor percent is 78.535%, and the non-labor percent is 21.465%.

Outlier Payments

Under the HHA PPS, outlier payments are made for episodes for which the estimated cost exceeds a threshold amount. The wage adjusted Fixed Dollar Loss (FDL) amount represents the amount of loss that an agency must bear before an episode becomes eligible for outlier payments. The FDL ratio, which is used in calculating the FDL amount, for CY 2015 is 0.45.

Outcome and Assessment Information Set (OASIS)

HHAs must collect OASIS data in order to participate in the TRICARE program. See [Addendum G](#) for the OASIS.

Temporary 3% Rural Add-On for the HHA PPS

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173, enacted on December 8, 2003, and as amended by Section 3131(c) of the Affordable Care Act) provides an increase of 3% of the payment amount otherwise made under Section 1895 of the Social Security Act for HH services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Social Security Act), for episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The 3% rural add-on is applied to the national standardized 60-day episode rate, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor when HH services are provided in rural (non-Core Based Statistical Area (CBSA)) areas. The applicable case-mix and wage index adjustments are subsequently applied. Episodes that qualify for the 3% rural add-on will be identified by a CBSA code that begins with '999'.

National 60-Day Episode Payment Amounts for Rural, Non-CBSA Areas

In order to calculate the national standardized 60-day episode payment for beneficiaries residing in a rural area, the CY 2015 national standardized 60-day episode payment of \$2,961.38 was increased by 3%. See [Figure 12.L.2015-5](#).

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Chapter 12, Addendum L (CY 2015)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015

FIGURE 12.L.2015-5 CY 2015 PAYMENT AMOUNTS FOR 60-DAY EPISODES FOR SERVICES PROVIDED IN A RURAL AREA

CY 2015 National, Standardized 60-Day Episode Payment Rate	Multiplied by the 3% Rural Add-On	CY 2015 Rural National, Standardized 60-Day Episode Payment Rate
\$2,961.38	x 1.03	\$3,050.22

Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment

The CY 2015 national per-visit amounts were increased by 3% for beneficiaries who reside in rural areas. See [Figure 12.L.2015-6](#).

FIGURE 12.L.2015-6 CY 2015 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA

HH Discipline Type	CY 2014 Per-Visit Rate	Multiplied by the 3% Rural Add-On	CY 2014 Rural Per-Visit Rate
HH Aide	\$57.89	x 1.03	\$59.63
MSS	204.91	x 1.03	211.06
OT	140.70	x 1.03	144.92
PT	139.75	x 1.03	143.94
SN	127.83	x 1.03	131.66
SLP	151.88	x 1.03	156.44

Payment for NRS

The NRS conversion factor for CY 2015 payments was increased by 3% for beneficiaries who reside in rural areas. See [Figure 12.L.2015-7](#) and [Figure 12.L.2015-8](#).

FIGURE 12.L.2015-7 CY 2015 NRS CONVERSION FACTOR FOR SERVICES PROVIDED IN A RURAL AREA

CY 2015 NRS Conversion Factor	Multiplied by the 3% Rural Add-On	CY 2015 NRS Conversion Factor
\$53.23	x 1.03	\$54.83

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Addendum L (CY 2015)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2015

FIGURE 12.L.2015-8 CY 2015 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM FOR BENEFICIARIES RESIDING IN A RURAL AREA

Severity Level	Points (Scoring)	Relative Weight	Total NRS Payment Amount For Rural Areas
1	0	0.2698	\$14.79
2	1 to 14	0.9742	53.42
3	15 to 27	2.6712	146.46
4	28 to 48	3.9686	217.60
5	49 to 98	6.1198	335.55
6	99+	10.5254	577.11

- END -

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2016

(Final payment amounts per 60-day episodes ending on or after January 1, 2016, and before January 1, 2017 - Continuing Calendar Year (CY) update.)

