CHAPTER 13
SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

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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.

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.

(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 $60, with the exception of injectable 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 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.

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.

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

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

(a) The payment for a HCPCS code with a SI of **N** is unconditionally packaged so that payment is always incorporated into the payments for the separately paid services with which it is reported.

(b) Payment for a HCPCS code with a SI of **Q** that is "**STVX**-packaged" is packaged unless the HCPCS code is not reported on the same day with a service that has a SI of **S**, **T**, **V**, or **X**, in which case it would be paid separately.

(c) Payment for a HCPCS code with a SI of "**T** packaged" is packaged unless the HCPCS code is not reported on the same day with a service that has a SI of **T**, in which case it would be paid separately.

(d) Payment for a HCPCS code with a SI of **Q** that is assigned to a composite APC is packaged into the payment for the composite APC when the criteria for payment of the composite APC are met.

(2) Categories of ancillary and supportive services for which the packaging status is changed for CY 2008 are as follows:

(a) Guidance services.

(b) Imaging processing services.

(c) Intraoperative services.

(d) Imaging supervision and interpretation services.

1 Certain imaging supervision and interpretation services are always packaged.

2 Others are packaged when the service appears on the same claim with a procedural HCPCS code that has been assigned SI **T**. These codes are **T** packaged codes.

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

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

(g) Observation services.

1 CMS created two composite APCs, APCs 8002 and 8003, for Extended Assessment and Management of which observation care is a component.

2 When eight hours or more of observation care is provided in conjunction with direct admission to observation or a high level clinical or Emergency Department (ED) visit or critical care services, then payment may be made for the extended encounter of care.

3 These Extended Assessment and Management composite APCs may be paid regardless of diagnosis, when the observation care is unrelated to a surgical procedure.

4 The OCE logic will handle the assignment of these composite APCs for payment.

NOTE: A hierarchy of categories has been created that determines which category each code appropriately falls into. This hierarchy is organized from the most clinically specific to the most general type of category. The hierarchy of categories is as follows: guidance services; image processing services; intraoperative services; and imagining supervision and interpretation services. Therefore, while CPT[1] code 93325 may logically be grouped with either image processing services or intraoperative services, it is treated as an image processing service because that group is more clinically specific and precedes intraoperative services in the hierarchy. It was not necessary to include diagnostic radiopharmaceuticals, contrast media or observation categories in this list because those services generally map to only one of those categories.

(3) Composite APCs provide a single payment when more than one of a specified set of major independent services are provided in a single encounter.

(a) Effective for services furnished on or after January 1, 2008, low dose rate prostate brachytherapy and cardiac electrophysiology evaluation and ablation will be paid using composite APCs when the claim contains the specified combination of services. This established an encounter based APC for each of these sets of services that would

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provide a single payment for certain common combinations of component services that were reported on the same date of service.

1 Composite APC for LDR Prostate Brachytherapy (APC 8001).

a A composite APC 8001, titled "LDR Prostate Brachytherapy Composite," has been created that will provide one bundled payment for LDR prostate brachytherapy when the hospital bills both CPT[2] codes 55875 and 77778 as component services provided during the same hospital encounter.

b CPT[1] code 55875 will continue to be paid through APC 0163 and CPT[1] code 77778 will continue to be paid through APC 0651 when the services are individually furnished other than on the same date of service in the same facility.

c These two CPT[2] codes will be assigned SI **Q** to signify their conditionally package status, and their composite APC assignments.

2 Composite APC for Cardiac Electrophysiologic Evaluation and Ablation (APC 8000).

a Another composite APC (APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite)) was also established in CY 2008 that will pay for a composite service made up of any number of services in groups A and B in Figure 13-2-1 when at least one code from group A and at least one code from group B appear on the same claim with the same date of service. The five CPT[2] codes involved in this composite APC are assigned to SI **Q** to identify their conditionally packaged status.

