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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 69
6010.55-M
NOVEMBER 6, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/ revision(s) to the 6010.55-M, issued August 2002.

CHANGE TITLE: **FINAL IMPLEMENTING INSTRUCTIONS FOR PHASE I (DEVELOPMENT AND IMPLEMENTATION) TO THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)**

PAGE CHANGE(S): See pages 2 and 3.

SUMMARY OF CHANGE(S): Ongoing changes/clarifications to TRICARE Hospital OPPS.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TOM, Change No. 56, Aug 2002 TPM, Change No. 63, and Aug 2002 TSM, Change No. 52.

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 174 PAGE(S)
DISTRIBUTION: 6010.55-M

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

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6010.55-M
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CHAPTER 1
SECTION 15

LEGEND DRUGS AND INSULIN

ISSUE DATE: August 26, 1985
AUTHORITY: 32 CFR 199.4(d)(3)(vi)

I. APPLICABILITY

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

II. ISSUE

How are legend drugs and insulin to be reimbursed?

III. POLICY

A. Pricing of legend drugs (those drugs that require a prescription by law) and insulin will depend on the claimant: beneficiary (consolidated drug claim) or provider (vendor pharmacy or physician).

B. For beneficiary submitted claims, reimbursement is to be based on the billed charge. For vendor pharmacy (participating provider) submitted claims, the allowable charge for outpatient prescription drugs paid to a vendor pharmacy will be the acquisition cost (taking into account the strength, quantity, and generic/nongeneric status) plus a flat amount determined by the contractor for each prescription. This fixed fee does not apply to insulin. The acquisition cost should include the sales tax.

C. The acquisition cost of drugs for participating providers, i.e., vendor pharmacies, physicians, etc., is to be determined from the Drug Topics Blue Book, which lists the wholesale price. In all cases the contractor is to use the latest annual edition of the Blue Book as well as the monthly updates.

D. Allergy preparations are custom made in a laboratory and are not considered prescription drugs. Since the cost of these allergy preparations are not found in the Drug Topics Blue Book, reimbursement will be based on the allowable charge methodology. The prevailing will include both the cost of the drug and the administrative fee. An allowance of a separate additional charge for an "office visit" would not be warranted where the services rendered did not really constitute a regular office visit.

E. The Centers for Medicare and Medicaid Services Common Procedure Coding System, National Level II Medicare "J" codes are to be priced using the following. Drugs administered other than oral method, including chemotherapy drugs, are to be priced from the "J" code pricing file except for home infusion drugs furnished through a covered item of durable medical equipment which will be paid the lesser of the billed amount or 95 percent of the AWP retroactive back to April 1, 2005. However, this retroactive coverage will not require the contractors to research their claims history and adjust previously submitted home infusion drug claims unless brought to their attention by a provider. Home infusion drugs will be billed using the appropriate J-code along with a specific National Drug Code (NDC) for pricing. The unique HCPCS "J" code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. Drugs that do not appear on the Medicare "J" code pricing file will also be priced using 95% of the AWP.

F. A separate payment shall be made for the pharmacy compounding and dispensing services under HCPCS S9430.

- END -

CHAPTER 1
SECTION 16

SURGERY

ISSUE DATE: August 26, 1985
AUTHORITY: 32 CFR 199.4(c)(2)(i), (c)(2)(ii), (c)(3)(i), (c)(3)(iii), and (c)(3)(iv)

I. APPLICABILITY

Paragraphs III.A. through G. apply to reimbursement of services provided by network and non-network providers. Paragraphs III.H. and I. apply only to non-network providers.

II. ISSUE

How is surgery to be reimbursed?

III. POLICY

A. Multiple Surgery and Discounting Reimbursement.

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

a. Discounting for Multiple Procedures.

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

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

(a) The reduced payment would apply only to the surgical procedure with the lower payment rate.

(b) The reduced payment for multiple procedures would apply to both the beneficiary copayment/cost-share and the TRICARE payment.

b. Discounting for Bilateral Procedures.

NOTE: Bilateral codes can be surgical and non-surgical.

(1) Following are the different categories/classifications of bilateral procedures:

(a) Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

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

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

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

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

(4) The above bilateral procedures will be discounted based on the application of discounting formulas appearing in Chapter 13, Section 3, paragraph III.A.5.c.(6) and (7).

c. Modifiers for Discounting Terminated Surgical Procedures.

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

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

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

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

2. Exceptions to the above policy prior to implementation of the hospital OPPS, are:

a. 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.

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

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.

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.

5. The OPPS inpatient only list shall apply to OPPS, non-OPPs, and professional providers. Refer to Chapter 13, Section 2, paragraph III.D. The inpatient only list is available on TMA's web site at http://www.tricare.mil/inpatientprocedures.

B. 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.

C. Assistant Surgeons. See Chapter 1, Section 17.

D. 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.

E. 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.

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

G. 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.

H. Second Opinion.

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

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

I. 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 ambulatory surgery center.

J. Upon implementation of OPPS, surgical procedures will be discounted in accordance with the provisions outlined in Chapter 13, Section 3, paragraph III.A.5.b. and c.

- END -

CHAPTER 1
SECTION 24

HOSPITAL REIMBURSEMENT - OUTPATIENT SERVICES FOR ALL SERVICES PRIOR TO IMPLEMENTATION OF OPPS, AND THEREAFTER, FOR SERVICES NOT OTHERWISE REIMBURSED UNDER HOSPITAL OPPS

ISSUE DATE: March 10, 2000
AUTHORITY: 32 CFR 199.14(a)(3) and (a)(5)

I. APPLICABILITY

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

II. ISSUE

How are outpatient hospital services to be reimbursed for all services prior to implementation of Outpatient Prospective Payment System (OPPS), and thereafter, for services performed in facilities that are not subject to the hospital OPPS?

III. POLICY

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

B. For all other services, payment shall be made based on allowable charges when the claim has HCPCS (Level I, II, III) coding information (these may include ambulance, durable medical equipment (DME) and supplies, drugs administered other than oral method, and oxygen and related supplies). For claims development, see TRICARE Operations Manual (TOM), Chapter 8, Section 6. Other services without allowable charges, such as facility charges, shall be paid as billed. For reimbursing drugs administered other than oral method, see Chapter 1, Section 15, paragraph E.

C. When coding information is provided, outpatient hospital services including emergency and clinical services, clinical laboratory services, rehabilitation therapy, venipuncture, and radiology services are paid using existing allowable charges. Such services are reimbursed under the allowable charge methodology that would also include the

CMAC rates. In addition, venipuncture services provided on an outpatient basis by institutional providers other than hospitals are also paid on this basis. Professional services billed on a CMS 1450 UB-04 will be paid at the professional CMAC if billed with the professional service revenue code and enough information to identify the rendering provider.

D. Freestanding Ambulatory Surgical Center (ASC) services are to be reimbursed in accordance with Chapter 9, Section 1.

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

F. Surgical outpatient procedures which are not otherwise reimbursed under the hospital OPPS will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under OPPS for services rendered on or after implementation of OPPS. Refer to Chapter 1, Section 16, paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for further detail.

- END -

duty in support of operations that result from the terrorist attacks on the World Trade Center and the Pentagon on September 11, 2001.

(2) The cost-share is partially waived in certain cases for these beneficiaries. On claims from non-participating professional providers for services rendered to Standard beneficiaries, the allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CMAC). In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

(3) The exception to the deductible and cost-share requirements under Operation Noble Eagle/Operation Enduring Freedom for TRICARE Standard and Extra is effective for services rendered from September 14, 2001, through October 31, 2007.

d. For Certain Reservists. The Director, TRICARE Management Activity, may waive the individual or family deductible for dependents of a reserve component member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a reserve component member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 U.S.C. 101(a)(13). Also, for this purpose a dependent is a lawful husband or wife of the member or an eligible child.

B. TRICARE Prime.

1. Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See Chapter 2, Addendum A for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act, P.L. 106-398, for services provided on or after April 1, 2001, a $0 copayment shall be charged to TRICARE Prime ADFMs of active duty service members (ADSMs) who are enrolled in TRICARE Prime. Pharmacy copayments and Point of Service charges are not waived by the FY01 Authorization Act.

2. In instances where the CMAC or allowable charge is less than the copayment shown on Addendum A, network providers may only collect the lower of the allowable charge or the applicable copayment.

3. The TRICARE Prime copayment requirement for emergency room services is on a PER VISIT basis; this means that only one copayment is applicable to the entire emergency room episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers.

4. No copayments or authorizations are required for TRICARE Prime clinical preventive services which are described in the TPM, Chapter 7, Section 2.2.

5. Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply):

a. Diagnostic radiology and ultrasound services included in the CPT[1] procedure code range from 70000 through 76999;

b. Diagnostic nuclear medicine services included in the CPT[1] procedure code range from 78000 through 78999;

c. Pathology and laboratory services included in the CPT[1] procedure code range from 80000 through 89399; and

d. Cardiovascular studies included in the CPT[1] procedure code range from 93000 through 93350.

e. Venipuncture included in the CPT[1] procedure code range from 36400 - 36416.

f. Fetal monitoring for CPT[1] procedure codes 59020, 59025, and 59050.

NOTE: Contractors are not required to search their files for claims for ancillary services which were not processed according to these guidelines. The contractor shall, however, if requested by an appropriate individual, adjust specific claims under these guidelines if the date of service is on or after March 26, 1998.

6. Point of Service option. See Chapter 2, Section 3.

C. Basic Program: TRICARE Standard.

1. Deductible Amount: Outpatient Care.

a. For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(1) Deductible, Individual: Each beneficiary is liable for the first fifty dollars ($50.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

(2) Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars ($100.00).

[1] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

b. For care rendered on or after April 1, 1991, for all TRICARE beneficiaries except family members of active duty sponsors of pay grade E-4 or below.

(1) Deductible, Individual: Each beneficiary is liable for the first one hundred and fifty dollars ($150.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

(2) Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed three hundred dollars ($300.00).

c. TRICARE-Approved Ambulatory Surgery Centers (ASCs), Birthing Centers, or Partial Hospitalization Programs (PHPs). No deductible shall be applied to allowable amounts for services or items rendered to ADFMs or authorized NATO family members.

d. Allowable Amount Does Not Exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than $100.00 (or $300.00 if paragraph I.C.1.b., applies), and no one beneficiary's allowable amounts exceed $50.00 (or $150.00 if paragraph I.C.1.b., applies), neither the family nor the individual deductible will have been met and no TRICARE benefits are payable.

e. In the case of family members of an active duty member of pay grade E-5 or above, with Persian Gulf conflict service who is, or was, entitled to special pay for hostile fire/imminent danger authorized by 37 U.S.C. 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm, the deductible shall be the amount specified in paragraph I.C.1.b., for care rendered after October 1, 1991.

NOTE: The provisions of paragraph I.C.1.e., also apply to family members of service members who were killed in the Gulf, or who died subsequent to Gulf service; and to service members who retired prior to October 1, 1991, after having served in the Gulf war, and to their family members.

f. Effective December 8, 1995, the annual TRICARE deductible has been waived for family members of selected reserve members called to active duty for 31 days or more in support of Operation Joint Endeavor (the Bosnia peacekeeping mission). Under a nationwide demonstration, TRICARE may immediately begin cost-sharing in accordance with standard TRICARE rules. These beneficiaries will be eligible to use established TRICARE Extra network providers at a reduced cost-share rate. Additionally, in those areas where TRICARE is in full operation, selected reserve members called to active duty for 31 days or more will have the option of enrolling their families in TRICARE Prime.

NOTE: This demonstration is effective December 8, 1995, and is in effect until such time as Executive Order 12982 expires. TRICARE eligible beneficiaries other than family members of reservists called to active duty in support of Operation Joint Endeavor are not eligible for participation. This demonstration is limited to the annual TRICARE Standard and Extra deductible; other TRICARE cost-sharing continues to apply. All current TRICARE rules, unless specifically provided otherwise, will continue to apply.

NOTE: Initially the option to enroll in TRICARE Prime was limited to family members of selected reserve members who were called to active duty for 179 days or more. This changed to 31 days or more as of March 10, 2003.

NOTE: Claims for these beneficiaries are to be paid from financially underwritten funds and reported as such. TMA periodically will calculate and reimburse the contractors for the additional costs incurred as a result of waiving the deductibles on these claims.

g. Adjustment of Excess. Any beneficiary identified under paragraph I.C.1.d., e., and f., above, who paid any deductible in excess of the amounts stipulated is entitled to an adjustment of any amount paid in excess against the annual deductible required under those paragraphs.

NOTE: The contractors need not search their records for deductibles paid in excess, but are authorized and required to adjust any deductible amounts paid in excess that are brought to their attention and that are verifiable.

h. The deductible amounts identified in this section shall be deemed to have been satisfied if the catastrophic cap amounts identified in Chapter 2, Section 2 have been met for the same fiscal year in which the deductible applies.

2. Deductible Amount: Inpatient Care: None.

3. Cost-share Amount:

a. Outpatient Care.

(1) ADFM or Authorized NATO Beneficiary. The cost-share for outpatient care is 20% of the allowable amount in excess of the annual deductible amount. This includes the professional charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC or birthing center.

(2) Other Beneficiary. The cost-share applicable to outpatient care for other than active duty and authorized NATO family member beneficiaries is 25% of the allowable amount in excess of the annual deductible amount. This includes: partial hospitalization for alcohol rehabilitation; professional charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC.

b. Inpatient Care.

(1) ADFM: Except in the case of mental health services, ADFMs or their sponsors are responsible for the payment of the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater. (Please reference daily rate chart below.) (For care provided on or after April 1, 2001, for Prime ADFMs, copayment is $0.)

UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS	
Use the daily charge (per diem rate) in effect for each day of the stay to calculate a cost-share for a stay which spans periods.	
PERIOD	**DAILY CHARGE**
October 1, 1997 - September 30, 1998	$10.20
October 1, 1998 - September 30, 1999	$10.45
October 1, 1999 - September 30, 2000	$10.85
October 1, 2000 - September 30, 2001	$11.45
April 1, 2001 (for Prime ADFMs only)	$0.00
October 1, 2001 - September 30, 2002 (for ADFMs not enrolled in Prime)	$11.90
October 1, 2002 - September 30, 2003 (for ADFMs not enrolled in Prime)	$12.72
October 1, 2003 - September 30, 2004 (for ADFMs not enrolled in Prime)	$13.32
October 1, 2004 - September 30, 2005 (for ADFMs not enrolled in Prime)	$13.90
October 1, 2005 - September 30, 2006 (for ADFMs not enrolled in Prime)	$14.35
October 1, 2006 - September 30, 2007 (for ADFMs not enrolled in Prime)	$14.80
October 1, 2007 - September 30, 2008 (for ADFMs not enrolled in Prime)	$15.15

(2) Other Beneficiaries: For services exempt from the DRG-based payment system and the mental health per diem payment system and services provided by institutions other than hospitals (i.e., RTCs), the cost-share shall be 25% of the allowable charges.

c. Cost-Shares: Maternity.

(1) Determination. Maternity care cost-share shall be determined as follows:

(a) Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded.

NOTE: Inpatient cost-share formula applies to prenatal and postnatal care provided in the office of a civilian physician or certified nurse-midwife in connection with maternity care ending in childbirth or termination of pregnancy in, or on the way to, a military treatment facility inpatient childbirth unit. ADFMs pay a per diem charge (or a $25.00 minimum charge) for an admission and there is no separate cost-share for them for separately billed professional charges or prenatal or postnatal care.

(b) Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted, and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

(c) Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

(d) Otherwise covered medical services and supplies directly related to "Complications of pregnancy", as defined in the Regulation, will be cost-shared on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

(2) Otherwise authorized services and supplies related to maternity care, including maternity related prescription drugs, shall be cost-shared on the same basis as the termination of pregnancy.

(3) Claims for pregnancy testing are cost-shared on an outpatient basis when the delivery is on an inpatient basis.

(4) Where the beneficiary delivers in a professional office birthing suite located in the office of a physician or certified nurse-midwife (which is not otherwise a TRICARE-approved birthing center) the delivery is to be adjudicated as an at-home birth.

(5) Claims for prescription drugs provided on an outpatient basis during the maternity episode but not directly related to the maternity care are cost-shared on an outpatient basis.

(6) Newborn cost-share. Effective for all inpatient admissions occurring on or after October 1, 1987, separate claims must be submitted for the mother and newborn. The cost-share for inpatient claims for services rendered to an beneficiary newborn is determined as follows:

(a) IN A DRG HOSPITAL:

1 Same newborn date of birth and date of admission.

2 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

3 For newborn family members of other than active duty members, unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of the number of hospital days minus three (3) multiplied by the per diem amount, OR 25% of the total billed charges (less duplicates and DRG non-reimbursables such as hospital-based professional charges).

4 Different newborn date of birth and date of admission. For family members of active duty members, there will be no cost-share during the period the newborn is deemed enrolled in Prime. For all other beneficiaries, the cost-share is applied to all days in the inpatient stay unless the newborn is deemed enrolled in Prime.

(b) IN DRG EXEMPT HOSPITAL:

1 Same newborn date of birth and date of admission.

2 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

3 For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

4 Different newborn date of birth and date of admission.

5 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

6 For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

(7) Maternity Related Care. Medically necessary treatment rendered to a pregnant woman for a non-obstetrical medical, anatomical, or physiological illness or condition shall be cost-shared as a part of the maternity episode when:

(a) The treatment is otherwise allowable as a benefit, and,

(b) Delay of the treatment until after the conclusion of the pregnancy is medically contraindicated, and,

(c) The illness or condition is, or increases the likelihood of, a threat to the life of the mother, or,

(d) The illness or condition will cause, or increase the likelihood of, a stillbirth or newborn injury or illness, or,

(e) The usual course of treatment must be altered or modified to minimize a defined risk of newborn injury or illness.

d. Cost-Shares: DRG-Based Payment System.

(1) General. These special cost-sharing procedures apply only to claims paid under the DRG-based payment system.

(2) TRICARE Standard.

(a) Cost-shares for ADFMs.

1 Except in the case of mental health services, ADFMs or their sponsors are responsible for the payment of the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

2 Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is $20 per day for each day of the inpatient admission.

(b) Cost-shares for beneficiaries other than ADFMs.

1 The cost-share will be the lesser of:

a An amount based on a single, specific per diem amount which will not vary regardless of the DRG involved. The following is the DRG inpatient TRICARE Standard cost-sharing per diems for beneficiaries other than ADFMs.

For FY 2005, the daily rate is $512.

For FY 2006, the daily rate is $535.

For FY 2007, the daily rate is capped at the FY 2006 level of $535, per Section 704 of NDAA FY 2007.

For FY 2008, the daily rate is $535.

(1) The per diem amount will be calculated as follows:

(a) Determine the total allowable DRG-based amounts for services subject to the DRG-based payment system and for beneficiaries other than ADFMs during the same database period used for determining the DRG weights and rates.

(b) Add in the allowance for capital and direct medical education which have been paid to hospitals during the same database period used for determining the DRG weights and rates.

(c) Divide this amount by the total number of patient days for these beneficiaries. This amount will be the average cost per day for these beneficiaries.

(d) Multiply this amount by 0.25. In this way total cost-sharing amounts will continue to be 25% of the allowable amount.

(e) Determine any cost-sharing amounts which exceed 25% of the billed charge (see paragraph I.C.3.d.(2)(b)1b below) and divide this amount by the total number of patient days in paragraph I.C.3.d.(2)(b)1a above). Add this amount to the amount in paragraph I.C.3.d.(2)(b)1a above. This is the per diem cost-share to be used for these beneficiaries.

(2) The per diem amount will be required for each actual day of the beneficiary's hospital stay which the DRG-based payment covers except for the day of discharge. When the payment ends on a specific day because eligibility ends on either a long-stay or short-stay outlier day, the last day of eligibility is to be counted for determining the per diem cost-sharing amount. For claims involving a same-day discharge which qualify

as an inpatient stay (e.g., the patient was admitted with the expectation of a stay of several days, but died the same day) the cost-share is to be based on a one-day stay. (The number of hospital days must contain one day in this situation.) Where long-stay outlier days are subsequently determined to be not medically necessary by a PRO, no cost-share will be required for those days, since payment for such days will be the beneficiary's responsibility entirely.

b Twenty-five percent (25%) of the billed charge. The billed charge to be used includes all inpatient institutional line items billed by the hospital minus any duplicate charges and any charges which can be billed separately (e.g., hospital-based professional services, outpatient services, etc.). The net billed charges for the cost-share computation include comfort and convenience items.

2 Under no circumstances can the cost-share exceed the DRG-based amount.

3 Where the dates of service span different fiscal years, the per diem cost-share amount for each year is to be applied to the appropriate days of the stay.

(3) TRICARE Extra.

(a) Cost-shares for ADFMs. The cost-sharing provisions for ADFMs are the same as those for TRICARE Standard.

(b) Cost-shares for beneficiaries other than ADFMs. The cost-sharing provisions for beneficiaries other than ADFMs is the same as those for TRICARE Standard, except the per diem copayment is $250.

(4) TRICARE Prime. Cost-shares for ADFMs. The cost-sharing provision for ADFMs is the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or a per diem rate of $11, whichever is greater. For care provided on or after April 1, 2001, for Prime ADFMs, cost-share is $0. See attached Table 1 of this Policy for further information.

(5) Maternity Services. See paragraph I.C.3.c., for the cost-sharing provisions for maternity services.

e. Cost-Shares: Inpatient Mental Health Per Diem Payment System.

