CHAPTER 13
SECTION 3

PROSPECTIVE PAYMENT METHODOLOGY

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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 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 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 cost-to-charge ratio is identified for each hospital's cost center ("cost center specific cost-to-charge ratios," or CCRs).

(b) The hospitals 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 hospital-specific 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 are packaged into major 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
250	Pharmacy
251	Generic
252	Nongeneric
254	Pharmacy Incident to Other Diagnostic
255	Pharmacy Incident to Radiology
257	Nonprescription Drugs
258	IV Solutions
259	Other Pharmacy
260	IV Therapy, General Class
262	IV Therapy/Pharmacy Services
263	Supply/Delivery
264	IV Therapy/Supplies
269	Other IV Therapy
270	M&S Supplies
271	Nonsterile Supplies
272	Sterile Supplies
274	Prosthetic/Orthotic Devices
275	Pacemaker Drug
276	Intraocular Lens Source Drug
278	Other Implants
279	Other M&S Supplies
280	Oncology
289	Other Oncology

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

REVENUE CODE	DESCRIPTION
290	Durable Medical Equipment
370	Anesthesia
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to Other Diagnostic
379	Other Anesthesia
390	Blood Storage and Processing
399	Other Blood Storage and Processing
560	Medical Social Services
569	Other Medical Social Services
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic
624	Investigational Device (IDE)
630	Drugs Requiring Specific Identification, General Class
631	Single Source
632	Multiple
633	Restrictive Prescription
637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic COMA)
681	Trauma Response, Level I
682	Trauma Response, Level II
683	Trauma Response, Level III
684	Trauma Response, Level IV
689	Trauma Response, Other
700	Cast Room
709	Other Cast Room
710	Recovery Room
719	Other Recovery Room
720	Labor Room
721	Labor
762	Observation Room
810	Organ Acquisition
819	Other Organ Acquisition

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

REVENUE CODE	DESCRIPTION
942	Education/Training

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, a HCPCS Level I or II code is required.

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 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 percent 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), OPPS weights are listed in Addendums A and B1 through B7.

b. Conversion Factor Update for CY 2005

(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 and differences in estimated pass-through payments.

3. Payment Status Indicators

A payment status indicator 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 outpatient PPS; 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, status indicator is assigned to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned. The following are the payment status indicators and 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. Some, but not all, of these other payment systems are identified in Addendum C1.

b. "B" to indicate the services that are not payable under the OPPS when submitted on an outpatient hospital bill type (bill type 12X, 13X, and 14X), but that may be payable by contractors to other provider types when submitted on an appropriate bill type.

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

d. "E" to indicate items or services that are not covered by TRICARE or codes that are not recognized 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 CRNA services that are paid on an allowable charge basis.

f. "G" to indicate a current drug, biological or radiopharmaceutical agent for which payment is made under the transitional pass-through.

g. "H" to indicate devices that are paid under the OPPS transitional pass-through rules and brachytherapy sources that are paid on an allowable charge basis.

h. "K" to indicate drugs, biologicals (including blood and blood products) and certain radiopharmaceutical agents that are paid in separate APCs under the OPPS, but that are not paid under OPPS transitional pass-through rules.

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.

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

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

m. "V" to indicate medical visits (including clinic or emergency department visits) for which payment is allowed under the hospital outpatient PPS.

n. "X" to indicate an ancillary service for which payment is allowed under the hospital outpatient PPS.

NOTE: The system payment logic looks to the status indicators attached to the HCPCS codes and APCs for direction in the processing of the claim. A status indicator, as well as an APC, must be assigned so that payment can be made for the service identified by the new code. The status indicators identified for each HCPCS code and each APC appear in Addendums A and B1.

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 Addendum A 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 outpatient PPS 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 Provider File with Wage Indexes on TMA's DRG home page at http://www.tricare.osd.mil/drgrates/ for annual DRG wage indexes used in the payment of hospital outpatient claims.)

(2) 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). (See Figure 13-3-2 and Figure 13-3-3 for hospital outpatient deductible and cost-sharing/copayment provisions under Prime, Extra and Standard TRICARE programs.)