FIGURE 13-2-1 GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES ON WHICH THE COMPOSITE APC IS BASED

CODES USED IN COMBINATION: AT LEAST ONE IN GROUP A AND ONE IN GROUP B	HCPCS CODE	CY 2007 APC	CY 2007 SI
GROUP A			
Electrophysiology Evaluation	93619	0085	T
Electrophysiology Evaluation	93620	0085	T
GROUP B			
Ablate Heart Dysrhythm Focus	93650	0086	T
Ablate Heart Dysrhythm Focus	93651	0086	T
Ablate Heart Dysrhythm Focus	93652	0086	T

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

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

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

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

(b) The TRICARE OCE logic will determine the assignment of the composite APCs for payment.

(c) Figure 13-2-2 provides the circumstances, effective January 1, 2008, under which a single composite APC payment will be made for multiple services that meet the criteria for payment through a composite APC. Where the criteria are not met, payment will occur under the usual associated non-composite APC to which the code is assigned.

FIGURE 13-2-2 COMPOSITE APCS AND CRITERIA FOR COMPOSITE PAYMENT

COMPOSITE APC	COMPOSITE APC TITLE	CRITERIA FOR COMPOSITE PAYMENT
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT[3] code 93619 or 93620 and at least one unit of CPT[2] code 93650, 93651, or 93652 on the same date of service.
8001	Low Dose Rate Prostate Brachytherapy Composite	One or more units of CPT[3] codes 55875 and 7778 on the same date of service.
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed— • One the same day as HCPCS code G0379; or • On the same day or the day after CPT[2] codes 99205 or 88215 and; 2) There is no service with SI=**T** on the claim on the same date of service or one day earlier than G0378
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed on the same date of service or the date of service after CPT[3] 99284, 99285, or 99291 and; 2) There is no service with SI=**T** on the claim on the same date of service or one day earlier than G0378.
0034	Mental Health Services Composite	Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0033.

C. Additional Payments Under The OPPS.

1. Clinical diagnostic testing (labwork).

2. Administration of infused drugs.

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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 ED.

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

2. If the ED 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.

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

2. If no treatment is furnished, medical screening examinations would be billed with a low-level ED 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 on May 1, 2009 (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. 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.

3. 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.

4. 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 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. This means that each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of services are reported in Form Locator (FL) 45 "Services Date" (MMDDYY) of the CMS 1450 UB-04.

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 13-2-3 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 2008[1]

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I[5] AND II CODES
0250	Pharmacy	HCPCS code not required.
043X	Occupational Therapy	G0129[2]
0900	Behavioral Health Treatment/Services	90801, 90802, 90899
0904	Activity Therapy (Partial Hospitalization)	G0176[3]
0911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899

1 The contractor will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The contractor will not edit for matching the revenue code to HCPCS.
2 The definition of code G0129 is as follows:
Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).
3 The definition of code G0176 is as follows:
Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).
4 The definition of code G0177 is as follows:
Training and educational services related to the care and treatment of patient's disabling mental problems, per session (45 minutes or more).
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NOTE: Codes G0129 and G0176, are used only for PHPs. Code G0177 may be used in both PHPs and outpatient mental health setting. Revenue code 250 does not require HCPCS.

FIGURE 13-2-3 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 2008[1] (CONTINUED)

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I[5] AND II CODES
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, 90845, 90865, or 90880
0915	Group Therapy	90849, 90853, or 90857
0916	Family Psychotherapy	90846, 90847, or 90849
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	Education Training	G0177[4]

1 The contractor will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The contractor will not edit for matching the revenue code to HCPCS.

2 The definition of code G0129 is as follows:
Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

3 The definition of code G0176 is as follows:
Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).

4 The definition of code G0177 is as follows:
Training and educational services related to the care and treatment of patient's disabling mental problems, per session (45 minutes or more).

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NOTE: Codes G0129 and G0176, are used only for PHPs. Code G0177 may be used in both PHPs and outpatient mental health setting. Revenue code 250 does not require HCPCS.