(1) General. These special cost-sharing procedures apply only to claims paid under the inpatient mental health per diem payment system. For inpatient claims exempt from this system, the procedures in paragraph I.C.3.b. or paragraph I.C.3.d. are to be followed.

(2) Cost-shares for ADFMs. Effective for care on or after October 1, 1995 and care on or prior to March 31, 2001, the inpatient cost-sharing for mental health services is $20 per day for each day of the inpatient admission. This $20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any residential treatment facility, any substance use disorder rehabilitation facility, and any PHP providing mental

health or substance use disorder rehabilitation services. For Prime ADFMs care provided on or after April 1, 2001, cost-share is $0 per day. See Table 1 of this Policy for further information.

(3) Cost-shares for beneficiaries other than ADFMs.

(a) Higher volume hospitals and units. With respect to care paid for on the basis of a hospital specific per diem, the cost-share shall be 25% of the hospital specific per diem amount.

(b) Lower volume hospitals and units. For care paid for on the basis of a regional per diem, the cost-share shall be the lower of paragraph I.C.3.e.(3)(b)1 or paragraph I.C.3.e.(3)(b)2 below:

1 A fixed daily amount multiplied by the number of covered days. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the inpatient mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to Chapter 7, Section 1. This fixed daily amount will also be furnished to contractors by TMA. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

a Fiscal Year 1998 - $137 per day.

b Fiscal Year 1999 - $140 per day.

c Fiscal Year 2000 - $144 per day.

d Fiscal Year 2001 - $149 per day.

e Fiscal Year 2002 - $154 per day.

f Fiscal Year 2003 - $159 per day.

g Fiscal Year 2004 - $164 per day.

h Fiscal Year 2005 - $169 per day.

i Fiscal Year 2006 - $175 per day.

j Fiscal Year 2007 - $181 per day.

k Fiscal Year 2008 - $187 per day.

2 Twenty-five percent (25%) of the hospital's billed charges (less any duplicates).

(4) Claim which spans a period in which two separate per diems exist. A claim subject to the Inpatient Mental Health Per Diem Payment System which spans a period in which two separate per diems exist shall have the cost-share computed on the actual per diem in effect for each day of care.

(5) Cost-share whenever leave days are involved. There is no patient cost-share for leave days when such days are included in a hospital stay.

(6) Claims for services that are provided during an inpatient admission which are not included in the per diem rate are to be cost-shared as an inpatient claim if the contractor cannot determine where the service was rendered and the status of the patient when the service was provided. The contractor would need to examine the claim for place of service and type of service to determine if the care was rendered in the hospital while the beneficiary was an inpatient of the hospital. This would include non-mental health claims and mental health claims submitted by individual professional providers rendering medically necessary services during the inpatient admission.

f. Cost-Shares: Partial Hospitalization.

Cost-sharing for partial hospitalization is on an inpatient basis. The inpatient cost-share also applies to the associated psychotherapy billed separately by the individual professional provider. These providers will have to identify on the claim form that the psychotherapy is related to a partial hospitalization stay so the proper inpatient cost-sharing can be applied. Effective for care on or after October 1, 1995 and on or prior to March 31, 2001, the cost-share for ADFMs for inpatient mental health services is $20 per day for each day of the inpatient admission. For care provided on or after April 1, 2001, the cost-share for ADFMs enrolled in Prime for inpatient mental health services is $0. For retirees and their family members, the cost-share is 25% of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for ADFMs is to be taken from the PHP claim.

g. Cost-Shares: Ambulatory Surgery.

For the basis of payment of ambulatory surgery, see Chapter 9, Section 1.

(1) ADFMs or Authorized NATO Beneficiary. For all services reimbursed as ambulatory surgery, the cost-share will be $25 and will be assessed on the facility claim. No cost-share is to be deducted from a claim for professional services related to ambulatory surgery. This applies whether the services are provided in a freestanding ASC, a hospital outpatient department or a hospital emergency room. So long as at least one procedure on the claim is reimbursed as ambulatory surgery, the claim is to be cost-shared as ambulatory surgery as required by this section-- that is, a $25 cost-share is to be assessed to the claim for the facility charges, and no cost-share is to be taken from any claim for related professional services.

(2) Other Beneficiaries. Since the cost-share for other beneficiaries is based on a percentage rather than a set amount, it is to be taken from all ambulatory surgery claims. For professional services, the cost-share is 25% of the allowed amount. For the facility claim, the cost-share is the lesser of:

(a) Twenty-five percent (25%) of the applicable group payment rate (see Chapter 9, Section 1); or

(b) Twenty-five percent (25%) of the billed charges; or

(c) Twenty-five percent (25%) of the allowed amount as determined by the contractor.

(d) The special cost-sharing provisions for beneficiaries other than ADFMs will ensure that these beneficiaries are not disadvantaged by these procedures. In most cases, 25% of the group payment rate will be less, but because there is some variation within each group, 25% of billed charges could be less in some cases. This will ensure that the beneficiaries get the benefit of the group payment rates when they are more advantageous, but they will never be disadvantaged by them. If there is no group payment rate for a procedure, the cost-share will simply be 25% of the allowed amount.

h. Cost-Shares and Deductible: Former Spouses.

(1) Deductible. In accordance with the FY 1991 Appropriations and Authorization Acts, Sections 8064 and 712 respectively, beginning April 1, 1991, an eligible former spouse is responsible for payment of the first one hundred and fifty dollars ($150.00) of the reasonable costs/charges for otherwise covered outpatient services and/or supplies provided in any one fiscal year. Although the law defines former spouses as family members of the member or former member, there is no legal familial relationship between the former spouse and the member or former member. Moreover, any TRICARE-eligible children of the former spouse will be included in the member's or former member's family deductible. Therefore, the former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of that of any TRICARE-eligible children. In other words, a former spouse must independently meet the $150.00 deductible in any fiscal year.

(2) Cost-Share. An eligible former spouse is responsible for payment of cost-sharing amounts identical to those required for beneficiaries other than ADFMs.

i. Cost-Share Amount: Under Discounted Rate Agreements. Under managed care, where there is a negotiated (discounted) rate agreed to by the network provider, the cost-share shall be based on the following:

(1) For noninstitutional providers providing outpatient care, and for institution-based professional providers rendering both inpatient and outpatient care; the cost-share (20%) for outpatient care to ADFMs, (25%) for care to all others) shall be applied to, (after duplicates and noncovered charges are eliminated), the lowest of the billed charge, the prevailing charge, the maximum allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge.

(2) For institutional providers subject to the DRG-based reimbursement methodology, the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

(a) The single, specific per diem supplied by TMA after the application of the agreed upon discount rate; OR,

(b) Twenty-five percent (25%) of the billed charge.

(3) For institutional providers subject to the Mental Health Per Diem Payment System (high volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be 25% of the hospital per diem amount after it has been adjusted by the discount.

(4) For institutional providers subject to the Mental Health per diem payment system (low volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

(a) The fixed daily amount supplied by TMA after the application of the agreed upon discount rate; OR,

(b) Twenty-five percent (25%) of the billed charge.

(5) For Residential Treatment Centers (RTC), the cost-share for other than ADFMs shall be 25% of the TRICARE rate after it has been adjusted by the discount.

(6) For institutions and for institutional services being reimbursed on the basis of the TRICARE-determined reasonable costs, the cost-share for beneficiaries other than ADFMs shall be 25% of the allowable billed charges **after** it has been adjusted by the discount.

NOTE: For all inpatient care for ADFMs, the cost-share shall continue to be either the daily charge or $25 per stay, whichever is higher. There is no change to the requirement for the ADFM's cost-share to be applied to the institutional charges for inpatient services. If the contractor learns that the participating provider has billed a beneficiary for a greater cost-share amount, based on the provider's usual billed charges, the contractor shall notify the provider that such an action is a violation of the provider's signed agreement. (Also, see paragraph I.C.3.d.) For Prime ADFMs, the cost-share is $0 for care provided on or after April 1, 2001.

D. TRICARE Extra.

1. For Extra deductibles and cost-shares, see Chapter 2, Addendum A.

2. If non-enrolled TRICARE beneficiary receives care from a network provider out of the region of residence, and if the beneficiary has not met the Fiscal Year Catastrophic Cap, the beneficiary shall pay the Extra cost-share to the provider. The contractor for the beneficiary's residence shall process the claim under TRICARE Extra claims processing

procedures if the TRICARE Encounter Provider Record (TEPRV) shows the provider to be contracted.

E. Cost-Shares: Ambulance Services.

For the basis of payment of ambulance services, see Chapter 1, Section 14.

1. Outpatient. The following are beneficiary copayment/cost-sharing requirements for medically necessary ambulance services when paid on an outpatient basis:

a. TRICARE Prime:

(1) For care provided prior to April 1, 2001, for ADFMs in pay grades E-1 through E-4, $10. For care provided on or after April 1, 2001, for ADFMs in pay grades E-1 through E-4, $0. See Chapter 2, Addendum A for further information.

(2) For care provided prior to April 1, 2001, for ADFMs in pay grades E-5 and above, $15. For care provided on or after April 1, 2001, for ADFMs in pay grades E-5 and above, $0. See Chapter 2, Addendum A for further information.

(3) For retirees and their family members, $20.

b. TRICARE Extra:

(1) A cost-share of 15% of the fee negotiated by the contractor for ADFMs.

(2) A cost-share of 20% of the fee negotiated by the contractor for retirees, their family members, and survivors.

c. TRICARE Standard:

(1) A cost-share of 20% of the allowable charge for ADFMs.

(2) A cost-share of 25% of the allowable charge for retirees, their family members, and survivors.

2. Inpatient: Non-Network Providers:

a. ADFMs: No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

b. Other Beneficiary: The cost-share applicable to inpatient care for beneficiaries other than ADFMs is 25% of the allowable amount.

F. Exceptions.

1. Inpatient cost-share applicable to each separate admission. A separate cost-share amount is applicable to each separate beneficiary for each inpatient admission EXCEPT:

a. Any admission which is not more than 60 days from the date of the last inpatient discharge shall be treated as one inpatient confinement with the last admission for cost-share amount determination.

b. Certain heart and lung hospitals are excepted from cost-share requirements. See Chapter 1, Section 28, entitled "Legal Obligation To Pay".

2. Inpatient Cost-Share: Maternity care. See paragraph I.C.3.c. All admissions related to a single maternity episode shall be considered one confinement regardless of the number of days between admissions. For ADFMs, the cost-share will be applied to the first institutional claim received.

3. Special Cost-Share Provisions. Effective October 1, 1987, the inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories cannot exceed that which would have been imposed if the service were subject to the DRG-based payment system. This will not affect ADFMs. For all other beneficiaries, the cost-share shall be the lesser of (1) that calculated according to paragraph I.C.3.b.(2), or (2) that calculated according to paragraph I.C.3.d.(2).

a. Child bone marrow transplant. All services related to discharges involving bone marrow transplant for a beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis code V42.8 and ICD-9 procedure codes 41.0 through 41.04, 41.06, and 41.91.

b. Child HIV Seropositivity. All services related to discharges involving HIV seropositive beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis codes 042, 079.53 and 795.71.

c. Child Cystic Fibrosis. All services related to discharges involving beneficiary less than 18 years old with ICD-9-CM principle or secondary diagnosis code 277.0 (cystic fibrosis).

4. Cost-Sharing for Family Members of a Member who Dies While on Active Duty. Those in Transitional Survivor status, are not distinguished from other ADFMs for cost-sharing purposes. After the Transitional Survivor status ends, eligible TRICARE beneficiaries may be placed in Survivor status and will be responsible for retiree cost-shares. See the Transitional Survivor Status policy in Chapter 10, Section 7.1.

G. Catastrophic Loss Protection.

See Chapter 2, Section 2.

- END -

CHAPTER 2
ADDENDUM A

BENEFITS AND BENEFICIARY PAYMENTS UNDER THE TRICARE PROGRAM

NOTE 1: Beneficiary copayments (i.e., beneficiary payments expressed as a specified amount) and enrollment fees may be updated for inflation annually (cumulative effect applied and rounded to the nearest whole dollar) by the national CPI-U medical index (the medical component of the Urban Consumer Price Index). Beneficiary cost shares (i.e., beneficiary payments expressed as a percentage of the provider's fee) will not be similarly updated.

I. TRICARE PRIME PROGRAM ANNUAL ENROLLMENT FEES

Does not apply to the TRICARE Extra Program (Also see "Point of Service Option", paragraph IV., below.):

TRICARE PRIME PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFMS)		RETIREES, THEIR FAMILY MEMBERS, ELIGIBLE FORMER SPOUSES & SURVIVORS
E1 - E4	E5 & ABOVE	
None	None	**$230 per Retiree or Family Member** **$460 Maximum per Family** EXCEPTION: Effective March 26, 1998, the enrollment fee is waived for those beneficiaries who are eligible for Medicare on the basis of disability or end stage renal disease and who maintain enrollment in Part B of Medicare.

II. TRICARE EXTRA PROGRAM ANNUAL FISCAL YEAR DEDUCTIBLE

Applies to all outpatient services, does not apply to the TRICARE Prime Program. (Also see "Point of Service Option".)

TRICARE EXTRA PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFMS)		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS
E1 - E4	E5 & ABOVE	
$50 per Individual **$100 Maximum per Family**	**$150 per Individual** **$300 Maximum per Family**	**$150 per Individual** **$300 Maximum per Family**

III. TRICARE STANDARD PROGRAM ANNUAL FISCAL YEAR DEDUCTIBLE

Applies to all outpatient services, does not apply to the TRICARE Prime or Extra Programs:

TRICARE STANDARD PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFMs)		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS
E1 - E4	E5 & ABOVE	
$50 per Individual $100 Maximum per Family	**$150 per Individual $300 Maximum per Family**	**$150 per Individual $300 Maximum per Family**

NOTE 2: These charts are not intended to be a comprehensive listing of all services covered under TRICARE. All care is subject to review for medical necessity and appropriateness:

NOTE 3: An eligible former spouse is responsible for payment of copayment/cost-sharing amounts identical to those required for beneficiaries other than family members of active duty members.

IV. OUTPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 9.)				
TYPE OF SERVICE (SEE NOTE 10.)	ADFMs		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
	E1 - E4	E5 & ABOVE			
INDIVIDUAL PROVIDER SERVICES Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; medical supplies used within the office including casts, dressings, and splints.	$0 copayment per visit.	$0 copayment per visit.	$12 copayment per visit.	**ADFMs:** Cost-share--15% of the fee negotiated by the contractor. **Retirees, their Family Members & Survivors:** Cost-share--20% of the fee negotiated by the contractor.	**ADFMs:** Cost-share--20% of the allowable charge. **Retirees, their Family Members & Survivors:** Cost-share--25% of the allowable charge.

IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 9.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ADFMs E1 - E4	ADFMs E5 & ABOVE	RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
OUTPATIENT HOSPITAL DEPARTMENTS Clinics visits; therapy visits; medical supplies; consultations; treatment room; etc. NOTE: Use other parts of this table for cost-sharing of ASC services, ER services, DME, etc.	$0 copayment per visit.	$0 copayment per visit.	$12 copayment per visit. No separate copayment/ cost-share for separately billed professional charges.	**ADFMs:** Cost-share--15% of the fee negotiated by the contractor. **Retirees, their Family Members & Survivors:** Cost-share--20% of the fee negotiated by the contractor.	**ADFMs:** Cost-share--20% of the allowable charge. **Retirees, their Family Members & Survivors:** Cost-share--25% of the allowable charge.
LABORATORY AND X-RAY SERVICES	$0 copayment per visit.	$0 copayment per visit.	$12 copayment per visit. (See Note 4)		
ANCILLARY SERVICES Refer to Chapter 2, Section 1 for specific CPT code ranges	$0 copayment per visit.	$0 copayment per visit.	No copayment (See Note 3.)	**ADFMs:** Cost-share--15% of the fee negotiated by the contractor. **Retirees, their Family Members & Survivors:** Cost-share--20% of the fee negotiated by the contractor.	**ADFMs:** Cost-share--20% of the allowable charge. **Retirees, their Family Members & Survivors:** Cost-share--25% of the allowable charge.
NOTE 4: If these services are performed by the office visit provider on a date different from the office visit or performed by a different provider such as an independent laboratory or radiology facility (even if performed on the same day as the related office visit) the beneficiary will owe a separate copayment for the services. Also, no copayment will be collected for these services when they are billed and provided as clinical preventive services to TRICARE Prime Enrollees.					
NOTE 5: For dates of service on or after March 26, 1998, under TRICARE Prime, services defined as "ancillary services" in Chapter 2, Section 1 require no copayment.					

IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 9.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ADFMs		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
ROUTINE PAP SMEARS Frequency to depend on physician recommendations based on the published guidelines of the American Academy of Obstetrics and Gynecology. (See Note 4.)	No copayment.	No copayment.	No copayment.	**ADFMs:** Cost-share--15% of the fee negotiated by the contractor. **Retirees, their Family Members & Survivors:** Cost-share--20% of the fee negotiated by the contractor.	**ADFMs:** Cost-share--20% of the allowable charge. **Retirees, their Family Members & Survivors:** Cost-share--25% of the allowable charge.
AMBULANCE SERVICES When medically necessary as defined in this Policy Manual and the service is a covered benefit.	$0 copayment per visit.	$0 copayment per visit.	$20 copayment per occurrence.		
EMERGENCY SERVICES Emergency and urgently needed care obtained on an outpatient basis, both network and non-network, and in and out of the Region.	$0 copayment per visit.	$0 copayment per visit.	$30 copayment per emergency room visit.		
DME (e.g., HEARING AIDS), PROSTHETIC DEVICES (e.g., AUGMENTATIVE COMMUNICATION DEVICES), AND MEDICAL SUPPLIES PRESCRIBED BY AN AUTHORIZED PROVIDER WHICH ARE COVERED BENEFITS (If dispensed for use outside of the office or after the home visit.)	$0 copayment per visit.	$0 copayment per visit.	Cost-share - 20% of the fee negotiated by the contractor.		

IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 9.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ADFMs		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
HOME HEALTH CARE Part-time or intermittent skilled nursing and home health aide services, physical, speech, & occupational therapy, medical social services, routine and non-routine medical services. NOTE: DME, osteoporosis drugs, pneumoccocal pnuemonia, influenza virus and hepatitis B vaccines, oral cancer drugs, antiemetic drugs, orthotics, prosthetics, enterral and parenteral nutritional therapy and drugs/biologicals administered by other than oral methods are services that can be paid in addition to the prospective payment amount subject to applicable copayment/ cost-sharing and deductible amounts.	$0 copayment.	$0 copayment.	$0 copayment.	$0 cost-share.	$0 cost-share.
HOSPICE CARE NOTE: A separate cost-share may be (optional) collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.					

IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 9.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ADFMs E1 - E4	ADFMs E5 & ABOVE	RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
FAMILY HEALTH SERVICES Family planning and well baby care (up to 24 months of age). The exclusions listed in this Policy Manual will apply.	$0 copayment per visit.	$0 copayment per visit.	$12 copayment per visit. (See Note 4.)	**Active Duty Family Members:** Cost-share--15% of the fee negotiated by the contractor.	**Active Duty Family Members:** Cost-share--20% of the allowable charge.
OUTPATIENT MENTAL HEALTH TO INCLUDE HOME One hour of therapy, no more than two times each week (when medically necessary).	$0 copayment per visit.	$0 copayment per visit.	$25 copayment for individual visits. $17 copayment for group visits.	**Retirees, their Family Members & Survivors:** Cost-share--20% of the fee negotiated by the contractor.	**Retirees, their Family Members & Survivors:** Cost-share--25% of the allowable charge.
PRESCRIPTION DRUGS See Addendum B.					
NOTE 6: If medically necessity is established for a non-formulary drug, patients may qualify for the $9 copayment for up to a 30-day supply in the TRRx or a 90-day supply in the TMOP program.					
AMBULATORY SURGERY (same day) Authorized hospital-based or freestanding ambulatory surgical center that is TRICARE certified.	$0 copayment per visit.	$0 copayment per visit.	$25 copayment	**ADFMs:** Cost-share--$25. for Ambulatory Surg.	**ADFMs:** $25.
OTHER NON-ASC SURGICAL PROCEDURES With the exclusion of those surgical procedures referenced in Chapter 2, Section 1, paragraph I.B.5.e. and f.			No separate copayment/ cost-share for separately billed professional charges.	**Retirees, their Family Members & Survivors:** Cost-share --20% of the institutional fee negotiated by the contractor.	**Retirees, their Family Members & Survivors:** Lesser of 25% of group rate or 25% of billed charge.
BIRTHING CENTER Prenatal care, outpatient delivery, and postnatal care provided by TRICARE authorized birthing center.	$0 copayment.	$0 copayment.	$25 copayment.	**ADFMs:** $25. **Retirees, their Family Members & Survivors:** Cost-share --20% of the fee negotiated by the contractor.	**ADFMs:** $25. **Retirees, their Family Members & Survivors:** Lesser of 25% of birthing center rate or 25% of billed charge.

IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 9.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ADFMs		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
IMMUNIZATIONS (See Note 7.) Immunizations required for active duty family members whose sponsors have permanent change of station orders to overseas locations.	$0 copayment per visit.	$0 copayment per visit.	Not covered under Prime.	**ADFMs:** Cost-share --15% of the fee negotiated by the contractor. **Retirees, their Family Members & Survivors:** Not covered under TRICARE Extra.	**ADFMs:** Cost-share--20% of the allowable charge. **Retirees, their Family Members & Survivors:** Not covered under TRICARE Standard.
EYE EXAMINATIONS (See Note 7.) One routine examination per year for family members of active duty sponsors.	$0 copayment per visit.	$0 copayment per visit.	Not covered under Prime. (See Note 7.)		
NOTE 7: Additional immunizations and eye examinations are covered under the TRICARE Prime Program's "clinical preventive services". See the TRICARE Policy Manual, Chapter 7, Section 2.2.					
CLINICAL PREVENTIVE SERVICES Includes those services listed in the TRICARE Policy Manual, Chapter 7, Sections 2.1 and 2.2.	$0 copayment	$0 copayment	$0 copayment	**ADFMs:** Cost-share--15% of the fee negotiated by contractor. **Retirees, their Family Members & Survivors:** Cost-share--20% of the fee negotiated by the contractor.	**ADFMs:** Cost-share--20% of the allowable charge. **Retirees, their Family Members & Survivors:** Cost-share--25% of the allowable charge.
NOTE 8: No copayment may be collected for these services when they are billed and provided as specified in the TRICARE Policy Manual, Chapter 7, Section 2.2.					
NOTE 9: No enhanced outpatient benefits under the TRICARE Extra Program.					

V. INPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ACTIVE DUTY FAMILY MEMBERS (ADFMs)	RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
Note 10:No enhanced inpatient benefits under the TRICARE Prime or Extra programs.				
HOSPITALIZATION Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and their surgical services, meals including special diets, drugs and medications while an inpatient, operating and recovery room, anesthesia, laboratory tests, x-ray and other radiology services, necessary medical supplies and appliances, blood and blood products.	$0 copayment per visit.	$11 per diem charge ($25 minimum charge per admission). No separate copayment/ cost-share for separated billed professional charges.	**ADFMs:** Per diem charge ($25 minimum charge per admission). No separate cost-share for separately billed professional charges. **Retirees, their Family Members & Survivors:** $250 per diem copayment or 25% cost-share of total charges (based on the fee schedule negotiated by the contractor), whichever is less, for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).	**ADFMs:** Per diem charge ($25 minimum charge per admission). No separate cost-share for separately billed professional charges. **Retirees, their Family Members & Survivors:** DRG per diem copayment or 25% cost-share of billed charges for institutional services, whichever is less, plus 25% cost-share of allowable for separately billed professional charges.
MATERNITY Hospital and professional services (prenatal, delivery, postnatal).				

$$\frac{1506.6}{250} = \$6.03$$

d. The conversion factors calculated for any profile year shall reflect prevailing charges calculated on the basis of charge data for the applicable profile year. Also, prevailing charges established through the use of a relative value scale and conversion factors, in effect, consist of two components. Consequently, the conversion factors used must be recalculated when there is an extensive change in the relative value units assigned to procedures (as may occur if the contractor begins to use a different or updated relative value scale but not if the unit value of a single procedure is changed) in order to ensure that the change(s) in unit values do not change resultant conversion factors.

e. Since conversion factors are a calculated amount and will only be used when multiplied by a relative value, conversion factors are to be rounded only to the nearest whole cent. It will not be acceptable to round to the nearest dollar or tenth dollar (dime).

E. Procedure Codes. The CPT[2] Coding System includes Level I: CPT Codes and Level II: Alpha Character and TMA approved codes for retail and mail order pharmacy. (Reference the TRICARE Systems Manual (TSM), Chapter 2, Addendum E and F.)

F. Professional surgical procedures will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under the Outpatient Prospective Payment System (OPPS) for services rendered on or after implementation of OPPS. Refer to Chapter 1, Section 16, paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for further detail.

G. Professional procedures which are terminated or are bilateral will be subject to discounting based on modifier guideline requirements as prescribed under the OPPS for services rendered on or after implementation of OPPS. Refer to Chapter 1, Section 16, paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for further detail.

H. Prevention Of Gross Dollar Errors. Parameters Consistent With Private Business. The contractor shall establish procedures for the review and authorization of payment for all claims exceeding a predetermined dollar amount. These authorization schedules shall be consistent with the contractor's private business standards.

III. ALLOWABLE CHARGE METHOD: APPLICATION

A. Durable Medical Equipment (DME), Durable Equipment (DE), And Supplies. Also, see Chapter 1, Section 11 and the TRICARE Policy Manual (TPM), Chapter 8, Section 2.1.

B. Physician Assistant Services. The allowable charge for physician assistant services is determined in accordance with the provisions of Chapter 1, Section 6, and is based on a

[2] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

percentage of the allowed charge for the service when performed by the employing physician. Only the employing physician may bill for physician assistant services. Physician assistants' billed and allowed charges must be excluded from calculation of physician profiles. Payment is made to the employing physician who is an authorized TRICARE provider.

C. Teaching Physicians. Payment for services of teaching physicians may be made on an allowable charge basis only if an attending physician relationship has been established between the teaching physician and the patient. Refer to Chapter 1, Section 4 for a full explanation of applicable prerequisites.

IV. ALTERNATIVE REIMBURSEMENT METHODS FOR NON-NETWORK PROVIDERS

The contractor, with the concurrence of the Executive Director, TMA (or a designee), may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to assure a high level of acceptance of the TRICARE-determined charge by the individual health care professionals or other non-institutional health care providers furnishing services and supplies to TRICARE beneficiaries. Alternative methods shall not result in reimbursement greater than under the allowable charge method above, nor result in a higher cost for the affected beneficiary population.

V. CHAMPUS MAXIMUM ALLOWABLE CHARGE SYSTEM

A. General. The CHAMPUS Maximum Allowable Charge (CMAC) System is effective for services rendered on and after May 1, 1992. Contractors shall process claims using the requirements specified in the TRICARE Policy Manual (specific TRICARE Policy Manual references follow). Adjustments shall be processed using the reimbursement system in place at the time the services were rendered. The zip code where the service was rendered determines the locality code to be used in determining the allowable charge under CMAC. In most instances the zip code used to determine locality code will be the zip code of the provider's office. For processing an adjustment on a claim which was reimbursed using CMAC, the zip code which was used to process the initial claim must be used to determine the locality for the allowable charge calculation for the adjustment. Adjustments shall be processed using the appropriate fee screen year, which shall be based on the date of service. Post Office Box zip codes are acceptable only for Puerto Rico and for providers whose major specialty is anesthesiology, radiology or pathology (see Chapter 5, Section 3).

B. Locality Code. For TED reporting, the locality code used in the reimbursement of the procedure code is to be reported for each payment record line item, i.e., on each line item where payment is based on a CMAC, the locality shall be reported. Any adjustment to a claim originally paid under CMAC without a locality code, shall include the locality code that it was priced on at the time of the initial payment. The locality code reported on the

initial claim shall be used to process any future adjustments of that claim unless one of the conditions listed below occurs:

1. The adjustment is changing the type of pricing from CMAC to state prevailing in which case the locality code should be blank filled, or;

2. The initial claim was priced incorrectly because of using a wrong locality code, in which case the correct locality code should be used.

VI. BONUS PAYMENTS IN MEDICALLY UNDERSERVED AREAS

A. An additional payment shall be made quarterly to physicians who qualify and provide services in medically underserved areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)]. To initiate action for the additional payment, providers shall use modifiers that will signify the provider is requesting the additional payment. The modifiers are "QU" (urban HPSA), "QB" [rural HPSA], and "AR" [PSA bonus payment]. "QU", "QB" and "AR" are modifiers to the CPT/HCPCS procedure codes. The provider shall be paid an additional 10% HPSA bonus of the total amount paid, excluding interest payments, for claims that were processed during the calendar quarter for services rendered on or after June 1, 2003. The provider shall be paid an additional five percent PSA bonus of the total amount paid, excluding interest payment, for claims that were processed during the calendar quarter for services rendered on or after January 1, 2005. The contractor shall have 30 calendar days from the end of the calendar quarter to make the payments to the providers who qualify. The bonus payments could be paid to network, non-network, participating, or non-participating physicians. Special programs such as TPR, SHCP, and TSP shall be included in the bonus payment process. Contractors shall send bonus payments directly to the non-participating physician. Contractors shall report these claims on TEDs as required by the TSM, Chapter 2, Section 2.7 (Procedure Code Modifiers). See Chapter 1, Section 33 for additional information.

NOTE: Effective January 1, 2006, for services rendered on or after this date, the "QU" and "QB" modifiers shall be replaced with modifier "AQ".

1. The contractor is to inform providers of the PSA and HPSA bonus payments through stuffers and their quarterly news bulletin. The stuffers and bulletin should provide direction on what is required in order to obtain the bonus payment.

2. Basis of bonus payments to TRICARE-authorized providers is solely when a "AQ", "QU", "QB", or "AR" modifier is found on the claim.

B. Bonus payments are passthrough payments, non-financially underwritten payments. The contractor shall follow the process below. This process is similar to the payment of capital and direct medical education found under the DRG reimbursement system (see Chapter 3, Section 2, paragraph II.).

1. All bonus payments are non-financially underwritten and shall be made from the non-financially underwritten, bank account (see the TRICARE Operations Manual (TOM), Chapter 3, Section 2).

2. Bonus Payment Procedures. The contractor shall use the following procedures in making bonus payments to physicians:

a. Accumulate and tally claims paid with "QU", "QB", or "AR" modifiers.

b. Compute the amount due each physician for submitted claims during the calendar quarter for HPSA services rendered on or after June 1, 2003 and PSA services rendered on or after January 1, 2005. The PSA bonus only goes through December 31, 2007. Stop processing prior to check writing. Compute the total amount due all physicians. For services with both a professional and technical component, only the professional component would be included in the calculation of the bonus payment. The amount due is computed from claims with the "QU", "QB" and "AR" modifiers, then based on the amount paid (see paragraph VI.B.3.d.).

c. Any interest payments shall not be included in the computation of the payable bonus amount.

d. On the first work day of the last week of the month following the quarter, submit a voucher (see paragraph VI.B.3.) by express mail to TMA, CRM (a fax copy is not necessary).

e. After receiving clearance from TMA, CRM, continue processing through check write and mail out checks within two work days.

3. Vouchers

a. Format
- Physician Name
- Physician Address
- Physician Provider Number
- Period Covered (Quarter)
- Amount Paid/Collected for Bonus (see paragraph VI.B.3.d.)
- Total Bonus Paid [5 and/or 10% of the above bullet]

b. Sort Bonus Payment
- By Type (e.g., standard or active duty)
- By Coverage (Prime, Extra, Standard)
- By Fiscal Year of Bank Account
- By Contract
- By City & State
- By Region
- By Physician
- By Physician Number

- By Specialty
- By Address & Zip
- By Participating & Non-Participating
- By Contracted (Network) and Not Contracted (Non-network)
- By Modifier ("QB", "QU" or "AR")

c. The contractor's worksheet showing the payment computation shall be attached to the quarterly voucher for each physician.

d. In general:

Bonus Payment = 5% or 10% x [Total Amount Paid (claims with "QB" and "QU" modifiers or claims with "AR" modifier) During the Quarter - Interest Payments Associated with the claims for the Bonus Payment]

VII. BALANCE BILLING LIMITATION FOR NON-PARTICIPATING PROVIDERS

A. General

For services provided on or after November 1, 1993, non-participating providers may not balance bill the beneficiary more than 115% of the allowable charge.

NOTE: When the billed amount is less than 115% of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit is to be applied to each line item on a claim.

EXAMPLE 1: No Other Health Insurance

Billed charge	$500
Allowable charge	$200
Amount billed to beneficiary (115% of $200)	$230

EXAMPLE 2: Other Health Insurance

Billed charge	$500
Allowable charge	$200
Amount paid by other health insurance to the beneficiary	$200
Amount billable to beneficiary (115% of $200)	$230

NOTE: When payment is made by other health insurance, this payment does not affect the amount billable to the beneficiary by the non-participating provider except, when it can be determined, that the other health insurance limits the amount that can be billed to the beneficiary by the provider.

EXAMPLE 3: Provider Refuses To File Claim Or Has Charged An Administrative Fee

Billed charge	$100.00
CMAC	$110.00
Allowed amount	$100.00
10% abatement ($100 x 0.10)	$10.00
Adjusted allowed amount ($100 - $10)	$90.00
Provider billed charge to beneficiary (Limited to billed amount.)	$100.00

EXAMPLE 4: Non-Participating Provider Refuses To File Claim Or Has Charged An Administrative Fee

Billed charge	$150.00
CMAC	$100.00
Allowed amount	$100.00
10% abatement ($100 x 0.10)	$10.00
Adjusted allowed amount ($100 - $10)	$90.00
Provider billed charge to beneficiary ($90.00 x 115%)	$103.50

1. Provider bulletins shall be used to notify authorized providers of the balance billing limitation of the amount that may be billed by a non-participating provider to the beneficiary.

2. Contractors shall notify beneficiaries of the balance billing limitation and the amount that may be legally billed by a non-participating provider to the beneficiary through stuffers.

3. The following language shall be used to respond to beneficiary inquiries concerning the TRICARE non-participating provider balance billing provision. Routine stuffers shall not be used to convey this information.

NOTE: In accordance with 32 CFR 199, a balance billing limitation for services provided by non-participating providers was effective on and after November 1, 1993. This provision limits non-participating providers from billing TRICARE beneficiaries more than 115% of the TRICARE allowable charge which is shown on the Explanation Of Benefits (EOB). Please note when the provider's billed charge is less than 115% of the TRICARE allowed amount, the billed charge becomes the billable amount to the beneficiary. However, this restriction does not apply to noncovered services. Nonparticipating providers who do not comply with the limitation shall be subject to exclusion from the TRICARE program as authorized providers and may be excluded as a Medicare provider. If a non-participating provider bills and/or collects more from the beneficiary than the amount the provider may bill, contact the contractor's Program Integrity Department in writing. The beneficiary should include information which documents the higher billed amount, such as a copy of the EOB, bills from the non-participating provider to the beneficiary, demand letter from the non-participating provider to the beneficiary requesting an amount above the 115% of the

allowable amount, and copies of cancelled checks that would identify excessive amounts paid by the beneficiary to the non-participating provider.

B. Failure To Comply

1. If a non-participating provider fails to comply with this balance billing limitation requirement, the provider shall be subject to exclusion from the TRICARE Program as an authorized provider and may be excluded as a Medicare provider.

2. When the contractor receives a complaint that a non-participating provider is balance billing a beneficiary for an amount greater than 115% of the allowable charge, the contractor's Program Integrity Department shall investigate the complaint, communicate their findings to the beneficiary and take action against the provider, if appropriate. A beneficiary complaint letter will serve as a release form in order to educate the provider and as the basis for resolving the balance billing requirement. Only information where there is a need to know such as the billed charges should be discussed or released.

3. To exclude a provider from the TRICARE program, a pattern of such billing practices must be established along with documented evidence that the provider was advised of the balance billing limitation for non-participating providers, but continued to bill beneficiaries higher amounts after being notified.

4. Documented evidence could include certified registered mail, special provider news bulletins, and documented telephone conversations and/or meetings with the provider concerning his/her TRICARE billing practices as they related to the balance billing limitation. In addition, the contractor's Program Integrity Department shall follow the instructions in the TOM, Chapter 14, Section 6.

C. Granting of Waiver Of Limitation

When requested by a TRICARE beneficiary, the contractor, on a case-by-case basis, may waive the balance billing limitation. If the beneficiary is willing to pay the non-participating provider for his/her billed charges, then the waiver shall be granted. The contractor shall obtain a signed statement from the beneficiary stating that he/she is aware that the provider is billing above the 115% limit, however, they feel strongly about using that provider and they are willing to pay the additional money. The beneficiary shall be advised that the provider still may be excluded from the TRICARE program, if he/she is over billing other TRICARE beneficiaries and they object. The waiver is controlled by the contractor, not by the provider. The contractor is responsible for communicating the potential costs to the beneficiary if the waiver statement is signed. A decision by the contractor to waive or not to waive the limit is not subject to the TRICARE appeals process.

- END -

contractor. Non-network RTCs (see the TRICARE Operations Manual, Chapter 4) shall be reimbursed based on the rate established by TMA, using the methodology specified in Chapter 7, Section 4.

VII. REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS

A. General

1. Payment for facility charges for ambulatory surgical services will be made using prospectively determined rates. The rates will be divided into 11 payment groups representing ranges of costs and will apply to all ambulatory surgical procedures identified by TMA regardless of whether they are provided in a freestanding ambulatory surgical center (ASC), in a hospital outpatient clinic, or in a hospital emergency room.

2. TMA will provide the facility payment rates to the contractors on magnetic media and will provide updates each year. The magnetic media will include the locality-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. In addition, the contractors will be provided a zip code to MSA crosswalk.

3. Contractors are required to maintain only two sets of rates on their on-line systems at any time.

4. Professional services related to ambulatory surgical procedures will be reimbursed under the instructions for individual health care professionals and other non-institutional health care providers in Chapter 3, Section 1.

5. See Chapter 9, Section 1 for additional instructions.

B. Payment Procedures. All rate calculations will be performed by TMA (or its data contractor) and will be provided to each contractor. In pricing a claim, the contractor will be required to identify the zip code of the facility which provided the services (for the actual location, not the billing address, etc.) and the procedure(s) performed. The contractor shall use the zip code to MSA crosswalk to identify the rates applicable to that facility and then will select the rate applicable to the procedure(s) performed. Multiple procedures are to be reimbursed in accordance with the instructions in the TRICARE Policy Manual (TPM). Surgical and bilateral procedures (both institutional and professional) will be subject to the multiple surgery discounting guidelines and modifier requirement as prescribed under Chapter 1, Section 16, paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for services rendered on or after implementation of the Outpatient Prospective Payment System (OPPS).

C. Claims Form Requirements. Claims for facility charges must be submitted on a CMS 1450 UB-04. Claims for professional charges may be submitted on either a CMS 1450 UB-04 or a CMS 1500 (08/05) claim form. The preferred form is the CMS 1500 (08/05). When professional services are billed on a CMS 1450 UB-04, the information on the CMS 1450 UB-04 should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

VIII. CLAIM ADJUSTMENTS

Facilities may not submit a late charge bill (frequency 5 in the third position of the bill type). They must submit an adjustment bill for any services required to be billed with HCPCS codes, units, and line item dates of service by reporting frequency 7 (replacement of a prior claim) or frequency 8 (void/cancel of a prior claim). Claims submitted with a frequency code of 7 or 8 should report the original claim number in Form Locator 64 on the CMS 1450 UB-04 claim form.

IX. PROPER REPORTING OF CONDITION CODES

Hospitals should report valid Condition Codes on the CMS 1450 UB-04 claim form as necessary.

A. Condition Codes are reported in FLs 18-28 when applicable.

B. The following are two examples of condition code reporting:

1. **Condition Code G (zero)** identifies when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day - in the morning for a broken arm and later for chest pain.

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

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

2. **Condition Code 41** identifies a claim being submitted for Partial Hospitalization Program (PHP) Services.

- END -

insurance which has paid $1,645.00 on the claim. The wage adjusted TRICARE APC rate for the procedure performed is $1,235.00.

STEP 1:
$ 1,235.00 - APC allowed amount
- 0.00 - Deductible and cost-sharing not applied since beneficiary is a Prime active duty family member
$ 1,235.00 - Amount payable by TRICARE in the absence of other coverage

STEP 2:
$ 2,450.00 - Billed charge
- 1,645.00 - OHI payment
$ 805.00 - Unpaid balance

STEP 3: TRICARE pays $805.00 balance, since it is less than what TRICARE would have paid in the absence of double coverage.

NOTE: The above COB methodology for hospital outpatient services will not go into effect until implementation of the hospital outpatient prospective payment system. This new reimbursement system is tentatively scheduled to become effective upon publication of the Outpatient Prospective Payment System (OPPS) Final Rule.

VII. EXAMPLES OF COMPUTATION OF THE TRICARE SHARE WHEN THE BENEFICIARY'S LIABILITY IS LIMITED UNDER THE OHI

EXAMPLE 1: The bill for outpatient care for an active duty dependent is $200.00, which is considered allowable by TRICARE. The TRICARE deductible has been met. The provider submitted the claim on a participating basis, along with an EOB from the OHI. The OHI discounted rate is $100.00 and it paid $90.00. The beneficiary's liability is limited to $100.00 under the OHI, and this is evident on the EOB from the OHI. The provider submitted a claim for $200.00.

STEP 1:
$ 200.00 - Allowable charges
x 80% - TRICARE portion for active duty dependents
$ 160.00 - Amount payable by TRICARE in the absence of other coverage

STEP 2:
$ 100.00 - OHI amount allowed
- 90.00 - Paid by OHI
$ 10.00 - Unpaid balance

STEP 3: TRICARE pays $10.00 to the provider since this is the lower of the two computations. The beneficiary owes nothing, since the full legal liability has been paid.

EXAMPLE 2: A provider's normal charge for an outpatient service is $160.00. The provider is a network provider and has a negotiated discount rate of 10% off the CMAC amount which is $145.00. The provider also has a discounted rate of $110.00 with the OHI and receives no OHI payment due to application of OHI deductible. The beneficiary is a retiree who is enrolled in Prime. The

beneficiary's liability is limited to $110.00 under the OHI, and this is evident on the EOB from the OHI.

STEP 1:
$ 160.00 - Billed amount
$ 145.00 - CMAC amount
$ 130.50 - Negotiated rate (10% off the CMAC amount)
- 12.00 - TRICARE Prime copay for retirees
$ 118.50 - Amount payable by TRICARE in the absence of other coverage

STEP 2:
$ 110.00 - OHI amount allowed
- 0.00 - Paid by OHI
$ 110.00 - Unpaid balance

STEP 3: TRICARE pays $110.00 since this is the lower of the two computations, and the beneficiary owes nothing.

