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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 26  
6010.58-M  
MARCH 12, 2010**

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

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

**CHANGE TITLE: OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) TECHNICAL  
CHANGES, FEBRUARY 2010**

**CONREQ: 14926**

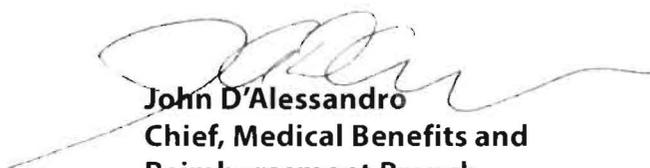
**PAGE CHANGE(S): See page 2.**

**SUMMARY OF CHANGE(S): This changes contains OPPS changes to include Active Duty Service Member (ADSM) inpatient procedures performed on an outpatient basis, changes to the observation stay policy, and the addition of new modifiers.**

**EFFECTIVE DATE: May 1, 2009, unless otherwise indicated.**

**IMPLEMENTATION DATE: Upon direction of the Contracting Officer.**

**This change is made in conjunction with Feb 2008 TOM, Change No. 18, Feb 2008 TPM, Change No. 27, and Feb 2008 TSM, Change No. 15.**

  
**John D'Alessandro  
Chief, Medical Benefits and  
Reimbursement Branch**

**ATTACHMENT(S): 64 PAGE(S)  
DISTRIBUTION: 6010.58-M**

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

**CHANGE 26**  
**6010.58-M**  
**MARCH 12, 2010**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 16, pages 1 through 4

Section 24, pages 1 and 2

**CHAPTER 5**

Section 3, pages 3 and 4

**CHAPTER 9**

Section 1, pages 3, 4, and 7

**CHAPTER 13**

Section 1, pages 3 - 6 and 9 - 13

Section 2, pages 1 - 6, 9 - 14, and 19 - 22

Section 3, pages 3 - 22, 41 - 44, 51, and 52

Section 4, pages 1 and 2

**INSERT PAGE(S)**

Section 16, pages 1 through 4

Section 24, pages 1 and 2

Section 3, pages 3 and 4

Section 1, pages 3, 4, and 7

Section 1, pages 3 - 6 and 9 - 13

Section 2, pages 1 - 6, 9 - 14, and 19 - 22

Section 3, pages 3 - 22, 41 - 44, 51, and 52

Section 4, pages 1 and 2

# Chapter 1

# Section 16

## Surgery

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)\(i\)](#), [\(c\)\(2\)\(ii\)](#), [\(c\)\(3\)\(i\)](#), [\(c\)\(3\)\(iii\)](#), and [\(c\)\(3\)\(iv\)](#)

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### 1.0 APPLICABILITY

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

### 2.0 ISSUE

How is surgery to be reimbursed?

### 3.0 POLICY

#### 3.1 Multiple Surgery And Discounting Reimbursement

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

##### 3.1.1.1 Discounting for Multiple Procedures

**3.1.1.1.1** When more than one surgical procedure code subject to discounting (see [Chapter 13, Section 3](#)) is performed during a single operative or outpatient session, TRICARE will reimburse the full payment and the beneficiary will pay the cost-share/copayment for the procedure having the highest payment rate.

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

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

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

### 3.1.1.2 Discounting for Bilateral Procedures

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

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

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

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

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

**3.1.1.2.4** The above bilateral procedures will be discounted based on the application of discounting formulas appearing in [Chapter 13, Section 3, paragraphs 3.1.5.3.6](#) and [3.1.5.3.7](#).

### 3.1.1.3 Modifiers for Discounting Terminated Surgical Procedures

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

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

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

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

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

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

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

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

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

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

## **3.2 Multiple Primary Surgeons**

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

## **3.3 Assistant Surgeons**

See [Section 17](#).

## **3.4 Pre-Operative Care**

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

## **3.5 Post-Operative Care**

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

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

subsequently administers chemotherapy services, these services are not part of the global surgery package.

### **3.6 Re-Operations For Complications**

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

### **3.7 Global Surgery For Major Surgical Procedures**

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

### **3.8 Second Opinion**

**3.8.1** Claims for patient-initiated, second-physician opinions pertaining to the medical need for surgery may be paid. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery.

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

### **3.9 In-Office Surgery**

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

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

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

## Hospital Reimbursement - Outpatient Services

Issue Date: March 10, 2000

Authority: [32 CFR 199.4\(a\)\(3\)](#) and [\(a\)\(5\)](#)

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### 1.0 APPLICABILITY

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

**1.2** Hospital reimbursement - outpatient services for all services prior to implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of the Outpatient Prospective Payment System (OPPS), and thereafter, for services not otherwise reimbursed under hospital OPPS.

### 2.0 POLICY

**2.1** When professional services or diagnostic tests (e.g., laboratory, radiology, electrocardiogram (EKG), electroencephalogram (EEG)) that have CHAMPUS Maximum Allowable Charge (CMAC) pricing ([Chapter 5, Section 3](#)) are billed, the claim must have the appropriate Current Procedural Terminology (CPT) coding and modifiers, if necessary. Otherwise, the service shall be denied. If only the technical component is provided by the hospital, the technical component of the appropriate CMAC shall be used.

**2.2** For all other services, payment shall be made based on allowable charges when the claim has Healthcare Common Procedure Coding System (HCPCS) (Level I, II, III) coding information (these may include ambulance, Durable Medical Equipment (DME) and supplies, drugs administered other than oral method, and oxygen and related supplies). For claims development, see TRICARE Operations Manual (TOM), [Chapter 8, Section 6](#). Other services without allowable charges, such as facility charges, shall be paid as billed. For reimbursing drugs administered other than oral method, see [Section 15, paragraph 3.3.1](#).

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

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

Chapter 1, Section 24

Hospital Reimbursement - Outpatient Services

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**2.3** When coding information is provided, outpatient hospital services including emergency and clinical services, clinical laboratory services, rehabilitation therapy, venipuncture, and radiology services are paid using existing allowable charges. Such services are reimbursed under the allowable charge methodology that would also include the CMAC rates. In addition, venipuncture services provided on an outpatient basis by institutional providers other than hospitals are also paid on this basis. Professional services billed on a CMS 1450 UB-04 will be paid at the professional CMAC if billed with the professional service revenue code and enough information to identify the rendering provider.

**2.4** Freestanding Ambulatory Surgical Center (ASC) services are to be reimbursed in accordance with [Chapter 9, Section 1](#).

**Note:** All hospital based ASC claims that are submitted to be paid under OPPS must be submitted with a Type Of Bill (TOB) 13X. If a claim is submitted to be paid with a TOB 83X the claim will be denied.

**2.5** Outpatient hospital services including professional services, provided in the state of Maryland are paid at the rates established by the Maryland Health Services Cost Review Commission (HSCRC). Since hospitals are required to bill these rates, reimbursement for these services is to be based on the billed charge.

**2.6** Surgical outpatient procedures which are not otherwise reimbursed under the hospital OPPS will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under OPPS for services rendered on or after implementation of OPPS. Refer to [Section 16, paragraph 3.1.1.1 through 3.1.1.3](#) and [Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3](#) for further detail.

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

**2.8** Effective December 1, 2009, hospital outpatient services provided in a CAH, including ambulatory surgery services, shall be paid under the reasonable cost method, reference [Chapter 15, Section 1](#).