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. Since there is no HCPCS code that specifies a partial hospitalization related service, partial hospitalizations are identified by means of a particular bill type and condition code (i.e., 13X TOB with Condition Code 41) along with HCPCS codes specifying the individual services that constitute PHPs. In order to be assigned payment under Partial Hospitalization APC 0033 there must be three or more codes/services off of the PHP List B below of which at least one service is from PHP List A on the same date. List A is a subset of List B and contains only psychotherapy codes, while List B includes al PHP codes.

FIGURE 13-2-4 PHP FOR CY 2008

PHP LIST A – PSYCHOTHERAPY	PHP LIST B – ALL PHP CODES
90818	90801
90819	90802

FIGURE 13-2-4 PHP FOR CY 2008 (CONTINUED)

PHP LIST A – PSYCHOTHERAPY	PHP LIST B – ALL PHP CODES
90821	90816
90822	90817
90826	90818
90827	90819
90828	90821
90829	90822
90845	90823
90846	90824
90847	90826
90849	90827
90853	90828
90857	90820
90865	90845
90880	90846
	90847
	90849
	90853
	90857
	90865
	90880
	90899
	96101
	96102
	96103
	96116
	96118
	96119
	96120
	G0129
	G0176
	G0177

e. In order to assign the partial hospitalization APC to one of the line items (i.e., one of listed services/codes in Figure 13-2-3) the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC. All other partial hospital services on the same day are packaged; (i.e., the SI is changed from **Q** to **N**.) Partial hospitalization services with SI **E** (items or services that are not covered by TRICARE) or B (more appropriate code required for TRICARE OPPS) are not packaged and are ignored in the PHP processing.

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

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

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

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

FIGURE 13-2-5 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - HIPAA 837 FORMAT

RECORD TYPE	REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGE
61	0915	90849	19980505	1	$80
61	0915	90849	19980529	2	$160

FIGURE 13-2-6 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - CMS 1450 FORMAT

REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGES
0915	90849	050598	1	$80
0915	90849	052998	2	$160

Claims will be returned to provider that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported outside of the covered statement period.

5. Reimbursement for a day of outpatient mental health services in a non-PHP program (i.e., those mental health services that are not accompanied with a condition code 41) will be capped at the partial hospital per diem rate. The payments for all of the designated mental health (MH) services will be totalled with the same date of service. If the sum of the payments for the individual MH services, for which there is an authorization on file, exceeds the partial hospitalization per diem, a special MH services composite payment APC (APC 0034) will be assigned to one of the line items that represent MH services. All other MH services will be packaged. The MH services composite payment APC amount is the same as the partial hospital APC per diem rate. MH services with SI **E** or **B** are not included in payments that are totaled and are not assigned the daily mental health composited APC amount.

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

H. Payment Policy For Observation Services.

1. Observations For Non-Maternity Conditions.

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

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

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

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

(3) There is no limitation on diagnosis for payment of these composite APCs; however, composite payment will not be made when observation services are reported in association with a surgical procedure (SI of **T**) or the hours of observation care reported are less than eight. Refer to Figure 13-2-7 for specific criteria for composite payment:

FIGURE 13-2-7 CRITERIA FOR PAYMENT OF EXTENDED ASSESSMENT AND MANAGEMENT COMPOSITE APCS

COMPOSITE APC	COMPOSITE APC TITLE	CRITERIA FOR COMPOSITE PAYMENT
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed— • On the same day as HCPCS code G0379; or • On the same day or the day after CPT codes 99205 or 88215; and 2) There is no service with SI=**T** on the claim on the same date of service or one day earlier than G0378.
8003	Level II Extended Assessment and Management Composite	1) 8 or more units of HCPCS code G0378 are billed on the same date of service or the date of service after CPT codes 99284, 99285, or 99291; and 2) There is no service with SI=T on the claim on the same date of service or one day earlier than G0378.

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

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

d. Direct Admission to Observation Care Using G0379.

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

(2) Payment for direct admission to observation will be made either:

(a) Separately as low level hospital clinic visit under APC 604

(b) Packaged into payment for composite APC 8002 (Level I Prolonged Assessment and Management Composite), or

(c) Packaged into payment for other separately payable services provided in the same encounter.