EXAMPLE 3: The billed charge for seven days of inpatient care in March 2002 for a retiree is $5,000.00. The claim is subject to the TRICARE DRG-based payment system, and the DRG- based amount is $6,000.00. The hospital has agreed to a 10% discount off the DRG amount. The retiree cost-share under the DRG-based payment system is $1,250.00, which is 25% of the billed charges. (This is lower than the per diem of $414.00 reduced by the 10% discount and multiplied by 7 days.) The OHI discounted rate is $4,200.00 and it paid $4,000.00. The beneficiary's liability is limited to $4,200.00 under the OHI, and this is evident on the EOB from the OHI. The hospital submits a claim for $1,000.00 along with an EOB from the OHI.

STEP 1:
$ 6,000.00 - DRG-based amount
- 600.00 - 10% discount
$ 5,400.00 - DRG amount reduced by the discount
- 1,250.00 - Cost-share
$ 3,150.00

STEP 2:
$ 5,400.00 - DRG amount reduced by the discount
- 4,000.00 - OHI payment
$ 1,400.00

STEP 3:
$ 4,200.00 - OHI amount allowed
- 4,000.00 - OHI payment
$ 200.00

STEP 4:
$ 4,200.00 - OHI amount allowed
- 1,250.00 - Cost-share
$ 2,950.00

STEP 5: TRICARE pays $200.00, since it is the lowest amount of Steps 1 - 4. The beneficiary owes nothing, since the full legal liability has been paid.

- END -

and pay the claim as the primary payer. In most cases, under served areas will be identified by zip codes for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs) on the CMS web site at http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/ and will automatically be paid as primary payer. In cases where the zip code for an underserved area is not identified on the CMS web site, or in areas where there are no or limited Medicare participating providers, a written waiver request with justification identifying the county where the service was received and a copy of the provider's private contract will be required by the contractor to pay the claim as the primary payer. TRICARE contractors will identify HPSA or PSA zip codes or the county for underserved areas on the above CMS web site and identify opt out providers based on the Medicare Part B carriers web sites.

NOTE: Under the TRICARE Provider Reimbursement Demonstration Project for the State of Alaska, TRICARE will pay as primary payer for the services of Medicare opt-out providers.

2. Services that are a benefit under Medicare but not under TRICARE. TRICARE will make no payment for services and supplies that are not a benefit under TRICARE, regardless of any action Medicare may take on the claim.

3. Services that are a benefit under TRICARE but not under Medicare. If the service or supply is a benefit under TRICARE but not under Medicare, TRICARE will process the claim as the primary payer assessing any applicable deductibles and cost-shares. If the contractor knows that a service or supply on the claim is not a benefit under Medicare, the contractor can process the claim without evidence of processing by Medicare for that service or supply.

4. Services that are provided in a non-DoD government facility. If services or supplies are provided in a TRICARE authorized non-DoD government facility, such as a Veterans Administration Hospital pursuant to the TRICARE Policy Manual, Chapter 11, Section 2.1, Medicare will make no payment. In such cases TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares.

NOTE: In order to achieve status as a TRICARE authorized provider, Veteran's Administration facilities must comply with the provisions of the TRICARE Policy Manual, Chapter 11, Section 2.1.

5. Services provided by a Medicare at-risk plan. If the beneficiary is a member of a Medicare at-risk plan (for example, Medicare Plus Choice), TRICARE will pay 100% of the beneficiaries co-pay for covered services. A claim containing the required information must be submitted to obtain reimbursement.

6. Beneficiary Cost-Shares. Beneficiary costs shares shall be based on the network status of the provider. Where TRICARE is primary payer, cost shares for services received from network providers shall be TRICARE Extra cost shares. Services received from non-network providers shall be TRICARE Standard cost shares. Network discounts shall only be applied when the discount arrangement specifically contemplated the TRICARE for Life population.

7. Application of Catastrophic Cap. Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

D. End Stage Renal Disease (ESRD) in TRICARE beneficiaries less than 65 years of age - Medicare is the primary payer and TRICARE is the secondary payer for beneficiaries entitled to Medicare Part A and who have Medicare Part B coverage.

II. TRICARE AND MEDICAID

Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting P.L. 97-377, it was the intent of Congress that no class of TRICARE beneficiary should have to resort to welfare programs, and therefore, Medicaid was exempted from these double coverage provisions. Whenever a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a TRICARE beneficiary, TRICARE shall reimburse the appropriate Medicaid agency for the amount TRICARE would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less. See Chapter 1, Section 20.

III. MATERNAL AND CHILD HEALTH PROGRAM/INDIAN HEALTH SERVICE

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage (see Chapter 4, Section 1).

IV. TRICARE AND VETERANS ADMINISTRATION

Eligibility for health care through the Veterans Administration (VA) for a service-connected disability is not considered double coverage. If an individual is eligible for health care through the VA and is also eligible for TRICARE, he/she may use either TRICARE or Veterans benefits. In addition, at any time a beneficiary may get medically necessary care through TRICARE, even if the beneficiary has received some treatment for the same episode of care through the VA. However, TRICARE will not duplicate payments made by or authorized to be made by the VA for treatment of a service-connected disability.

V. TRICARE AND WORKER'S COMPENSATION

TRICARE benefits are not payable for work-related illness or injury which is covered under a Worker's Compensation program. The TRICARE beneficiary may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. If a claim indicates that an illness or injury might be work related, the contractor will process the claim following the provisions as provided in TRICARE Operations Manual (TOM), Chapter 11, Section 5, paragraphs 5.0. and 6.1. and refer the claim to the Uniformed Service Claims Office for recovery, if appropriate.

D. The CHAMPUS Maximum Allowable Charge applies to all fifty states, Puerto Rico, and the Philippines. Further information regarding the reimbursement of professional services in the Philippines, see the TRICARE Policy Manual, Chapter 12, Section 11.1. Guam and the Virgin Islands are to still be paid as billed for professional services.

E. Provisions which affect the TRICARE allowable charge payment methodology.

NOTE: The first CMAC file update for 1999, raises all CMACs for physicians and psychologists that are priced using the Medicare RVUs to the Medicare Fee Schedule levels. CMACs for mental health providers (clinical social workers, certified marriage and family therapists, and pastoral and mental health counselors under a physician's supervision) shall be reduced by 15 percent in 1999 and a further 10 percent in 2000 so that they will be equal to 75 percent of the CMAC for psychiatrists and psychologists by the year 2000. Medicare reimburses these providers at the same differential.

Effective for services provided on or after September 1, 2003, the payment for certain provider changes to the physician payment level. These providers include: podiatrists, oral surgeons, optometrists, occupational therapists, speech therapists, physical therapists, audiologists, and psychologists. Previously, psychologists were paid under the physician payment level, and the above remaining providers were paid under the non-physician payment level. Podiatrists, oral surgeons, and optometrists shall also come under the HPSA bonus payment. See Chapter 1, Section 33.

1. Reductions in maximum allowable payments to Medicare levels.

2. Balance billing limitation.

a. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. This limit is 115 percent of the TRICARE allowable charge, not to exceed the billed charge.

NOTE: When the billed amount is less than 115 percent of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit is to be applied to each line item on a claim.

EXAMPLE 1: No Other Health Insurance

Billed charge	$500
Allowable charge	$200
Amount billed to beneficiary (115% of $200)	$230

EXAMPLE 2: Other Health Insurance

Billed charge	$500
Allowable charge	$200
Amount paid by other health insurance to the beneficiary	$200
Amount billable to beneficiary (115% of $200)	$230

NOTE: When payment is made by other health insurance, this payment does not affect the amount billable to the beneficiary by the nonparticipating provider except, when it can be determined that the other health insurance limits the amount that can be billed to the beneficiary by the provider.

b. Failure to Comply. If a nonparticipating provider fails to comply with this balance billing limitation requirement, the provider shall be subject to exclusion from the TRICARE Program as an authorized provider and may be excluded as a Medicare provider.

c. Granting of Waiver of Limitation. When requested by a TRICARE beneficiary, the contractor, on a case-by-case basis, may waive the balance billing limitation. If the beneficiary is willing to pay the nonparticipating provider for his/her billed charges, then the waiver shall be granted. The contractor shall obtain a signed statement from the beneficiary stating that he/she is aware that the provider is billing above the 115 percent limit, however, they feel strongly about using that provider and they are willing to pay the additional money. The beneficiary shall be advised that the provider still may be excluded from the TRICARE program, if he/she is over billing other TRICARE beneficiaries and they object. The waiver is controlled by the contractor, not by the provider. The contractor is responsible for communicating the potential costs to the beneficiary if the waiver statement is signed. A decision by the contractor to waive or not to waive the limit is not subject to the appeals process. For the TRICARE Outpatient Prospective Payment System (OPPS), the granting of waivers for balance billing limitations applies only to EXEMPT OPPS providers.

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

a. Categories.

Category 1: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 0510), residential treatment centers, ambulances, hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, etc.

Category 2: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a non-facility including provider offices, home settings, and all other non-facility settings.

Category 3: Services, of all other providers not found in category 1, provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 0510), residential treatment centers, ambulances,

hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, etc.

Category 4: Services, of all other providers not found in category 2, provided in a non-facility including provider offices, home settings, and all other non-facility settings.

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

c. Payment of 0510 and 0760 series revenue codes.

(1) Effective for services on or after April 1, 2005, payment of 0510 and 0760 series revenue codes shall begin. Payment would be made as billed unless a discounted negotiated rate can be obtained for OPPS exempt providers.

(2) Effective for services on or after implementation of OPPS, payment of 0510 and 0760 series revenue codes will be based on the HCPCS codes submitted on the claim and reimbursed under the OPPS for providers reimbursed under the OPPS methodology.

d. Reimbursement Hierarchy For Procedures Paid Outside The OPPS.

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

The following table includes the list of rate columns on the CMAC file. The columns are number 1 through 6 by description. The pricing hierarchy for facility CMAC is 8, 6, 4, then 2.

COLUMN	DESCRIPTION
1	Non-facility CMAC for physician/LLP class
2	Facility CMAC for physician/LLP class
3	Non-facility CMAC for non-physician class
4	Facility CMAC for non-physician class
5	Physician class Professional Component (PC) rate
6	Physician class Technical Component (TC) rate
7	Non-physician class PC rate
8	Non-physician class TC rate
Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the Physician class TC rate. Otherwise, if the Facility CMAC for non-physician class > 0, then pay the Facility CMAC for non-physician class. Otherwise, pay Facility CMAC for physician/LLP class.	

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

(2) DMEPOS. If there is no DMEPOS available, the contractor shall reimburse the procedure using state prevailings.

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

e. Informing the provider community of the pricing changes for 2005. The contractors are to inform the provider community of the pricing changes based on site of service beginning April 1, 2005, for services rendered on or after this date. Medicare has been using site of service for some time. TMA would simply be adopting this pricing from Medicare. Contractors may need to renegotiate agreements with providers reflecting this change.

f. Services and procedure codes not affected by site of service. Anesthesia services, laboratory services, component pricing services such as radiology, and "J" codes are some of the more common services and codes that will not be affected by site of service.

g. CMAC history files. The contractor is to retain and maintain previous years CMAC files for historical purposes. Since the 2005 CMAC file format is different, it will be more difficult to link to the previous years CMAC files.

4. Multiple Surgery Discounting. Professional surgical procedures which are reimbursed under the CMAC payment methodology will be subject to the same multiple surgery guidelines and modifier requirement as prescribed under the OPPS for services rendered on or after implementation of OPPS. Refer to Chapter 1, Section 16, paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for further detail.

- END -

J7198 Anti-Inhibitor	1.43 per unit
Q0160 Factor IX (antihemophilic factor, purified, non-recombinant)	1.05 per unit
Q0161 Factor IX (antihemophilic factor, recombinant)	1.12 per unit

e. For admissions occurring on or after October 1, 2002, through September 30, 2003, the following HCPCS codes and payment rates shall be used for blood clotting factors:

J7190 Factor VIII (antihemophilic factor - human), per IU	$0.86 per unit
J7191 Factor VIII (antihemophilic factor - porcine), per IU	2.04 per unit
J7192 Factor VIII (antihemophilic factor - recombinant), per IU	1.24 per unit
J7193 Factor IX (antihemophilic factor, purified - non-recombinant), per IU	1.05 per unit
J7194 Factor IX (complex), per IU	0.33 per unit
J7195 Factor IX (antihemophilic factor - recombinant), per IU	1.12 per unit
J7198 Anti-Inhibitor, per IU	1.43 per unit
J7199 Hemophilia Clotting Factor, not otherwise classified (the provider must report the name of the drug and how the drug is dispensed in the remarks section of the claim)	
Q0187 Factor VIIa (coagulation factor - recombinant) one billing unit per 1.2mg	1,596 per unit
Q2022 Von Willebrand Factor (complex - human) per IU	0.95 per unit

f. For admissions occurring on or after October 1, 2003, contractors shall use the "J" code pricing file to price blood clotting factor. For pricing of blood clotting factor that is not listed in the "J" code pricing file, the contractor shall use 95 percent of the median AWP.

g. For admissions occurring on or after October 1, 2005, contractors shall make payment for blood clotting factor using Average Sale Price (ASP) plus 6 percent, using the Medicare Part B Drug Pricing file. The price allows for payment of a furnishing fee and is included in the ASP per unit.

D. Hospitals subject to the TRICARE/CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are authorized to provide services to TRICARE/CHAMPUS beneficiaries are subject to the DRG-based payment system except for those hospitals and hospital units below.

E. Substance Use Disorder Rehabilitation Facilities. With admissions on or after July 1, 1995, substance use disorder rehabilitation facilities, are subject to the DRG-based system.

F. The following types of hospitals or units which are exempt from the Medicare PPS, are exempt from the TRICARE CHAMPUS DRG-based payment system. In order for hospitals and units which do not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system, they must meet the same criteria (as determined by the TRICARE Management Activity, or designee) as required for exemption from the Medicare PPS as contained in Section 412 of Title 42 CFR.

1. Hospitals within hospitals.

2. Psychiatric hospitals.

3. Rehabilitation hospitals.

4. Psychiatric and rehabilitation units (distinct parts).

5. Long-term hospitals.

6. Sole Community Hospitals (SCHs). Any hospital which has qualified for special treatment under the Medicare PPS as a sole community hospital and has not given up that classification is exempt from the TRICARE/CHAMPUS DRG-based payment system. For additional information on SCHs, refer to Chapter 14, Section 1.

7. Christian Science sanitariums.

8. Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare PPS is exempt from the TRICARE/CHAMPUS DRG-based payment system.

9. Hospitals outside the 50 United States, the District of Columbia, and Puerto Rico.

10. Satellite facilities.

G. Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized TRICARE/CHAMPUS provider. However, any hospital which is subject to the TRICARE/CHAMPUS DRG-based payment system and which otherwise meets TRICARE/CHAMPUS requirements but which is not a Medicare-participating provider (having completed a CMS 1561, Health Insurance Benefit Agreement, and a CMS 1514, Hospital Request for Certification in the Medicare/ Medicaid Program) must complete a participation agreement (Chapter 6, Addendum A) with TMA. By completing the participation agreement, the hospital agrees to participate on all inpatient claims and to accept the TRICARE/CHAMPUS-determined allowable amount as payment in full for its services. Any hospital which does not participate in Medicare and does not complete a participation agreement with TMA will not be authorized to provide services to program beneficiaries.

H. Critical Access Hospitals (CAHs). CAHs are subject to the DRG-based payment system. For additional information on CAHs, refer to Chapter 15, Section 1.

- END -

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 1995	117.20%	2.1720
September 30, 1996	123.83%	2.2383
September 30, 1997	126.20%	2.2620
September 30, 1998	116.93%	2.1693
September 30, 1999	129.19%	2.2919
September 30, 2000	128.82%	2.2882
September 30, 2001	131.83%	2.3183
September 30, 2002	141.57%	2.4157
September 30, 2003	159.90%	2.5990
September 30, 2004	171.39%	2.7139
September 30, 2005	185.93%	2.8593
September 30, 2006	200.58%	2.9724
September 30, 2007	205.85%	2.9785

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

By definition, a new hospital is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the Medicare and or TRICARE programs under the present and previous ownership for less than 3 full years. A change in ownership in itself does not constitute a new hospital.

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

4. Request for a Review of Higher or Lower Volume Classification. Any hospital or unit which TMA improperly fails to classify as a higher or lower volume hospital or unit may apply to the appropriate contractor for such a classification. The hospital or unit shall have the burden of proof.

G. Payment for Hospital Based Professional Services.

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

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

H. Leave Days.

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

2. Does not Constitute a Discharge/Do not Count Toward Day Limit. The government shall not count a patient's departure for a leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital.

I. Exemptions from the TRICARE Inpatient Mental Health Per Diem Payment System.

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

2. Services Which Group into DRG 424. Admissions to psychiatric hospitals and units for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424) are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

3. Non-Mental Health Procedures. Admissions for non-mental health procedures that group into DRGs 1 through 423, DRGs 438 through 494, and DRGs 600 through 636 in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

4. Sole Community Hospital (SCH). Any hospital which has qualified for special treatment under the Medicare Prospective Payment System (PPS) as a SCH and has not given up that classification is exempt. For additional information on SCHs, refer to Chapter 14, Section 1.

CHAPTER 9

AMBULATORY SURGERY CENTERS (ASCS)

CHAPTER 9
SECTION 1

AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT PRIOR TO IMPLEMENTATION OF OPPS, AND THEREAFTER, FREESTANDING ASCS, AND NON-OPPS FACILITIES REIMBURSEMENT

ISSUE DATE: August 26, 1985
AUTHORITY: 32 CFR 199.14(d)

I. APPLICABILITY

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

II. ISSUE

Reimbursement of surgical procedures performed in an Ambulatory Surgical Center (ASC) prior to implementation of TRICARE's Outpatient Prospective Payment System (OPPS), and thereafter, freestanding ASCs, and other providers who are exempt from the TRICARE OPPS and provide scheduled ambulatory surgery. For purposes of this section, these facilities are known as non-OPPS facilities. Non-OPPS facilities include any facility not subject to the OPPS as outlined in Chapter 13, Section 1, paragraph III.D.1.b.

III. BACKGROUND

A. Reimbursement System Prior to Implementation of TRICARE's OPPS.

1. General. Ambulatory surgery procedures performed in ASCs will be reimbursed using prospectively determined rates. The rates will be: established on a cost-basis, divided into eleven payment groups representing ranges of costs, and adjusted for area labor costs based on Metropolitan Statistical Areas (MSAs).

2. Applicability.

a. This payment system applies to all ambulatory surgery procedures identified in the list in Addendums A and B. (Creation and updating of Addendums A and B is the responsibility of TMA, and the inclusion or omission of any given procedure in Addendums A and B cannot be the basis for appealing any claim. Changes to Addendums A and B will be provided to the contractors when changes are made.) The payment system is to be used for ambulatory surgery procedures performed prior to implementation of OPPS, regardless of

where the ambulatory surgery procedures are provided, that is, in a freestanding ASC, in a hospital outpatient department, or in a hospital emergency room (ER).

b. The payment system is to be used for ambulatory surgery procedures provided in freestanding ASCs. The payment rates established under this system apply only to the facility charges for ambulatory surgery. The facility rate is a standard overhead amount that includes nursing and technician services; use of the facility; drugs including take-home drugs for less than $40; biologicals; surgical dressings, splints, casts and equipment directly related to provision of the surgical procedure; materials for anesthesia; intraocular lenses (IOLs); and administrative, recordkeeping and housekeeping items and services. The rate does not include items such as physicians' fees (or fees of other professional providers authorized to render the services identified in Addendums A and B and to bill independently for them); laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure); prosthetic devices (except IOLs); ambulance services; leg, arm, and back braces; artificial limbs; and durable medical equipment for use in the patient's home.

NOTE: A radiology and diagnostic procedure is considered directly related to the performance of the surgical procedure only if it is an inherent part of the surgical procedure, e.g., the CPT code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description (i.e., CPT[1] procedure code 47560).

3. State Waiver. Ambulatory surgery services provided by freestanding ASCs in Maryland are not exempt from this system and are to be reimbursed using the procedures set forth in this section. (See Chapter 1, Section 24, paragraph III.E. for payment of professional services related to ambulatory surgery.)

4. Ambulatory Surgery Payment Rates.

a. TMA, or its data contractor, will calculate the payment rates and will provide them electronically to the claims processing contractors. The magnetic media will include the locally-adjusted payment rate for each payment group for each MSA and will identify, by procedure code, the procedures in each group and the effective date for each procedure. Additions or deletions to the list of procedures will be given to the contractors as they occur, but the electronic data will be provided only on an annual basis. The MSAs and corresponding wage indexes will be those used by Medicare.

b. In addition to the payment rates, the contractors will be provided a zip code to MSA crosswalk, so that they can determine which payment rate to use for each ambulatory surgery provider. For this purpose the zip code of the facility's physical address (as opposed to its billing address) is to be used. This crosswalk may be updated periodically throughout the year and sent to the contractors.

c. In order to calculate payment rates, only those procedures with at least 25 claims nationwide during the database period will be used.

[1] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

d. The rates were initially calculated using the following steps.

(1) For each ambulatory surgery procedure, a median standardized cost was calculated on the basis of all ambulatory surgery charges nationally under TRICARE during the one year database period. The steps in this calculation included:

(a) Standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare;

(b) Applying the cost-to-charge ratio (CCR) using the Medicare CCR for freestanding ASCs for TRICARE ASCs.

(c) Calculating a median cost for each procedure; and

(d) Updating to the year for which the payment rates were in effect by the Consumer Price Index-Urban (CPI-U).