Home Health Agency Prospective Payment System (HHA PPS) - Determination of Standard HHA PPS amounts

Section 1895(b)(3)(B) of the Act, as amended by section 5201 of the Deficit Reduction Act (DRA), requires for CY 2016 that the standard prospective payment amount be increased by a factor equal to the applicable Home Health (HH) market basket update for HHAs.

Rebasing of 60-Day Episode Payment Amount, National Per-Visit Rates, and the Non-Routine Medical Supplies (NRS) Conversion Factor

Beginning in CY 2014, as required by section 3131(a)(1) of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS), in their Final Rule published December 2, 2013, rebased the national, standardized 60-day episode payment amount, the national per-visit rates, and the NRS conversion factor. The rebasing adjustments will continue through CY 2017. For CY 2016 the rebasing adjustment is \$80.95.

National 60-Day Episode Payment Amounts - CY 2016

In order to calculate the CY 2016 national standardized 60-day episode, the CY 2015 estimated average payment per 60-day episode of \$2,961.38 is adjusted by the wage-index budget neutrality factor, a case-mix weights budget neutrality factor, an adjustment for nominal case-mix growth, the rebasing adjustment, and the home health market basket update, as reflected in [Figure 12.L.2016-1](#).

FIGURE 12.L.2016-1 CY 2016 NATIONAL STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNTS

CY 2015 National Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	Nominal Case-Mix Growth Adjustment	CY 2016 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	CY 2016 National, Standardized 60-Day Episode Payment
\$2,961.38	x 1.0011	x 1.0187	x0.9903	- \$80.95	x 1.019	= \$2,965.12

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 12, Addendum L (CY 2016)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2016

National Per-Visit Amounts Used to Pay Low Utilization Payment Adjustments (LUPAs) and Compute Costs of Outlier - CY 2016

To calculate the CY 2016 national per-visit rates, the 2015 national per-visit rates are adjusted by a wage index budget neutrality factor, and are then increased by the rebasing adjustments described in the December 2, 2013, CMS Final Rule. Finally, the rates are updated by the CY 2016 HH market basket update. National per-visit rates are not subjected to the nominal increase in case-mix. The final updated CY 2016 national per-visit rates per discipline are reflected in [Figure 12.L.2016-2](#):

FIGURE 12.L.2016-2 CY 2016 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAs

HH Discipline Type	CY 2015 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2016 Rebasing Adjustment	CY 2016 HH Payment Update Percentage	CY 2016 Per-Visit Payment
HH Aide	\$57.89	x 1.0010	+ \$1.79	x 1.019	\$60.87
Medical Social Services (MSS)	204.91	x 1.0010	+ 6.34	x 1.019	215.47
Occupational Therapy (OT)	140.70	x 1.0010	+ 4.35	x 1.019	147.95
Physical Therapy (PT)	139.75	x 1.0010	+ 4.32	x 1.019	146.95
Skilled Nursing (SN)	127.83	x 1.0010	+ 3.96	x 1.019	134.42
Speech-Language Pathology (SLP)	151.88	x 1.0010	+ 4.70	x 1.019	159.71

Payment of LUPA Episodes

For CY 2016, as described in the December 2, 2013, CMS Final Rule, the per-visit payment amount for the first SN, PT, and SLP visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes is multiplied by the LUPA add-on factors, which are: 1.8451 for SN; 1.6700 for PT; and 1.6266 for SLP.

NRS Conversion Factor Update

Payments for the NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. For CY 2016, the 2015 NRS conversion factor was adjusted using the 2.82 rebasing adjustment factor, as described in the December 2, 2013, CMS Final Rule, and then updated by the CY 2016 HH market basket. See [Figure 12.L.2016-3](#).

FIGURE 12.L.2016-3 CY 2016 NRS CONVERSION FACTOR

CY 2015 NRS Conversion Factor	CY 2016 Rebasing Adjustment	CY 2016 HH Payment Update Percentage	CY 2016 NRS Conversion Factor
\$53.23	x 0.9718	x 1.019	= \$52.71

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The payment amounts, using the above computed CY 2016 NRS conversion factor (\$52.71), for the various severity levels based on the updated conversion factor are calculated in [Figure 12.L.2016-4](#).