(3) Criteria for payment of HCPCS code G0379 under either APC 8002 or APC 0604 include:

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

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

(c) If either of the above criteria (i.e., paragraph III.H.1.d.(3)(a) or (b)) is not met, HCPCS code G0379 will be assigned a SI of **N** and will be packaged into payment for other separately payable services provided in the same encounter.

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

(e) If the composite is not applicable, payment for HCPCS code G0379 may be made under APC 0604. In general, this would occur when the units of observation reported under HCPCS code G0378 are less than eight and no services with a SI of **T** or **V** or Critical Care (APC 0617) were provided on the same day of service as HCPCS code G0379. The final median cost of APC 0604 for CY 2008 is approximately $53.

2. Observations For Maternity Conditions.

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

(1) The maternity observation claim must have a maternity diagnosis as Principal Diagnosis (PDX) or Reason Visit Diagnosis (VRDX). Refer to Figure 13-2-8 for listing of maternity diagnoses.

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

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

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

c. Multiple maternity observations on a claim are paid separately if the required criteria are met for each observation and condition code "G0" is present on the claim or modifier 27 is present on additional lines with G0378.

d. If multiple payable maternity observations are submitted without condition code "G0" or modifier 27, the first encountered is paid and additional observations for the same day are denied.

FIGURE 13-2-8 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	
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	

FIGURE 13-2-8 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		
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	
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

FIGURE 13-2-8 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		
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
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
647.9	Unspecified infection or infestation	0, 3

FIGURE 13-2-8 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		
648.0	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
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
651.7	Multiple gestation following elective fetal reduction	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
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

FIGURE 13-2-8 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		
655.7	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
678.0	Fetal hematologic conditions	0, 3
678.1	Fetal conjoined twins	0, 3
679.0	Maternal complications from in utero procedure	0, 3
679.1	Fetal complications from in utero procedure	0, 3

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.

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.

J. APC For Vaginal Hysterectomy.

When billing for vaginal hysterectomies, hospitals shall report the appropriate CPT code.

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.

L. Special Billing/Codings Requirements as of January 1, 2008.

1. Payment for Alcohol and/or Substance Abuse Assessment and Intervention Services. Two parallel Level II HCPCS "G" codes (HCPCS codes G0396 and G0397) were created to allow for appropriate reporting and payment of alcohol and substance abuse structured assessment and intervention services that are not provided as screening services, but are performed in the context of the diagnosis or treatment of illness or injury.

a. Contractors shall make payment under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco)) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention greater than 30 minutes), only when the service is provided to evaluate patients with signs/symptoms of illness or injury.

b. HCPCS codes G0396 and G0397 are to be used for structured alcohol and/or substance (other than tobacco) abuse assessment and intervention services that are distinct from other clinic and emergency department visit services performed during the same encounter.

2. Payment for Cardiac Rehabilitation Services. Cardiac rehabilitation programs require that programs must be comprehensive and to be comprehensive they must include a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education and counseling. For CY 2008, hospitals will continue to use CPT[4] code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT[4] code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)) to report cardiac rehabilitation services.

a. However, effective with dates of service January 1, 2008 or later, hospitals may report more than one unit of HCPCS codes 93797 or 93798 for a date of service if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day.

b. In order to report more than one session for a given date of service, each session must be a minimum of 60 minutes. For example, if the services provided on a given day total one hour and 50 minutes, then only one session should be billed to report the cardiac rehabilitation services provided on that day.

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3. Billing for Wound Care Services.

a. Following CPT[5] codes are classified as "sometimes therapy" services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care:

(1) 97597 - Active wound care/20 cm or <

(2) 97598 - Active wound care > 20 cm

(3) 97602 - Wound(s) care non-selective

(4) 97605 - Neg press wound tx, < 50 cm

(5) 97606 - Neg pres wound tx, >50cm

b. Hospitals would receive separate payment under the OPPS when they bill for wound care services described by CPT[5] codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by individuals independent of a therapy plan of care.