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

### Chapter 5, Section 3

#### CHAMPUS Maximum Allowable Charges (CMAC)

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

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

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

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

#### **3.6.2 Site of Service**

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

##### **3.6.2.1 Categories**

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

**3.6.2.2 Linking The Site Of Service With The Payment Category**

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

**3.6.2.3 Payment Of 0510 And 0760 Series Revenue Codes**

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

**3.6.2.4 Reimbursement Hierarchy For Procedures Paid Outside The OPPS**

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

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

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

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

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

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

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

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

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

### Chapter 9, Section 1

#### Ambulatory Surgical Center (ASC) Reimbursement

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

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

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

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

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

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

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

## **2.1.5 Payments**

### **2.1.5.1 General**

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

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

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

### 2.1.5.3 Multiple and Terminated Procedures

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

#### 2.1.5.3.1 Discounting for Multiple Surgical Procedures

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

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

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

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

## 2.5 Claims for Ambulatory Surgery

### 2.5.1 Claim Forms

Claims for facility charges must be submitted on a Centers for Medicare and Medicaid Services (CMS) 1450 UB-04. Claims for professional charges may be submitted on either a CMS 1450 UB-04 or a CMS 1500 (08/2005) claim form. The preferred form is the CMS 1500 (08/2005). When professional services are billed on a CMS 1450 UB-04, the information on the CMS 1450 UB-04 should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

### 2.5.2 Claim Data

**2.5.2.1 Billing Data.** The claim must identify all procedures which were performed (by CPT-4 or HCPCS code). The facility claim shall be submitted on the CMS 1450 UB-04, the procedure code will be shown in Form Locator (FL) 44.

**Note:** Claims from ASCs must be **submitted** on the CMS 1450 UB-04 claim form. Claims not submitted on the appropriate claim form will be denied.

**2.5.2.2 TRICARE Encounter Data (TED).** All ambulatory surgery services are to be reported on the TED using the appropriate CPT-4 code. The only exception is services which are billed using a HCPCS code and for which no CPT-4 code exists. These services are to be reported on the TED using one of the codes in the TRICARE Systems Manual (TSM), [Chapter 2, Addendum N](#).

## 2.6 Wage Index Changes

If, during the year, Medicare revises any of the wage indexes used for ambulatory surgery reimbursement, such changes will not be incorporated into the TRICARE payment rates until the next routine update. These changes will not be incorporated regardless of the reason Medicare revised the wage index.

## 2.7 Subsequent Hospital Admissions

If a beneficiary is admitted to a hospital subject to the DRG-based payment system as a result of complications, etc. of ambulatory surgery, the ambulatory surgery procedures are to be billed and reimbursed separately from the hospital inpatient services. The same rules applicable to ER services are to be followed.

## 2.8 Cost-Shares For Ambulatory Surgery Procedures

All surgical procedures performed in an outpatient setting shall be cost-shared at the ASC cost-sharing levels. Refer to [Chapter 2, Section 1, paragraph 1.3.3.7](#).

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

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

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

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

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

### 3.4 Applicability and Scope of Coverage

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

#### 3.4.1 Provider Categories

##### 3.4.1.1 Providers Included In OPSS:

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

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

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

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

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

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

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

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

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

**3.4.1.1.4.1** Currently under Medicare, small rural and SCHs in rural areas are subject to Transitional Outpatient Payments (TOPs). These TOPs will expire on December 31, 2009.

**3.4.1.1.4.2** TRICARE will delay implementation of its OPPS for small rural hospitals with 100 or fewer beds and rural SCHs with 100 or fewer beds until January 1, 2010.

**3.4.1.2 Providers Excluded From OPPS:**

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

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

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

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

**3.4.1.2.5** Specialty care providers to include:

- Cancer and children's hospitals
- Freestanding Ambulatory Surgery Centers (ASCs)
- Freestanding PHPs that offer psych and substance use treatments, and Substance Use Disorder Rehabilitation Facilities (SUDRFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Home Health Agencies (HHAs)
- Hospice programs
- Community Mental Health Centers (CMHCs)

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

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

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

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

#### 3.4.2 Scope of Services

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

**3.4.2.1.1** Physician services.

**3.4.2.1.2** NP and CNS services.

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

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

**3.4.2.1.5** Services of qualified psychologists.

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

**3.4.2.1.7** Services of an anesthetist.

**3.4.2.1.8** Screening and diagnostic mammographies.

**3.4.2.1.9** Influenza and pneumococcal pneumonia vaccines.

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

**3.4.2.1.10** Clinical diagnostic laboratory services.

**3.4.2.1.11** Take home surgical dressings.

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

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

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

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

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

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

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

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

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

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

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

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

**3.4.2.2.4** Costs of teaching physicians.

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

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

- Clinical Homogeneity. The definition of each APC group should be “clinically meaningful”; that is, the procedures or services included within the APC group relate generally to a common organ system or etiology, have the same degree of extensiveness, and utilize the same method of treatment - for example, surgical, endoscopic, etc.
- Provider Concentration. The degree of provider concentration associated with the individual services that comprise the APC is considered. If a particular service is offered only in a limited number of hospitals, then the impact of payment for the services is concentrated in a subset of hospitals. Therefore, it is important to have an accurate payment level for services with a high degree of provider concentration. Conversely, the accuracy of payment levels for services that are routinely offered by most hospitals does not bias the payment system against any subset of hospitals.
- Frequency of Service. Unless there is a high degree of provider concentration, creating separate APC groups for services that are infrequently performed is avoided. Since it is difficult to establish reliable payment rates for low volume APC groups, HCPCS codes are assigned to an APC that is most similar in terms of resource use and clinical coherence.

### 3.6 Basic Reimbursement Methodology

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

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

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

**3.6.3** Each APC weight represents the median hospital cost of the services included in the APC relative to the median hospital cost of services included in APC 0601, Mid-Level Clinic Visits. The APC weights are scaled to APC 0601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Note:** The questionable list of covered services may be different among the contractors. Providers will need to contact the contractor directly concerning these differences.

### **3.9 PRICER Program**

**3.9.1** The APC PRICER will be straightforward in that the site-of-service wage index will be used to wage adjust the payment rate for the particular APC HCPCS Level I and II code (e.g., a HCPCS code with a designated Status Indicator (SI) of **S**, **T**, **V**, or **X**) reported off of the hospital outpatient claim. The PRICER will also apply discounting for multiple surgical procedures performed during a single operative session and outlier payments for extraordinarily expensive cases. TMA will provide

the contractor's a common TRICARE PRICER to include quarterly updates. The contractors will be required to replace the existing PRICER with the updated PRICER within 21 days of receipt.

**Note:** Claims received with service dates on or after the OPPS quarterly effective dates (i.e., January 1, April 1, July 1 and October 1 of each calendar year) but prior to 21 days from receipt of either the OPPS OCE or PRICER update cartridge may be considered excluded claims as defined by the TRICARE Operations Manual (TOM), [Chapter 1, Section 3, paragraph 1.5.2](#).

**3.9.2** The contractors shall provide 3M with those pricing files to maintain and update the TRICARE OPPS PRICER within five weeks prior to the quarterly update. For example, statewide prevailings for ambulance services and state specific non-professional component birthing center rates. Appropriate deductible, cost-sharing/copayment amounts and catastrophic caps limitations will be applied outside the PRICER based on the eligibility status of the TRICARE beneficiary at the time the outpatient services were rendered.

### 3.10 Geographical Wage Adjustments

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

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

An OPD, remote location hospital, satellite facility, or provider-based entity must be either created or acquired by a main provider (hospital) for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial/administrative control of the main provider, in order to qualify for payment under the OPPS. The CMS will retain sole responsibility for determining provider-based status under the OPPS.

### 3.12 Implementing Instructions

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

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

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## Chapter 13, Section 1

### General

#### IMPLEMENTING INSTRUCTIONS/SERVICES (CONTINUED)

##### ADDENDA

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

### 3.13 OPPS Data Elements Available On TMA's Web Site

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

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

### 4.0 EFFECTIVE DATE

May 1, 2009.

