CHAPTER 13
SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

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Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

I. 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 TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

II. ISSUE

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

III. POLICY

A. 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.

B. Packaging of Services Under APC Groups.

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:

a. Use of an operating suite.

b. Procedure room or treatment room.

c. Use of the recovery room or area.

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d. Use of an observation bed.

e. 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.

f. Supplies and equipment for administering and monitoring anesthesia or sedation.

g. Intraocular lenses (IOLs).

h. Capital-related costs.

i. Costs incurred to procure donor tissue other than corneal tissue.

j. Incidental services such as venipuncture.

k. Implantable items used in connection with diagnostic X-ray testing, diagnostic laboratory tests, and other diagnostics.

l. 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.

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).

a. 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.

(1) For the drugs paid under the OPPS, hospitals can bill both for the drug and for the administration of the drug.

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

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(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.

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

(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:

(a) Current orphan drugs, as designated under section 526 of the Federal Food, Drugs, and Cosmetic Act;

(b) Current drugs and biological agents used for treatment of cancer;

(c) Current radiopharmaceutical drugs and biological products; and

(d) 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.

(2) Separate APC payment for drugs and radiopharmaceuticals for which the median cost per line exceeds $55, with the exception of injectible and oral forms of antiemetics.

(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.

(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.

(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.

(6) Separate payment for new drugs, biologicals and radiopharmaceuticals enabling hospitals to begin billing for drugs and biologicals that are newly approved by the

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FDA, and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup.

(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.

(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).

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

c. Corneal tissue acquisition costs.

(1) Corneal tissue acquisition costs not packaged into the payment rate for corneal transplant surgical procedures.

(2) Separate payment will be made based on the hospital's reasonable costs incurred to acquire corneal tissue.

(3) 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.

d. Costs for other procedures or services not packaged in the APC payment.

(1) Blood and blood products, including anti-hemophilic agents.

(2) Casting, splinting and strapping services.

(3) Immunosuppressive drugs for patients following organ transplant.

(4) 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.

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e. 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:

(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.

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

(a) These edits will be applied at the HCPCS I and II code levels rather than at the APC level.

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

C. Additional Payments Under The OPPS.

1. Clinical diagnostic testing (labwork).

2. Administration of infused drugs.

3. Therapeutic procedures including resuscitation that are furnished during the course of an emergency visit.

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.

5. Cases that fall far outside the normal range of costs. These cases will be eligible for an outlier adjustment.

D. Payment For Patients Who Die In The Emergency Department.

1. If the patient dies in the emergency department, and the patient's status is outpatient, the hospital should bill for payment under the OPPS for the services furnished.

2. If the emergency department or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient.

a. If the patient had been admitted as an inpatient, pay under the hospital DRG-based payment system.

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b. If the patient was not admitted as an inpatient, pay under the OPPS (an APC-based payment) for the services that were furnished.

c. If the patient was not admitted as an inpatient and the procedure designated as an inpatient-only procedure (by OPPS payment status indicator (SI) of "C") is performed, the hospital should bill for payment under the OPPS for the services that were furnished on that date and should include modifier -CA on the line with the HCPCS code for the inpatient procedure. Payment for all services other than the inpatient procedure designated under OPPS by the SI of "C", furnished on the same date, is bundled into a single payment under APC 0375.

3. Billing and Payment Rules for Using New Modifier -CA - *Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission*.

a. All the following conditions must be met in order to receive payment for services billed with modifier -CA:

(1) The status of the patient is outpatient;

(2) The patient has an emergent, life-threatening condition;

(3) A procedure on the inpatient list (designated by payment SI of "C") is performed on an emergency basis to resuscitate or stabilize the patient; and

(4) The patient dies without being admitted as an inpatient.

b. If all of the conditions for payment are met, the claim should be submitted using a 013X bill type for all services that were furnished, including the inpatient procedure (e.g., a procedure designated by OPPS payment SI of "C"). The hospital should include modifier -CA on the line with the HCPCS code for the inpatient procedure.

NOTE: When a line with a procedure code that has a SI of "C" assigned and has a patient status of "20" (deceased) and one of the modifiers is "CA" (patient dies). The OCE software will change the "SI" of the procedure to "S" and price the line using the adjusted APC rate formula.

c. Payment for all services on a claim that have the same date of service as the HCPCS billed with modifier -CA is made under APC 0375. Separate payment is not allowed for other services furnished on the same date.