c. When these services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, **GP** for physical therapy, **GO** for occupational therapy, and **GN** for speech-language pathology) or report their charges under a therapy revenue code (that is, 0420, 0430, or 0440) or both, to receive payment under the professional fee schedule.

d. The OCE logic assigns these services to the appropriate APC for payment under the OPPS if the services are not provided under a certified therapy plan of care or directs contractors to the fee schedule payment rates if the services are identified on hospital claims with therapy modifier or therapy revenue code as a therapy service.

e. Revised the list of therapy revenue codes effective January 1, 2008, that may be reported with CPT[5] codes 97597, 97598, 97602, 97605, and 97606 to designate them as services that are performed by a qualified therapist under a certified therapy plan of care and payable under the professional fee schedule – revenue codes expanded to 042X, 043X, or 044X.

4. Billing for Bone Marrow and Stem Cell Processing Services.

a. Effective January 1, 2008, the three Level II HCPCS codes (G0265, G0266, and G0267) for the special treatment of stem cells prior to transplant will be deleted.

b. Hospital are required to bill the appropriate CPT[5] codes, specifically 38207 through 38215, in order to report bone marrow and stem cell processing services under OPPS.

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FIGURE 13-2-9 BILLING FOR BONE MARROW AND STEM CELL PROCESSING SERVICES

HCPCS CODE	CPT[6] CODE
G0265	38207
G0266	38208, 38209
G0267	38210, 38211, 38212, 38213, 38214, 38215

c. For CY 2008, CPT[6] codes 38207, 38208, and 38209 for cryopreserving, thawing, and washing bone marrow and stem cells will be assigned to APC 0110, with a median cost of approximately $214 and a SI of **S**. In addition, CPT[6] codes 38210 - 38215, reported for depletion services of bone marrow and stem cells will be assigned APC 0393, which is renamed "Hematologic Processing and Studies," with a median cost of approximately $358 and a SI of **S**.

5. Billing for Implantable Cardioverter Defibrillators (ICDs).

Effective January 1, 2008, the four Level II HCPCS codes (G0297, G0298, G0299, and G0300) for ICD insertion procedures will be deleted. Hospitals are required to bill the appropriate CPT codes, specifically CPT[6] codes 33240 or 33249, as appropriate, along with the applicable device C codes, for payment under the OPPS.

6. Payment for Brachytherapy Sources.

a. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, enacted on July 15, 2008, extended the use of the cost-to-charge payment methodology for Brachytherapy through January 1, 2010 with the exception of C2637, which is non-payable.

b. As a result, the SIs for Brachytherapy source HCPCS codes will remain "H," and as such, Brachytherapy will not be eligible for outlier payments or rural Sole Community Hospital (SCH) adjustments up through January 1, 2010.

c. Providers should bill for the number of units of the appropriate source HCPCS **C** code according to the number of brachytherapy sources in the strand (billing for stranded sources). They should not bill as one unit per strand.

d. Following is a list of brachytherapy sources that will continue to be reimbursed under the cost-to-charge payment methodology up through January 1, 2010:

FIGURE 13-2-10 COMPREHENSIVE LIST OF BRACHYTHERAPY SOURCES PAID UNDER COST-TO-CHARGE METHODOLOGY UP THROUGH JANUARY 1, 2010

CPT/ HCPCS	LONG DESCRIPTOR	SI	APC
A9257	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	H	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	H	1717

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FIGURE 13-2-10 COMPREHENSIVE LIST OF BRACHYTHERAPY SOURCES PAID UNDER COST-TO-CHARGE METHODOLOGY UP THROUGH JANUARY 1, 2010 (CONTINUED)

CPT/ HCPCS	LONG DESCRIPTOR	SI	APC
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	H	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	H	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	H	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium- 103, greater than 2.2 mCi (NIST), per source	H	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	H	2636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	B	
C2638	Brachytherapy source, stranded, Iodine-125, per source	H	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	H	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	H	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	H	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	H	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	H	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	H	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	H	2699

7. Billing for Drugs, Biologicals, and Radiopharmaceuticals.

a. Hospitals should report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used.

b. It is also important that the reported units of the service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used, as reflected in the longer descriptor of the HCPCS code.

c. If commercially available products are being mixed together to facilitate concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code).