- END -



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

Issue Date: July 27, 2005

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

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### 1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

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

### 3.0 POLICY

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

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

### 3.2 Packaging of Services Under APC Groups

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

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

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### Chapter 13, Section 2

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

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

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

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

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

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

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

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

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

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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 **\$60**, 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.

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

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

#### **3.2.2.3** Corneal tissue acquisition costs.

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

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

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

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

#### **3.2.2.5** Reporting Requirements for Device Dependent Procedures.

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

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

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

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

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

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

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

**FIGURE 13.2-1 CALENDAR YEAR (CY) 2009 DEVICE-DEPENDENT APCS**

APC	SI	APC TITLE
0039	S	Level I Implantation of Neurostimulator
0040	S	Percutaneous Implantation of Neurostimulator Electrodes
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes
0082	T	Coronary or Non Coronary Atherectomy
0083	T	Coronary or Non Coronary Angioplasty and Percutaneous Valvuloplasty
0084	S	Level I Electrophysiologic Procedures
0085	T	Level II Electrophysiologic Procedures
0086	T	Level III Electrophysiologic Procedures
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes
0090	T	Insertion/Replacement of Pacemaker Pulse Generator
0104	T	Transcatheter Placement of Intracoronary Stents
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes
0107	T	Insertion of Cardioverter-Defibrillator
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads
0115	T	Cannula/Access Device Procedures
<b>0168</b>	<b>T</b>	<b>Level II Urethral Procedures</b>
0202	T	Level VII Female Reproductive Procedures
0222	S	Level II Implantation of Neurostimulator
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve
0227	T	Implantation of Drug Infusion Device
0229	T	Transcatheter Placement of Intravascular Shunts
0259	T	Level VII ENT Procedures
0293	T	Level V Anterior Segment Eye Procedures
0315	S	Level III Implantation of Neurostimulator
0384	T	GI Procedures with Stents
0385	S	Level I Prosthetic Urological Procedures
0386	S	Level II Prosthetic Urological Procedures
0418	T	Insertion of Left Ventricular Pacing Elect.
0425	T	Level II Arthroplasty or Implementation with Prosthesis
0427	T	Level II Tube or Catheter Changes or Repositioning
0622	T	Level II Vascular Access Procedures
0623	T	Level III Vascular Access Procedures
0648	T	Level IV Breast Surgery
0652	T	Insertion of Intraperitoneal and Pleural Catheters
0653	T	Vascular Reconstruction/Fistula Repair with Device
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0674	T	Prostate Cryoblation
0680	S	Insertion of Patient Activated Event Recorders
0681	T	Knee Arthroplasty

**3.2.2.6** Changes to Packaged Services for CY 2008 OPPS. Effective for services furnished on or after January 1, 2008, seven additional categories of HCPCS codes describing ancillary and supportive services have been packaged either conditionally or unconditionally, and four new composited APCs have been created.

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

- The payment for a HCPCS code with a SI of **N** is unconditionally packaged so that payment is always incorporated into the payments for the separately paid services with which it is reported.
- Payment for a HCPCS code with a SI of **Q** that is "**STVX**-packaged" is packaged unless the HCPCS code is not reported on the same day with a service that has a SI of **S**, **T**, **V**, or **X**, in which case it would be paid separately.
- Payment for a HCPCS code with a SI of "**T** packaged" is packaged unless the HCPCS code is not reported on the same day with a service that has a SI of **T**, in which case it would be paid separately.
- Payment for a HCPCS code with a SI of **Q** that is assigned to a composite APC is packaged into the payment for the composite APC when the criteria for payment of the composite APC are met.

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

**3.2.2.6.2.1** Guidance services.

**3.2.2.6.2.2** Imaging processing services.

**3.2.2.6.2.3** Intraoperative services.

**3.2.2.6.2.4** Imaging supervision and interpretation services.

- Certain imaging supervision and interpretation services are always packaged.
- Others are packaged when the service appears on the same claim with a procedural HCPCS code that has been assigned SI **T**. These codes are **T** packaged codes.

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

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

**FIGURE 13.2-2 GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES UPON WHICH THE COMPOSITE APC 8000 IS BASED**

CODES USED IN COMBINATION: AT LEAST ONE IN GROUP A AND ONE IN GROUP B	CY 2009		
	HCPCS CODE	FINAL SINGLE CODE APC	FINAL SI (COMPOSITE)
Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	93620	0085	Q3
<b>GROUP B</b>			
Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	93650	0086	Q3
Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination	93651	0086	Q3
Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia	93652	0086	Q3

**3.2.2.6.3.1.2.2** The OCE will recognize when the criteria for payment of the composite APC are met and will assign the composite APC instead of the single procedure APCs as currently occurs. The Pricer will make a single payment for the composite APC that will encompass the program payment for the code in Group A and code in Group B, and any other codes reported in Groups A or B, as well as the packaged services furnished on the same date of services.

**3.2.2.6.3.1.2.3** The composite APC would have a SI of **T** so that payment for other procedures also assigned to SI **T** with lower payment rates would be reduced by 50% when furnished on the same date of service as the composite services.

**3.2.2.6.3.1.2.4** Separate payment will continue for other separately paid services that are not reported under the codes in Groups A and B (such as chest x-rays and electrocardiograms).

**3.2.2.6.3.1.2.5** Also where a service in Group A is furnished on a date of service that is different from the date of service for a code in Group B for the same beneficiary, payments would be made under the single procedure APCs and the composite APC would not apply.

**3.2.2.6.3.1.3** Multiple Imaging Composite APCs (8004, 8005, 8006, 8007, and 8008)

**3.2.2.6.3.1.3.1** Under current OPPS policy, hospitals receive a full APC payment for each imaging service on a claim, regardless of how many procedures are performed during a single session using the same imaging modality or whether the procedures are performed on contiguous body areas.

**3.2.2.6.3.1.3.2** In CY 2009 will now utilize the three OPPS imaging families with contrast and without contrast in creation of five multiple imaging composite APCs:

- 8004 (Ultrasound (US) Composite)

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- 8005 (Computerized Tomography (CT) and Computerized Tomography Angiography (CTA) without Contrast Composite)
- 8006 (CT and CTA with Contrast Composite)
- 8007 (Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) without Contrast Composite)
- 8008 (MRI an MRA with Contrast Composite)

**3.2.2.6.3.1.3.3** The composite APCs have SIs of S signifying that payment for the APC is not reduced when it appears on the same claim with other significant procedures.

**3.2.2.6.3.1.3.4** One composite APC payment will be provided each time a hospital bills more than one procedure described by the HCPCS codes in an OPPS imaging family displayed in [Figure 13.2-3](#), on a single date of services.

**3.2.2.6.3.1.3.5** If the hospital performs a procedure without contrast during the same session as a least one other procedure with contrast using the same imaging modality, then the hospital will receive payment for the “with contrast” composite APC.

**3.2.2.6.3.1.3.6** A single imaging procedure, or imaging procedures reported with HCPCS codes assigned to different OPPS imaging families, will be paid according to the standard OPPS methodology through the standard (sole service) imaging APCs to which they are assigned in CY 2009.

**3.2.2.6.3.1.3.7** Hospitals will continue to use the same HCPCS codes to report imaging procedures, and the OCE will determine when combinations of imaging procedures qualify for composite APC payment or map to standard APCs for payment.

**3.2.2.6.3.1.3.8** Single payment will be made for those imaging procedures that qualify for composite APC payment, as well as any packaged services furnished on the same date of service.