E. Medical Screening Examinations.

1. Appropriate emergency department codes will be used for medical screening examinations including ancillary services routinely available to the emergency department in determining whether or not an emergency condition exists.

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2. If no treatment is furnished, medical screening examinations would be billed with a low-level emergency department code.

F. HCPCS/Revenue Coding Required Under OPPS. Hospital outpatient departments should use the CMS 1450 UB-04 Editor as a guide for reporting HCPCS and revenue codes under the OPPS.

G. Treatment of Partial Hospitalization Services. Effective upon implementation of OPPS, hospital-based Partial Hospitalization Programs (PHPs) (psych and Substance Use Disorder Rehabilitation Facilities (SUDRFs)) will be reimbursed a national per diem APC payment under the OPPS. Freestanding PHPs (psych and SUDRFs) will continue to be reimbursed under the existing PHP per diem payment.

1. The National Quality Monitoring Contractor (NQMC) shall include in their authorized provider reports to the contractors additional data elements indicating whether the facility is a freestanding PHP (psych or SUDRF) or a hospital-based PHP (psych). The contractors shall identify hospital-based PHPs (SUDRFs) that are subject to the per diem payment under the OPPS.

2. Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in lieu of inpatient psychiatric care in a hospital outpatient department.

3. Services of physicians, clinical psychologists, Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs), and Physician Assistants (PAs) furnished to partial hospitalization patients will continue to be billed separately as professional services and are not considered to be partial hospitalization services, as long as these providers are not employed by or contracted by the facility.

4. Payment for PHP (psych) services represents the provider's overhead costs, support staff, and the services of Clinical Social Workers (CSWs) and Occupational Therapists (OTs), whose professional services are considered to be included in the PHP per diem rate. For SUDRFs, the costs of alcohol and addiction counselor services would also be included in the per diem.

a. Hospitals will not bill the contractor for the professional services furnished by CSWs, OTs, and alcohol and addiction counselors.

b. Rather, the hospital's costs associated with the services of CSWs, OTs, and alcohol and addiction counselors will continue to be billed to the contractor and paid through the PHP per diem rate.

5. Per diem is the unit of payment since it defines the structure and scheduling of partial hospitalization services. The established per diem represents the median hospital cost

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of furnishing a day of partial hospitalization. The following are billing instructions for submission of partial hospitalization claims/services:

a. Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services.

b. The following is a complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services or other mental health services outside partial hospitalization:

FIGURE 13-2-1 REVENUE AND HCPCS LEVEL I AND II CODES USED IN BILLING FOR PARTIAL HOSPITALIZATION SERVICES AND OTHER MENTAL HEALTH SERVICES OUTSIDE PARTIAL HOSPITALIZATION FOR CY 2003

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I[1] AND II CODES
0250	Pharmacy	HCPCS code not required
0911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
0912	Partial Hospitalization Program - Less Intensive (Half-day PHP)	H0035
0913	Partial Hospitalization Program - Intensive (Full-day PHP)	H0037
0914	Individual Psychotherapy	90816- 90819, 90821- 90824, 90826-90829
0915	Group Therapy	90849, 90853, 90857
0916	Family Psychotherapy	90846, 90847, 90849
0918	Psychiatric Testing	96100, 96115, 96117

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

c. To bill for partial hospitalization services under the hospital OPPS, hospitals are to use the above HCPCS and revenue codes and are to report partial hospitalization services under bill type 013X, along with condition code 41 on the CMS 1450 UB-04 claim form.

d. The claim must include a mental health diagnosis and an authorization on file for each day of service, along with a designated "H" code (i.e., either H0035 for half-day PHP or H0037 for full-day PHP) and its accompanying revenue code, prior to assigning a full- or half-day partial hospitalization APC. Claims that do not meet the above criteria (e.g., claim filed without condition code 41, appropriate "H" coding - H0035 or H0037, and/or revenue code) will undergo further prepayment review to ensure that outpatient department mental health procedures do not exceed the full-day partial hospitalization per diem amount; i.e., the sum of the individual mental health APC amounts on any particular day does not exceed

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the full-day partial hospitalization per diem amount. The following are basic reporting requirements for assigning full- and half-day partial hospitalization APCs:

Reporting Requirements for PHP:

- Bill Type 013x
- Mental Health (MH) Primary Diagnosis
- Condition code 41, PH HCPCS, PH revenue code (yes/no)
  - ***Yes***
    - Authorization on File
      - Yes
        - H0035/RC 0912 - APC T0001 (half-day PHP)
        - H0037/RC 0913 - APC 0033 (full-day PHP)
      - ***No*** - deny claim
  - ***No*** (Bill Type 012x, 013x, 014x without condition code 41)
    - Sum of Mental Health APCs >PHP APC 0033 payment amount on a given day (yes/no)
      - ***Yes***
        - Assign daily MH service payment APC 0034
        - Package all other MH services
        - Apply standard APC payment rule to non-MH services
      - ***No*** - Apply standard APC payment rules

(1) Each day of service will be assigned to a partial hospitalization APC, and the partial hospitalization per diem amount will be paid.

(2) Other mental health services billed on the same day as the PHP service will be packaged into a single PHP code for the same date of service with the exception of Electroconvulsive Therapy (ECT).

(3) Only one PHP APC will be paid per day.

(a) If multiples of the same "H" code (either H0035 or H0037 but not both) appear on the claim for the same date of service, the first "H" code will be designated for APC assignment and all other specific therapy codes will be packaged into the "H" code line for remittance reporting.

(b) If both "H" codes (H0035 and H0037) appear on the claim for the same date of service, payment will default to the less intensive treatment modality (half-day PHP); i.e., H0035 will be recognized for payment. Other therapy codes reported on the same date of service will be packaged into the less intensive "H" code for remittance reporting.

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(4) Non-mental health services submitted on the same day will be processed and paid separately.

(5) Revenue codes 0912 and 0913 must be accompanied by an appropriately designated HCPCS code (refer to Figure 13-2-1 for designated PHP coding). If revenue codes 912 and 913 are submitted without a HCPCS, the line and/or claim will be denied.

(6) Claims that include days that do not meet the above requirements for assignment to a partial hospitalization APC will be identified for further review.

(7) The total amount payable for psychiatric services furnished in a hospital outpatient department (not under the partial hospitalization program) for an individual for one day will be limited to the APC per diem payment amount for full-day partial hospitalization.

(8) Half-day PHP per diem will be priced at 75% of the full-day PHP rate.

6. Freestanding psychiatric partial hospitalization services will continue to be reimbursed under all-inclusive per diem rates established under Chapter 7, Section 2.

H. Billing and Payment Requirements for Observation Services.

1. Observation Stays with Diagnoses of Chest Pain, Asthma, Congestive Heart Failure or Maternity.

a. Two new HCPCS codes have been created to be used by hospitals to report all observation services, whether separately payable or packaged, and direct admission for observation care, whether separately payable or packaged:

(1) G0378 -- Hospital observation services, per hour, and

(2) G0379 -- Direct admission of patient for hospital observation care.

b. The determination of whether or not observation services are separately payable under APC 0339 (observation) has been shifted from the hospital billing department to the OPPS claims processing logic.

(1) The hospital will bill HCPCS code G0378 when observation services are provided to any patient admitted to "observation status", regardless of the patient's condition.

(2) In addition to the HCPCS code G0378, hospitals will bill HCPCS code G0379 when observation services are the result of a direct admission to "observation status" without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of or day before the observation services.

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(3) The above HCPCS (G0378 & G0379) will be assigned a new SI of "Q" (packaged service subject to separate payment based on criteria) that will trigger the OCE logic during the processing of the claim to determine if the observation service or direct admission service is packaged with the other separately payable hospital services provided, or if a separate APC payment for observation services or direct admission to observation is appropriate.

(4) The units of services reported with HCPCS code G0378 will equal the number of hours the patient is in observation status.

c. Direct admission to observation will continue to be paid at a rate equal to that of a Low Level Clinic Visit (APC 600) when a beneficiary is seen by a physician in the community and then is directly admitted into a hospital outpatient department for observation care that does not qualify for separate payment under APC 0339, and under T0002.

(1) In order to receive separate payment for a direct admission into observation (APC 0600), the claim must show:

(a) Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service.

(b) That no service with SI of "T" or "V" (clinic or emergency department visit) or critical care (APC 0620) were provided on the same day of service as HCPCS code G0379.