FIGURE 12.L.2016-4 CY 2016 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM

Severity Level	Points (Scoring)	Relative Weight	CY 2015 NRS Payment Amounts
1	0	0.2698	\$14.22
2	1 to 14	0.9742	51.35
3	15 to 27	2.6712	140.80
4	28 to 48	3.9686	209.18
5	49 to 98	6.1198	322.57
6	99+	10.5254	554.79

Labor And Non-Labor Percentages

For CY 2016, the labor percent is 78.535%, and the non-labor percent is 21.465%.

Outlier Payments

Under the HHA PPS, outlier payments are made for episodes for which the estimated cost exceeds a threshold amount. The wage adjusted Fixed Dollar Loss (FDL) amount represents the amount of loss that an agency must bear before an episode becomes eligible for outlier payments. The FDL ratio, which is used in calculating the FDL amount, for CY 2016 is 0.45.

Outcome and Assessment Information Set (OASIS)

HHAs must collect OASIS data in order to participate in the TRICARE program. See [Addendum G](#) for the OASIS.

Temporary 3% Rural Add-On for the HHA PPS

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173, enacted on December 8, 2003, and as amended by Section 3131(c) of the Affordable Care Act) provides an increase of 3% of the payment amount otherwise made under Section 1895 of the Social Security Act for HH services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Social Security Act), for episodes and visits ending on or after April 1, 2010, and before January 1, 2018. The 3% rural add-on is applied to the national standardized 60-day episode rate, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor when HH services are provided in rural (non-Core Based Statistical Area (CBSA)) areas. The applicable case-mix and wage index adjustments are subsequently applied. Episodes that qualify for the 3% rural add-on will be identified by a CBSA code that begins with '999'.

National 60-Day Episode Payment Amounts for Rural, Non-CBSA Areas

In order to calculate the national standardized 60-day episode payment for beneficiaries residing in a rural area, the CY 2016 national standardized 60-day episode payment of \$2,965.12 was increased by 3% to \$3,054.07.

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Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment

The CY 2016 national per-visit amounts were increased by 3% for beneficiaries who reside in rural areas. See [Figure 12.L.2016-5](#).

FIGURE 12.L.2016-5 CY 2016 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA

HH Discipline Type	CY 2016 Per-Visit Rate	Multiplied by the 3% Rural Add-On	CY 2016 Rural Per-Visit Rate
HH Aide	\$60.87	x 1.03	\$62.70
MSS	215.47	x 1.03	221.93
OT	147.95	x 1.03	152.39
PT	146.95	x 1.03	151.36
SN	134.42	x 1.03	138.45
SLP	159.71	x 1.03	164.50

CY 2016 NRS Conversion Factor For Services Provided In A Rural Area

The CY 2015 NRS Conversion Factor was multiplied by the 3% rural add-on to result in a NRS Conversion Factor of \$54.29 for CY 2016.

CY 2016 NRS Payment Amounts For Services Provided In Rural Areas

The CY 2016 NRS payment amounts for services provided in rural areas are summarized in [Figure 12.L.2016-6](#):

FIGURE 12.L.2016-6 CY 2016 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM FOR BENEFICIARIES RESIDING IN A RURAL AREA

Severity Level	Points (Scoring)	Relative Weight	Total NRS Payment Amount For Rural Areas
1	0	0.2698	\$14.65
2	1 to 14	0.9742	52.89
3	15 to 27	2.6712	145.02
4	28 to 48	3.9686	215.46
5	49 to 98	6.1198	332.24
6	99+	10.5254	571.42

- END -

Chapter 12

Addendum M (CY 2015 - CY 2016)

Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2015 - CY 2016

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

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

Beginning January 1, 2016, the wage index for all HH PPS payments will be fully based on the new OMB delineations. In CY 2016, CMS updated the HH wage index using solely the new geographic delineations.

The CY 2016 wage index is available for download at <http://www.health.mil/rates>.