FIGURE 13-3-2 HOSPITAL OUTPATIENT DEDUCTIBLES

TRICARE PROGRAMS	ACTIVE DUTY FAMILY MEMBERS		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS
	E1 - E4	E5 & ABOVE	
Prime	None	None	None
Extra	$50 per Individual $100 Maximum per family	$150 per Individual $300 Maximum per family	$150 per Individual $300 Maximum per family
Standard	$50 per Individual $100 Maximum per family	$150 per Individual $300 Maximum per family	$150 per Individual $300 Maximum per family

FIGURE 13-3-3 HOSPITAL OUTPATIENT COPAYMENTS/COST-SHARING

TRICARE PRIME PROGRAM			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
ACTIVE DUTY FAMILY MEMBER		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
E1 - E4	E5 & ABOVE			
$0 Copayment per visit	$0 Copayment per visit	$12 Copayment per visit	**Active Duty Family Members**: Cost-share - 15% of fee negotiated by contractor. **Retirees, their Family Members & Survivors**: Cost-share - 20% of the fee negotiated by the contractor.	**Active Duty Family Members**: Cost-share - 20% of the allowable charge. **Retirees, their Family Members & Survivors**: Cost-share - 25% of the allowable charge.

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 percent 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

(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 percent 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 percent 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. The hospital DRF wage index will be used given the inseparable, subordinate status of the outpatient department within the hospital.

(2) Wage index changes will be implemented on a fiscal year (FY) basis (refer to the Provider File with Wage Indexes on TMA's DRG home page at http://www.tricare.osd.mil/drgrates/ for annual DRG wage indexes used in payment of hospital outpatient claims) to coincide with their updating under the DRG payment system. This way only one wage index file will have to be maintained for both the OPPS and DRG payment system.

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

(4) Steps in Applying Wage Adjusts under OPPS

(a) Calculate 60 percent (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 percent (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) 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 percent 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 percent), and the nonlabor-related portion of the payment rate is $120 ($300 x 40 percent). It is assumed that the beneficiary deductible has been met.

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

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

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 Procedures

(1) Outpatient PPS 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 of this manual for additional guidelines on discounting of surgical procedures.

(a) Line items with a status indicator 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 status indicator "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 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 for type "T" procedures should not occur, and the discounting factor would be set so as to result in the equivalent of a single procedure.

(3) There is no terminated procedure or multiple bilateral discounting performed for non-type "T" procedures.

(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 13-3-4 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)

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

FIGURE 13-3-5 APPLICATION OF DISCOUNTING FORMULAS

			DISCOUNTING FORMULA NUMBER			
			TYPE "T" PROCEDURE		NON TYPE "T" PROCEDURE	
PAYMENT AMOUNT	MODIFIER 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	1	1
Highest	No	Yes	4	2	8	1
Highest	Yes	Yes	3	3	8	1
Not Highest	No	No	5	5	1	1
Not Highest	Yes	No	6	6	1	1
Not Highest	No	Yes	7	5	8	1
Not Highest	Yes	Yes	6	6	8	1

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 APC rate plus a fixed dollar threshold and a fixed multiple of the outpatient PPS payment as adjusted by pass-through payments.

(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 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 calendar year basis which requires that a hospital's cost for a service exceed the APC payment rate for that service by a specified multiple of the APC payment rate and the sum of the 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 CY 2005 multiple and fixed dollar thresholds.

STEP 1: Identify all APCs on the claim.

STEP 2: Determine the ratio of each APC payment to the total payment of the claim.

HCPCS CODE	STATUS INDICATOR (SI)	APC	SERVICE	PAYMENT RATE	PERCENTAGE OF APC TO TOTAL PAYMENT
99284	V	0612	High-level emergency visit	$226.39	47%
70481	S	0283	CT scan with contrast material	$234.98	49%
93041	S	0099	EKG	$19.20	4%

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

REVENUE CODE	OPPS SERVICE OR SUPPLY	TOTAL CHARGES
250	Pharmacy	$2,986.50
270	Medical Supplies	$3,957.80
350	CT scan	$3,514.00
450	ER	$2,597.00
730	EKG	$237.00

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

APC	PERCENTAGE ALLOCATION	OPPS SERVICE	250 (PHARMACY)	270 (MEDICAL SUPPLIES)
0612	47%	High-level emergency visit	$1403.66	$1,860.17
0283	49%	CT scan with contrast material	$1463.38	$1,939.32
0099	4%	EKG	$119.46	$158.31

STEP 5: Calculate the total charges for each OPPS service (APC) and reduce them to costs by applying the overall hospital specific cost-to-charge ratio. Assume that the hospital has an overall outpatient cost-to-charge ratio of 31.4 percent.