(c) The observation care does not qualify for separate payment under APC 0339.

d. Criteria for separate observation payments include:

(1) Documentation of specific ICD-9-CM diagnostic codes.

(a) The beneficiary must have one of four medical conditions: congestive heart failure, chest pain, asthma, or maternity.

(b) The hospital bill must report at least one of the ICD-9-CM diagnoses listed in Figure 13-2-2 through Figure 13-2-5 as the reason for visit or principal diagnosis:

1 The qualifying ICD-9-CM diagnosis code must be reported in Form Locator (FL) 69, Patient Reason for Visit, (FL 70) or FL 67, principal diagnosis, or both, in order for the hospital to receive separate payment for APC 0339.

2 If a qualifying ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis field but is not reported in either the Patient Reason for Visit field (FL

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70) or in the principal diagnosis field (FL 67), separate payment for APC 0339 will not be allowed.

FIGURE 13-2-2 REQUIRED DIAGNOSES FOR CHEST PAIN

ICD-9-CM	DESCRIPTION
411.0	Postmyocardila infarction syndrome
411.1	Intermediate coronary syndrome
411.81	Coronary occlusion without myocardial infarction
411.89	Other acute ischemic heart disease
413.0	Angina decubitus
413.1	Pinzmetal angina
413.9	Other and unspecified angina pectoris
786.05	Shortness of breath
786.50	Chest pain, unspecified
786.51	Precordial pain
786.52	Painful respiration
786.59	Other chest pain

FIGURE 13-2-3 REQUIRED DIAGNOSES FOR ASTHMA

ICD-9-CM	DESCRIPTION
493.01	Extrinsic asthma with status asthmaticus
493.02	Extrinsic asthma with acute exacerbation
493.11	Intrinsic asthma with status asthmaticus
493.12	Intrinsic asthma with acute exacerbation
493.21	Chronic obstructive asthma with status asthmaticus
493.22	Chronic obstructive asthma with acute exacerbation
493.91	Asthma, unspecified with status asthmaticus
493.92	Asthma, unspecified with acute exacerbation

FIGURE 13-2-4 REQUIRED DIAGNOSES FOR CONGESTIVE HEART FAILURE

ICD-9-CM	DESCRIPTION
391.8	Other acute rheumatic heart disease
398.91	Rheumatic heart failure (congestive)
402.01	Malignant hypertensive heart disease with congestive heart failure
402.11	Benign hypertensive heart disease with congestive heart failure
402.91	Unspecified hypertensive heart disease with congestive heart failure

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FIGURE 13-2-4 REQUIRED DIAGNOSES FOR CONGESTIVE HEART FAILURE (CONTINUED)

ICD-9-CM	DESCRIPTION
404.01	Malignant hypertensive heart and renal disease with congestive heart failure
404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure
404.11	Benign hypertensive heart and renal disease with congestive heart failure
404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure
404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
404.93	Unspecified hypertensive heart and renal disease with congestive heart and renal failure
428.0	Congestive heart failure
428.1	Left heart failure
428.20	Unspecified systolic heart failure
428.21	Acute systolic heart failure
428.22	Chronic systolic heart failure
428.23	Acute or chronic systolic heart failure
428.30	Unspecified diastolic heart failure
428.31	Acute diastolic heart failure
428.32	Chronic diastolic heart failure
428.33	Acute or chronic diastolic heart failure
428.40	Unspecified combined systolic and diastolic heart failure
428.41	Acute combined systolic and diastolic heart failure
428.42	Chronic combined systolic and diastolic heart failure
428.43	Acute or chronic combined systolic and diastolic heart failure
428.9	Heart failure, unspecified

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: **0 unspecified as to episode of care or not applicable** **1 delivered, with or without mention of antepartum condition** **2 delivered, with mention of postpartum complication** **3 antepartum condition or complication** **4 postpartum condition or complication**		
V22	Normal pregnancy	
V22.0	Supervision of normal first pregnancy	
V22.1	Supervision of other normal pregnancy	