**FIGURE 13.2-3 OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS - FINAL CY 2009**

FAMILY 1 - ULTRASOUND (US)	
APC 8004 (COMPOSITE)	APPROXIMATE APC MEDIAN COST = \$188
76604	US exam, chest.
76700	US exam, abdom, complete
76705	Echo exam of abdomen.
76770	US exam abdo back wall, comp.
76775	US exam abdo back wall, lim.
76776	US exam k transpl w/Doppler
76831	Echo exam, uterus.
76856	US exam, pelvic, complete.
76857	US exam, pelvic.
76870	US exam, scrotum.

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**FIGURE 13.2-3 OPPTS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS - FINAL CY 2009 (CONTINUED)**

<b>FAMILY 2 – CT AND CTA WITH AND WITHOUT CONTRAST</b>	
<b>APC 8005 (WITHOUT CONTRAST COMPOSITE)</b>	<b>APPROXIMATE APC MEDIAN COST = \$406</b>
0067T	CT colonography; dex
70450	CT head/brain w/o dye.
70480	CT orbit/ear/fossa w/o dye.
70486	CT maxillofacial w/o dye.
70490	CT soft tissue neck w/o dye.
71250	CT thorax w/o dye.
72125	CT neck spine w/o dye.
72128	CT chest spine w/o dye.
72131	CT lumbar spine w/o dye.
72192	CT pelvis w/o dye.
73200	CT upper extremity w/o dye.
73700	CT lower extremity w/o dye.
74150	CT abdomen w/o dye.
<b>APC 8006 (WITH CONTRAST COMPOSITE)</b>	<b>APPROXIMATE APC MEDIAN COST = \$621</b>
70487	CT maxillofacial w/dye.
70460	CT head/brain w/dye.
70470	CT head/brain w/o & w/dye.
70481	CT orbit/ear/fossa w/dye.
70482	CT orbit/ear/fossa w/o & w/dye.
70488	CT maxillofacial w/o & w/dye.
70491	CT soft tissue neck w/dye.
70492	CT sft tsue nck w/o & w/dye.
70496	CT angiography, head.
70498	CT angiography, neck.
71260	CT thorax w/dye.
71270	CT thorax w/o & w/dye.
71275	CT angiography, chest.
72126	CT neck spine w/dye.
72127	CT neck spine w/o & w/dye.
72129	CT chest spine w/dye.
72130	CT chest spine w/o & w/dye.
72132	CT lumbar spine w/dye.
72133	CT lumbar spine w/o & w/dye.
72191	CT angiograph pelv w/o & w/dye.
72193	CT pelvis w/dye.
72194	CT pelvis w/o & w/dye.
73201	CT upper extremity w/dye.

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**FIGURE 13.2-3 OPPTS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS - FINAL CY 2009 (CONTINUED)**

73202	CT upper extremity w/o & w/dye.
73206	CT angio up extrm w/o & w/dye.
73701	CT lower extremity w/dye.
73702	CT lwr extremity w/o & w/dye.
73706	CT angio lwr extr w/o & w/dye.
74160	CT abdomen w/dye.
74170	CT abdomen w/o & w/dye.
74175	CT angio abdomen w/o & w/dye.
75635	CT angio abdominal arteries.
<b>FAMILY 3 – MRI AND MRA WITH AND WITHOUT CONTRAST</b>	
<b>APC 8007 (WITHOUT CONTRAST COMPOSITE)</b>	<b>APPROXIMATE APC MEDIAN COST = \$695</b>
70336	Magnetic image, jaw joint.
70540	MRI orbit/face/neck w/o dye.
70544	MR angiography head w/o dye.
70547	MR angiography neck w/o dye.
70551	MRI brain w/o dye.
70554	FMRI brain by tech.
71550	MRI chest w/o dye.
72141	MRI neck spine w/o dye.
72146	MRI chest spine w/o dye.
72148	MRI Lumbar spine w/o dye.
72195	MRI Pelvis w/o dye.
73218	MRI Upper extremity w/o dye.
73221	MRI joint up extremity w/o dye.
73718	MRI lower extremity w/o dye.
73721	MRI jnt of lwr extre w/0 dye.
74181	MRI abdomen w/o dye.
75557	Cardiac mri for morph.
75599	Cardiac mri w/stress img.
C8901	MRA w/o cont. abd.
C8904	MRI w/o cont. breast, uni.
C8907	MRI w/o cont. breast, bi.
C8910	MRA w/o cont. chest
C8913	MRA w/o cont. lwr ext.
C8919	MRA w/o cont. pelvis.
<b>APC 8008 (WITH CONTRAST COMPOSITE)</b>	<b>APPROXIMATE APC MEDIAN COST = \$968</b>
70549	MR angiograph neck w/o & w/dye.
70542	MRI orbit/face/neck w/dye.
70543	MRI orbit/fac/nck w/o & w/dye.

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**FIGURE 13.2-3 OPPTS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS - FINAL CY 2009 (CONTINUED)**

70545	MR angiography head w/dye.
70546	MR angiograph head w/o & w/dye.
70548	MR angiography neck w/dye.
70552	MRI brain w/dye.
70553	MRI brain w/o & w/dye.
71551	MRI chest w/dye.
71552	MRI chest w/o & w/dye.
72142	MRI neck spine w/dye.
72147	MRI chest spine w/dye.
72149	MRI lumbar spine w/dye.
72156	MRI neck spine w/o & w/dye.
72157	MRI chest spine w/o & w/dye.
72158	MRI lumbar spine w/o & w/dye.
72196	MRI pelvis w/dye.
72197	MRI pelvis w/o & w/dye.
73219	MRI upper extremity w/dye.
73220	MRI upper extremity w/o & w/dye.
73222	MRI joint upr extreme w/dye.
73223	MRI joint upr extr w/o & w/dye.
73719	MRI lower extremity w/dye.
73720	MRI lwr extremity w/o & w/dye.
73722	MRI joint of lwr extr w/dye.
73723	MRI joint lwr extr w/o & w/dye.
74182	MRI abdomen w/dye.
74183	MRI abdomen w/o & w/dye.
75561	Cardiac mri for morph w/dye.
75563	Cardiac mri w/stress img & dye.
C8900	MRA w/cont, abd.
C8902	MRA w/o fol w/cont, abd.
C8903	MRI w/cont, breast, uni.
C8905	MRI w/o fol w/cont, brst, un.
C8906	MRI w/cont, breast, bi.
C8908	MRI w/o fol w/cont, breast.
C8909	MRA w/cont, chest.
C8911	MRA w/o fol w/cont, chest.
C8912	MRA w/cont, lwr ext.
C8914	MRA w/o fol w/cont, lwr ext.
C8918	MRA w/cont, pelvis.
C8920	MRA w/o fol w/cont, pelvis

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**3.2.2.6.3.2** The TRICARE OCE logic will determine the assignment of the composite APCs for payment.

**3.2.2.6.3.3** Figure 13.2-4 provides the circumstances, effective January 1, 2008, under which a single composite APC payment will be made for multiple services that meet the criteria for payment through a composite APC. Where the criteria are not met, payment will occur under the usual associated non-composite APC to which the code is assigned.

**FIGURE 13.2-4 COMPOSITE APCS AND CRITERIA FOR COMPOSITE PAYMENT**

COMPOSITE APC	COMPOSITE APC TITLE	CRITERIA FOR COMPOSITE PAYMENT
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT* code 93619 or 93620 and at least one unit of CPT* code 93650, 93651, or 93652 on the same date of service.
8001	Low Dose Rate Prostate Brachytherapy Composite	One or more units of CPT* codes 55875 and 77778 on the same date of service.
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed— On the same day as HCPCS code G0379; or On the same day or the day after CPT* codes 99205 or 99215 and; 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed— On the same date of service as HCPCS code G0378; or On the date of service after CPT* 99284, 99285, or 99291 and; 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378.
0034	Mental Health Services Composite	Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0173.

