CHAPTER 2
ADDENDUM E

OTHER SPECIAL PROCEDURE CODES

FIGURE 2-E-1 PROCEDURE CODES FOR OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTER, BIRTHING CENTER, AND HOSPITAL/OUTPATIENT BIRTHING ROOM CLAIMS

Contractors are to use the following hierarchy to code outpatient hospital claims:

1. Use CPT-4 procedure codes[1] if the services to be coded are physical therapy (97010 - 97799) or speech therapy (92507 - 92508).
2. In addition to valid CPT procedure codes, Psychiatric and PFPWD are included in Figure 2-E-6 and Figure 2-E-7.
3. The appropriate CPT[1]/HCPCs codes are to be used when available. This would apply to, but not limited to radiology and laboratory charges.
4. Use the following procedure codes if above codes, are not appropriate:

DESCRIPTION OF PROCEDURE	CODES[1]
Radiology Charge	76499
Laboratory Charge	84999
Whole Blood Charges	90593
Recovery Room Charge	90596
Operating Room Charge	90597
Emergency Room Charge	90599
Unlisted Pulmonary Services or Procedure	94799
Medical/Surgical Supplies and Devices	99070
Other Room, Ancillary and Drug Charges	99088
Birthing Center - All-Inclusive Charge - Complete	99590
Birthing Center - All-Inclusive Charge - Partial	99591
Hospital Outpatient Birthing Room Charges	99592

5. For ambulatory surgery claims, charges for x-rays, laboratory fees, physicians' fees, anesthesia services, and other identifiable charges need not be itemized by hospitals. If these services are itemized, contractors need not report the itemization to TMA. Bills must be itemized for birthing center, and hospital-outpatient birthing room and Ambulatory Surgery claims. Codes[1] 99590, 99591 (to be used when birthing center bill is

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not for all inclusive maternity care because the woman was discharged prior to delivery), and 99592 may only be used for the services described. The charges reported for the codes for complete or partial birthing center charges and for hospital outpatient birthing rooms are **aggregate amounts.**

FIGURE 2-E-2 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1] PURCHASES
These HCPCS Level III codes must be used when submitting payment records containing procedures for purchase of the following durable medical equipment and medical supplies.	
Chemotherapy Equipment and Supplies (excluding Drugs)	06892
Flutter Device for use in Cystic Fibrosis	06952
Therapeutic Shoes	06954
Wigs and Hairpieces	09977
NOTE: When multiple units are used in a single episode of care, such as one box of twelve syringes, code only one (1) supply or service.	

FIGURE 2-E-3 SPECIAL PROCEDURAL CODES

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1]
The following are special codes that are valid and payable	
Extracorporeal Immunoadsorption (ECI) With Protein A Columns	36526
Combined Liver-Kidney Transplant	47150
Services of a Home Health Aide/Homemaker (If code 90l99 is used, Special Processing Flag must be 6.)	90199
Outpatient Group Care, Substance Use Disorder (SUDRF)	90834
Drugs; the procedure code to be used for all Drug HCSRs (Program Indicator = 'D')	98800
Combined Small Intestine - Liver Transplant	47155
Multivisceral Transplant	44250
Small Intestine Transplant	44701

FIGURE 2-E-4 SPECIAL STATISTICAL TRACKING CODES

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1]
The following codes are not approved for payment authorization, but reporting them is required for TMA statistical purposes. These codes may only be used when amount allowed dollars in the occurrence portion of the HCSR are zero.	
Invitro Bone Marrow Processing (Purging)	38298
Non-covered Refractive Services which are rendered as part of an eye examination (that part of an eye examination to evaluate the patient's functional vision). (TRICARE Reimbursement Manual, Chapter 2, Section 3, "Ophthalmological Services - Basic Program".)	92190
Supervision of Treatment Team for Outpatient Care, Inpatient Care or Partial Hospital Care; e.g., day or night care, including occupational or recreational therapists, psychologists, custodial physicians, or psychiatric nurses - 50 minutes	92845
Marathon Therapy	92860
Non-covered, nonadjunctive dental services	98691

FIGURE 2-E-5 CPT-4 CODE FOR ANESTHESIA SERVICES

DESCRIPTION OF PROCEDURES	LEVEL I CODES[1]
The following CPT-4 codes shall be used when submitting payment records to TMA for anesthesia services for dates on or after 11/01/1998.	
Anesthesia Codes:	00100 - 01999 (except 01996) 99100 - 99140

NOTE: Contractors shall report the above procedures as appropriate with the provider specialty coded as "anesthesiology" (05) or "anesthetist" (80) as appropriate. A '0' or a '1' must be coded in the Number of Services field. This field must be coded as '1' on all RPM = Blank or H initial submission **payment records**. Contractors shall request specific information concerning pricing from the providers, however, pricing units are not to be submitted on payment records.

