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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 83
6010.58-M
JULY 16, 2013**

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

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PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

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**ATTACHMENT(S): 3 PAGE(S)
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**CHANGE 83
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REMOVE PAGE(S)

CHAPTER 1

Section 16, pages 3 and 4

INSERT PAGE(S)

Section 16, pages 3 - 5

SUMMARY OF CHANGES

CHAPTER 1

Section 16. This change clarifies TRICARE's patient-initiated second opinion policy to include other major nonsurgical procedures.

- 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 **or other major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy)** may be paid. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery **or other major nonsurgical diagnostic and therapeutic procedure.**

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

3.9 In-Office Surgery

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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 1, Section 16

Surgery

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 CPT¹ procedure codes for venipuncture, fetal monitoring and collection of blood specimens; 36400-36416, 36591, 36592, 59020, 59025, 59050, and 59051.

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