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**3.3 Additional Payments Under The OPPTS**

**3.3.1** 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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Payment APC (0172) 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 13.2-6](#)). All other PHP services rendered on the same day will be packaged into the PHP APCs (0172 and 0173). All PHP lines will be denied if there are less than three codes/service appearing on the claim.

**FIGURE 13.2-6 PHP FOR CY 2008**

PHP LIST A	PHP LIST B	
90818	90801	90846
90819	90802	90847
90821	90816	90865
90822	90817	96101
90826	90818	96102
90827	90819	96103
90828	90821	96116
90829	90822	96118
90845	90823	96119
90846	90824	96120
90847	90826	G0129
90865	90827	G0176
G0410	90828	G0177
G0411	90829	G0410
	90845	G0411

**3.7.4.4.5** In order to assign the partial hospitalization APC to one of the line items (i.e., one of listed services/codes in [Figure 13.2-5](#)) the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC. All other partial hospital services on the same day are packaged; (i.e., the SI is changed from **Q** to **N**.) Partial hospitalization services with SI **E** (items or services that are not covered by TRICARE) or **B** (more appropriate code required for TRICARE OPPS) are not packaged and are ignored in the PHP processing.

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

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

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

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

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**FIGURE 13.2-7 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 13.2-8 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.

**3.7.5** 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 (0173), 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.

**3.7.6** 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 Observations For Non-Maternity Conditions**

**3.8.1.1** Effective for dates of service on or after January 1, 2008, no separate payment will be made for observation services reported with HCPCS code G0378. Instead these hourly observation services will be assigned the SI of **N**, signifying that payment is always packaged.

**3.8.1.2** However, in certain circumstances when observation care is provided as an integral part of a patient's extended encounter of care, payment may be made for the entire care encounter through one of two composite APC when certain criteria are met.

**3.8.1.2.1** APC 8002 (Level I Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration (eight or more hours).

**3.8.1.2.2** APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration.

**3.8.1.2.3** There is no limitation on diagnosis for payment of these composite APCs; however, composite payment will not be made when observation services are reported in association with a surgical procedure (SI of **T**) or the hours of observation care reported are less than eight. Refer to [Figure 13.2-9](#) for specific criteria for composite payment:

**FIGURE 13.2-9 CRITERIA FOR PAYMENT OF EXTENDED ASSESSMENT AND MANAGEMENT COMPOSITE APCS**

COMPOSITE APC	COMPOSITE APC TITLE	CRITERIA FOR COMPOSITE PAYMENT
8002	Level I Extended Assessment and Management Composite	<ol style="list-style-type: none"> <li>Eight or more units of HCPCS code G0378 are billed— On the same day as HCPCS code G0379; or On the same day or the day after CPT* codes 99205 or 99215; and</li> <li>There is no service with SI=<b>T</b> on the claim on the same date of service or one day earlier than G0378.</li> </ol>
8003	Level II Extended Assessment and Management Composite	<ol style="list-style-type: none"> <li>Eight or more units of HCPCS code G0378 are billed on the same date of service or the date of service after CPT* codes 99284, 99285, or 99291; and</li> <li>There is no service with SI=<b>T</b> on the claim on the same date of service or one day earlier than G0378.</li> </ol>

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**3.8.1.2.4** The beneficiary must also be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

**3.8.1.3** The OCE will evaluate every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the OCE, in conjunction with the TRICARE OPPS Pricer, will determine the appropriate SI, APC, and payment for every code on the claim.

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

**3.8.1.4.1** Hospitals should report G0379 when observation services are the result of a direct admission to observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or surgical procedure (T SI procedure) on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community.

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

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

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

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

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

**3.8.1.4.3.1** Both HCPCS codes G0378 (Hospital observation services, per hour) and G0379 (Direct admission of patient for hospital observation care) are reported with the same date of service.

**3.8.1.4.3.2** A service with a SI of **T** or **V** or Critical Care (APC 0617) is not provided on the same date of service as HCPCS code G0379.

**3.8.1.4.3.3** If either of the above criteria (i.e., paragraphs 3.8.1.4.3.1 or 3.8.1.4.3.2) is not met, HCPCS code G0379 will be assigned a SI of **N** and will be packaged into payment for other separately payable services provided in the same encounter.

**3.8.1.4.3.4** The composite APC will apply, regardless of the patient's particular clinical condition, if the hours of observation services (HCPCS code G0378) are greater or equal to eight and billed on the same date as HCPCS code G0379 and there is not a **T** SI procedure on the same date or day before the date of HCPCS code G0378.

**3.8.1.4.3.5** If the composite is not applicable, payment for HCPCS code G0379 may be made under APC 0604. In general, this would occur when the units of observation reported under HCPCS code G0378 are less than eight and no services with a SI of **T** or **V** or Critical Care (APC 0617) were provided on the same day of service as HCPCS code G0379.

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

**3.8.2.1** Maternity observation stays will continue to be paid separately under TRICARE APC T0002 using HCPCS code G0378 (Hospital observation services by hour) if the following criteria are met:

**3.8.2.1.1** The maternity observation claim must have a maternity diagnosis as Principal Diagnosis (PDX) or Reason Visit Diagnosis (VRDX). Refer to [Figure 13.2-10](#) for listing of maternity diagnoses.

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

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

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

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Prospective Payment Methodology

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

REVENUE CODE	DESCRIPTION
0391	Blood Administration (e.g., transfusions)
0399	Other Blood Storage and Processing
0621	Supplies Incident to Radiology
0622	Supplies Incident to Other Diagnostic
0623	Surgical Dressings
0624	Investigational Device (IDE)
0631	Single Source
0632	Multiple
0633	Restrictive Prescription
0637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic COMA)
0700	Cast Room
0709	Other Cast Room
0710	Recovery Room
0719	Other Recovery Room
0720	Labor Room
0721	Labor
0762	Observation Room
0770	General Classification
0771	Vaccine Administration

**3.1.2.1.2.4.1** Some instructions have been issued that require that specific revenue codes be billed with certain HCPCS codes, such as specific revenue codes that must be used when billing for devices that qualify for pass-through payments.

**Note:** If the revenue code is not listed in [Figure 13.3-1](#), refer to the TRICARE Systems Manual (TSM), [Chapter 2, Addendum N](#), for reporting requirements.

**3.1.2.1.2.4.2** Where specific instructions have not been issued, contractors should advise hospitals to report charges under the revenue code that would result in the charges being assigned to the same cost center to which the cost of those services were assigned in the cost report.

**Example:** Operating room, treatment room, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, casts and splints, and donor tissue, bone, and organ charges were used in calculating surgical procedure costs. The charges for items such as medical and surgical supplies, drugs and observation were used in estimating medical visit costs.

**3.1.2.1.2.5** Costs are standardized for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the current hospital Inpatient Prospective Payment System (IPPS) wage index. Sixty percent (60%) is used to represent the estimated portion of costs attributable, on average, to labor.

**3.1.2.1.2.6** Standardized labor related cost and the nonlabor-related cost component for each billed item are summed to derive the total standardized cost for each procedure or medical visit.

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

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

**3.1.2.1.2.9** Relative payment weights are calculated for each APC, by dividing the median cost of each APC by the median cost for APC 00606 (mid-level clinic visit), Outpatient Prospective Payment System (OPPS) weights are listed on TMA's OPPS web site at <http://www.tricare.mil/opps>.

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

### **3.1.2.2 Conversion Factor Update**

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

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

**3.1.2.2.3** The market basket increase update factor of 3.6% for CY 2009, the required wage index budget neutrality adjustment of approximately 1.0013, and the adjustment of 0.02% of projected OPPS spending for the difference in the pass-through set aside resulted in a full market basket conversion factor for CY 2009 of \$66.059.