(1) If the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted code (J9999 or J3490).

(2) It is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

d. Following are new HCPCS codes which have been created for reporting drugs, biologicals in the hospital outpatient setting for CY 2008.

FIGURE 13-2-11 NEW HCPCS CODES EFFECTIVE FOR CERTAIN DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS IN CY 2008

2008 HCPCS	2008 SHORT DESCRIPTOR	2008 SI	2008 APC
A9501	Tc99m tebroxmine	N	
A9509	I 123 sodium iodide, dx	N	
A9569	Technetium TC-99m auto WBC	N	
A9570	Indium In-111 auto wbc	N	
A9571	Indium In-111 auto platelet	N	
A9576	Inj prohance multipack	N	
A9577	Inj multihance	N	
A9578	Inj multihance multipack	N	
C9237	Injection, lanreotide acetate	K	9237
C9238	Inj. Levetiracetam	K	9238
C9239	Inj. Temsirolimus	G	1168
C9240	Injection, ixabepilone	K	9240
C9354	Veritas collagen matrix, cm2	G	9354
C9355	Neuromatrix nerve, cuff, cm	G	9355
J0400	Aripiprazole injections	K	1165
J1573	Hepagam B intravenous, inj	K	1138
J2724	Protein C concentrate	K	1139
J92266	Supprelin LA implant	K	1142

e. Changes in HCPCS code descriptors for drugs, biologicals and radiopharmaceuticals effective in CY 2008. Also deletion of several temporary C codes and replacement with new permanent codes. The affected HCPCS codes are listed below:

FIGURE 13-2-12 HCPCS CODE AND DOSAGE DESCRIPTOR CHANGES EFFECTIVE FOR CERTAIN DRUGS, BIOLOGICALS AND RADIOPHARMACEUTICALS IN CY 2008

CY 2007		CY 2008	
HCPCS	DESCRIPTOR	HCPCS	DESCRIPTOR
C9232	Injection, idusulfase, 1mg	J1743	Injection, idusulfase, 1mg
C9233	Injection, ranilbizumab, 0.5 mg	J2778	Injection, ranilbizumab, 0.1 mg
C9234	Injection, agucosidase alfa, 10 mg	J0220	Injection, agucosidase alfa, 10 mg
C9235	Injection, panitumumab, 10 mg	J9303	Injection, panitumumab, 10 mg
C9236	Injection, eculizumab, 10 mg	J1300	Injection, eculizumab, 10 mg
C9350	Microporous collagen tube of nonhuman origin, per centimeter length	C9352	Microporous collagen implantable tube (Neuragen Nerve Guide), per centimeter length
C9350	Microporous collagen tube of nonhuman origin, per centimeter length	C0353	Microporous collagen implantable tube (Neuragen Nerve Protector), per centimeter length

FIGURE 13-2-12 HCPCS CODE AND DOSAGE DESCRIPTOR CHANGES EFFECTIVE FOR CERTAIN DRUGS, BIOLOGICALS AND RADIOPHARMACEUTICALS IN CY 2008 (CONTINUED)

CY 2007		CY 2008	
HCPCS	DESCRIPTOR	HCPCS	DESCRIPTOR
C9351	Acellular dermal tissue matrix of nonhuman origin, per square centimeter (Do not report C9351 in conjunction with J7345)	J7348	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (tissuemend) per square centimeter
C9351	Acellular dermal tissue matrix of nonhuman origin, per square centimeter (Do not report C9351 in conjunction with J7345)	J7349	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (primatrix) per square centimeter

f. New HCPCS Drug Codes Separately Payable under OPPS as of January 1, 2008.

FIGURE 13-2-13 NEW DRUG CODES SEPARATELY PAYABLE UNDER OPPS AS OF JANUARY 1, 2008

HCPCS CODE	APC	SI	LONG DESCRIPTOR
C9237	9237	K	Injection, lanreotide acetate, 1 mg
C9240	9240	K	Injection, ixabepilone, 1mg

g. Drugs and biologicals with payment based on Average Sales Price (ASP) effective January 1, 2008. The updated payment rates for drugs and biologicals based on ASPs effective January 1, 2008, can viewed on the TRICARE web site.

h. Correct Reporting of Units for Drugs.