APC	OPPS SERVICE	TOTAL CHARGES	TOTAL CHARGES REDUCED TO COSTS (CCR = 0.3140)
0612	High-level emergency visit	$5860.83	$1,840.30
0283	CT scan with contrast material	$6916.70	$2,171.84
0099	EKG	$514.77	$161.64

STEP 6: Apply the cost test to each APC service or procedure to determine if it qualifies for an outlier payment. If the cost of a service (APC) exceeds both the APC multiplier threshold (1.75 times the APC payment rate) and the fixed dollar threshold (APC rate plus $1,175), multiply the costs in excess of the APC multiplier by 50 percent to get the additional outlier payment.

APC	APC RATE	COSTS	FIXED DOLLAR THRESHOLD (APC RATE + $1,175)	MULTIPLIER THRESHOLD (1.75 X APC RATE)	COSTS IN EXCESS OF MULTIPLIER THRESHOLD	OUTLIER PAYMENT COSTS OF APC -- (1.75 X APC RATE) X 0.50
0612	$226.39	$1,840.30	$1,401.39	$396.18	$1444.12	$722.06
0283	$234.98	$2,171.84	$1,409.98	$411.22	$1760.62	$880.31
0099	$19.20	$161.64	$1,194.20	$33.60	$128.04	-0-**

**** Does not qualify for outlier payment since the APC's costs did not exceed the fixed dollar threshold (APC Rate + $1,175).**

The total outlier payment on the claim was $1602.37.

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.

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.

d. New Medical Devices, Drugs, and Biologicals

New medical devices, drugs, and biologic agents, 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 outpatient PPS 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 status indicator "H".

b. Pass-through drugs and biological agents are identified by status indicator "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 average sales price (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 average sales prices 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 average sales price 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 percent of the average sales price for the HCPCS code or 106 percent 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 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 percent 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 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).

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 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, 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: 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.

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 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 Food and Drug Administration (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 hospital's cost-to-charge ratio to its charges on the claim and subtracting any appropriate pass-through offset.

(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 cost-to-charge ratio (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 with which it is normally billed.

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 = $2,710.57 (CY 2003)

Coinsurance amount = $542.11 (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 amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. 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:

$2,710.57 – $542.11 = $2,168.46

TRICARE payment for pass-through device C1884 = $397.94

Beneficiary cost-share liability for APC 0083 = $542.11

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

$2,168.46	TRICARE program payment for HCPCS Level I[1] code 92982 when used with device code C1884
542.11	Beneficiary coinsurance amount for HCPCS Level I[1] code 92982
397.94	Transitional pass-through payment for device
$3,108.51	Total amount received by the provider

[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.

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 = $3,230.27

Coinsurance amount = $646.05 (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 = $0.

NOTE: The total offset amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. 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:

$3,230.27 – $646.05 = $2,584.25

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

Beneficiary cost-share liability for APC 0083 = $646.05

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

$2,584.25	TRICARE program payment for HCPCS Level I[2] code 92982 when used with device code C1884
646.05	Beneficiary coinsurance amount for HCPCS Level I[2] code 92982
1,500.00	Transitional pass-through payment for device
$4,730.30	Total amount received by the provider

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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

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 line for the drug or radiopharmaceutical is less than $50. Separate APC payment is established for drugs and radiopharmaceuticals for which the median cost per line exceeds $50.

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.

(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 Limitations

The following payment limits are specified for three categories of "specified covered outpatient drugs" based on their "reference average wholesale price" (i.e., the AWP for the drug, biological, or radiopharmaceutical included within the "specified covered outpatient drug" category).

(1) Sole-source Drugs

These are brand name drugs for which there is no FDA generic drug approval. Each drug is produced or delivered under an original new drug application approved by the FDA. Payment will be no less than 83 percent and no more than 95 percent of the reference average wholesale price (AWP). In other words, payments for sole source drugs, biologicals, and radiopharmaceuticals established under the median cost methodology are compared to their reference AWPs. If payment falls below 83 percent of the reference AWP, it is increased to 83 percent of the reference AWP. If payment exceeds 95 percent of the reference AWP, it is reduced to 95 percent of the reference AWP. If the payment is no lower than 83 percent and no higher than 95 percent of the reference AWP, there is no change in payment.