FIGURE 2-E-6 MENTAL HEALTH PROCEDURE CODES

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1]
PARTIAL HOSPITALIZATION	
Outpatient services provided in a group setting by a Substance Use Disorder Rehabilitation Facility.	90834
Partial Hospitalization, all-inclusive per diem payment for alcohol rehabilitation, 6 hours or more	92891
Partial Hospitalization, all-inclusive per diem payment for alcohol rehabilitation, 3-5 hours (half day program)	92892
Partial Hospitalization, Night Time Care (reimbursement not to exceed amount allowed for half day)	92893
Psychiatric Partial Hospitalization, all inclusive per diem payment of nonsubstance abuse partial hospitalization programs of 6 hours or more	92898
Psychiatric Partial Hospital, all-inclusive per diem payment of nonsubstance abuse programs of 3 - 5 hours (half-day program)	92899
NOTE: The only other service that may be cost-shared, in addition to these codes is the one hour of psychotherapy per day for individual or family therapy (not to exceed five per week) performed by authorized mental health professionals not employed by or contracted with the partial hospitalization facility.	
WRAPAROUND DEMONSTRATION	
Psychiatric in home services (psychotherapy provided in the beneficiary's home)	90892
Brief, time limited, respite services	90893
Therapeutic foster homes (psychotherapy provided in the foster home)	90894
Therapeutic group homes (psychotherapy provided in the group home)	90895
Crisis stabilization in group homes (psychotherapy provided in a group home, patient unstable)	90896
Other residential or nonresidential ancillary mental health services not included in the above codes	90897

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FIGURE 2-E-6 MENTAL HEALTH PROCEDURE CODES (CONTINUED)

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1]
Case Management Services	90898

NOTE: Wraparound Services include nontraditional mental health services that will provide the flexibility needed to assist a child or adolescent to be maintained in the least-restrictive and least-costly setting. This demonstration will be implemented February 1, 1998 and run for two years. Medically necessary institutional care, i.e., provided in a psychiatric hospital, RTC, etc., under this demonstration shall be billed on the appropriate institutional claim form. **All Mental health services both ancillary and institutional shall be coded by Merit Behavioral Corporation (MBC) with the special processing code for this demonstration**.

FIGURE 2-E-7 SPECIAL CODES FOR THE PROGRAM FOR PERSONS WITH DISABILITIES

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1]
The following special codes shall be used when submitting payment records containing the following Program for Persons with Disabilities procedures. This listing does not include all possible codes that should be used for PFPWD beneficiaries such as laboratory and radiology. Valid CPT-4 codes shall be used when appropriate.	
VOCATIONAL OR EDUCATIONAL SERVICES	
Visiting Teacher Services	98220
Vocational Training in Sheltered Workshop or Similar Facility	98230
Vocational Training Services for Homebound Patient	98240
Reading Therapy	98250
Other Special Education or Vocational Services	98290
PURCHASE OR RENTAL OF DURABLE MEDICAL EQUIPMENT	
	See Figure 2-E-2

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FIGURE 2-E-8 TMA-ASSIGNED PROCEDURAL CODES FOR REPORTING FACILITY CHARGES WHEN AN ONAS IS REQUIRED

MDC	CATEGORY DESCRIPTION	TMA CODE[1]
61	GYN Laparoscopy	58998
62	Cataract Removal	66998
63	GI Endoscopy	43299
64	Myringotomy or Tympanostomy	69438
65	Arthroscopy	29900
66	Dilation and Curettage	58125
67	Tonsillectomy or Adenoidectomy	42839
68	Cystoscopy	52345
69	Hernia	49595
70	Nose Repair	30525
71	Ligation or Transection of Fallopian Tubes	58625
72	Strabismus Repair	67338
73	Breast Mass or Tumor Excision	19135 (effective 1 Jan 94)
74	Neuroplasty	64730

NOTE: For outpatient services provided on or after September 23, 1996, the ONAS requirement is eliminated for all TRICARE beneficiaries.

PROCEDURE: This figure applies only for care provided during period of October 1, 1991 through September 22, 1996. The TRICARE claims processors are required to use the above TMA codes to report facility-related ambulatory surgery charges on a non-institutional HCSR when an ONAS is required. They will convert the revenue codes (if submitted on a UB-82), or other CPT-4 codes (if submitted on another claim form) to the appropriate TMA code from the above list, and report it along with the facility charges on a non-institutional HCSR. All facility charges are to be summarized and reported under the appropriate code; no itemization is to be reported.

If multiple surgeries are performed during the same episode of care, the claims processors should attempt to report the facility charges for each surgery using the appropriate code from the list above. If this is not possible, all charges should be summarized and reported under the primary surgical procedure code.