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

(3) The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

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

(a) Calculating a volume-weighted ratio of TRICARE payment rates to Medicare payment rates for those procedures with sufficient data;

(b) Applying the ratio to the Medicare payment rate for each procedure; and

(c) Assigning the procedure to the appropriate payment group.

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

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

5. Payments.

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

b. Procedures Which are Not in Addendums A and B and Are Provided by an ASC. Only those procedures contained in Addendums A and B are to be reimbursed under this reimbursement process. If a claim is received from an ASC for a procedure which is not in Addendums A and B, the facility charges are to be reimbursed using the process in paragraph III.B.

c. Multiple and Terminated Procedures. The following rules are to be followed whenever there is a terminated surgical procedure or more than one procedure is included on an ambulatory surgery claim. The claim for professional services, regardless of what type of ambulatory surgery facility provided the services and regardless of what procedures were provided, is to be reimbursed according to the multiple surgery guidelines in Chapter 1, Section 16, paragraph III.A.1.a. through c.

(1) Discounting for Multiple Surgical Procedures.

(a) If all the procedures on the claim are included in Addendums A and B, the claim is to be reimbursed at 100% of the group payment rate for the major procedure (the procedure which allows the greatest payment) and 50% of the group payment rate for each of the other procedures. This applies regardless of the groups to which the procedures are assigned.

(b) If the claim includes procedures included in Addendums A and B as well as procedures not included in Addendums A and B, the following rule is to be followed.

Each service is to be reimbursed according to the method appropriate to it. That is, the allowable amount for procedures in Addendums A and B is to be based on the appropriate group payment amount while the allowable amount for procedures not in Addendums A and B is to be based on the process in paragraph III.B. Regardless of the method used for determining the reimbursement for each procedure, only one procedure (the procedure which allows the greatest payment) is to be reimbursed at 100%. All other procedures are to be reimbursed at 50%. If the contractor is unable to determine the charges for each procedure (i.e., a single billed charge is made for all procedures), the contractor is to develop the claim for the charges using the steps contained in the TRICARE Operations Manual (TOM). If development does not result in usable charge

data, the contractor is to reimburse the major procedure (the procedure for which the greatest amount is allowed) if that can be determined (e.g., the major procedure is in Addendums A and B or is identified on the claim) and deny the other procedures using EOB message "Requested information not received". If the major procedure cannot be determined, the entire claim is to be denied.

(2) Discounting for Bilateral Procedures.

(a) Following are the different categories/classifications of bilateral procedures:

1 Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

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

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

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

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

(3) Modifiers for Discounting Terminated Surgical Procedures.

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

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

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

2 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.

(4) Unbundling of Procedures. Contractors should ensure that reimbursement for claims involving multiple procedures conforms to the unbundling guidelines as outlined in Chapter 1, Section 3.

(5) Incidental Procedures. The rules for reimbursing incidental procedures as contained in Chapter 1, Section 3, are to be applied to ambulatory surgery procedures reimbursed under the rules set forth in this section. That is, no reimbursement is to be made for incidental procedures performed in conjunction with other procedures which are not classified as incidental. This limitation applies to payments for facility claims as well as to professional services.

6. Updating Payment Rates.

a. The rates will be updated annually by TMA by the same update factor as is used in the Medicare annual updates for ASC payments. Periodically the rates will be recalculated using the steps in paragraph III.A.4.d.

b. The rates were updated by 3.2% effective November 1, 1995. This update included the wage indexes as updated by Medicare.

c. The rates were updated by 2.6% effective November 1, 1996. This update included the wage indexes as updated by Medicare.

d. The rates were updated by 0.6% effective November 1, 1997. This update included the wage indexes as updated by Medicare.

e. There was no update to the rates effective November 1, 1998. However, the wage indexes were updated in accordance with Medicare.

f. The rates were updated by 0.8% effective November 1, 1999. This update included the wage indexes as updated by Medicare.

g. The rates were updated by 1.0% effective November 1, 2000. This update included the wage indexes as updated by Medicare.

h. The rates were updated by 0.9% effective November 1, 2001. This update included the wage indexes as updated by Medicare.

i. The rates were updated by 3.0% effective November 1, 2002. This update included the wage indexes as updated by Medicare.

j. The group payment rates that are effective November 1, 2003, have been recalculated using the steps in paragraph III.A.4.d. However, we used 100 claims rather than 25 claims to calculate a rate for individual procedures, because it produced more statistically valid results while still resulting in calculated rates for about 83% of TRICARE ambulatory surgery services. In addition, the rates were updated by the Medicare update factor of 2.0% and included the wage indexes as updated by Medicare.

k. The rates were reduced by 2.0% effective April 1, 2004.

B. Reimbursement for procedures not in Addendums A and B. Prior to January 28, 2000, these procedures were to be denied if performed in an ASC and reimbursed in accordance with Chapter 1, Section 24. Effective January 28, 2000, ambulatory surgery procedures that are not in Addendums A and B, and are performed in either a freestanding ASC or hospital may be cost-shared. These procedures are reimbursed at the lessor of billed charges or network discount. Upon implementation of OPPS, these non-ASC procedures are subject to Chapter 13 discounting of surgical, bilateral and terminated procedures.

C. Reimbursement System upon Implementation of OPPS.

1. For ambulatory surgery procedures performed in an OPPS qualified facility, the provisions in Chapter 13 shall apply.

2. For ambulatory surgery procedures performed in freestanding ASCs and non-OPPS facilities, the provisions in paragraph III.A. shall apply, except as follows:

a. Contractors will no longer be allowed to group other procedures not included in Addendums A and B. Upon implementation of OPPS, these groupers will be end dated. Only ambulatory surgery procedures outlined in Addendums A and B are to be grouped.

b. Multiple and Terminated Procedures. For services rendered after implementation of OPPS, the professional services shall be reimbursed according to the multiple surgery guidelines in Chapter 13, Section 3, paragraph III.A.5.b. and c.

c. Discounting for Multiple Surgical Procedures. For services rendered after implementation of OPPS, discounting for multiple surgical procedures are subject to the provisions in Chapter 13, Section 1.

d. Discounting for Bilateral Procedures. For services rendered after implementation of OPPS, bilateral procedures will be discounted based on the application of discounting formulas appearing in Chapter 13, Section 3, paragraph III.A.5.c.(6) and (7).

D. Claims for Ambulatory Surgery.

1. Claims for facility charges must be submitted on a CMS 1450 UB-04. Claims for professional charges may be submitted on either a CMS 1450 UB-04 or a CMS 1500 (08/05) claim form. The preferred form is the CMS 1500 (08/05). When professional services are billed on a CMS 1450 UB-04, the information on the CMS 1450 UB-04 should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

2. Claim Data.

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

b. TRICARE Encounter Data (TED). All ambulatory surgery services are to be reported on the TED using the appropriate CPT-4 code. The only exception is services which are billed using a HCPCS code and for which no CPT-4 code exists.

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

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

- END -

CHAPTER 10
SECTION 1

FREESTANDING AND HOSPITAL-BASED BIRTHING CENTER REIMBURSEMENT

ISSUE DATE: February 14, 1984
AUTHORITY: 32 CFR 199.6(b)(4)(xi)(A)**(3)** and 32 CFR 199.14(e)

I. APPLICABILITY

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

II. DESCRIPTION

A birthing center is a freestanding or institution affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

III. POLICY

A. A freestanding or institution affiliated birthing center may be considered for status as an authorized institutional provider.

B. Reimbursement for all-inclusive maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the TRICARE established all-inclusive rate or the billed charge.

C. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility. The rate includes physician services for routine consultation when certified nurse-midwife is the attending professional.

NOTE: The initial complete newborn examination by a pediatrician is not included in the Birthing Center all-inclusive fee and is to be cost-shared as a part of the maternity episode when performed within 72 hours of the delivery.

D. Claims for professional services and tests where the beneficiary has been screened but rejected for admission into the program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, should be priced as individual services and items, subject to current policies for obstetrical care professional services and reported as appropriate CPT[1] procedure code with place of service "25" for birthing center.

E. Extraordinary maternity care services (services in excess of the quantity or type usually associated with all-inclusive maternity care and childbirth service for a normal pregnancy) may be cost-shared as part of the birthing center maternity episode and paid as the lesser of the billed charge or the allowable charge when the service is determined to be otherwise authorized and medically necessary and appropriate.

F. Calculation of the TRICARE maximum allowable birthing center all-inclusive rate.

1. The TRICARE maximum allowable all-inclusive rate is equal to the sum of the Class 3 CHAMPUS Maximum Allowable Charge (CMAC) for total obstetrical care for a normal pregnancy and delivery (CPT[1] procedure code 59400) plus the TMA supplied non professional price component amount. TMA will supply each contractor with non professional price components for each state annually (Chapter 10, Addendum A) to be effective for the forthcoming fiscal year.

2. The maximum allowable all-inclusive rate shall be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update.

G. Claims processing.

1. The cost-share amount for birthing center claims is calculated using the ambulatory surgery cost-share formula.

2. Claims from birthing centers will be processed as outpatient hospital claims using revenue code 724 and the following CPT[1] procedure code with place of service "25" for birthing center.

59400 Birthing Center, all-inclusive charge, complete

3. Both the technical and professional components of usual tests are included in the all-inclusive rate.

H. Excluded services[1] when billed separately.

99071 Patient education materials
99078 Group health education

- END -

[1] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

FIGURE 10-A-3 BIRTHING CENTER RATE NON-PROFESSIONAL COMPONENT - FY 2006

FISCAL YEAR 2006 TRICARE-AUTHORIZED BIRTHING CENTER PROVIDER NON-PROFESSIONAL COMPONENT FOR ALL-INCLUSIVE PRICING FORMULA			
Alabama	$2,965.78	Montana	$1,399.53
Alaska	$3,156.82	Nebraska	$1,894.80
Arizona	$1,604.68	Nevada	$2,849.86
Arkansas	$3,788.53	New Hampshire	$1,879.12
California	$3,533.86	New Jersey	$5,726.79
Colorado	$2,214.47	New Mexico	$2,149.67
Connecticut	$3,045.34	New York	$1,451.65
Delaware	$2,578.53	North Carolina	$2,483.29
District of Columbia	$2,614.79	North Dakota	$893.46
Florida	$2,768.17	Ohio	$2,316.77
Georgia	$2,381.60	Oklahoma	$3,055.18
Hawaii	$2,318.61	Oregon	$1,887.67
Idaho	$1,669.21	Pennsylvania	$2,927.86
Illinois	$2,056.84	Puerto Rico	$802.83
Indiana	$2,115.11	Rhode Island	$3,160.76
Iowa	$1,720.53	South Carolina	$2,604.70
Kansas	$2,107.07	South Dakota	$1,443.10
Kentucky	$2,115.30	Tennessee	$1,713.33
Louisiana	$2,650.81	Texas	$2,595.58
Maine	$1,689.12	Utah	$1,548.56
Maryland	$1,700.66	Vermont	$1,972.22
Massachusetts	$2,678.64	Virginia	$2,307.44
Michigan	$2,432.86	Washington	$2,291.03
Minnesota	$2,665.68	West Virginia	$1,503.66
Mississippi	$2,308.79	Wisconsin	$1,612.33
Missouri	$2,244.08	Wyoming	$1,785.16

These state specific non-professional component amounts are to be used in creating the maximum allowable all-inclusive TRICARE-authorized birthing center prices during Fiscal Year 2006. The all-inclusive prices are to be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update. (See Chapter 10, Section 1, for instruction for the use of these amounts.)

FIGURE 10-A-4 BIRTHING CENTER RATE NON-PROFESSIONAL COMPONENT - FY 2007

FISCAL YEAR 2006 TRICARE-AUTHORIZED BIRTHING CENTER PROVIDER NON-PROFESSIONAL COMPONENT FOR ALL-INCLUSIVE PRICING FORMULA			
Alabama	$3,686.88	Montana	$1,466.57
Alaska	$3,040.73	Nebraska	$2,024.74
Arizona	$1,946.13	Nevada	$2,920.62
Arkansas	$3,807.75	New Hampshire	$2,551.56
California	$3,548.31	New Jersey	$5,010.10
Colorado	$2,303.01	New Mexico	$2,501.06
Connecticut	$3,701.71	New York	$1,451.56
Delaware	$2,736.36	North Carolina	$2,662.36
District of Columbia	$2,504.93	North Dakota	$1,373.26
Florida	$3,411.22	Ohio	$2,557.72
Georgia	$2,420.48	Oklahoma	$3,077.71
Hawaii	$2,591.73	Oregon	$1,892.26
Idaho	$1,772.36	Pennsylvania	$2,770.11
Illinois	$2,337.80	Puerto Rico	$784.50
Indiana	$2,481.09	Rhode Island	$3,533.74
Iowa	$2.050.04	South Carolina	$2,806.01
Kansas	$2,641.96	South Dakota	$1,408.77
Kentucky	$2,180.78	Tennessee	$2,032.68
Louisiana	$2,303.50	Texas	$2,863.58
Maine	$1,829.51	Utah	$1,511.88
Maryland	$2,002.51	Vermont	$1,565.74
Massachusetts	$2,647.58	Virginia	$2,568.48
Michigan	$2,651.53	Washington	$2,339.51
Minnesota	$2,631.52	West Virginia	$1,395.96
Mississippi	$3,232.74	Wisconsin	$1,665.50
Missouri	$2,221.82	Wyoming	$2,544.07

These state specific non-professional component amounts are to be used in creating the maximum allowable all-inclusive TRICARE-authorized birthing center prices during Fiscal Year 2007. The all-inclusive prices are to be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update. (See Chapter 10, Section 1, for instruction for the use of these amounts.)

FIGURE 10-A-5 BIRTHING CENTER RATE NON-PROFESSIONAL COMPONENT - FY 2008

FISCAL YEAR 2008 TRICARE-AUTHORIZED BIRTHING CENTER PROVIDER NON-PROFESSIONAL COMPONENT FOR ALL-INCLUSIVE PRICING FORMULA			
Alabama	$3,602.84	Montana	$1,531.25
Alaska	$3,501.39	Nebraska	$2,269.24
Arizona	$2,053.43	Nevada	$2,991.98
Arkansas	$3,804.33	New Hampshire	$2,548.65
California	$3,585.95	New Jersey	$4,906.20
Colorado	$2,427.58	New Mexico	$2,539.70
Connecticut	$4,124.86	New York	$1,555.18
Delaware	$2,963.51	North Carolina	$2,755.86
District of Columbia	$2,570.57	North Dakota	$1,592.29
Florida	$3,376.03	Ohio	$2,851.25
Georgia	$2,591.50	Oklahoma	$3,135.88
Hawaii	$2,609.55	Oregon	$2,013.77
Idaho	$1,872.15	Pennsylvania	$3,210.49
Illinois	$2,295.17	Puerto Rico	$755.41
Indiana	$2,689.04	Rhode Island	$3,987.66
Iowa	$2,143.45	South Carolina	$3,253.52
Kansas	$2,825.61	South Dakota	$1,547.54
Kentucky	$2,693.68	Tennessee	$2,336.24
Louisiana	$2,380.46	Texas	$2,998.22
Maine	$1,799.89	Utah	$1,491.17
Maryland	$2,047.58	Vermont	$2,074.73
Massachusetts	$2,638.70	Virginia	$2,498.14
Michigan	$2,851.37	Washington	$2,598.50
Minnesota	$2,808.39	West Virginia	$1,761.87
Mississippi	$4,286.17	Wisconsin	$1,972.49
Missouri	$2,447.10	Wyoming	$2,939.36

These state specific non-professional component amounts are to be used in creating the maximum allowable all-inclusive TRICARE-authorized birthing center prices during Fiscal Year 2008. The all-inclusive prices are to be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update. (See Chapter 10, Section 1, for instruction for the use of these amounts.)

- END -

CHAPTER 13

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) - AMBULATORY PAYMENT CLASSIFICATIONS (APCS)

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

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

CHAPTER 13
SECTION 1

GENERAL

ISSUE DATE: July 27, 2005
AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

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

II. ISSUE

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

III. POLICY

A. Statutory Background.

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 may, 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 of 1997 (BBA 1997), (Public Law (PL) 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.

Centers for Medicare and Medicaid Services (CMS) published a proposed rule in the

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

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

Subsequent to publication of the proposed rule, the Balanced Budget Refinement Act of 1999 (BBRA 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):

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

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

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

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.

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.

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.

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

8. Established hold harmless provisions for rural and cancer hospitals.

B. 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).

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

C. Unbundling Provisions.

As a prelude to implementation of the OPPS, the Omnibus Budget Reconciliation Act of 1996 (OBRA 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, nurse practitioners and clinical nurse specialists. 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:

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.

2. Skilled Nursing Facility (SNF) consolidated billing requirements do not apply to the following exceptionally intensive hospital outpatient services:

a. Cardiac catheterization;

b. Computerized Axial Tomography (CAT) scans;

c. Magnetic Resonance Imagings (MRIs);

d. Ambulatory surgery involving the use of an operating room;

e. Emergency Room (ER) services;

f. Radiation therapy;

g. Angiography; and

h. 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.

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

D. Applicability and Scope of Coverage.

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

1. Provider Categories.

a. Providers Included In OPPS:

(1) All hospitals participating in the Medicare program, except for those excluded under paragraph III.D.1.b.

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

(a) Be certified pursuant to TRICARE certification standards.

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

(c) Currently accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under the current edition of the **Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Development Disabilities Services**.

(d) Has a written participation agreement with TRICARE.

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

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

b. Providers Excluded From OPPS:

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

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

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

(3) CAHs. The contractors shall monitor TMA's web site at http://www.tricare.mil/hospitalclassification for quarterly updates to the critical access hospital list and update their systems to reflect the most current information on the list. For additional information on CAHs, refer to Chapter 15, Section 1.

(4) Hospitals located outside one of the 50 states, the District of Columbia, and Puerto Rico.

(5) Specialty care providers to include:

(a) Cancer and children's hospitals.

(b) Freestanding Ambulatory Surgery Centers (ASCs).

(c) Freestanding PHPs, Psych and Substance Use Disorder Rehabilitation Facilities (SUDRFs).

(d) Comprehensive Outpatient Rehabilitation Facilities (CORFs).

(e) Home Health Agencies (HHAs).

(f) Hospice programs.

(g) 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.

(h) 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.

(i) Freestanding Birthing Centers.

(j) Veterans Affairs (VA) hospitals.

(k) Freestanding End Stage Renal Dialysis (ESRD) Facilities.

(l) SNFs.

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

2. Scope of Services.

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

(1) Physician services.

(2) Nurse practitioner and clinical nurse specialist services.

(3) Physician assistant services.

(4) Certified nurse-midwife services.

(5) Services of qualified psychologists.

(6) Clinical social worker services.

(7) Services of an anesthetist.

(8) Screening and diagnostic mammographies.

(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.

(10) Clinical diagnostic laboratory services.

(11) Take home surgical dressings.

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

(a) 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.

(b) 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.

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

(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.

(14) Services and procedures designated as requiring inpatient care.

(15) Services excluded by statute (excluded from the definition of "covered Outpatient Department (OPD) Services"):

(a) Ambulance services;

(b) Physical therapy;

(c) Occupational therapy;

(d) Speech-language pathology.

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

(16) Ambulatory surgery procedures performed in freestanding ASCs will continue to be reimbursed under the per diem system established in Chapter 9, Section 1 of this manual.

b. Costs excluded under the hospital OPPS:

(1) Direct cost of medical education activities.

(2) Costs of approved nursing and allied health education programs.

(3) Costs associated with interns and residents not in approved teaching programs.

(4) Costs of teaching physicians.

(5) Costs of anesthesia services furnished to hospital outpatients by qualified non-physician anesthetists (certified registered nurse anesthetists (CRNA) and anesthesiologists' assistants (AAs)) employed by the hospital or obtained under arrangements, for hospitals.

(6) Bad debts for uncollectible and coinsurance amounts.

(7) Organ acquisition costs.

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

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

C. Services included in payment under the OPPS (not an all-inclusive list).

(1) Hospital-based full- and half-day PHPs (psych and SUDRFs) which are paid a per diem OPPS. 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.

(2) All hospital outpatient services, except those that are identified as excluded. The following are services that are included in OPPS:

(a) Surgical procedures.

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

(b) Radiology, including radiation therapy.

(c) Clinic visits.

(d) Emergency department visits.

(e) Diagnostic services and other diagnostic tests.

(f) Surgical pathology.

(g) Cancer chemotherapy.

(h) Implantable medical items.

1 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);

2 Implantable DME (e.g., pacemakers, defibrillators, drug pumps, and neurostimulators)

3 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.

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

(i) 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:

1 Cardiac catheterization;

2 CAT scans;

3 MRIs;

4 Ambulatory surgery involving the use of an operating room;

5 ER services;

6 Radiation therapy;

7 Angiography;

8 Lymphatic and venous procedures.

(j) Certain preventive services furnished to healthy persons, such as colorectal cancer screening.

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

(l) ESRD Services. Since TRICARE does not have an ESRD composite rate, ESRD services are included in TRICARE's OPPS.

E. Description of APC Groups.

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 OPPS.

1. Grouping of Procedures/Services Under APC System.

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.

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

(1) *Resource Homogeneity* - The amount and type of facility resources (e.g., operating room time, medical surgical supplies, and equipment) that are used to furnish or perform the individual procedures or services within each APC should be homogeneous.

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

That is, the resources used are relatively constant across all procedures or services even though resource use may vary somewhat among individual patients.

(2) *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.

(3) *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.

(4) *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.