- END -

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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, \$100 for CY 2016), 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

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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 **HCPCS 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 **Current Procedural Terminology (CPT) and HCPCS** 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.

3.2.2.5.5 Beginning January 1, 2016, all qualifying extended assessment and management encounters will be paid through a newly created “comprehensive observation services” C-APC. Please see paragraph 3.8 for more information.

3.3 Additional Payments Under The OPPTS

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 OPPTS for the services furnished.

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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. **Beginning January 1, 2016, APC 0375 will be renumbered to APC 5881, and all services reported on the same claim as an inpatient only procedure with modifier "-CA" will be paid through a single prospective payment for the comprehensive service.**

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.

3.4.3.4 Beginning January 1, 2016, APC 0375 will be renumbered to APC 5881, and all services reported on the same claim as an inpatient only procedure with modifier “-CA” will be paid through a single prospective payment for the comprehensive service.

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 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 3.4 and 3.5](#). 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.

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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 13.2-1](#)). 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

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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 Beginning January 1, 2016, APC 0175 and 0176 are renumbered to 5861 and 5862, respectively.

3.7.6 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. **APC 8009 is deleted effective January 1, 2016.** 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 Beginning January 1, 2016, all qualifying extended assessment and management encounters will be paid through a "Comprehensive Observation Services" Comprehensive -APC (C-APC), 8011, and will assign the services within this APC to SI of **J2**. In order to be eligible for payment under this C-APC, claims must meet the following criteria:

- The claims do not contain a procedure described by a HCPCS code with assigned SI of **T** that is reported with a date of service on the same day or one day earlier than the date of service associated with services described by HCPCS code G0378;
- The claims contain eight or more units of services described by HCPCS code G0378 (Observation services, per hour);
- The claims contain services described by one of the following codes: HCPCS code G0379 on the same date of service as services described by HCPCS code G0378; CPT¹ code 99284; CPT¹ code 99285 or HCPCS code G0384; CPT¹ code 99291; or HCPCS code G0463 provided on the same date of service or one day before the date of service for services described by HCPCS code G0378; and
- The claims do not contain services described by a HCPCS code with assigned SI of **J1**.
- Observations for maternity conditions that meet the above criteria will be reimbursed utilizing this logic. See paragraph 3.8.3 for all other maternity observation services.

3.8.3 Observations For Maternity Conditions

3.8.3.1 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:

3.8.3.1.1 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.

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

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

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

3.8.3.3 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 HCPCS code G0378.

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3.8.3.4 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 **one**. 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. **Beginning January 1, 2016, APC 0375 will be renumbered to APC 5881, and all services reported on the same claim as an inpatient only procedure with modifier "-CA" will be paid through a single prospective payment for the comprehensive service. Also, beginning January 1, 2016, the assignment of the C-APC will be across the claim, rather than the day. See paragraph 3.4.3.4.**

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 OPSS

The CMS 1450 UB-04 Claim Form allows 11 values for condition codes, however, the OCE can only accommodate seven, therefore, OPSS 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 -

indicator identifies:

3.1.3.1 A to indicate services that are paid under some payment method other than OPSS, 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 OPSS.

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

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 OPSS.

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 J2 to indicate hospital outpatient department services that may be paid through a comprehensive APC.

3.1.3.10 K to indicate non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals that are paid in separate APCs under the OPSS.

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

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

3.1.3.13 Q to indicate packaged services subject to separate payment under OPSS.

3.1.3.14 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.

3.1.3.15 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.

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

3.1.3.16 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.

3.1.3.17 Q4 to indicate conditionally packaged laboratory services.

Note: HCPCS codes with SI of **Q** are either separately payable or packaged depending on the specific circumstances of their billing. Outpatient Code Editor (OCE) claims processing logic will be applied to codes assigned SI of **Q** in order to determine if the service will be packaged or separately payable.

3.1.3.18 R to indicate separate APC payment for blood and blood products.

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

3.1.3.20 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.