### **3.1.3 Payment Status Indicators (SIs)**

A payment SI is provided for every code in the HCPCS to identify how the service or procedure described by the code would be paid under the hospital OPPS; i.e., it indicates if a service represented by a HCPCS code is payable under the OPPS or another payment system, and also which particular OPPS payment policies apply. One, and only one, SI is assigned to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same SI as the APC to which it is assigned. The following are the payment SIs and descriptions of the particular services each indicator identifies:

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

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

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

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

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**3.1.3.5 F** to indicate acquisition of corneal tissue, which is paid on an allowable charge basis (i.e., paid based on the CMAC reimbursement system or statewide prevalings) and certain Certified Registered Nurse Anesthetist (CRNA) services and hepatitis B vaccines that are paid on an allowable charge basis.

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

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

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

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

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

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

**3.1.3.12 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**. In all other circumstances, payment is made through a separate APC payment.

**3.1.3.13 Q2** to indicate APC payment if billed on the same date of service as a HCPCS code assigned SI of **T**. In all other circumstances, payment is made through a separate APC payment.

**3.1.3.14 Q3** to indicate composite APC payment based on OPSS composite specific payment criteria. Payment is packaged into single payment for specific combinations of service. In all circumstances, payment is made through a separate APC payment for those services.

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

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

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

**3.1.3.17 T** to indicate surgical services for which payment is allowed under the hospital OPSS. Services with this payment indicator are the only services to which the multiple procedure payment reduction applies.

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

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

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

**3.1.3.21 X** to indicate an ancillary service for which payment is allowed under the hospital OPPS.

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

**3.1.3.23 TB** to indicate TRICARE reimbursement not allowed for CPT/HCPCS code submitted.

**Note:** The system payment logic looks to the SIs attached to the HCPCS codes and APCs for direction in the processing of the claim. A SI, as well as an APC, must be assigned so that payment can be made for the service identified by the new code. The SIs identified for each HCPCS code and each APC listed on TMA's OPPS web site at <http://www.tricare.mil/opps>.

### 3.1.4 Calculating TRICARE Payment Amount

**3.1.4.1** The national APC payment rate that is calculated for each APC group is the basis for determining the total payment (subject to wage-index adjustment) the hospital will receive from the beneficiary and the TRICARE program. (Refer to TMA's OPPS web site at <http://www.tricare.mil/opps> for national APC payment rates.)

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

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

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

**3.1.4.4.1** Apply the appropriate wage index adjustment to the national payment rate that is set annually for each APC group. (Refer to the OPPS Provider File with Wage Indexes on TMA's OPPS home page at <http://www.tricare.mil/opps> for annual **Diagnosis** Related Group (DRG) wage indexes used in the payment of hospital outpatient claims, effective January 1 of each year.)

**3.1.4.4.2** Multiply the wage-adjusted APC payment rate by the OPPS rural adjustment (1.071) if the provider is a Sole Community Hospital (SCH) in a rural area **with 100 or more beds. Effective January 1, 2010, the OPPS rural adjustment will apply to all SCHs in rural areas.**

**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

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to [Chapter 2, Addendum A](#) for applicable deductible and/or cost-sharing/copayment amounts for Hospital Outpatient Departments (HOPDs) and Ambulatory Surgery Centers (ASCs).

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

**Example 1:** Assume that the wage-adjusted rate for an APC is \$400; the beneficiary receiving the services is an Active Duty Family Member (ADFM) enrolled under Prime, and as such, is not subject to any deductibles or copayments.

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

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

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

**Example 2:** Assume that the wage-adjusted rate for an APC is \$400 and the beneficiary receiving the outpatient services is a Prime retiree family member subject to a \$12 copayment. Deductibles are not applied under the Prime program.

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

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

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

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

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

- Subtract the standard ADFM cost-share (i.e., 20% of the allowable charge) from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

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

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

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

### **3.1.5 Adjustments to APC Payment Amounts**

#### **3.1.5.1 Adjustment for Area Wage Differences**

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

**3.1.5.1.2** The OPSS will use the same wage index changes as the TRICARE DRG-based payment system, except the effective date for the changes will be January 1 of each year instead of October 1 (refer to the OPSS Provider File with Wage Indexes on TMA's OPSS home page at <http://www.tricare.mil/opps>).

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

**3.1.5.1.4** Sixty percent (60%) of the hospital's outpatient department costs are recognized as labor-related costs that would be standardized for geographic wage differences. This is a reasonable estimate of outpatient costs attributable to labor, as it fell between the hospital DRG operating cost labor factor of 71.1% and the ASC labor factor of 34.45%, and is close to the labor-related costs under the inpatient DRG payment system attributed directly to wages, salaries and employee benefits (61.4%).

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

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

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

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

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

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

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

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

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

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

### 3.1.5.2 Discounting of Surgical and Terminating Procedures

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

**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.

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**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).

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

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

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

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

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

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

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

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

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

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

FIGURE 13.3-3 APPLICATION OF DISCOUNTING FORMULAS

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

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

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

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

3.1.5.4 Multiple discounting will not be applied to the following CPT<sup>1</sup> codes for venipuncture, fetal monitoring and collection of blood specimens: 36400 - 36416, 36591, 36592, 59020, 59025, and 59050-59051.

3.1.5.5 Outlier Payments

An additional payment is provided for outpatient services for which a hospital's charges, adjusted to cost, exceed the sum of the wage-adjusted APC rate plus a fixed dollar threshold and a fixed multiple of the wage-adjusted APC rate. Only line item services with SIs of P, R, S, T, V, or X will be eligible for outlier payment under OPPTS. 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

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aggregation of OPPS payments, thereby introducing some degree of offset among services; that is, the aggregation of low cost services and high cost services on a bill may result in no outlier payment being made. While service-based outliers are somewhat more complex to administer, under this method, outlier payments will be more appropriately directed to those specific services for which a hospital incurs significantly increased costs.

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

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

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

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

**3.1.5.5.6** Example of outlier payment calculation.

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

**Step 1:** Identify all APCs on the claim.

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

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

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

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

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

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

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

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

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

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

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

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

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**3.1.5.6** Rural SCH payments will be increased by 7.1%. This adjustment will apply to all services and procedures paid under the OPPS (SIs of **P, S, T, V, and X**), excluding drugs, biologicals and services paid under the pass-through payment policy (SIs of **G and H**).

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

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

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

**3.1.5.7.1** On May 1, 2009 (implementation of TRICARE's OPPS), the TTPAs shall apply to all network and non-network hospitals. For network hospitals, the TTPAs will cover a four year period. The four year transition will set higher payment percentages for the 10 APC codes 604-609 and 613-616 during the first year, with reductions in each of the transition years. For non-network hospitals, the adjustment will cover a three year period, with reductions in each of the transition years for the same 10 APC codes. [Figure 13.3-4](#) provides the TTPA percentage adjustments for the 10 visit APC codes for network and non-network hospitals. **An applicable Explanation of Benefits (EOB) message will be applied.**

**3.1.5.7.2** TTPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

**FIGURE 13.3-4 TTPA ADJUSTMENT PERCENTAGES FOR 10 VISIT APC CODES**

YEARS	NETWORK		NON-NETWORK	
	EMERGENCY ROOM	HOSPITAL CLINIC	EMERGENCY ROOM	HOSPITAL CLINIC
Year 1	200%	175%	140%	140%
Year 2	175%	150%	125%	125%
Year 3	150%	130%	110%	110%
Year 4	130%	115%	100%	100%
Year 5	100%	100%	100%	100%