F. Basic Reimbursement Methodology.

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.

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:

a. New temporary technology APCs for certain approved services that are structured based on cost rather than clinical homogeneity.

b. Separate APCs for certain medical devices, drugs, biologicals, radiopharmaceuticals and devices of brachytherapy under transitional pass-through provisions.

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.

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

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 2 times greater than the lowest median cost for an item or service within the same group. However, exceptions may be made to the 2 times rule "in unusual cases, such as low volume items and services."

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

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.

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 OPPS.

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 CPT[1]/HCPCS 36400-36416, 59020, 59025, and 59050, for venipuncture and fetal monitoring. Reference Chapter 2, Section 1, paragraph I.B.5.e. and f.

G. Reimbursement Hierarchy For Procedures Paid Outside The OPPS.

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

The following tables includes the list of rate columns on the CMAC file. The columns are number 1 through 6 by description. The pricing hierarchy for facility CMAC is 8, 6, 4, then 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
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, if the Facility CMAC for non-physician class > 0, then pay the Facility CMAC for non-physician class. Otherwise, pay Facility CMAC for physician/LLP class.	

[1] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

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

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

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

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

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

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

H. Outpatient Code Editor (OCE).

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 Chapter 13, Addendum A1, for quarterly review/update process.

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

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

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

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

I. PRICER Program.

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, July1 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 TOM, Chapter 1, Section 3, paragraph 1.3.2.

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.

J. 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.

K. Provider-Based Status for Payment Under OPPS.

An outpatient department, 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.

L. 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, Section 1 through 5:

IMPLEMENTING INSTRUCTIONS/SERVICES	
POLICIES	
General Overview	Chapter 13, Section 1
Billing and Coding of Services under APC Groups	Chapter 13, Section 2
Reimbursement Methodology	Chapter 13, Section 3
Claims Submission and Processing Requirements	Chapter 13, Section 4
Medical Review And Allowable Charge Review Under The Hospital OPPS	Chapter 13, Section 5
ADDENDA	
Development Schedule for TRICARE OCE/APC - Quarterly Update	Chapter 13, Addendum A1
OPPS OCE Notification Process for Quarterly Updates	Chapter 13, Addendum A2

M. 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.

1. APCs with SIs and Payment Rates.

2. Payment SI by HCPCS Code.

3. Payment SIs/Descriptions.

4. CPT Codes That Are Paid Only as Inpatient Procedures.

5. Statewide Cost-to-Charge Ratios (CCRs).

6. 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 1 of each year for OPPS.

7. Zip to Wage Index Crosswalk.

- END -

CHAPTER 13
SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

ISSUE DATE: July 27, 2005
AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

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.

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

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.

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

(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

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

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.

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

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.

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

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.

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

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

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

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 codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.**

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

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

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.

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

(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.

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

(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

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

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

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

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	

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		
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	

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		
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

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		
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.

- END -

CHAPTER 13
SECTION 3

PROSPECTIVE PAYMENT METHODOLOGY

ISSUE DATE: July 27, 2005
AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

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

II. ISSUE

To describe the payment methodology for hospital outpatient services.

III. POLICY

A. Basic Methodology for Determining Prospective Payment Rates for Outpatient Services.

1. Setting of Payment Rates.

The prospective payment rate for each Ambulatory Payment Classification (APC) is calculated by multiplying the APC's relative weight by the conversion factor.

2. Recalibration of Group Weights and Conversion Factor.

a. Relative Weights for Services Furnished on a Calendar Year (CY) basis.

(1) The most recent Medicare claims and facility cost report data are used in recalibrating the relative APC weights for services furnished on a CY basis.

(2) Weights are derived based on median hospital costs for services in the hospital outpatient APC groups. Billed charges are converted to costs and aggregated to the procedure or visit level. Calculation of the median hospital cost per APC group include the following steps:

(a) The statewide Cost-to-Charge Ratio (CCR) is identified for each hospital's cost center ("statewide CCRs") and applied based on the from date on the claim.

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

(b) The statewide CCRs are then crosswalked to revenue centers. The CCRs included operating and capital costs but excluded costs associated with direct graduate medical education and allied health education.

(c) A cost is calculated for every billed line item charged on each claim by multiplying each revenue center charge by the appropriate statewide CCR.

(d) Revenue center changes that contain items integral to performing the procedure or visit are used to calculate the per-procedure or per-visit costs. Following is a list of revenue centers whose charges could be packaged into major Healthcare Common Procedure Coding System (HCPCS) codes when appearing in the same claim.

FIGURE 13-3-1 LIST OF REVENUE CENTERS PACKAGED INTO MAJOR HCPCS CODES WHEN APPEARING IN THE SAME CLAIM

REVENUE CODE	DESCRIPTION
0250	Pharmacy, Drugs Requiring Specific Identification, General Class
0251	Generic
0252	Nongeneric
0253	Take Home Drugs
0254	Pharmacy Incident to Other Diagnostic
0255	Pharmacy Incident to Radiology
0257	Nonprescription Drugs
0258	IV Solutions
0259	Other Pharmacy
0260	IV Therapy, General Class
0262	IV Therapy/Pharmacy Services
0263	Supply/Delivery
0264	IV Therapy/Supplies
0269	Other IV Therapy
0270	M&S Supplies
0271	Nonsterile Supplies
0272	Sterile Supplies
0273	Take Home supplies
0275	Pacemaker Drug
0276	Intraocular Lens Source Drug
0277	Oxygen Take Home
0278	Other Implants
0279	Other M&S Supplies
0280	Oncology
0289	Other Oncology
0370	General Classification

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

FIGURE 13-3-1 LIST OF REVENUE CENTERS PACKAGED INTO MAJOR HCPCS CODES WHEN APPEARING IN THE SAME CLAIM (CONTINUED)

REVENUE CODE	DESCRIPTION
0371	Anesthesia Incident to Radiology
0372	Anesthesia Incident to Other Diagnostic Services
0374	Acupuncture
0379	Other Anesthesia
0390	Blood Storage and Processing
0391	Blood Administration (e.g., transfusions)
0399	Other Blood Storage and Processing
0621	Supplies Incident to Radiology
0622	Supplies Incident to Other Diagnostic
0623	Surgical Dressings
0624	Investigational Device (IDE)
0631	Single Source
0632	Multiple
0633	Restrictive Prescription
0637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic COMA)
0700	Cast Room
0709	Other Cast Room
0710	Recovery Room
0719	Other Recovery Room
0720	Labor Room
0721	Labor
0762	Observation Room
0770	General Classification
0771	Vaccine Administration

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

NOTE: If the revenue code is not listed above, refer to the TRICARE Systems Manual (TSM), Chapter 2, Addendum O, for reporting requirements.

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

EXAMPLE: Operating room, treatment room, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, casts

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and splints, and donor tissue, bone, and organ charges were used in calculating surgical procedure costs. The charges for items such as medical and surgical supplies, drugs and observation were used in estimating medical visit costs.

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

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

(g) Each procedure or visit cost is mapped to its assigned APC.

(h) The median cost is calculated for each APC.

(i) Relative payment weights are calculated for each APC, by dividing the median cost of each APC by the median cost for APC 00601 (mid-level clinic visit), Outpatient Prospective Payment System (OPPS) weights are listed on TMA's OPPS web site at http://www.tricare.mil/opps.

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

b. Conversion Factor Update.

(1) The conversion factor is updated annually by the hospital inpatient market basket percentage increase applicable to hospital discharges.

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

3. Payment Status Indicators (SIs).

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

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descriptions of the particular services each indicator identifies:

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

b. "B" to indicate more appropriate code required for TRICARE OPPS.

c. "C" to indicate inpatient services that are not paid under the OPPS.

d. "E" to indicate items or services are not covered by TRICARE.

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

f. "G" to indicate drug/biological pass-through that are paid in separate APCs under the OPPS.

g. "H" to indicate pass-through device categories, brachytherapy sources, and radiopharmaceutical agents allowed on a cost basis.

h. "K" to indicate non-pass-through drugs and biologicals and blood and blood products that are paid in separate APCs under the OPPS.

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

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

k. "Q" to indicate packaged services subject to separate payment under OPPS.

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

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

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

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

n. "V" to indicate medical visits (including clinic or emergency department (ED) visits) for which payment is allowed under the hospital OPPS.

o. "W" to indicate invalid HCPCS or invalid revenue code with blank HCPCS.

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

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

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

4. Calculating TRICARE Payment Amount.

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

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

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

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

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

(2) Multiply the wage adjusted APC payment rate by the OPPS rural adjustment (1.071) if the provider is a Sole Community Hospital (SCH) in a rural area.

(3) Determine any outlier amounts and add them to the sum of either (1) or (2) above.

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

(4) Subtract from the adjusted APC payment rate the amount of any applicable deductible and/or cost-sharing/copayment amounts based on the eligibility status of the beneficiary at the time the outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra and Standard beneficiary categories). Refer to Chapter 2, Addendum A for applicable deductible and/or cost-sharing/copayment amounts for Outpatient Hospital Departments and Ambulatory Surgery Centers (ASCs).

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

(1) Example #1. Assume that the wage adjusted rate for an APC is $400; the beneficiary receiving the services is an active duty family member enrolled under Prime, and as such, is not subject to any deductibles or copayments.

(a) Adjusted APC payment rate: $400.

(b) Subtract any applicable deductible:

$400 - $0 = $400

(c) Subtract the Prime active duty family member copayment from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$400 - $0 = $400 TRICARE final payment

(d) TRICARE would pay 100% of the adjusted APC payment rate for active duty family members enrolled in Prime.

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

(a) Adjusted APC payment rate: $400.

(b) Subtract any applicable deductible:

$400 - $0 = $400

(c) Subtract the Prime retiree family member copayment from the adjusted APC payment rate less deductible to calculate the final TRICARE payment amount.

$400 - $12 = $388 TRICARE final payment

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

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

(3) Example #3. This example illustrates a case in which both an outpatient deductible and cost-share are applied. Assume that the wage-adjusted payment rate for an APC is $400 and the beneficiary receiving the outpatient services is a standard active duty family member subject to an individual $50 deductible (active duty sponsor is an E3) and 20% cost-share.

(a) Adjusted APC payment rate: $400.

(b) Subtract any applicable deductible:

$400 - $50 = $350

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

$350 x .20 = $70 cost-share

$350 - $70 = $280 TRICARE final payment

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

5. Adjustments to APC Payment Amounts.

a. Adjustment for Area Wage Differences.

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

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

(3) Sixty percent (60%) of the hospital's outpatient department costs are recognized as labor-related costs that would be standardized for geographic wage differences. This is a reasonable estimate of outpatient costs attributable to labor, as it fell between the hospital DRG operating cost labor factor of 71.1% and the ASC labor factor of

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

34.45%, and is close to the labor-related costs under the inpatient DRG payment system attributed directly to wages, salaries and employee benefits (61.4%).

(4) Steps in Applying Wage Adjusts under OPPS.

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

(b) Determine the wage index in which the hospital is located and identify the wage index level that applies to the specific hospital.

(c) Multiply the applicable wage index determined under (b) and (c) by the amount under (a) that represents the labor-related portion of the national unadjusted payment rate.

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

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

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

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

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

1 Wage-Adjusted Payment Rate (rounded to nearest cent):

= ($180 x 1.0234) = $184.21 + $120 = $304.21

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

2 Cost-share for standard retiree family member (rounded to nearest cent):

= ($304.21 x .20) = $60.84

3 Subtract the standard retiree family member cost-share from the wage-adjusted rate to get the final TRICARE payment

= ($304.21 - $60.84) = $243.37

b. Discounting of Surgical and Terminating Procedures.

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

(a) Line items with a SI of "T" are subject to multiple procedure discounting unless modifiers 76, 77, 78 and/or 79 are present.

(b) When more than one procedure with payment SI "T" is performed during a single operative session, TRICARE will reimburse the full payment and the beneficiary will pay the cost-share/copayment for the procedure having the highest payment rate.

(c) Fifty percent (50%) of the usual PPS payment amount and beneficiary copayment/cost-share amount would be paid for all other procedures performed during the same operative session to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

1 The reduced payment would apply only to the surgical procedure with the lower payment rate.

2 The reduced payment for multiple procedures would apply to both the beneficiary copayment/cost-share and the TRICARE payment.

(2) Hospitals are required to use modifiers on bills to indicate procedures that are terminated before completion.

(a) Fifty percent (50%) of the usual OPPS payment amount and beneficiary copayment/cost-share will be paid for a procedure terminated before anesthesia is induced.

1 Modifier -73 (Discontinued Outpatient Procedure Prior to Anesthesia Administration) would identify a procedure that is terminated after the patient

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

has been prepared for surgery, including sedation when provided, and taken to the room where the procedure is to be performed, but before anesthesia is induced (for example, local, regional block(s), or general anesthesia).

2 Modifier -52 (Reduced Services) would be used to indicate a procedure that did not require anesthesia, but was terminated after the patient had been prepared for the procedure, including sedation when provided, and taken to the room where the procedure is to be performed.

(b) Full payment will be received for a procedure that was started but discontinued after the induction of anesthesia, or after the procedure was started.

1 Modifier -74 (Discontinued Procedure) would be used to indicate that a surgical procedure was started but discontinued after the induction of anesthesia (for example, local, regional block, or general anesthesia), or after the procedure was started (incision made, intubation begun, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient.

2 This payment would recognize the costs incurred by the hospital to prepare the patient for surgery and the resources expended in the operating room and recovery room of the hospital.

c. Discounting for Bilateral Procedures.

(1) Following are the different categories/classifications of bilateral procedure:

(a) Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

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

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

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

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

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

(4) The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.

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

(6) Following are the different discount formulas that can be applied to a line item:

FIGURE 13-3-2 DISCOUNTING FORMULAS FOR BILATERAL PROCEDURES

DISCOUNTING FORMULA NUMBER	FORMULAS
1	1.0
2	(1.0 + D (U - 1))/U
3	T/U
4	(1 + D)/U
5	D
6	TD/U
7	D (1 + D)/U
8	2.0

Where:

D = discounting fraction (currently 0.5)
U = number of units
T = terminated procedure discount (currently 0.5)

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

(7) The following figure summarizes the application of above discounting formulas:

FIGURE 13-3-3 APPLICATION OF DISCOUNTING FORMULAS

			DISCOUNTING FORMULA NUMBER			
			TYPE "T" PROCEDURE		NON-TYPE "T" PROCEDURE	
PAYMENT AMOUNT	MODIFIER 52 OR 73	MODIFIER 50	CONDITIONAL OR INDEPENDENT BILATERAL	INHERENT OR NON-BILATERAL	CONDITIONAL OR INDEPENDENT BILATERAL	INHERENT OR NON-BILATERAL
Highest	No	No	2	2	1	1
Highest	Yes	No	3	3	3	3
Highest	No	Yes	4	2	4/8*	1
Highest	Yes	Yes	3	3	3	3
Not Highest	No	No	5	5	1	1
Not Highest	Yes	No	6	6	3	3
Not Highest	No	Yes	7	5	4/8*	1
Not Highest	Yes	Yes	6	6	3	3
For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (**T**) any applicable offset, will be applied prior to selecting the **T** procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first before the terminated procedure discount. This applies only on claims reimbursed under the OPPS reimbursement methodology						
*If not terminated, non-type **T** Conditional bilateral procedures with modifier 50 will be assigned discount formula #4; non-type **T** Independent bilateral procedures with modifier 50 will be assigned to formula #8.						

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

d. Outlier Payments.

An additional payment is provided for outpatient services for which a hospital's charges, adjusted to cost, exceed the sum of the wage adjusted APC rate plus a fixed dollar threshold and a fixed multiple of the wage adjusted APC rate. Only line item services with SIs "P', "S", "T", "V", or "X" will be eligible for outlier payment under OPPS. No outlier payments will be calculated for line item services with SIs "G", "H", "K", "N", and "K", with the exception of blood and blood products.

(1) Outlier payments will be calculated on a service-by-service basis. Calculating outliers on a service-by-service basis was found to be the most appropriate way to calculate outliers for outpatient services. Outliers on a bill basis requires both the aggregation of costs and the aggregation of OPPS payments, thereby introducing some degree of offset among services; that is, the aggregation of low cost services and high cost services on a bill may result in no outlier payment being made. While service-based outliers are somewhat more complex to administer, under this method, outlier payments will be

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

more appropriately directed to those specific services for which a hospital incurs significantly increased costs.

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

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

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

STEP 1: Identify all APCs on the claim.

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

HCPCS CODE	SI	APC	SERVICE	WAGE ADJUSTED APC PAYMENT RATE	RATIO OF APC TO TOTAL PAYMENT
99285	V	0616	Level 5 Emergency Visit	$325.26	0.5425611
70481	S	0283	CT scan with contrast material	$250.94	0.4185891
93041	S	0099	Electrocardiogram	$23.29	0.0388496

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

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

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

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

APC	RATIO ALLOCATION	OPPS SERVICE	250 (PHARMACY)	270 (MEDICAL SUPPLIES)
0616	0.5425611	Level 5 Emergency Visit	$1,863.97	$2,309.03
0283	0.4185891	CT scan with contrast material	$1,438.06	$1,781.43
0099	0.0388496	Electrocardiogram	$133.47	$165.34

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

APC	OPPS SERVICE	TOTAL CHARGES	TOTAL CHARGES REDUCED TO COSTS (CCR = 0.3140)
0616	Level 5 Emergency Visit	$7,159.00	$2,247.93
0283	CT scan with contrast material	$7,176.49	$2,253.42
0099	Electrocardiogram	$634.81	$199.33

STEP 6: Apply the cost test to each wage adjusted APC service or procedure to determine if it qualifies for an outlier payment. If the cost of a service (wage adjusted APC) exceeds both the APC multiplier threshold (1.75 times the wage adjusted APC payment rate) and the fixed dollar threshold (wage adjusted APC rate plus $1,825), multiply the costs in excess of the wage adjusted APC multiplier by 50% to get the additional outlier payment.

APC	WAGE ADJUSTED APC RATE	COSTS	FIXED DOLLAR THRESHOLD (WAGE ADJUSTED APC RATE + $1,825)	MULTIPLIER THRESHOLD (1.75 X WAGE INDEX APC RATE)	COSTS IN EXCESS OF MULTIPLIER THRESHOLD	OUTLIER PAYMENT COSTS OF WAGE ADJUSTED APC - (1.75 X WAGE ADJUSTED APC RATE) X 0.50
0616	$325.26	$2,247.93	$2,150.26	$569.21	$1,678.72	$839.34
0283	$250.94	$2,253.42	$2,075.94	$439.15	$1,814.27	$907.14
0099	$23.29	$199.33	$1,848.29	$40.76	$158.56	-0-**

**** Does not qualify for outlier payment since the APC's costs did not exceed the fixed dollar threshold (APC Rate + $1,825).**

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

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

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

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

(2) The adjustment is budget neutral and will be applied before calculating outliers and copayments/cost-sharing.

B. Transitional Pass-Through for Innovative Medical Devices, Drugs, and Biologicals.

1. Items Subject to Transitional Pass-Through Payments.

a. Current Orphan Drugs.

A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

NOTE: Orphan drugs will be paid separately at the Average Sales Price (ASP) + 6%, which represents a combined payment for acquisition and overhead costs associated with furnishing these products. Orphan drugs will no longer be paid based on the use of drugs because all orphan drugs, both single-indication and multi-indication, will be paid under the same methodology. The TRICARE contractors will not be required to calculate orphan drug payments.

b. Current Cancer Therapy Drugs, Biologicals and Brachytherapy.

These items are drugs or biologicals that are used in cancer therapy, including (but not limited to) chemotherapeutic agents, antiemetics, hematopoietic growth factors, colony stimulating factors, biological response modifiers, biphosphonates, and a device of brachytherapy if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

c. Current Radiopharmaceutical Drugs and Biological Products.

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

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

d. New Medical Devices, Drugs, and Biologicals.

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

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

a. Pass-through device categories are identified by SI "H".

b. Pass-through drugs and biological agents are identified by SI "G".

3. Payment of Pass-Through Drugs and Biologicals.

a. Pass-through drugs and biologicals, will be paid a rate equivalent to what would be received in a physician's office setting; i.e., the ASP methodology established under the Medicare physician fee schedule. Following is the applicable payment methodology for transitional pass-through drugs or biologicals:

(1) Calculation of ASP.

(a) The ASP for both multiple and sole source drug products included within the same billing payment code (or HCPCS code) is the volume-weighted average of the manufacturer's ASPs reported across all the National Drug Codes (NDCs) assigned to the HCPCS determined by:

1 Computing the sum of the products (for each National Code assigned to those drug products) of the manufacturer's ASP and the total number of units sold; and

2 Dividing the sum by the sum of the total number of units sold for all NDCs assigned to those drug products.

(b) The ASP is determined without regard to any special packaging, labeling, or identifiers on the dosage form, product or package.

(2) Payment Allowances for Single and Multiple Source Drugs.

(a) Single Source Drugs.

The payment allowance for a single source drug HCPCS code will be equal to the lesser of 106% of the ASP for the HCPCS code or 106% of the wholesale acquisition cost of the HCPCS code, subject to applicable deductible and copayment/cost-sharing and limitations related to widely available market prices and average manufacturer

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

prices in the Medicaid drug rebate program. The payment limit may also be adjusted in response to public emergency.

(b) Multiple Source Drugs.

The payment allowance for a multiple source drug included within the same HCPCS code will be equal to 106% of the ASP for the HCPCS code subject to applicable deductible and copayment/cost-sharing, along with the same payment limitations/adjustments as described under the single source drug payment allowance outlined above.