3.1.3.21 U to indicate separate APC payment for brachytherapy sources.

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

3.1.3.23 W to indicate invalid HCPCS or invalid revenue code with blank HCPCS.

3.1.3.24 X to indicate an ancillary service for which payment is allowed under the hospital OPPS².

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

3.1.3.26 TB to indicate TRICARE reimbursement not allowed for **Current Procedural Terminology (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.)

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

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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 OPSS is calculated as follows:

3.1.4.4.1 Apply the appropriate wage index adjustment to the national payment rate that is set annually for each APC group. (Refer to the OPSS Provider File with Wage Indexes on DHA's OPSS 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 OPSS 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 OPSS 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 OPSS 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.

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

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

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

- Adjusted APC payment rate: \$400.
- Subtract any applicable deductible: $\$400 - \$50 = \$350$
- Subtract the standard ADFM cost-share (i.e., 20% of the allowable charge) from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$$\$350 \times 0.20 = \$70 \text{ cost-share}$$

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

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

3.1.5 Adjustments to APC Payment Amounts

3.1.5.1 Adjustment for Area Wage Differences

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

3.1.5.1.2 The 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 OPSS

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

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):

$$= (\$180 \times 1.0234) = \$184.21 + \$120 = \$304.21$$

- Cost-share for standard ADFM (rounded to nearest cent):
 $= (\$304.21 \times 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.

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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	$(1 + D)/U$
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

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

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

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

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

3.1.5.4 Multiple discounting will not be applied to the following CPT³ codes for venipuncture, fetal monitoring and collection of blood specimens: 36400 - 36416, 36591, 36592, 59020, 59025, and 59050-59051.

3.1.5.5 Outlier Payments

An additional payment is provided for outpatient services for which a hospital's charges, adjusted to cost, exceed the sum of the wage-adjusted APC rate plus a fixed dollar threshold and a fixed multiple of the wage-adjusted APC rate. Only line item services with SIs of **J1, J2, 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.

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

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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).

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

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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

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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 OPSS (SIs of **J1, J2, P, S, T, V,** and **X⁵**), 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 OPSS), 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%

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

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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 4	130%	115%	100%	100%
Year 5	100%	100%	100%	100%

3.1.5.8 Temporary Military Contingency Payment Adjustments (TMCPAs)

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

3.1.5.8.1 Transitional TMCPAs

In view of the ongoing military operations in Afghanistan and Iraq, the 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.

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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

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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 OPSS years and the current OPSS 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 OPSS Year (May 1, 2009 through April 30, 2010); Second OPSS Year (May 1, 2010 through April 30, 2011); and Third OPSS Year (May 1, 2011 through April 30, 2012)

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 OPSS 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 OPSS 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 OPSS visits by ADSMs and ADDs during the previous OPSS 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 OPSS Year (May 1, 2009 through April 30, 2010); Second OPSS Year (May 1, 2010 through April 30, 2011); and Third OPSS Year (May 1, 2011 through April 30, 2012)

3.1.5.8.2.3.1 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 OPPTS year (May 1, 2009 through April 30, 2010); second OPPTS year (May 1, 2010 through April 30, 2011); and third OPPTS 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 OPPTS 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 OPPTS 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 OPPTS 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

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additional payment after the end of the OPSS year (May 1 through April 30). Subsequent adjustments will be issued to the qualifying hospitals for the prior OPSS 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 OPSS 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 OPSS years and the current OPSS 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 OPSS pass-through purposes, radiopharmaceuticals are considered to be “drugs” where the transitional pass-through for the drugs and biologicals is the difference between the amount paid ASP + 4% or the Part B drug CAP rate and the otherwise applicable OPSS payment amount of ASP + 6%.

