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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 34
6010.58-M
AUGUST 10, 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: CODING AND CLARIFICATION UPDATES APRIL 2010

CONREQ: 15021

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: As indicated, otherwise upon direction of the Contracting Officer.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TOM, Change No. 21 and Feb 2008 TPM, Change No. 34.



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

**ATTACHMENT(S): 22 PAGE(S)
DISTRIBUTION: 6010.58-M**

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

**CHANGE 34
6010.58-M
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REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 11, page 5

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CHAPTER 7

Addendum D (FY 2010), pages 1 through 5

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CHAPTER 13

Section 1, pages 1 through 13

Section 1, pages 1 through 13

APPENDIX A

pages 3 and 4

pages 3 and 4

SUMMARY OF CHANGES

CHAPTER 1

1. Section 11. Added HCPCS modifiers RA and RB to identify replacement or repair of an item of DME.

CHAPTER 7

2. Addendum G (FY 2010). Updated the list of Residential Treatment Centers (RTCs) that are TRICARE-authorized providers.

CHAPTER 13

3. Section 1. Clarified that hospital-based Partial Hospitalization Programs (PHPs) no longer require TRICARE-specific certification as of 11/30/2009.

APPENDIX A

4. Administrative changes.

available to the beneficiary. Maintenance may be covered for patient owned-DME when such maintenance must be performed by an authorized technician.

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

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

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

4.0 EXCLUSIONS AND LIMITATIONS

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

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

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

5.0 EFFECTIVE DATE

September 1, 2005.

- END -

Chapter 7

Addendum D (FY 2010)

TRICARE-Authorized Residential Treatment Centers (RTCs) -
FY 2010

The rates in this Addendum will be used for payment of claims for services rendered on or after October 1, 2009. The rates were adjusted by the lesser of the FY 2009 Medicare update factor (2.1%) or the amount that brought the rate up to the new cap amount of \$758.

This listing is for RTC per diem rates only. It does not reflect a facility's current status as a TRICARE-authorized RTC. Information regarding a facility's current status as an authorized provider can be obtained from the appropriate contractor.

FACILITY	TRICARE RATE
ALASKA	
DeBarr Residential Treatment Center Frontline Hospital, LLC 1500 DeBarr Circle Anchorage, AK 99508 EIN: 72-1539254	758.00
ARKANSAS	
BHC Pinnacle Pointe Hospital 11501 Financial Center Parkway Little Rock, AR 72211 EIN: 62-1658502	753.00
COLORADO	
PSI Cedar Springs Hospital, Inc. Cedar Springs Behavioral Health Systems, Inc 2135 Southgate Road Colorado Springs, CO 80906 EIN: 74-3081810	758.00
CBR Youth Connect 28071 Hwy 109 La Junta, CO 81050 EIN: 84-0500375	697.00
FLORIDA	
LaAmistad Behavioral Health Services 1650 Park Avenue North Maitland, FL 32751 EIN: 58-1791069	719.00

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FACILITY	TRICARE RATE
Ten Broeck Ocala Behavioral 3130 SW 27th Ave Ocala, FL 34474 EIN: 32-0235544	387.00
River Point Behavioral Health TBJ Behavioral, LLC 6300 Beach Blvd Jacksonville, FL 32216 EIN: 20-4865566	584.00
Tampa Bay Academy Youth & Family Centered Services of Florida, Inc 12012 Boyette Road Riverview, FL 33569 EIN: 52-1955335	590.00
Manatee Palms Youth Service 4480 51st Street West Bradenton, FL 34210 EIN: 65-0816927	675.00
GEORGIA	
Costal Harbor Treatment Center UHS of Savannah, LLC 1150 Cornell Avenue Savannah, GA 31406 EIN: 20-0931196	419.00
HAWAII	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	758.00
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	731.00
IDAHO	
Eastern Idaho Regional Medical Center - Behavioral Health Center 2280 E 25th Street Idaho Falls, ID 83404 EIN: 82-0436622	344.00