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

4. Transitional Pass-Through Device Categories.

a. Excluded Medical Devices.

Equipment, instruments, apparatuses, implements or items that are generally used for diagnostic or therapeutic purposes that are not implanted or incorporated into a body part, and that are used on more than one patient (that is, are reusable), are excluded from pass-through payment. This material is generally considered to be a part of hospital overhead costs reflected in the APC payments.

b. Included Medical Devices.

(1) The following implantable items may be considered for the transitional pass-through payments:

(a) Prosthetic implants (other than dental) that replace all or part of an internal body organ.

(b) Implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

NOTE: Any Durable Medical Equipment (DME), orthotics, and prosthetic devices for which transitional pass-through payment does not apply will be paid under the DMEPOS fee schedule when the hospital is acting as the supplier (paid outside the PPS).

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

c. Pass-Through Payment Criteria for Devices.

Pass-through payments will be made for new or innovative medical devices that meet the following requirements:

(1) They were not recognized for payment as a hospital outpatient service prior to 1997 (i.e., payment was not being made as of December 31, 1996). However, the medical device shall be treated as meeting the time constraint (i.e., payment was not being made for the device as of December 31, 1996) if either:

(a) The device is described by one of the initial categories established and in effect, or

(b) The device is described by one of the additional categories established and in effect, and

1 An application under the Federal Food, Drug, and Cosmetic Act has been approved; or

2 The device has been cleared for market under section 510(k) of the Federal Food, Drug, and Cosmetic Act; or

3 The device is exempt from the requirements of section 510(k) of the Federal Food, Drug, and Cosmetic Act under section 510(l) or section 510(m) of the Act.

(2) They have been approved/cleared for use by the Food and Drug Administration (FDA).

(3) They are determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

(4) They are an integral and subordinate part of the procedure performed, are used for one patient only, are surgically implanted or inserted via a natural or surgically created orifice on incision, and remain with that patient after the patient is released from the hospital outpatient department.

(a) Reprocessed single-use devices that are otherwise eligible for pass-through payment will be considered for payment if they meet FDA's most recent regulatory criteria on single-use devices.

(b) It is expected that hospital charges on claims submitted for pass-through payment for reprocessed single-use devices will reflect the lower cost of these devices.

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

NOTE: The FDA published guidance for the processing of single-use devices on August 14, 2000 - "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals".

(5) They are not equipment, instruments, apparatuses, implements, or such items for which depreciation and financing expenses are recovered as depreciable assets.

(6) They are not materials and supplies such as sutures, clips, or customized surgical kits furnished incidental to a service or procedure.

(7) They are not material such as biologicals or synthetics that may be used to replace human skin.

(8) No existing or previously existing device category is appropriate for the device.

(9) The associated cost is not insignificant in relation to the APC payment for the service in which the innovative medical equipment is packaged.

(10) The new device category must demonstrate that utilization of its devices provide substantial clinical improvement for beneficiaries compared with currently available treatments, including procedures utilizing devices in existing or previously existing device categories.

d. Duration of Transitional Pass-Through Payments.

(1) The duration of transitional pass-through payments for devices is for at least 2, but not more than 3 years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category.

(2) The costs of devices no longer eligible for pass-through payments will be packaged into the costs of the procedures with which they are normally billed.

e. General Coding and Billing Instructions and Explanations.

(1) Devices Implanted, Removed, and Implanted Again, Not Associated With Failure (Applies to Transitional Pass-Through Devices Only):

(a) In instances where the physician is required to implant another device because the first device fractured, the hospitals may bill for both devices - the device that resulted in fracture and the one that was implanted into the patient.

(b) It is realized that there may be instances where an implant is tried but later removed due to the device's inability to achieve the necessary surgical result or due to inappropriate size selection of the device by the physician (e.g., physician implants an

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

anchor to bone and the anchor breaks because the bone is too hard or must be replaced with a larger anchor to achieve a desirable result). In such instances, separate reimbursement will be provided for both devices. This situation does not extend to devices that result in failure or are found to be defective. For failed or defective devices, hospitals are advised to contact the vendor/manufacturer.

NOTE: This applies to transitional pass-through devices only and not to devices packaged into an APC.

(2) Kits - Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, codes for such kits have not been established. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payment, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

(3) Multiple units - Hospitals must bill for multiple units of items that qualify for transitional pass-through payments, when such items are used with a single procedure, by entering the number of units used on the bill.

(4) Reprocessed devices - Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with the enforcement guidance of the FDA relating to the reprocessing of devices applicable at the time the service is delivered.

f. Calculation of Transitional Pass-Through Payment for a Pass-Through Device.

(1) Device pass-through payment is calculated by applying the statewide CCR to the hospital's charges on the claim and subtracting any appropriate pass-through offset. Statewide CCRs are based on the geographical CBSA (two digit = rural, five digit = urban).

(2) The following are two examples of the device pass-through calculations, one incorporating a device offset amount applicable to CY 2003 and the other only applying the CCR (offsets set to $0 for CY 2005).

(3) The offset adjustment is applied only when a pass-through device is billed in addition to the APC[1].

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

Example #1 Transitional Pass-Through Payment Calculation with Offset:

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = $1,200.00

Associated procedure: HCPCS Level I[1] code 92982 (APC0083)

Payment rate = $3,289.42

Coinsurance amount = $657.88 (standard active duty family member who has met his/her yearly deductible)

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

NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph III.B.4.f.(4) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

$1,200 - $802.06 = $397.94

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

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

TRICARE payment for pass-through device C1884 = $397.94

Beneficiary cost-share liability for APC 0083 = $657.88

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

$2,631.54	TRICARE program payment for HCPCS Level I[1] code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I[1] code 92982
397.94	Transitional pass-through payment for device
$3,687.36	Total amount received by the provider

Example #2 Transitional Pass-Through Payment Calculation without Offset

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = $1,500.00

Associated procedure: HCPCS Level I[2] code 92982 (APC0083)

Payment rate = $3,289.42

Coinsurance amount = $657.88 (standard active duty family member who has met his/her yearly deductible)

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

Total offset amount to be applied for each APC that contains device costs = $0.

NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph III.B.4.f.(4) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

$1,500 - $0 = $1,500

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

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

TRICARE payment for pass-through device C1884 = $1,500

Beneficiary cost-share liability for APC 0083 = $657.88

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

$2,631.54	TRICARE program payment for HCPCS Level I[2] code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I[2] code 92982
1,500.00	Transitional pass-through payment for device
$4,789.42	Total amount received by the provider

NOTE: Transitional payments for devices (SI=H) are not subject to beneficiary cost-sharing/copayments.

(4) Steps involved in applying multiple discounting factors to offset amounts prior to subtracting from the device cost.

STEP 1: For each APC with an offset multiply the offset by the discount percent (whether it is 50%, 75%, 100% or 200%) and the units of service.

(Offset x Discount Rate x Units of Service)

STEP 2: Sum the products of Step 1.

[2] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

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

STEP 3: Wage adjust the sum of the products calculated in Step 2.

(Step 2 Amount x Labor % x Wage Index) + Step 2 Amount x Nonlabor %)

STEP 4: If the units of service from the procedures with offsets are greater than the device units of service, then Step 3 is adjusted by device units divided by procedure offset units.

[(Step 2 Amount x Labor % x Wage Index) + (Step 2 Amount x Nonlabor %) x (Device Units ÷ Offset Procedure Units)]

otherwise

(Step 2 Amount x Labor % x Wage Index) Step 2 Amount x Non-Labor %)

EXAMPLE: If there are two procedures with offsets but only one device, then the final offset is reduced by 50%.

STEP 5: If there is only one line item with a device, then the amount calculated in Step 4 is subtracted from the line item charge adjusted to cost.

[Step 4 Amount - (Line Item Charge x State CCR)]

If there are multiple devices, then the amount from Step 4 is allocated to the line items with devices based on their charges.

(Line Item Device Charge ÷ Sum of Device Charges)

C. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status.

1. Radiopharmaceuticals, drugs, and biologicals which do not have pass-through status, are paid in one of three ways:

a. Packaged payment, or

b. Separate payment (individual APCs), or

c. Allowable charge.

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

2. The cost of drugs and radiopharmaceuticals are generally packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished:

a. Hospitals do not receive separate payment for packaged items and supplies; and

b. Hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or services.

3. Although diagnostic and therapeutic radiopharmaceutical agents are not classified as drugs or biologicals, separate payment has been established for them under the same packaging threshold policy that is applied to drugs and biologicals; i.e., the same adjustments will be applied to the median costs for radiopharmaceuticals that will apply to non-pass-through, separately paid drugs and biologicals.

D. Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals.

1. Generally, the cost of drugs and radiopharmaceuticals are packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished. However, packaging for certain drugs and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

2. Payments for drugs and radiopharmaceuticals are packaged into the APCs with which they are billed if the median cost per day for the drug or radiopharmaceutical is less than $55. Separate APC payment is established for drugs and radiopharmaceuticals for which the median cost per day exceeds $55.

3. An exception to the packaging rule is being made for injectable oral forms of antiemetics.

4. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged.

a. "Specified Covered Outpatient Drugs" Classification

(1) Special classification (i.e., "specified covered outpatient drug") is required for certain separately payable radiopharmaceutical agents and drugs or biologicals for which there are specifically mandated payments.

(2) A "specified covered outpatient drug" is a covered outpatient drug for which a separate APC exists and that is either a radiopharmaceutical agent or drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

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

(3) The following drugs and biologicals are designated exceptions to the "specified covered outpatient drugs" definition (i.e., not included within the designated category classification):

(a) A drug or biological for which payment was first made on or after January 1, 2003, under the transitional pass-through payment provision.

(b) A drug or biological for which a temporary HCPC code has been assigned.

(c) Orphan drugs.

b. Payment of Specified Outpatient Drugs, Biological, and Radiopharmaceuticals.

(1) Specified outpatient drugs and biologicals will be paid a combined rate of the ASP plus 6% which is reflective of the present hospital acquisition and overhead costs for separately payable drugs and biologicals under the OPPS.

(2) Since there is no ASP data for separately payable specified radiopharmaceuticals, reimbursement will be based on charges converted to costs. This is the best proxy for the average acquisition cost of a radiopharmaceutical until better alternative information/data sources become available; e.g., basing payments on mean costs derived from hospital claims or creating charge-based payment rates.

(3) The following payment methods will be employed for separately payable specified outpatient drugs, biologicals and radiopharmaceuticals whose HCPCS codes will be payable for the first time under OPPS but whose codes do not crosswalk to other HCPCS codes previously recognized under the OPPS:

(a) Payment will be based on ASP plus 6% in accordance with the ASP methodology used in the physician office setting.

(b) In the absence of ASP data, the Wholesale Acquisition Cost (WAC) will be used for the product to establish the initial payment rate. If the WAC is also unavailable, then payment will be calculated at 95% of the most recent Average Wholesale Prices (AWP).

c. Designated SI.

The HCPCS codes for the above three categories of "specified covered outpatient drugs" are designated with the SI "K" - non-pass-through drugs, biologicals, and radiopharmaceuticals paid under the hospital OPPS (APC Rate). Refer to TMA's OPPS web site at http://www.tricare.mil/opps for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

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

5. Payment for New Drugs and Biologicals With HCPCS Codes and Without Pass-Through Application and Reference AWP or Hospital Claims Data.

a. New drugs and biologicals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals will be paid a rate that is equivalent to the payment they would receive in the physician office setting (i.e., the ASP plus 6%).

b. These new drugs and biologicals will be treated the same irrespective of whether pass-through status has been determined. SI "K" will be assigned to HCPCS codes for new drugs and biologicals for which pass-through applications have not been received.

6. Drugs and Biologicals Not Eligible for Pass-Through Status and Receiving Separate Nonpass-Through Payment.

a. Payment will be based on median costs derived from CY claims data for drugs and biologicals that have been:

(1) Separately paid since implementation of the OPPS under Medicare, but were not eligible for pass-through status; and

(2) Historically packaged with the procedures with which they were billed, even though their median cost per day was above the $55 packaging threshold.

b. Payment based on median costs should be adequate for hospitals since these products are generally older or low-cost items.

7. Payment for New Drugs, Biologicals and Radiopharmaceuticals Before HCPCS Codes Are Assigned.

a. The following payment methodology will enable hospitals to begin billing for drugs and biologicals that are newly approved by the FDA and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup that could qualify them for pass-through payment under the OPPS:

(1) Hospitals should be instructed to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code C9399, "Unclassified Drug or Biological."

(2) When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.

(3) The new drug, biological and/or radiopharmaceutical will be priced at 95% of its AWP using Red Book or an equivalent recognized compendium, and process the claim for payment.

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

(4) The above approach enables hospitals to bill and receive payment for a new drug, biological or radiopharmaceutical concurrent with it's approval by the FDA.

b. Hospitals will discontinue billing C9399 and the NDC upon implementation of a HCPCS code, SI, and appropriate payment amount with the next quarterly OPPS update.

E. Drug Administration Coding and Payment.

1. The following HCPCS Level I drug administration codes will be assigned to their respective APCs for payment:

FIGURE 13-3-4 CROSSWALK FROM HCPCS LEVEL I[1] CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCS

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	X	0353
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	X	0359
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	X	0352
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0116
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0116
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0116
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0116
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0117
96420	Chemotherapy administration, intra-arterial; push technique	S	0116
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0117
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	A	--
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0117
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0116
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0116

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

FIGURE 13-3-4 CROSSWALK FROM HCPCS LEVEL I[1] CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCS (CONTINUED)

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0116
96521	Refilling and maintenance of portable pump	T	0125
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	T	0125
96523	Irrigation of implanted venous access device for drug delivery systems	N	--
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0116
96549	Unlisted chemotherapy procedure	S	0116

2. Only 20 of the 33 drug administration CPT codes are being adopted for billing and payment purposes under OPPS.

3. Six new HCPCS "C" codes are being used instead of the remaining 13 CPT codes not recognized under the OPPS. The following "C" codes (see Figure 13-3-5) are being adopted in an effort to minimize the administrative burden of adopting all 33 drug administrative CPT codes.

a. The "C" codes will permit straightforward billing of types of pushes for the first hour and then each additional hour of infusion or for each intravenous push.

b. The OCE logic will determine the appropriate payments to make for a single drug administration encounter in one day or multiple separate encounters in the same day.

FIGURE 13-3-5 OPPS DRUG ADMINISTRATION CODES

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
C8950	Intravenous infusion for therapy/diagnosis; up to 1 hour	S	0120
C8951	Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950)	N	--
C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push	X	0359
C8953	Chemotherapy administration, intravenous; push technique	S	0116
C8954	Chemotherapy administration, intravenous; infusion technique, up to one hour	S	0117
C8955	Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)	N	--

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

4. The following non-chemotherapy HCPCS codes have also been created that are similar to CPT codes for initiation of prolonged chemotherapy infusion requiring a pump and pump maintenance and refilling codes so hospitals can bill for services when provided to patients who require extended infusions for non-chemotherapy medications including drugs for pain (see Figure 13-3-6).

FIGURE 13-3-6 NON-CHEMOTHERAPY PROLONGED INFUSION CODES THAT REQUIRE A PUMP

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0120

[1] **HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.**

5. Packaged HCPCS Level I codes for drug administration should continue to be billed to ensure accurate payment in the future. These are bill changes for HCPCS Level I codes with SI = N that will be used as the basis for setting median costs for each drug administration HCPCS Level I code in the future.

6. HCPCS Level I[3] codes 90772-90774 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

7. Drugs for which the median cost per day is greater than $55 are paid separately and are not packaged into the payment for the drug administration. Separate payment for drugs with a median cost in excess of $55 will result in more equitable payment for both the drugs and their administration.

F. Coding and Payment Policies for Drugs and Supplies.

1. Drug Coding.

a. Drugs for which separate payment is allowed are designated by SI "K" and must be reported using the appropriate HCPCS code.

b. Drugs that are reported without a HCPCS code will be packaged under the revenue center code, under OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633.

c. Drugs billed using revenue code 636 ("Drugs requiring detailed coding") require use of the appropriate HCPCS code, or they will be denied.

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

d. Reporting charges of packaged drugs is critical because packaged drug costs are used for calculating outlier payments and hospital costs for the procedure and service with which the drugs are used in the course of the annual OPPS updates.

2. Payment for the Unused Portion of a Drug.

a. Once a drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, hospitals are encouraged to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a TRICARE patient, the provider may bill for the amount of the drug discarded, along with the amount administered.

b. In the event that a drug is ordered and reconstituted by the hospital's pharmacy, but not administered to the patient, payment will be made under OPPS.

EXAMPLE 1: Drug X is available only in a 100-unit size. A hospital schedules three patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to OPPS on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen, and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

EXAMPLE 2: An appropriate hospital staff member must administer 30 units of drug X to a patient, and it is not practical to schedule another patient for the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and does not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and OPPS pays for 100 units.

c. Coding for Supplies.

(1) Supplies that are an integral component of a procedure or treatment are not reported with a HCPCS code.

(2) Charges for such supplies are typically reflected either in the charges on the line for the HCPCS for the procedure, or on another line with a revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

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

(3) Hospitals should report drugs that are treated as supplies because they are an integral part of a procedure or treatment under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs.

G. Orphan Drugs.

1. Continue to use the following criteria for identifying single indication orphan drugs that are used solely for orphan conditions:

a. The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan condition(s).

b. The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

2. Twelve single indication orphan drugs have currently been identified as having met these criteria.

3. Payment Methodology.

a. Pay all 12 single indication orphan drugs at the rate of 88% of AWP or 106 of the ASP, whichever is higher.

b. However, for drugs where 106% of ASP would exceed 95% of AWP, payment would be capped at 95% of AWP, which is the upper limit allowed for sole source specified covered outpatient drugs.

H. Vaccines.

1. Hospitals will be paid for influenza, pneumococcal pneumonia and hepatitis B vaccines based on allowable charge methodology; i.e., will be paid the CMAC rate for these vaccines.

2. Separately payable vaccines other than influenza, pneumococcal pneumonia and hepatitis B will be paid under their own APC.

3. See Figure 13-3-7 for vaccine administration codes and SIs.

FIGURE 13-3-7 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS

HCPCS LEVEL 1[1] CODE	DESCRIPTION	SI	APC
G0008	Influenza vaccine administration	X	0350

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

FIGURE 13-3-7 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS (CONTINUED)

HCPCS LEVEL 1[1] CODE	DESCRIPTION	SI	APC
G0009	Pneumococcal vaccine administration	X	0350
G0010	Hepatitis B vaccine administration	N	--
90465	Immunization admin, under 8 yrs old, with counseling; first injection	N	--
90466	Immunization admin, under 8 yrs old, with counseling; each additional injection	N	--
90467	Immunization admin, under 8 yrs old, with counseling; first intranasal or oral	N	--
90468	Immunization admin, under 8 yrs old, with counseling; each additional intranasal or oral	N	--
90471	Immunization admin, one vaccine injection	X	0353
90472	Immunization admin, each additional vaccine injections	X	0353
90473	Immunization admin, one vaccine by intranasal or oral	N	
90474	Immunization admin, each additional vaccine by intranasal or oral	N	--

[1] **HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.**

I. Payment Policy for Radiopharmaceuticals.

Separately paid radiopharmaceuticals are classified as "specified covered outpatient drugs" subject to the following packaging and payment provisions:

1. The threshold for the establishment of separate APCs for radiopharmaceuticals is $55.

2. A radiopharmaceutical that is covered and furnished as part of covered outpatient department services for which a HCPCS code has not been assigned will be reimbursed an amount equal to 95% of its AWP.

3. Radiopharmaceuticals will be excluded from receiving outlier payments.

4. Applications will be accepted for pass-through status; however, in the event the manufacturer seeking pass-through status for a radiopharmaceutical does not submit data in accordance with the requirements specified for new drugs and biologicals, payment will be set for the new radiopharmaceutical as a "specified covered outpatient drug."

J. Blood and Blood Products.

1. Since the OPPS was first implemented, separate payment has been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. The APCs for these products are intended to recover the costs of the products.

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

2. Administrative costs for the processing and storage specific to the transfused blood product are included in the APC payment, which is based on hospitals' charges.

3. Payment for the collection, processing, and storage of autologous blood, as described by HCPCS Level I[4] code 86890 and used in transfusion, is made through APC 347 (Level III Transfusion Laboratory Procedures).

4. Payment rates for blood and blood products will be determined based on median costs. Refer to Figure 13-3-8 for APC assignment of blood and blood product codes.