(2) Innovator Multiple Source Drugs

These are drugs that were originally sole-source drugs, but now have

had their generic equivalents approved by the FDA. Payment will be no more than 68 percent of the reference AWP.

(3) Noninnovator Multiple Source Drugs

These are drugs that are not innovator, multiple-source drugs, which are effectively generic drugs approved by the FDA. Payment will be no more than 46 percent of the reference AWP.

NOTE: Some drugs may be considered for more than one of the above classifications if used for indications different than the ones for which they were originally approved. However, once a drug becomes qualified for either of the above multiple source categories it cannot return to the sole source category based on the treatment of a different indication.

c. Designated Status Indicator

The HCPCS codes for the above three categories of "specified covered outpatient drugs" are designated with the status indicator "K" – non-pass-through drugs, biologicals, and radiopharmaceuticals paid under the hospital OPPS (APC Rate). Refer to Addendums A and B1 of this chapter for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

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.

b. These new drugs and biologicals will be treated the same irrespective of whether pass-through status has been determined. Status indicator "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 2003 claims data for drugs and biologicals that have been:

(1) Separately paid since implementation of the OPPS under Medicare (August 1, 2000), 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 $50 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) The new drug, biological and/or radiopharmaceutical will be priced at 95 percent of its AWP using Red Book or an equivalent recognized compendium.

b. Hospitals will discontinue billing C9399 and the NDC upon implementation of a HCPCS code, status indicator, 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 13-3-6 CROSSWALK FROM HCPCS LEVEL I[1] CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCS

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC	MAXIMUM APC UNITS WITHOUT 59 MODIFIER	MAXIMUM APC UNITS WITH 59 MODIFIER
96400	Chemotherapy sc/im	S	0116	1	2
96405	Intralesional chemo admin	S	0116	1	2
96406	Intralesional chemo admin	S	0116	1	2
96408	Chemotherapy, push technique	S	0116	1	2
96410	Chemotherapy, infusion method	S	0117	1	2
96412	Chemo, infuse method add-on	N	--	0	0
96414	Chemo, infuse method add-on	S	0117	1	2
96420	Chemotherapy, push technique	S	0116	1	2
96422	Chemotherapy, infusion method	S	0117	1	2
96423	Chemo, infuse method add-on	N	--	0	0

The last two columns of this table indicate the maximum number of units of the APC that the OCE will assign without, or with, modifier 59, respectively.

[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.**

FIGURE 13-3-6 CROSSWALK FROM HCPCS LEVEL I[1] CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCS (CONTINUED)

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC	MAXIMUM APC UNITS WITHOUT 59 MODIFIER	MAXIMUM APC UNITS WITH 59 MODIFIER
96425	Chemotherapy, infusion method	S	0117	1	2
96440	Chemotherapy, intracavitary	S	0116	1	2
96445	Chemotherapy, intracavitary	S	0116	1	2
96450	Chemotherapy into CNS	S	0116	1	2
96542	Chemotherapy injection	S	0116	1	2
96545	Provide chemotherapy agent	N	--	0	0
96549	Chemotherapy, unspecified	S	0116	1	2
90780	IV infusion therapy, 1 hour	T	0120	1	4
90781	IV infusion, additional hour	N	--	0	0

The last two columns of this table indicate the maximum number of units of the APC that the OCE will assign without, or with, modifier 59, respectively.

[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.**

2. Packaged HCPCS Level I codes for drug administration should continue to be billed for CY 2005 to ensure accurate payment in the future. These are bill charges 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.

3. Modifier 59 may be used with codes in APCs 0116, 0117, and 0120 to signify additional encounters on the same date of service for which additional APC payment may be made.

4. The status indicator of "T" will be retained for HCPCS Level I[3] code 90780 (IV infusion therapy 1 hour) which has been crosswalk to Q0081 (infusion of drugs other than chemotherapy).

a. The code will be reduced by 50 percent if it is the lower priced service on the same claim with another procedure with the status indicator "T".

b. This reduction will occur when there is a separate procedure performed on the same day as the infusion and there would be significant efficiencies in administering an infusion.

c. If the infusion is performed by itself or with a visit, or with a service with status code "S", the multiple procedure reduction will not apply.

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5. HCPCS Level I[4] codes 90782-90788 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.