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FACILITY	TRICARE RATE
Kootenai Medical Center 2003 Lincoln Way Coeur d'Alene, ID 83814 EIN: 82-0231746	436.00
INDIANA	
Michiana Behavioral Health Center HHC Indiana, Inc 1800 North Oak Road Plymouth, IN 46563 EIN: 20-0768028	427.00
Valle Vista Hospital, LLC Valle Vista Health System 898 East Main Street Greenwood, IN 46143 EIN: 62-1740366	453.00
KENTUCKY	
Ten Broeck Hospital -- Louisville KMI Acquisition, LLC 8521 LaGrange Road Louisville, KY 40242 EIN: 20-5048153	682.00
Ten Broeck Hospital -- Dupont TBD Acquisition, LLC Louisville, KY 40207 EIN: 20-5048087	641.00
MISSOURI	
Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 EIN: 44-0545808	326.00
Heartland Behavioral Health Services, Inc Great Plains Hospital, Inc 1500 W. Asland Nevada, MO 64772 EIN: 43-1328523	399.00
Lakeland Regional Hospital Lakeland Hospital Acquisition Corporation 440 South Market Avenue Springfield, MO 65806 EIN: 58-2291915	408.00

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FACILITY	TRICARE RATE
MONTANA	
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	436.00
NEVADA	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	758.00
NEW MEXICO	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	320.00
NORTH CAROLINA	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 56-1317433	464.00
OHIO	
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 EIN: 62-1658523	400.00
SOUTH CAROLINA	
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	435.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	727.00
TENNESSEE	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	451.00

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FACILITY	TRICARE RATE
Dickson Recovery Center 222 Church Street Dickson, TN 37055 EIN: 20-4990101	413.00
Youth Villages, Inc 3320 Brother Blvd Memphis, TN 38133 EIN: 58-1716970	758.00
TEXAS	
Cedar Crest Hospital and RTC HMTN Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	696.00
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	758.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	632.00
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	711.00
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	653.00
VIRGINIA	
Poplar Springs West HHC Poplar Springs, Inc 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	730.00
The Pines Residential Treatment Center - Kempsville, The 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	632.00

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FACILITY	TRICARE RATE
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	495.00
WASHINGTON	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	628.00

- END -

Chapter 13

Section 1

General

Issue Date: July 27, 2005

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

1.0 APPLICABILITY

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

2.0 ISSUE

A general overview of the coverage and reimbursement of hospital outpatient services.

3.0 POLICY

3.1 Statutory Background

3.1.1 Under 10 United States Code (USC) 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE shall, by regulation, be established "to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare." Similarly, under 10 USC 1079(h), the amount to be paid to health care professionals and other non-institutional health care providers "shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules used by Medicare." Based on these statutory provisions, TRICARE will adopt Medicare's prospective payment system for reimbursement of hospital outpatient services currently in effect for the Medicare program as required under the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), which provided comprehensive provisions for establishment of a hospital Outpatient Prospective Payment System (OPPS). The Act required development of a classification system for covered outpatient services that consisted of groups arranged so that the services within each group were comparable clinically and with respect to the use of resources. The Act described the method for determining the Medicare payment amount and the beneficiary coinsurance amount for services covered under the OPPS. This included the formula for calculating the conversion factor and data requirements for establishing relative payment weights.

3.1.2 Centers for Medicare and Medicaid Services (CMS) published a proposed rule in the **Federal Register** (FR) on September 8, 1998 (63 FR 47552) setting forth the proposed PPS for hospital outpatient services. On June 30, 1999, a correction notice was published (64 FR 35258) to

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correct a number of technical and typographical errors contained in the September 8, 1998 Proposed Rule.