FIGURE 13-3-8 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9010		K	Whole blood for transfusion	0950
P9011		K	Split unit of blood	0967
P9012		K	Cryoprecipitate each unit	0952
P9016		K	RBC leukocytes reduced	0954
P9017		K	Plasma 1 donor frz w/in 8 hr	9508
P9019		K	Platelets, each unit	0957
P9020		K	Platelet rich plasma unit	0958
P9021		K	Red blood cells unit	0959
P9022		K	Washed red blood cells unit	0960
P9023		K	Frozen plasma, pooled, sd	0949
P9031		K	Platelets leukocytes reduced	1013
P9032		K	Platelets, irradiated	9500
P9033		K	Platelets leukoreduced irradiated	0968
P9034		K	Platelets, pheresis	9507
P9035		K	Platelets pheresis leukoreduced	9501
P9036		K	Platelet pheresis irradiated	9502
P9037		K	Platelet pheresis leukoreduced irradiated	1019
P9038		K	RBC irradiated	9505
P9039		K	RBC deglycerolized	9504
P9040		K	RBC leukoreduced irradiated	0969
P9043		K	Plasma protein fract, 5%, 50 ml	0956
P9044		K	Cryoprecipitate reduced plasma	1009
P9048		K	Granulocytes, pheresis unit	9506
P9051	C1010	K	Blood, L/R, CMV-NEG	1010
P9052	C1011	K	Platelets, HLA-m, L/R, unit	1011
P9053	C1015	K	Plt, pher, L/R, CMV, irradiated	1020

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

FIGURE 13-3-8 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES (CONTINUED)

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9054	C1016	K	Blood, L/R, Froz/Degly/Washed	1016
P9055	C1017	K	Plt, Aph/Pher, L/R, CMV-Neg	1017
P9056	C1018	K	Blood, L/R, Irradiated	1018
P9057	C1020	K	RBC, frz/deg/wash, L/R irradiated	1021
P9058	C1021	K	RBC, L/R, CMV-Neg, irradiated	1022
P9059	C1022	K	Plasma, frz within 24 hours	0955
P9060	C9503	K	Fresh frozen plasma, ea unit	9503

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

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

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

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

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

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

3. The presence of the modifier "FB" ["Item Provided Without Cost to Provider, Supplier, or Practitioner or Credit Received for Replacement (examples include, but are not limited to devices covered under warranty, replaced due to defect, or provided as free samples)"] would trigger the adjustment in payment if the procedure code to which modifier "FB" was amended appeared in Figure 13-3-9 and was also assigned to one of the APCs listed in Figure 13-3-10.

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

FIGURE 13-3-9 DEVICES FOR WHICH THE "FB" MODIFIER MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACEMENT DEVICE

DEVICE	DESCRIPTION
C1721	AICD, dual chamber
C1722	AICS, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep Dev urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual rate-resp
C1786	Pmkr, single rate-resp
C1813	Prostheses, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro, rechg bat sys
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Pmkr, other than sing/dual
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system

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

FIGURE 13-3-10 ADJUSTMENTS TO APCS IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED

APC	SI	APC GROUP TITLE	CY 2007 OFFSET AMT (PERCENT)
0039	S	Level I Implantation of Neurostimulator	78.85
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	54.06
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluded	60.06
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	77.11
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74.74
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	41.88
0107	T	Insertion of Cardioverter-Defibrillator	90.44
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	77.75
0222	T	Implantation of Neurological Device	77.65
0225	S	Implantation of Neurostimulator Electrodes, Cranial	79.04
0227	T	Implantation of Drug Infusion Devices	80.27
0229	T	Transcatheter Placement of Intravascular Shunts	46.17
0259	T	Level IV ENT Procedures	84.61
0315	T	Level II Implantation of Neurostimulator	76.03
0385	S	Level I Prosthetic Urological Procedures	83.19
0386	S	Level II Prosthetic Urological Procedures	61.16
0418	T	Insertion of Left Ventricular Pacing Elect	87.32
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	77.35
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	76.59
0680	S	Insertion of Patient Activated Event Recorders	76.40
0681	T	Knee Arthroplasty	73.37

4. If the APC to which the device code (i.e., one of the codes in Figure 13-3-9) is assigned is on the APCs listed in Figure 13-3-10, the unadjusted payment rate for the procedure APC will be reduced by an amount equal to the percent in Figure 13-3-10 times the unadjusted payment rate.

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

6. Multiple procedure reductions would also continue to apply even after the APC payment adjustment to remove payment for the device cost, because there would still be the expected efficiencies in performing the procedure if it was provided in the same operative session as another surgical procedure. Similarly, if the procedure was interrupted before

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

administration of anesthesia (i.e., there was modifier 52 or 73 on the same line as the procedure), a 50% reduction would be taken from the adjusted amount.

L. Policies Affecting Payment of New Technology Services.

1. A process was developed that recognizes new technologies that do not otherwise meet the definition of current orphan drugs, or current cancer therapy drugs and biologicals and brachytherapy, or current radiopharmaceutical drugs and biologicals products. This process, along with transitional pass-throughs, provides additional payment for a significant share of new technologies.

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

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

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

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

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

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

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

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

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

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

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

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

(1) From $0 to $50 in increments of $10.

(2) From $50 to $100 in a single $50 increment.

(3) From $100 through $2,000 in intervals of $100.

(4) From $2,000 through $6,000 in intervals of $500.

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

11. Process and Criteria for Assignment to a New Technology APC Group.

a. Services Paid Under New Technology APCs.

(1) Limit eligibility for placement in new technology APCs to complete services and procedures.

(2) Items, material, supplies, apparatuses, instruments, implements, or equipment that are used to accomplish a more comprehensive service or procedure would not be eligible for placement in a new technology APC.

(3) A service that qualifies for a new technology APC may be a complete, stand-alone service (for example, water-induced thermotherapy of the prostate or cryosurgery of the prostate), or it may be a service that would always be billed in combination with other services (for example, coronary artery brachytherapy).

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

(a) In the latter case, the new technology procedure, even though billed in combination with other, previously existing procedures, describes a distinct procedure with a beginning, middle, and end.

(b) Drugs, supplies, devices, and equipment in and of themselves are not distinct procedures with a beginning, middle and end. Rather drugs, supplies, devices, and equipment are used in the performance of a procedure.

(4) Unbundled components that are integral to a service or procedure (for example, preparing a patient for surgery or preparation and application of a wound dressing for wound care) are not eligible for consideration for a new technology.

b. Criteria for determining whether a service will be assigned to a new technology APC.

(1) The most important criterion in determining whether a technology is "truly new" and appropriate for a new APC is the inability to appropriately, and without redundancy, describe the new, complete (or comprehensive) service with any combination of existing HCPCS Level I and II codes. In other words, a "truly new" service is one that cannot be appropriately described by existing HCPCS codes, and a new HCPCS code needs to be established in order to describe the new procedure.

(2) The service is one that could not have been adequately represented in the claims data being used for the most current annual payment update; i.e., the item is one service that could not have been billed to the Medicare program in 1996 or, if it was available in 1996, the costs of the service could not have been adequately represented in 1996 data.

(3) The service does not qualify for an additional payment under the transitional pass-through provisions.

(4) The service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs. It is unnecessary to assign a new service to a new technology APC if it may be appropriately placed in a current APC.

(5) The service falls within the scope of TRICARE benefits.

(6) The service is determined to be reasonable and necessary.

NOTE: The criterion that the service must have a HCPCS code in order to be assigned to a new technology APC has been removed. This is supported by the rationale that in order to be considered for a new technology APC, a truly new service cannot be adequately described by existing codes. Therefore, in the absence of an appropriate HCPCS code, a new HCPCS code will be created that describes the new technology service. The new HCPCS would be solely for hospitals to use when billing under the OPPS.

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

M. Coding And Payment Of Emergency Department (ED) Visits.

1. The five Type B ED "G" codes listed in Figure 13-3-11 have been established for EDs meeting the definition of a dedicated emergency department (DED) under the Emergency Medical Treatment and Labor Act (EMTALA) regulations, but which are not Type A EDs (i.e., they may meet the DED definition but are not available 24 hours a day, seven days a week).

FIGURE 13-3-11 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDS

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0380	Level 1 Hosp Type B Visit	Level 1 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0381	Level 2 Hosp Type B Visit	Level 2 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0382	Level 3 Hosp Type B Visit	Level 3 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

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

FIGURE 13-3-11 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDS

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0384	Level 4 Hosp Type B Visit	Level 4 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0385	Level 5 Hosp Type B Visit	Level 5 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

2. A new "G" code (G0390 - Trauma response team activation associated with hospital critical care services) was also created (effective January 1, 2007) to be used in addition to CPT[5] procedure codes 99291 and 99292 to address the meaningful cost difference between critical care when billed with and without trauma activation.

a. If critical care is provided without trauma activation, the hospital will bill with either CPT[5] procedure code 99291 or 99292, receiving payment for APC 0617 with a median cost of $402.67.

b. However if trauma activation occurs, the hospital would be called to bill one unit of "G" code (G0390), report with revenue code 68x on the same date of service, thereby receiving $491.66 under APC 0618.

3. Hospitals will continue to bill CPT codes for both clinic and Type A ED visits until national guidelines have been established.

[5] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

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

4. The CPT Evaluation and Management (E/M) codes and other HCPCS codes currently assigned to the clinic visit APCs have been mapped in Figure 13-3-12 to 11 new APCs; five for clinic visits; five for ED visits; and one for critical care services, based on median costs and clinical consideration.

FIGURE 13-3-12 ASSIGNMENT OF CPT E/M CODES AND OTHER HCPCS CODES TO NEW VISIT APCS FOR CY 2007

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 1 Hospital Clinic Visits	0604	92012	Eye exam, established pat
		99201	Office/outpatient visit, new (Level 1)
		99211	Office/outpatient visit, est (Level 1)
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam Pt lops
		G0241	Office consultation (Level 1)
		G0271	Confirmatory consultation (Level 1)
		G0264	Assmt otr CHF, CP, asthma
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level 2)
		99212	Office/outpatient visit, est (Level 2)
		99213	Office/outpatient visit, est (Level 3)
		99243	Office consultation (Level 3)
		99242	Office consultation (Level 2)
		99273	Confirmatory consultation (Level 3)
		99272	Confirmatory consultation (Level 2)
		99431	Initial care, normal newborn
		G0246	Follow-up eval of foot pt lop
		G0344	Initial preventive exam
Level 3 Hospital Clinic Visits	0606	92004	Eye exam, new patient
		99203	Office/outpatient visit, new (Level 3)
		99214	Office/outpatient visit, est (Level 4)
		99274	Confirmatory consultation (Level 4)
		99244	Office consultation (Level 4)
Level 4 Hospital Clinic Visits	0607	99204	Confirmatory consultation (Level 1)
		99215	Office/outpatient visit, est (Level 5)
		99245	Office consultation (Level 5)
		99275	Confirmatory consultation (Level 5)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level 5)
		G0175	OPPS service, sched team conf
Level 1 Type A Emergency Visits	0609	99281	Emergency department visit

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

FIGURE 13-3-12 ASSIGNMENT OF CPT E/M CODES AND OTHER HCPCS CODES TO NEW VISIT APCS FOR CY 2007 (CONTINUED)

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 2 Type A Emergency Visits	0613	99282	Emergency department visit
Level 3 Type A Emergency Visits	0614	99283	Emergency department visit
Level 4 Type A Emergency Visits	0615	99284	Emergency department visit
Level 5 Type A Emergency Visits	0616	99285	Emergency department visit
Critical Care	0617	99291	Critical care, first hour

N. OPPS PRICER.

1. Common PRICER software will be provided to the contractor that includes the following data sources:

a. National APC amounts

b. Payment status by HCPCS code

c. Multiple surgical procedure discounts

d. Fixed dollar threshold

e. Multiplier threshold

f. Device offsets

g. Other payment systems pricing files (CMAC, DMEPOS, and statewide prevailings)

2. The following data elements will be extracted and forwarded to the outpatient PRICER for line item pricing.

a. Units;

b. HCPCS/Modifiers;

c. APC;

d. Status payment indicator;

e. Line item date of service;

f. Primary diagnosis code; and

g. Other necessary OCE output.

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

3. The following data elements will be passed into the PRICER by the contractors:

   a. Wage indexes (same as DRG wage indexes);

   b. Statewide cost-to-charge ratios as provided in CMS Final Rule;

   c. Locality Code: Based on CBSA - two digit = rural and five digit = urban;

   d. Hospital Type: Rural SCH = 1 and All Others = 0

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

5. If a claim has more than one service with a SI of "T" or a SI of "S" within the coding range of 10000 - 69999, and any lines with SI of "T" or a SI within the coding range of 10000 - 69999 have less than $1.01 as charges, charges for all lines will be summed and the charges will then be divided up proportionately to the payment rates for each line (refer to Figure 13-3-13). The new charge amount will be used in place of the submitted charge amount in the line item outlier calculator.

FIGURE 13-3-13 PROPORTIONAL PAYMENT FOR "T" LINE ITEMS

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

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

O. TRICARE Specific Procedures/Services.

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

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

P. Validation Reviews.

OPPS claims are not subject to validation review.

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

Q. Hospital-Based Birthing Centers.

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

- END -

CHAPTER 13
SECTION 4

CLAIMS SUBMISSION AND PROCESSING REQUIREMENTS

ISSUE DATE: July 27, 2005
AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

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

II. ISSUE

To describe additional claims submission and processing requirements.

III. POLICY

Appropriate Bill Types:

A. Bill types subject to Outpatient Prospective Payment System (OPPS).

All outpatient hospital bills (bill types 013X with condition code 41, 013X without condition code 41), with the exception of bills from providers excluded under Chapter 13, Section 1, paragraph III.D.1.b.(5) will be subject to the OPPS.

B. Reporting Requirements.

1. Payment of outpatient hospital claims will be based on the from date on the claim.

EXAMPLE: Claims with from dates prior to implementation of OPPS will not process as OPPS - this will also apply to version changes and pricing changes.

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

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

C. Procedures for Submitting Late Charges.

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

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

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

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

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

E. Proper Reporting of Condition Code G0 (Zero).

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

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

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

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

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

5. The following figure describes actions the OCE will take when multiple medical visits occur on the same day in the same revenue code center:

FIGURE 13-4-1 ACTIONS TAKEN WHEN MULTIPLE MEDICAL VISITS OCCUR ON THE SAME DAY

EVALUATION & MANAGEMENT (E&M)	REVENUE CENTER	CONDITION CODE	OCE ACTION
2 or more	Two or more E&M codes have the same revenue center	No G0	Assign medical APC to each line item with E&M code and deny all line items with E&M code except the line item with the highest APC payment
2 or more	Two or more E&M codes have the same revenue center	G0	Assign medical APC to each line item with E&M code

F. Clinical Diagnostic Laboratory Services Furnished to Outpatients.

1. Payment for clinical diagnostic laboratory services will not be paid under OPPS.

2. Payment for these services will be made under the CHAMPUS Maximum Allowable Charge (CMAC) System.

3. Hospitals should report HCPCS codes for clinical diagnostic laboratory services.

G. OPPS Modifiers.

TRICARE requires the reporting of HCPCS Level I and II modifiers for accuracy in reimbursement, coding consistency, and editing.

- END -

CHAPTER 13
SECTION 5

MEDICAL REVIEW AND ALLOWABLE CHARGE REVIEW UNDER THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

ISSUE DATE: July 27, 2005
AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

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

II. ISSUE

To describe the medical review and allowable charge review of hospital outpatient claims.

III. POLICY

A. Medical review under the hospital OPPS.

1. The methodology of review for outpatient claims does not change under the OPPS.

2. The goal of medical review is to identify inappropriate billing and to ensure that payment is not made for noncovered services. Contractors may review any claim at any time, including requesting medical records, to ensure that payment is appropriate.

B. All OPPS review of claims processing with the exception of the Inpatient Only Procedures List, would be considered allowable charge review.

- END -

CHAPTER 13
ADDENDUM A1

DEVELOPMENT SCHEDULE FOR TRICARE OCE/APC QUARTERLY UPDATE

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

CRITICAL TASKS & MILESTONES			
#	WHO	EVENT	DAYS
1	3M	Preliminary CMS edit & logic changes to TRICARE (new edits, logic, flags, etc.)	
2	TMA/ Contractors	Provide TRICARE-specific edit/logic changes to 3M	10 days
3	3M	CMS data changes to TRICARE (new codes, APC, SI) Plus Intersection Report	
4	TMA/ Contractors	Provide TRICARE-specific data changes to 3M (APC, SI, edit assignment, …) (see Chapter 13, Addendum A2)	10 days
5	3M	Update TC Working specifications	3 days
6	3M	Write code for TRICARE program logic/edit and product changes: (Component, MF)	5 days
7	3M	Update TC mods files & Build TC Read-Only-Tables	6 days
8	3M	TRICARE Working specs & Data Summary to TRICARE - For Review/Approval	5 days
9	3M	Unit test TC program & product changes - Component, MF (need ROT from step 7)	1 day
10	3M	Build TC ROT #2 … If necessary. (To correct errors or make late CMS changes)	3 days
11	3M	Create User Documentation	12 days
12	3M	Test case creation Alpha testing Install testing	7 days 8 days 2 days
13	3M	Media and Documents production	1 day
14	3M	Release - General Release to TRICARE and Contractors	
NOTE: **The above quarterly time expectations are ideal, but may be subject to change.**			

- END -

CHAPTER 13
ADDENDUM A2

OPPS OCE NOTIFICATION PROCESS FOR QUARTERLY UPDATES

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

<table>
<tr><td></td><td colspan="4">MCSC:
OCE Version:
Summary of Data Changes:
OCE/APC Working Specification:
Effective Date:</td></tr>
<tr><td>4 days
(Checklist)</td><td colspan="4">Review Updates:
1. HCPC/CPT Procedure Code Changes
• Adds/Deletes procedure code
• HCPC Changes - APC, Status Indicator and/or Edit Assignment
2. Diagnosis Code Changes
• Adds/Deletes diagnosis
• Age/Sex Relations
3. Revenue Codes (Appendix K)
• Add Revenue Codes
• Revenue Code Status Indicator Changes
4. Government No Pay List Updates
5. HCPC Intersection Report (compare SI differences between CMS and TRICARE)
6. Edit Assignment (applicable TRICARE edits)
Impacts:
File format changes ☐ (record layout) Describe:
New values: ☐ Describe:
Policy: ☐ Manual: TRM Chapter: Sections:
Manual: TRM Chapter: Sections:
Manual: TRM Chapter: Sections:
Comments:</td></tr>
<tr><td>3 days</td><td colspan="4">Gather feedback for all Primes - Prime responsibility for OCE response to 3M will rotate quarterly.
• Schedule meeting with Primes
• Assigned resource will consolidate feedback using 3M templates</td></tr>
<tr><td>1 day</td><td colspan="4">Submit feedback to TMA
• TMA sends to 3M and copies OCE Quarterly Update Team
• Notify TMA of changes impacting TRICARE policy</td></tr>
<tr><td>1 day</td><td colspan="4">Meet with 3M on feedback (maintain open date on Thursdays at 11:00 a.m. EDT/EST or 8:00 a.m. Pacific)
• Review responses
• Address policy impacts (TMA)
• Update changes (if needed)
• Concur on changes</td></tr>
</table>

NOTE: The above quarterly time expectations are ideal, but may be subject to change.

- END -

CHAPTER 14

SOLE COMMUNITY HOSPITALS

CHAPTER 14
SECTION 1

SOLE COMMUNITY HOSPITALS (SCHS)

ISSUE DATE: November 6, 2007
AUTHORITY: 32 CFR 199.14(a)(1)(ii)(D)**(6)**

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

II. ISSUE

How are SCHs to be reimbursed?

III. POLICY

A. Any hospital which has qualified for special treatment under the Medicare Prospective Payment System (PPS) as a SCH and has not given up that classification is exempt from the TRICARE/CHAMPUS DRG-based payment system, and the TRICARE mental health per diem system.

B. TMA will maintain the SCH listing on TMA's web site: http://www.tricare.mil/hospitalclassification, and will update the list on a quarterly basis and notify the contractors by e-mail when the list is updated.

C. After June 1, 2006, if a SCH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

D. If the contractor receives documentation from a SCH indicating their status is different than what is on the SCH listing on TMA's web site, the contractor shall send the information to TMA, Medical Benefits & Reimbursement Systems (MB&RS) to update the listings on the web.

- END -

CHAPTER 15

CRITICAL ACCESS HOSPITALS (CAHS)

CHAPTER 15
SECTION 1

CRITICAL ACCESS HOSPITALS (CAHS)

ISSUE DATE: November 6, 2007
AUTHORITY: 32 CFR 199.14(a)(1)(ii)(D)

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

II. ISSUE

How are CAHs to be reimbursed?

III. POLICY

A. CAHs are subject to the DRG-based payment system.

1. TMA will maintain the CAH listing on the TMA's web site at http://www.tricare.mil/hospitalclassification/, and will update the list on a quarterly basis and will notify the contractors by e-mail when the list is updated.

2. For payment purposes for those facilities that were listed on both the CAH and Sole Community Hospital (SCH) lists prior to June 1, 2006, the contractors shall use the implementation date of June 1, 2006, as the effective date for reimbursing CAHs under the DRG-based payment system. The June 1, 2006, effective date is for admissions on or after June 1, 2006. For admissions prior to June 1, 2006, if a facility was listed on both the CAH and SCH lists, the SCH list took precedence over the CAH list. The contractors shall not initiate recoupment action for any claims paid billed charges where the CAH was also on the SCH list, prior to the June 1, 2006, effective date.

3. The effective date on the CAH list is the date supplied by the Centers for Medicare and Medicaid Services (CMS) upon which the facility began receiving reimbursement from Medicare as a CAH, however, if a facility was listed on both the CAH and SCH lists prior to June 1, 2006, the effective date for TRICARE DRG reimbursement is June 1, 2006.

4. After June 1, 2006, if a CAH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

5. If the contractor receives documentation from a CAH indicating their status is different than what is on the CAH listing on TMA's web site, the contractor shall send the information to TMA, Medical Benefits & Reimbursement Systems (MB&RS) to update the listings on the web

B. CAHs participating in the demonstration in the state of Alaska are exempt from the DRG-based payment system and are subject to the payment rates under the TRICARE Demonstration Project. For information on the demonstration, refer to the TRICARE Operations Manual (TOM), Chapter 20, Section 9.

C. The contractor's shall update their institutional provider files to include CAH's and their Indirect Medical Education (IDME) factors, if applicable, as the CMS Inpatient Provider Specific File used to update the annual DRG Provider File does not contain CAH information.

- END -

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