6. Drugs for which the median cost per day is greater than $50 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 $50 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

Since no new drug administration code requirements are being implemented, the need for more detailed drug coding has been removed.

a. Hospitals are not required to report every drug with a HCPCS that is administered to a patient.

b. However, in order to receive payment for a drug for which separate payment is provided, hospitals will have to continue to bill for the drug using revenue code 636 ("Drugs requiring detail coding") and report the appropriate HCPCS code for the drug.

c. Drugs for which separate payment is allowed are designated by status indicator "K".

d. Coding instructions for Packaged Drugs.

(1) Hospitals should continue to bill for packaged drugs, which are assigned status indicator "N", using any of the drug revenue codes that are packaged revenue codes under the OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633.

(2) Hospitals are not required to use HCPCS codes when billing for packaged drugs, unless revenue code 636 is used.

(3) Although hospitals are not required to report HCPCS codes for packaged drugs, it is essential that hospitals continue to bill charges for packaged drugs by including the charge for packaged drugs in the charge for the procedure or service with which the drug is used, or as a separate drug charge (whether or not it is separately payable).

(4) Reporting charges of packaged drugs is critical because packaged drug costs are used for calculating outlier payments and hospital costs for the procedure and services with which the drugs are used in the course of the annual OPPS updates.

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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.

(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 percent of AWP or 106 of the ASP, whichever is higher.

b. However, for drugs where 106 percent of ASP would exceed 95 percent of AWP, payment would be capped at 95 percent of AWP, which is the upper limit allowed for sole source specified covered outpatient drugs.

H. Vaccines

Hospitals will be paid for influenza and pneumococcal pneumonia vaccines based on allowable charge methodology; i.e., will be paid the CMAC rate for these vaccines.

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 $50.

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 percent 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.

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[5] 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 13-3-7 for APC assignment of blood and blood product codes.

FIGURE 13-3-7 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

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FIGURE 13-3-7 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES (CONTINUED)

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
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
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. 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 status indicator "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 outpatient PPS.

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 status indicator 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 status indicator.

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 $100 in increments of $50.

(2) From $100 through $2,000 in intervals of $100.

(3) 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). (See Figure 13-3-2 and Figure 13-3-3 for hospital outpatient deductible and cost-sharing/copayment provisions under Prime, Extra and Standard TRICARE programs.)

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).

(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.

L. OPPS PRICER

1. Common PRICER software will be developed using the following data sources:

a. National APC amounts

b. Payment status by HCPCS code

c. Outpatient provider file

d. DRG wage indexes

e. Multiple surgical procedure discounts

f. Hospital specific cost-to-charge ratios

2. The following data elements will be extracted and forwarded to the outpatient PRICER for line item pricing.

a. Provider specific file data;

b. Units;

c. HCPCS/Modifiers;

d. APC;

e. Status payment indicator;

f. Line item date of service;

g. Primary diagnosis code; and

(a) Other necessary OCE output.

3. The outpatient PRICER will return the line item APC pricing and outlier information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary explanation of benefits (EOB).

M. TRICARE Specific Procedures/Services

1. TRICARE specific APCs have already been assigned for half-day partial hospitalization programs (PHP) and maternity observation stays.

2. Other procedures that are normally covered under TRICARE but not under Medicare will be assigned status indicator "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.

N. Medical Education Costs

1. TRICARE will allow additional payments for certain medical education costs that are not paid under the OPPS. Following are guidelines for payment of educational pass-through costs:

a. Medical education costs must be allowed under the Medicare hospital OPPS in order to be considered for reimbursement under TRICARE.

b. The outpatient educational costs will be separately invoiced on an annual basis as part of the reimbursement process for hospitals (see Chapter 3, Section 2 and Chapter 6, Section 8).

c. Hospitals with outpatient department medical education costs will include appropriate lines from the cost report and the ratio of TRICARE visits to total facility outpatient visits. TRICARE visits will not include any days determined to be not medically necessary, and visits included on claims for which TRICARE made no payment because other health insurance or Medicare paid the full TRICARE allowable amount.

d. The product of the above ratio will equal the portion that TRICARE will pay.

2. The hospital's reimbursement requests will be sent on a voucher to the TMA Finance Office for payment as a pass-through cost (see Chapter 3, Section 3 of the TRICARE Operations Manual).

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