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FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: **0 unspecified as to episode of care or not applicable** **1 delivered, with or without mention of antepartum condition** **2 delivered, with mention of postpartum complication** **3 antepartum condition or complication** **4 postpartum condition or complication**		
V22.2	Pregnant state, incidental	
V23	Supervision of high-risk pregnancy	
V23.0	Pregnancy with history of infertility	
V23.1	Pregnancy with history of trophoblastic disease	
V23.2	Pregnancy with history of abortion	
V23.3	Grand multiparity	
V23.4	Pregnancy with other poor obstetric history	
V23.41	Pregnancy with history of pre-term labor	
V23.49	Pregnancy with other poor obstetric history	
V23.5	Pregnancy with other poor reproductive history	
V23.7	Insufficient prenatal care	
V23.81	Elderly primigravida	
V23.82	Elderly multigravida	
V23.83	Young primigravida	
V23.84	Young multigravida	
V23.89	Other high-risk pregnancy	
V23.9	Unspecified high-risk pregnancy	
630	Hydatidiform mole	
631	Other abnormal product of conception	
632	Missed abortion	
633.00	Abdominal pregnancy without intrauterine pregnancy	
633.01	Abdominal pregnancy with intrauterine pregnancy	
633.10	Tubal pregnancy without intrauterine pregnancy	
633.11	Tubal pregnancy with intrauterine pregnancy	
633.20	Ovarian pregnancy without intrauterine pregnancy	
633.21	Ovarian pregnancy with intrauterine pregnancy	
633.80	Other ectopic pregnancy without intrauterine pregnancy	
633.81	Other ectopic pregnancy with intrauterine pregnancy	
633.90	Unspecified ectopic pregnancy without intrauterine pregnancy	

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FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: **0 unspecified as to episode of care or not applicable** **1 delivered, with or without mention of antepartum condition** **2 delivered, with mention of postpartum complication** **3 antepartum condition or complication** **4 postpartum condition or complication**		
633.91	Unspecified ectopic pregnancy with intrauterine pregnancy	
640.0	Threatened abortion	0, 3
640.8	Other specified hemorrhage in early pregnancy	0, 3
640.9	Unspecified hemorrhage in early pregnancy	0, 3
641.0	Placenta previa without hemorrhage	0, 3
641.1	Hemorrhage from placenta previa	0, 3
641.2	Premature separation of placenta	0, 3
641.3	Antepartum hemorrhage associated with coagulation defects	0, 3
641.8	Other antepartum hemorrhage	0, 3
641.9	Unspecified antepartum hemorrhage	0, 3
642.0	Benign essential hypertension complicating pregnancy, childbirth and the puerperium	0, 3
642.1	Hypertension secondary to renal disease, complicating pregnancy, childbirth and the puerperium	0, 3
642.2	Other pre-existing hypertension complicating pregnancy, childbirth and the puerperium	0, 3
642.3	Transient hypertension of pregnancy	0, 3
642.4	Mild or unspecified pre-eclampsia	0, 3
642.5	Severe pre-eclampsia	0, 3
642.6	Eclampsia	0, 3
642.7	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension	0, 3
642.9	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium	0, 3
643.0	Mild hyperemesis gravidarum	0, 3
643.1	Hyperemesis gravidarum with metabolic disturbance	0, 3
643.2	Late vomiting of pregnancy	0, 3
643.8	Other vomiting complicating pregnancy	0, 3
643.9	Unspecified vomiting of pregnancy	0, 3
644.0	Threatened premature labor	0, 3

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FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: **0 unspecified as to episode of care or not applicable** **1 delivered, with or without mention of antepartum condition** **2 delivered, with mention of postpartum complication** **3 antepartum condition or complication** **4 postpartum condition or complication**		
644.1	Other threatened labor	0, 3
644.2	Early onset of delivery	0, 3
645.1	Post term pregnancy	0, 3
645.2	Prolonged pregnancy	0, 3
646.0	Papyraceous fetus	0, 3
646.1	Edema or excessive weight gain in pregnancy, without mention of hypertension	0, 3
646.2	Unspecified renal disease in pregnancy, without mention of hypertension	0, 3
646.3	Habitual aborter	0, 3
646.4	Peripheral neuritis in pregnancy	0, 3
646.5	Asymptomatic bacteriuria in pregnancy	0, 3
646.6	Infections of genitourinary tract in pregnancy	0, 3
646.7	Liver disorders in pregnancy	0, 3
646.8	Other specified complications of pregnancy	0, 3
646.9	Unspecified complication of pregnancy	0, 3
647.0	Syphilis	0, 3
647.1	Gonorrhea	0, 3
647.2	Other venereal diseases	0, 3
647.3	Tuberculosis	0, 3
647.4	Malaria	0, 3
647.5	Rubella	0, 3
647.6	Other viral diseases	0, 3
647.8	Other specified infectious and parasitic diseases	0, 3
648.0	Diabetes mellitus	0, 3
648.1	Thyroid dysfunction	0, 3
648.2	Anemia	0, 3
648.3	Drug dependence	0, 3
648.4	Mental disorders	0, 3