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

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

**3.1.5.8.1 Transitional TMCPAs**

In view of the ongoing military operations in Afghanistan and Iraq, the TMA Director has determined that it is impracticable to support military readiness and contingency operations without adjusting OPPS payments for network hospitals that provide a significant portion of the health care of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs). Therefore, network hospitals that have received OPPS payments of \$1.5 million or more for care to ADSMs and ADDs during a one-year period shall be granted a Transitional TMCPA in addition to the TTPAs for that year. The total TRICARE OPPS payments for each one of these qualifying hospitals will

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be increased by 20% by way of an additional payment within three months after the end of the year; i.e., 15 months after implementation of OPSS to ensure that the adjustment is based on a full 12 months of claims history (May 1, 2009 through April 30, 2010). Second and subsequent year adjustments (assuming a hospital continues to meet the \$1.5 million threshold) will be reduced by 5% per year until the OPSS payment levels are reached; (i.e., 15% year two, 10% year three, and 5% year four). In year five, the outpatient payments will be at established APC levels. The adjustment will be applied to the total year OPSS payment amount received by the hospital for all active duty members and all TRICARE beneficiaries (including ADDs, retirees and their family members but excluding TRICARE For Life (TFL) beneficiaries) for whom TRICARE is primary payer.

**3.1.5.8.1.1** Contractors will run a query of their claims history to determine which network hospitals qualify for Transitional TMCPAs at year end; i.e., those network hospitals receiving OPSS payments of \$1.5 million or more for care of ADSMs and ADDs during a one-year period - 12 months from implementation of TRICARE's OPSS (May 1, 2009).

**3.1.5.8.1.2** The query will run within three months after the year end date to ensure a full 12 months of claims history/payment on which to base the Transitional TMCPAs.

**3.1.5.8.1.3** The Transitional TMCPAs will be year-end adjusted based on vouchers submitted by the MCSCs in accordance with the requirements. The voucher shall be sent electronically to RM.Invoices@tma.osd.mil at the TMA Contract Resource Management (CRM) Office for approval before releasing the checks. The vouchers received should contain the following information: hospital name, address, tax identification number, and calculations used for amount to be paid.

**3.1.5.8.1.4** These queries will be run in subsequent Transitional TMCPA years (i.e., within three months after each of the remaining transitional years) to determine those network hospitals qualifying for Transitional TMCPAs.

**3.1.5.8.1.5** Hospitals that previously qualified for Transitional TMCPAs but subsequently fell below \$1.5 million revenue threshold would no longer be eligible for the adjustment.

**3.1.5.8.1.6** 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 TMA Director, or designee at any time after OPSS implementation, also 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 TMA Director may approve a TMCPA for hospitals that serve a disproportionate share of ADSMs and ADDs. In order for a hospital to be considered for a General TMCPAs, the hospital's outpatient revenue from TRICARE ADSMs and ADDs must have been at least 10% of the hospital's total outpatient revenue during the 12-month period ending three months prior to the date of the TMCPA application, or the number of outpatient visits by

ADSMs and ADDs during that same 12-month period must have been at least 50,000.

#### **3.1.5.8.2.1 General TMCPA Process**

**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** General TMCPA payments cannot result in a hospital receiving under OPPS (including basic OPPS, Transitional TTPA, Transitional TMCPA, and General TMCPA payments) more than 95% of the amount that it would have received under TRICARE pre-OPPS payment policies. This applies to TRICARE beneficiaries when TRICARE is the primary payer.

**3.1.5.8.2.1.3** Total TRICARE OPPS payments (including the TTPAs) of the qualifying hospital will be increased by the Director TMA's, or designee's, approved adjustment percentage by way of an additional payment within three months after the end of the year; i.e., 15 months after implementation of OPPS to ensure that the adjustment is based on a full 12 months of claims history (May 1, 2009 through April 30, 2010). For subsequent years, if a hospital continues to meet the qualifying criteria for a General TMCPA, an additional payment will be made 15 months after the end of each year.

**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 year end adjustment to total OPPS payments.

**3.1.5.8.2.1.5** The hospital's initial and all subsequent requests for a General TMCPA shall include the data requirements in [paragraph 3.1.5.8.2.2](#), and a full 12 months of claims payment data. If the initial request is approved by the TMA Director, or designee, and the hospital wants to ensure the adjustments continue in subsequent years (based on meeting the qualifying criteria in [paragraph 3.1.5.8.2](#)), they must submit their request to the MCSC three months prior to the termination date of the current TMCPA, i.e., nine months after the approval date, to allow sufficient time for review and approval.

**3.1.5.8.2.1.6** The General TMCPAs will be year-end adjusted based on vouchers submitted by the MCSCs in accordance with requirements. The vouchers shall be sent electronically to [RM.Invoices@tma.osd.mil](mailto:RM.Invoices@tma.osd.mil) at the TMA CRM Office for approval before releasing the checks. The vouchers received should contain the following information: hospital name, address, tax identification number, and calculations used for amount to be paid.

#### **3.1.5.8.2.2 Annual Data Requirements for General TMCPAs**

Hospital required data submissions to the Managed Care Support Contractor (MCSC) for review and consideration:

**3.1.5.8.2.2.1** The hospital's percent of revenue derived from ADSM plus ADD outpatient visits (e.g., Emergency Room (ER) and HOPD); i.e., the revenue from TRICARE ADSM plus ADD visits

divided by total outpatient revenue during the 12-month period ending three months prior to the date of the TMCPA application.

**3.1.5.8.2.2.2** The number of outpatient visits by ADSMs and ADDs during the 12-month period ending three months prior to the date of the TMCPA application.

**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 percent of TRICARE outpatient visits (ER and HOPD); i.e., the TRICARE outpatient visits divided by total outpatient visits during the 12-month period ending three months prior to the date of the TMCPA application.

**3.1.5.8.2.2.6** The hospital's percent of TRICARE outpatient revenue (ER and HOPD); i.e., the TRICARE outpatient revenue divided by total outpatient revenue during the 12-month period ending three months prior to the date of the TMCPA application.

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

### **3.1.5.8.2.3 Annual MCSC Data Review Requirements**

**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 MCSC 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** 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 Office of Medical Benefits and Reimbursement Branch (MB&RB) to be forwarded to the Director, TMA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RB for TMA Director review and approval.

**3.1.5.8.2.5** TMA Director, or designee review.

- The Director, TMA or designee is the final approval authority.
- A decision by the Director TMA or designee to adopt modify or extend TMCPAs is not subject to appeal.
- Signed letters of intent to accept the percentage adjustments approved by the TMA, Director or designee, must be submitted prior to approval of TMCPAs.

**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 MCSC'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.

**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 and General TMCPA costs shall be paid as pass-through costs. The MCSC does not financially underwrite these costs.

**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 OPSS was implemented.

### **3.2.1.3 Current Radiopharmaceutical Drugs and Biological Products**

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

### **3.2.1.4 New Medical Devices, Drugs, and Biologicals**

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

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

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

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

**3.2.3.1** Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug Competitive Acquisition Program (CAP) at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Social Security Act (SSA) rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug or biological.

**3.2.3.2** Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug CAP at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Act, rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug and biological.

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

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

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**3.2.3.5** Therapeutic radiopharmaceuticals with pass-through status in CY 2009 will be paid at hospital charges adjusted to cost, the same payment methodology as other therapeutic radiopharmaceuticals in CY 2009.

**3.2.3.6** If a drug or biological that has been granted pass-through status for CY 2009 becomes covered under the Part B drug CAP (if the program is reinstated) the Centers for Medicare and Medicaid Services (CMS) will provide payment for Part B Drugs that are granted pass-through status and are covered under the Part B drug CAP at the Part B drug CAP rate.