3.1.3 Subsequent to publication of the proposed rule, the Balanced Budget Refinement Act (BBRA) of 1999, enacted on November 29, 1999, made major changes that affected the proposed OPPS. The following BBRA 1999 provisions were implemented in a Final Rule (65 FR 18434) published on April 7, 2000:

3.1.3.1 Made adjustments for covered services whose costs exceeded a given threshold (i.e., an outlier payment).

3.1.3.2 Established transitional pass-through payments for certain medical devices, drugs, and biologicals.

3.1.3.3 Placed limitations on judicial review for determining outlier payments and the determination of additional payments for certain medical devices, drugs, and biologicals.

3.1.3.4 Included as covered outpatient services implantable prosthetics and Durable Medical Equipment (DME) and diagnostic x-ray, laboratory, and other tests associated with those implantable items.

3.1.3.5 Limited the variation of costs of services within each payment classification group by providing that the highest median cost for an item or service within the group cannot be more than two times greater than the lowest median cost for an item or service within the group (referred to as the "two times rule"). An exception to this requirement may be made in unusual cases, such as low volume items and services, but may not be made in the case of a drug or biological that has been designated as an orphan drug under Section 526 of the Federal Food, Drug and Cosmetic Act.

3.1.3.6 Required at least annual review of the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, the addition of new services, new cost data, and other relevant information or factors.

3.1.3.7 Established transitional corridors that would limit payment reductions under the hospital OPPS.

3.1.3.8 Established hold harmless provisions for rural and cancer hospitals.

3.2 Participation Requirement

In order to be an authorized provider under the TRICARE OPPS, an institutional provider must be a participating provider for all claims in accordance with [32 CFR 199.6\(a\)\(8\)](#).

3.3 Unbundling Provisions

As a prelude to implementation of the OPPS, Omnibus Budget Reconciliation Act (OBRA) of 1996 prohibited payment for nonphysician services furnished to hospital patients (inpatients and outpatients), unless the services were furnished either directly or under arrangement with the hospital except for services of Physician Assistants (PAs), Nurse Practitioners (NPs), and Clinical Nurse Specialists (CNSs). This facilitated the payment of services included within the scope of each

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

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

3.3.2 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 OPPS.

3.4.1 Provider Categories

3.4.1.1 Providers Included In OPPS

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

3.4.1.1.2 Hospital-based Partial Hospitalization Programs (PHPs) **before November 30, 2009**, that are subject to the more restrictive TRICARE authorization requirements under [32 CFR 199.6\(b\)\(4\)\(xii\)](#). Following are the specific requirements for authorization and payment under the Program:

3.4.1.1.2.1 Be certified pursuant to TRICARE certification standards.

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

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

3.4.1.1.2.4 Has a written participation agreement with TRICARE.

3.4.1.1.3 Hospital-based PHPs on or after November 30, 2009, shall no longer require separate TRICARE certification. Authorization of a hospital by TRICARE is sufficient for its PHP to be an authorized TRICARE provider.

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

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

3.4.1.1.5 Small Rural and Sole Community Hospitals (SCHs) in Rural Areas

3.4.1.1.5.1 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.

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

3.4.1.2 Providers Excluded From OPSS

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

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

3.4.1.2.3 CAHs. 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.

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3.4.1.2.5 Specialty care providers to include:

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

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

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

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

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

3.4.2 Scope of Services

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

3.4.2.1.1 Physician services.

3.4.2.1.2 NP and CNS services.

3.4.2.1.3 Physician Assistant (PA) services.

3.4.2.1.4 Certified Nurse-Midwife (CNM) services.

3.4.2.1.5 Services of qualified psychologists.

3.4.2.1.6 Clinical Social Worker (CSW) services.

3.4.2.1.7 Services of an anesthetist.

3.4.2.1.8 Screening and diagnostic mammographies.

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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.

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.