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: **0 unspecified as to episode of care or not applicable** **1 delivered, with or without mention of antepartum condition** **2 delivered, with mention of postpartum complication** **3 antepartum condition or complication** **4 postpartum condition or complication**		
648.5	Congenital cardiovascular disorders	0, 3
648.6	Other cardiovascular diseases	0, 3
648.7	Bone and joint disorders of back, pelvis, and lower limbs	0, 3
648.8	Abnormal glucose tolerance	0, 3
648.9	Other current conditions classifiable elsewhere	0, 3
649.0	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium	0, 3
649.1	Obesity complicating pregnancy, childbirth, or the puerperium	0, 3
649.2	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium	0, 3
649.3	Coagulation defects complicating pregnancy, childbirth, or the puerperium	0, 3
649.4	Epilepsy complicating pregnancy, childbirth, or the puerperium	0, 3
649.5	Spotting complicating pregnancy	0, 3
649.6	Uterine size date descrepancy	0, 3
650	Normal delivery	
651.0	Twin pregnancy	0, 3
651.1	Triplet pregnancy	0, 3
651.2	Quadruplet pregnancy	0, 3
651.3	Twin pregnancy with fetal loss and retention of one fetus	0, 3
651.4	Triplet pregnancy with fetal loss and retention of one or more fetus(es)	0, 3
651.5	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es)	0, 3
651.6	Other multiple pregnancy with fetal loss and retention of one or more fetus(es)	0, 3
651.8	Other specified multiple gestation	0, 3
651.9	Unspecified multiple gestation	0, 3
655.0	Central nervous system malformation in fetus	0, 3
655.1	Chromosomal abnormality in fetus	0, 3

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION	VALID 5TH DIGIT
Fifth digit subclassification denotes the current episode of care: **0 unspecified as to episode of care or not applicable** **1 delivered, with or without mention of antepartum condition** **2 delivered, with mention of postpartum complication** **3 antepartum condition or complication** **4 postpartum condition or complication**		
655.2	Hereditary disease in family possibly affecting fetus	0, 3
655.3	Suspected damage to fetus from viral disease in the mother	0, 3
655.4	Suspected damage to fetus from other disease in the mother	0, 3
655.5	Suspected damage to fetus from drugs	0, 3
655.6	Suspected damage to fetus from radiation	0, 3
655.7	Decreased fetal movements	0, 3
655.8	Other known or suspected fetal abnormality, not elsewhere classified	0, 3
655.9	Unspecified	0, 3
656.0	Fetal-maternal hemorrhage	0, 3
656.1	Rhesus isoimmunization	0, 3
656.2	Isoimmunization from other and unspecified blood-group incompatibility	0, 3
656.3	Fetal distress	0, 3
656.4	Intrauterine death	0, 3
656.5	Poor fetal growth	0, 3
656.6	Excessive fetal growth	0, 3
656.7	Other placental conditions	0, 3
656.8	Other specified fetal and placental problems	0, 3
656.9	Unspecified fetal and placental problem	0, 3
657.0	Polyhydramnios	0, 3
658.0	Oligohydramnios	0, 3
658.1	Premature rupture of membranes	0, 3
658.2	Delayed delivery after spontaneous or unspecified rupture of membranes	0, 3
658.3	Delayed delivery after artificial rupture of membrane	0, 3
658.4	Infection of amniotic cavity	0, 3
658.8	Other	0, 3
658.9	Unspecified	0, 3
664.6	Anal sphincter tear	0

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

(2) Observation time requirements.

(a) Observation time must be documented in the medical record.

(b) A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

(c) A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

(d) The number of units reported with HCPCS code G0378 must equal or exceed 8 hours for observation stays with diagnoses of chest pain, asthma or congestive heart failure and a minimum of 4 hours for maternity observations services.