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

**3.2.3.8** Drugs and biologicals that are continuing pass-through status or have been granted pass-through status as of January 2009 for CY 2009 are displayed in [Figure 13.3-5](#).

**FIGURE 13.3-5 DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2009**

CY 2008	CY 2009			
HCPCS	HCPCS	SHORT DESCRIPTOR	SI	APC
C9238	J1953	Levetiracetam injection	G	9238
C9239	J9330	Temsirolimus injection	G	1168
C9240*	J9207	Exabepilone injection	G	9240
C9241	J1267	Doripenem injection	G	9241
C9242	J1453	Fosaprepitant injection	G	9242
C9243	J9033	Bendamustine injection	G	9243
C9244	J2785	Injection, regadenoson	G	9244
C9354	C9354	Veritas collagen matrix, cm2	G	9354
C9355	C935	Neuromatrix nerve cuff, cm	G	9355
C9356	C9356	TendoGlide Tendon prot, cm2	G	9356
C9357	Q4114	Integra flowable wound matri	G	1251
C9358	C9358	SurgiMend, 0.5cm2	G	9358
C9359	C9359	Implant, bone void filler	G	9359
J1300	J1300	Eculizumab injection	G	9236
J1571	J1571	Hepagam b im injection	G	0946
J1573	J1573	Hepagam b intravenous, inj	G	1138
J3488*	J3488	Reclast injection	G	0951
J9225*	J9225	Vantas implant	G	1711
J9226	J9226	Supprelin LA implant	G	1142
J9261	J9261	Nelarabine injection	G	0825
Q4097	J1459	Inj IVIG privigen 500 mg	G	1214
	C9245	Injection, romiplostim	G	9245
	C9246	Inj, gadoxetate	G	9246
	C9248	Inj, clevidipine butyrate	G	9248

\* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology (prior to January 1, 2009) while identified as pass-through under the OPPS.

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

**3.2.4.1** Prior to CY 2008, certain diagnostic radiopharmaceuticals were paid separately under the OPSS if their mean per day cost were greater than the applicable year's drug packaging threshold.

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

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

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

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

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

**3.2.4.7** Offset Calculations.

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

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

**3.2.4.8** Effective April 1, 2009, diagnostic radiopharmaceutical HCPCS code C9247, Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries, has been granted pass-through status under the OPSS and will be assigned SI of **G**.

**3.2.4.8.1** Beginning April 1, 2009, payment for HCPCS code C9247 will be made at 106% of ASP if ASP data are submitted by the manufacturer. Otherwise, payment will be made based on the product's WAC. Further if WAC data is not available, payment will be made at 95% of the AWP.

**3.2.4.8.2** Effective for nuclear medicine services furnished on and after April 1, 2009, when HCPCS code C9247 is billed on the same claims with a nuclear medicine procedure, the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 will be reduced by the corresponding nuclear medicine procedure's portion of its APC payment (offset amount) associated with diagnostic radiopharmaceutical; i.e., the payment for HCPCS code C9247 will be reduced by the estimated amount of payment that is attributable to the predecessor

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

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

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

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

**3.12.3** The presence of the modifier **FB** ["Item Provided Without Cost to Provider, Supplier, or Practitioner or Credit Received for Replacement (examples include, but are not limited to devices covered under warranty, replaced due to defect, or provided as free samples)"] would trigger the adjustment in payment if the procedure code to which modifier **FB** was amended appeared in [Figure 13.3-11](#) and was also assigned to one of the APCs listed in [Figure 13.3-12](#). OPPS payments for implantation procedures to which the **FB** modifier is appended are reduced to 100% of the device offset for no-cost/full credit cases.

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

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

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

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

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

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

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

APC	SI	APC GROUP TITLE	DEVICE OFFSET PERCENTAGE FOR NO-COST/FULL CREDIT CASE	DEVICE OFFSET PERCENTAGE FOR PARTIAL CREDIT CASE
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 13.3-11](#)) is assigned is on the APCs listed in [Figure 13.3-12](#), the unadjusted payment rate for the procedure APC will be reduced by an amount equal to the percent in [Figure 13.3-12](#) times the unadjusted payment rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### Chapter 13, Section 3

#### Prospective Payment Methodology

**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 TMA's OPSS web site at <http://www.tricare.mil/opps>;
- Locality Code: Based on CBSA - two digit = rural and five digit = urban;
- Hospital Type: Rural SCH = 1 and All Others = 0

**3.15.4** The outpatient PRICER will return the line item APC and cost outlier pricing information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary EOB with exception for an electronic 835 transaction. Paper EOB and remits will reflect APCs at the line level and will also include indication of outlier payments and pricing information for those services reimbursed under other than OPSS methodology's, e.g., CMAC (SI of **A**) when applicable.

**3.15.5** If a claim has more than one service with a SI of **T** or a SI of **S** within the coding range of 10000 - 69999, and any lines with SI of **T** or a SI within the coding range of 10000 - 69999 have less than \$1.01 as charges, charges for all **T** lines will be summed and the charges will then be divided up proportionately to the payment rates for each **T** line (refer to [Figure 13.3-15](#)). The new charge amount will be used in place of the submitted charge amount in the line item outlier calculator.

**FIGURE 13.3-15 PROPORTIONAL PAYMENT FOR "T" LINE ITEMS**

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
T	\$19,999	\$6,000	\$12,000
T	\$1	\$3,000	\$6,000
T	\$0	\$1,000	\$2,000
Total	\$20,000	\$10,000	\$20,000

**Note:** Because total charges here are \$20,000 and the first SI of T gets \$6,000 of the \$10,000 total payment, the new charge for that line is  $\$6,000/\$10,000 \times \$20,000 = \$12,000$ .

### 3.16 TRICARE Specific Procedures/Services

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

**3.16.2** Other procedures that are normally covered under TRICARE but not under Medicare will be assigned SI of **A** (i.e., services that are paid under some payment method other than OPSS) until they can be placed into existing or new APC groups.

### **3.17 Validation Reviews**

OPPS claims are not subject to validation review.

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

Hospital-based birthing centers will be reimbursed the same as freestanding birthing centers except the all inclusive rate consisting of the CMAC for CPT<sup>7</sup> code 59400 and the state specific non-professional component, will lag two months (i.e., April 1 instead of February 1).

## **4.0 EFFECTIVE DATE**

May 1, 2009.

- END -

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## Claims Submission And Processing Requirements

Issue Date: July 27, 2005

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

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### 1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

To describe additional claims submission and processing requirements.

### 3.0 POLICY

Appropriate bill types:

#### 3.1 Bill Types Subject To OPPS

All outpatient hospital bills (bill types 013X with condition code 41, 013X without condition code 41, **014X for diagnostic services**), with the exception of bills from providers excluded under [Section 1, paragraph 3.4.1.2.5](#) will be subject to the Outpatient Prospective Payment System (OPPS).

#### 3.2 Reporting Requirements

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

**Example:** Claims with from dates before May 1, 2009 (implementation of OPPS) will not process as OPPS - this will also apply to version changes and pricing changes.

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

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

### 3.3 Procedures for Submitting Late Charges

**3.3.1** Hospitals may not submit a late charge bill (frequency 5 in the third position of the bill type) for bill types 013X effective for claims with dates of service on or after **May 1, 2009** (implementation of OPSS).

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

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

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

### 3.4 Claim Adjustments

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

### 3.5 Proper Reporting of Condition Code G0 (Zero)

**3.5.1** Hospitals should report Condition Code G0 on FLs 18-28 when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day - in the morning for a broken arm and later for chest pain.

**3.5.2** Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim.

**3.5.3** Claims with condition code G0 should not be automatically rejected as a duplicate claim.

**3.5.4** Proper reporting of Condition Code G0 allows for proper payment under OPSS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.