3.2.3.3 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: CPT⁶ code 92982 (APC0083)

Payment rate = \$3,289.42

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

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

Note: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to [paragraph 3.2.7.4](#) 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 HCPCS code C1884 = \$397.94

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

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

\$2,631.54 TRICARE program payment for CPT⁷ code 92982 when used with device HCPCS code C1884

657.88 Beneficiary coinsurance amount for CPT⁷ 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: CPT⁷ 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: $\$1,500 - \$0 = \$1,500$

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

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

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

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

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

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

\$2,631.54 TRICARE program payment for **CPT**⁸ code 92982 when used with device
HCPCS code C1884

657.88 Beneficiary coinsurance amount for **CPT**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%.

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

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)

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, \$100 for CY 2016), 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 (\$95 for CY 2015, \$100 for CY 2016).

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

3.4.4.2.2 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 OPSS annual Final Rule (**\$95 for CY 2015, \$100 for CY 2016**) 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 OPSS (APC Rate). Refer to DHA’s OPSS web site at <http://www.health.mil/rates> for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

3.4.5 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 OPSS hospital claims data, will be paid at ASP + 4% consistent with its final payment methodology for other separately payable non-pass-through drugs and biologicals.

3.4.5.2 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 OPSS 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 OPSS annual final rule (\$95 for CY 2015, \$100 for CY 2016) 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 OPSS 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 (\$95 for CY 2015, \$100 for CY 2016).

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 OPPTS:

- 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 its 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 OPPTS 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 OPPTS annual Final Rule (\$95 for CY 2015, \$100 for CY 2016) 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 (\$95 for CY 2015, \$100 for CY 2016) 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 OPPTS annual Final Rule (\$95 for CY 2015, \$100 for CY 2016).

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 CPT⁹ 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

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

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 one procedure on the claim with a SI of **T**), discontinued service (signified by modifier 73) or reduced service (signified by modifier 52) apply.

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

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

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

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 appended 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

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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
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual rate-resp
C1786	Pmkr, single rate-resp
C1789	Prosthesis, breast, imp
C1813	Prostheses, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro, rechg bat sys
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
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

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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
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 OPPTS.

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

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

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

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

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

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

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

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 prohibits a delay in providing required screening or stabilization services in order to inquire about the individual’s payment method or insurance status.

3.14.3 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 CPT¹¹ codes 99281-99285 and Type **B** ED visits using G0380-G0384.

3.14.7 A new **HCPCS 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 CPT¹¹ 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 CPT¹¹ codes 99291 or 99292, receiving payment for APC 0617.
- However if trauma activation occurs, the hospital would be called to bill one unit of **HCPCS G** code (G0390), report with revenue code 68x on the same date of service, thereby receiving payment for APC 0618.

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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 prevalings)

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 $\$6,000/\$10,000 \times \$20,000 = \$12,000$.

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

3.17 Validation Reviews

OPSS claims are not subject to validation review.

3.18 Hospital-Based Birthing Centers

Hospital-based birthing centers will be reimbursed the same as freestanding birthing centers except the all inclusive rate consisting of the CMAC for CPT¹² 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 -

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Chapter 13, Section 4

Claims Submission And Processing Requirements

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.

3.6.4 Beginning January 1, 2016, laboratory tests (regardless of date of service) on a claim with a service that is assigned a Status Indicator (SI) of **S**, **T**, or **V**, unless an exception applies or the laboratory test is "unrelated" to the other service(s) on the claim, will be conditionally packaged and will be assigned SI of **Q4**. When laboratory tests are the only service(s) on a claim, a separate payment may be made.

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 -

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Acronyms And Abbreviations

CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CARC	Claim Adjustment Reason Code
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBL	Commercial Bill of Lading
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCCT	Clomiphene Citrate Challenge Test
CCD	Corporate Credit or Debit
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCSW	Certified Clinical Social Worker
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology

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CEA	Carotid Endarterectomy
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CES	Cranial Electrotherapy Stimulation
CF	Conversion Factor Cystic Fibrosis
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRD	Cystic Fibrosis-Related Diabetes
CFS	Chronic Fatigue Syndrome
CGMS	Continuous Glucose Monitoring System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CID	Central Institute for the Deaf
CIF	Central Issuing Facility Common Intermediate Format
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CM	Case Management
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty

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

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

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

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

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

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

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ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FOUO	For Official Use Only
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records

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

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Acronyms And Abbreviations

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

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HSCRC	Health Services Cost Review Commission
HSWL	Health, Safety and Work-Life
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
I&OD	Infrastructure & Operations Division
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer

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IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFC	Interim Final Rule with comment
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHC	Immunohistochemistry
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRF	Inpatient Rehabilitation Facility
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System

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ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVD	In Vitro Diagnostic Ischemic Vascular Disease
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
LE ESWT	Low Energy Extracorporeal Shock Wave Therapy
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
LIS	Low Income Subsidy
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent

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LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
LVSD	Left Ventricular Systolic Dysfunction
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MAP	MYH-Associated Polyposis
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health

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MHCC	Maryland Health Care Commission
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MM	Medical Management
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMPCMHP	Maryland Multi-Payer Patient-Centered Medical Home Program
MMPP	Maryland Multi-Payer Patient
MMR	Mismatch Repair
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPC	Medical Payments Coverage
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
MS	Microsoft® Multiple Sclerosis
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSI	Microsatellite Instability
MSIE	Microsoft® Internet Explorer

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MSP	Medicare Secondary Payer
MSS	Medical Social Services
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
MYH	mutY homolog
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACHA	National Automated Clearing House Association
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCCN	National Comprehensive Cancer Network
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial

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NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLDA	Nursery and Labor/Delivery Adjustment
NLT	No Later Than
NMA	Non-Medical Attendant
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)

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OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office for Civil Rights Optical Character Recognition
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OIT	Oral Immunotherapy
OLT	Orthotopic Liver Transplantation
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OTCD	Ornithine Transcarbamylase Deficiency
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&CL	Privacy & Civil Liberties [Office]
P&T	Pharmacy And Therapeutics (Committee)

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PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAS	Privacy Act Statement
PAT	Performance Assessment Tracking
PATH Intl	Professional Association of Therapeutic Horsemanship International
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMH	Patient-Centered Medical Home
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Pelvic Congestion Syndrome Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System

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PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
PGD	Preimplantation Genetic Diagnosis
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PII	Personally Identifiable Information
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones

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POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPC-PCMH	Physician Practice Connections Patient-Centered Medical Home
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSF	Provider Specific File
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty

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PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QABA	Qualified Applied Behavior Analysis
QASP	Qualified Autism Services Practitioner
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RARC	Remittance Advice Remark Code
RBT	Registered Behavior Technician
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHA	Records Holding Area

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RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RIA	Radioimmunoassay
RM	Records Management
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROMF	Record Object Metadata File
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation Specified Authorization Staff (formerly Service Point of Contact (SPOC))
SAT	Service Assist Team
SAVR	Surgical Aortic Valve Replacement
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program

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SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SLP	Speech-Language Pathology
SMC	System Management Center
SME	Subject Matter Expert
SMHC	Supervised Mental Health Counselor
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons System of Records
SORN	System of Records Notice
SP	Special Publication
SPA	Simple Power Analysis
SPC	Special Processing Code

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SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUD	Substance Use Disorder
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVP	State Vaccine Program State Vaccine Program entity
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
T-3	TRICARE Third Generation
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAH	Total Artificial Heart
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TAVR	Transcatheter Aortic Valve Replacement
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor

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TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDR	Total Disc Replacement
TDRL	Temporary Disability Retired List
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TN	Termination Notice
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill

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TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
TP	Treatment Plan
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program

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Appendix A

Acronyms And Abbreviations

TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouses
URL	Universal Resource Locator
US	Ultrasound United States
US-CERT	United States-Computer Emergency Readiness Team
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USCYBERCOM	United States Cyber Command
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps

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Appendix A

Acronyms And Abbreviations

USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WDR	Written Determination Report
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language

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Appendix A

Acronyms And Abbreviations

ZIFT Zygote Intrafallopian Transfer

2D Two Dimensional

3D Three Dimensional

- END -

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