(3) Additional hospital services provided before, during and after receiving observation care.

(a) The hospital must provide on the same day or the day before and report on the same claim for asthma, chest pain and congestive heart failure:

1 An emergency department visit (APC 0310, 0611, or 0612); or

2 A clinic visit (APC 0600, 0601, or 0602); or

3 Critical care (APC 0620); or

4 Direct admission to observation services using HCPCS code G0379 (APC 0600).

NOTE: The above criteria does not apply to maternity observation stays.

(b) No procedure with a SI of "T" can be reported on the same day or day before observation care is provided.

(4) Ongoing physician evaluation.

(a) The beneficiary must 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.

(b) The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

e. Additional billing requirements.

(1) Separate payment for observation stays that meet the required conditions are only allowed when billed as a 013X bill type.

(2) Observation stays that qualify for separate payment will be reimbursed one observation APC for each qualifying occurrence.

(3) If the period of observation spans more than one calendar day, hospitals should include all of the hours for the entire period of observation on a single line and enter as the date of service for that line the date the patient is admitted to observation.

(4) If there are multiple maternity observation stays on the same day without condition code G0 or 27 to indicate that the visits were distinct and independent of each other, pay for the first listed observation stay and deny the rest; i.e., line item denial for all subsequent observation stays listed on that particular day.

(5) Do not allow separate payment for any hours a beneficiary spends in observation over 24 hours; all costs beyond 24 hours will be included in the APC payment for observation services.

(6) The previous requirement for specific diagnostic testing for coverage/ reimbursement of observation stays was removed. Instead clinical judgement, in combination with an internal and external quality review process, will be relied upon to ensure that appropriate diagnostic testing (which is expected to include some of the previously required diagnostic tests) is provided for patients receiving high quality medically necessary observation care.

(7) Medical review is no longer required for observation stays longer than 24 hours.

(8) All other observation stays (i.e., observation stays that do not meet the criteria/requirements for separate payment under HCPCS code G0378) will be packaged under the primary procedure.

l. Inpatient Only Procedures.

1. The inpatient list on TMA's OPPS web site at http://www.tricare.mil/opps specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. Denial of payment for procedures on the inpatient only list are appealable under the Appeal of Factual (Non-Medical Necessity) Determinations. Refer to the TRICARE Operations Manual (TOM), Chapter 13, Section 5 for appeal procedures.

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

2. The following criteria are used when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under OPPS:

a. Most outpatient departments are equipped to provide the services to the Medicare population.

b. The simplest procedure described by the code may be performed in most outpatient departments.

c. The procedure is related to codes that we have already removed from the inpatient list.

d. It has been determined that the procedure is being performed in multiple hospitals on an outpatient basis.

3. Under the hospital outpatient PPS, payment will not be made for procedures that are designated as "inpatient only". Refer to TMA's Inpatient Procedures web site at http://www.tricare.mil/inpatientprocedures for a list of "inpatient only" procedures.

4. The list will be updated in response to comments as often as quarterly to reflect current advances in medical practice.

5. On rare occasions, a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient.

a. Hospitals are instructed to submit an outpatient claim for all services furnished, including the procedure code with SI of "C" to which a newly designated modifier (-CA) is attached.

b. Such patients would typically receive services such as those provided during a high-level emergency visit, appropriate diagnostic testing (X-ray, CT scan, EKG, and so forth) and administration of intravenous fluids and medication prior to the surgical procedure.

c. Because these combined services constitute an episode of care, claims will be paid with a procedure code on the inpatient list that is billed with the new modifier under new technology APC 0375 (Ancillary Outpatient Services when Patient expires). Separate payment will not be allowed for other services furnished on the same date.

d. The -CA modifier is not to be used to bill for a procedure with SI of "C" that is performed on an elective basis or scheduled to be performed on a patient whose status is that of an outpatient.

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

J. APC For Vaginal Hysterectomy.

When billing for vaginal hysterectomies, hospitals must use procedure code 58260, which will be assigned to APC 0202.

K. Billing of Condition Codes Under OPPS.

The CMS 1450 UB-04 claim form allows 11 values for condition codes, however, the OCE can only accommodate seven, therefore, OPPS hospitals should list those condition codes that affect outpatient pricing first.

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