(1) Hospitals should ensure that units of drugs used in the care of patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor--that is, units should be reported in multiples of the units included in the HCPCS descriptor.

EXAMPLE: 1: If the description for the drug code is 6 mg, and 6 mg of the drug was used in the care of the patient the units billed should be one.

EXAMPLE: 2: If the description for the drug code is 50 mg but 200 mg of the drug was used in the care of the patient, the units billed should be four.

(2) Hospitals should not bill the units based on the way the drug is packaged, stored or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of drug was used, the hospital should bill 10 units, even though only one vial was used.

8. Payment for Therapeutic Radiopharmaceuticals.

a. The MIPPA of 2008, enacted on July 15, 2008, extended the use of the cost-to-charge payment methodology for therapeutic radiopharmaceuticals through January 1, 2010.

b. As a result, the SIs for therapeutic radiopharmaceutical HCPCS codes will remain "H," and as such, therapeutic radiopharmaceuticals will not be eligible for outlier payments or rural SCH adjustments up through January 1, 2010.

c. Following is a list of therapeutic radiopharmaceuticals that will continue to be reimbursed under the cost-to-charge payment methodology up through January 1, 2010:

FIGURE 13-2-14 COMPREHENSIVE LIST OF THERAPEUTIC RADIOPHARMACEUTICALS PAYABLE AS OF JANUARY 1, 2008

CPT/ HCPCS	LONG DESCRIPTOR	SI	APC
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	H	1064
A9520	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	H	1150
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	H	1643
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	H	1645
A9563	Sodium phosphate P-32, therapeutic, per millicurie	H	1675
A0564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	H	1676
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	H	0701
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	H	0702

d. Hospitals are required to submit the diagnostic radiopharmaceutical on the same claim as the nuclear medicine procedure along with the date that a particular service was provided.

9. Drug Administration.

a. For CY 2008, hospitals will use the full set of CPT codes for billing drug administration services provided in the hospital outpatient department setting.

b. This includes new CPT codes for CY 2008 listed in Figure 13-2-15.

c. Hospitals are to report all drug administration services, regardless of whether they are separately paid or packaged.

FIGURE 13-2-15 NEW DRUG ADMINISTRATION CPT CODES EFFECTIVE IN CY 2008

CPT CODE[1]	LONG DESCRIPTOR	CY 2008	
		SI	APC
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	S	0440
90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure	S	0437
90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	S	0438

FIGURE 13-2-15 NEW DRUG ADMINISTRATION CPT CODES EFFECTIVE IN CY 2008 (CONTINUED)

CPT CODE[1]	LONG DESCRIPTOR	CY 2008 SI	CY 2008 APC
90776	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure.)	N	

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10. Billing for Cardiac Echocardiography Services.

a. Cardiac Echocardiography Without Contrast. Hospitals are instructed to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT[7] code(s) (93303-93350).

b. Cardiac Echocardiograph With Contrast.

(1) Hospitals are instructed to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in Figure 13-2-16.

(2) Hospitals should also report the appropriated units for the HCPCS code for the contrast agents used in the performance of the echocardiograms.

FIGURE 13-2-16 HCPCS CODE(S) FOR BILLING ECHOCARDIOGRAMS WITH CONTRAST

HCPCS	LONG DESCRIPTOR
C8921	Transthroacic echocardiography with contrast for congenital cardiac anomalies; complete
C8922	Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study
C8923	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording complete
C8924	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-code recording; follow-up or limited study
C8925	Transesophageal echocardiograph (TEE) with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
C8926	Transesophageal echocardiograph (TEE) with contrast for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927	Transesophageal echocardiograph (TEE) with contrast for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928	Transthoracic echocardiography with contrast, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

IV. EFFECTIVE DATE May 1, 2009.

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