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

3.4.2.2.4 Costs of teaching physicians.

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

3.4.2.2.6 Bad debts for uncollectible and coinsurance amounts.

3.4.2.2.7 Organ acquisition costs.

3.4.2.2.8 Corneal tissue acquisition costs incurred by hospitals that are paid on a reasonable cost basis.

3.4.2.3 Services included in payment under the OPSS (not an all-inclusive list).

3.4.2.3.1 Hospital-based full- and half-day PHPs (psych and SUDRFs) which are paid a per diem OPSS. Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients who have profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

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

3.4.2.3.2.1 Surgical procedures.

Note: Hospital-based ASC procedures will be included in the OPSS/APC system even though they are currently paid under the ASC grouper system. The new OPSS/APC system covers procedures on the ASC list when they are performed in a HOPD, hospital ER, or hospital-based ASC. ASC group payment will still apply when they are performed in freestanding ASCs.

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

3.4.2.3.2.2 Radiology, including radiation therapy.

3.4.2.3.2.3 Clinic visits.

3.4.2.3.2.4 Emergency Department (ED) visits.

3.4.2.3.2.5 Diagnostic services and other diagnostic tests.

3.4.2.3.2.6 Surgical pathology.

3.4.2.3.2.7 Cancer chemotherapy.

3.4.2.3.2.8 Implantable medical items.

- Prosthetic implants (other than dental) that replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care and including replacement of these devices);
- Implantable DME (e.g., pacemakers, defibrillators, drug pumps, and neurostimulators);
- Implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

Note: Because implantable items are now packaged into the APC payment rate for the service or procedure with which they are associated, certain items may be candidates for the transitional pass-through payment.

3.4.2.3.2.9 Specific hospital outpatient services furnished to a beneficiary who is admitted to a Medicare-participating SNF but who is not considered to be a SNF resident, for purposes of SNF consolidated billing, with respect to those services that are beyond the scope of SNF comprehensive care plans. They include:

- Cardiac catheterization;
- CAT scans;
- MRIs;
- Ambulatory surgery involving the use of an OR;
- ER services;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

3.4.2.3.2.10 Certain preventive services furnished to healthy persons, such as colorectal cancer screening.

3.4.2.3.2.11 Acute dialysis (e.g., dialysis for poisoning).

3.4.2.3.2.12 ESRD Services. Since TRICARE does not have an ESRD composite rate, ESRD services are included in TRICARE's OPSS.

3.5 Description of APC Groups

3.5.1 Group services identified by Healthcare Common Procedure Coding System (HCPCS) codes and descriptors within APC groups are the basis for setting payment rates under the hospital OPSS.

3.5.2 Grouping of Procedures/Services Under APC System.

3.5.2.1 The APC system establishes groups of covered services so that the services within each group are comparable clinically and with respect to the use of resources.

3.5.2.2 Fundamental criteria for grouping procedures/services under the APC system:

- **Resource Homogeneity.** The amount and type of facility resources (e.g., OR time, medical surgical supplies, and equipment) that are used to furnish or perform the individual procedures or services within each APC should be homogeneous. That is, the resources used are relatively constant across all procedures or services even though resource use may vary somewhat among individual patients.
- **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.

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

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

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

3.6.7 Applicable deductible and/or cost-sharing/copayment amounts will be subtracted from the adjusted APC payment rate based on the eligibility status of the beneficiary at the time outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra, and Standard beneficiary categories). TRICARE will retain its current hospital outpatient deductibles, cost-sharing/copayment amounts and catastrophic loss protection under the 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)¹/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

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

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COLUMN	DESCRIPTION
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., 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.

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

3.13 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 -

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Appendix A

Acronyms And Abbreviations

ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ATA	American Telemedicine Association
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BC	Birth Center
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNAF	Budget Neutrality Adjustment Factor
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BRest CAncer (genetic testing)

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Appendix A

Acronyms And Abbreviations

BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAP	Competitive Acquisition Program
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBHCO	Community-Based Health Care Organizations
CBSA	Core Based Statistical Area
CC	Common Criteria Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive