

CHAPTER 13  
SECTION 2

## BILLING AND CODING OF SERVICES UNDER APC GROUPS

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**Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.**

### 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

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 APCs for those services that are unique to the TRICARE beneficiary population (e.g., maternity care).**

#### 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.

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e. Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations.

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

g. Intraocular lenses (IOLs).

h. Capital-related costs.

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

j. Incidental services such as venipuncture.

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

l. Implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices.

2. Costs associated with certain expensive procedures and services are not packaged within an APC payment rate. Instead, separate APC payment will be made for these particular items and services under the OPPS. Additional payments will be provided for certain packaged medical devices, drugs, and biologicals that are eligible for transitional pass-throughs (i.e., payments for expensive drugs or devices that are temporarily reimbursed in addition to the APC amount for the service or procedure to which they are normally associated), while strapping and casting will be paid under two new APC groupings (0058 and 0059).

a. Costs of drugs, biologicals and devices packaged into APCs to which they are normally associated.

The costs of drugs, biologicals and pharmaceuticals are generally packaged into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished. No separate payment is made under the OPPS for drugs, biologicals and pharmaceuticals whose costs are packaged into the APCs with which they are associated.

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

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

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(3) Each time a drug is billed with an administration code, the total payment thus includes the acquisition cost for the billed drug, the packaged cost of all other drugs and the overhead.

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

(1) Special transitional pass-through payments (additional payments) made for at least 2 years, but not more than 3 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 CMS website: <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 \$50, with the exception of injectible and oral forms of antiemetics.

(3) Separately payable radiopharmaceuticals, drugs and biologicals classified as "specified covered outpatient drugs" for which payment was made on a pass-through basis on or before December 31, 2002, and a separate APC exists.

(4) Separate payment for new drugs and biologicals that have assigned HCPCS codes, but that do not have a reference 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.

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(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

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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 OPSS in order to improve the claims data used annually to update the OPSS payment rates.

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

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

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

**C. Treatment of Clinic and Emergency Departments.**

1. Payment groups for medical visits were constructed using level I and II HCPCS procedure codes.

2. Thirty-one (31) HCPCS Level I and II codes were collapsed into six groups, three each for the clinics and the emergency department. The final APC groups for clinic and emergency visits are as follows:

- a. APC 0600 - Low-Level Clinic Visits
- b. APC 0601 - Mid-Level Clinic Visits
- c. APC 0602 - High-Level Clinic Visits
- d. APC 0603 - Interdisciplinary Team Conference
- e. APC 0610 - Low-Level Emergency Visits
- f. APC 0611 - Mid-Level Emergency Visits
- g. APC 0612 - High-Level Emergency Visits
- h. APC 0620 - Critical Care

(1) HCPCS code 99291 is required to report outpatient encounters in which critical care services are furnished.

(2) HCPCS code 99291 is used in place of, but not in addition to, a code for medical visit for an emergency department service.

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3. It is important that each facility accurately assess the intensity, resource use, and charges for evaluation and management (E/M) services. There is interest in developing and implementing a standardized coding process for facility reporting of E/M services. This process could include the use of current HCPCS codes or the establishment of new HCPCS codes in conjunction with guidelines for facility coding.

a. Current coding used in reporting evaluation and management (E/M) services:

(1) Under OPSS, 31 codes are used to indicate visits with payment differentials for more or less intense services.

(2) The following E/M coding should be used in differentiating the level and intensity of services provided in a hospital outpatient setting (i.e., coding used in differentiating clinic and emergency visit services): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, and G0175.

(3) Because HCPCS Level I coding is more descriptive of practitioner than of facility services, hospitals should use HCPCS Level I coding guidelines when applicable, or crosswalk hospital coding structures to HCPCS. For example, a hospital that has 8 levels of emergency and trauma care, depending on nursing ratios, should walk those 8 levels to the HCPCS Level I codes for emergency care.

**D.** Additional payments under the OPSS.

1. Clinical diagnostic testing (labwork).
2. Administration of infused drugs.
3. Therapeutic procedures including resuscitation that are furnished during the course of an emergency visit.
4. Certain high-cost drugs, such as the expensive "clotbuster" drugs that must be given within a short period of time following a heart attack or stroke.
5. Cases that fall far outside the normal range of costs. These cases will be eligible for an outlier adjustment.

**E.** Payment for patients who die in the emergency department.

1. If the patient dies in the emergency department, and the patient's status is outpatient, the hospital should bill for payment under the OPSS for the services furnished.
2. If the emergency department or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient.

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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 status indicator "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 status indicator "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 status indicator "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 13X bill type for all services that were furnished, including the inpatient procedure (e.g., a procedure designated by OPPS payment status indicator "C"). The hospital should include modifier -CA on the line with the HCPCS code for the inpatient procedure.

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.

**F. Medical Screening Examinations.**

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

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

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G. HCPCS/Revenue Coding Required Under OPSS. Hospital outpatient departments should use the UB-92 Editor as a guide for reporting HCPCS and revenue codes under the OPSS.

H. Treatment of Partial Hospitalization Services. **Effective February 1, 2007, hospital-based PHPs (psych and SUDRFs) will be reimbursed a per diem payment under the OPSS. 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 OPSS.**

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

3. Services of physicians, clinical psychologists, clinical nurse specialists (CNSs), nurse practitioners (NPs), and physician assistants (PAs) furnished to partial hospitalization patients will continue to be billed separately as professional services and are not considered to be partial hospitalization services.

4. Payment for partial hospitalization 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 partial hospitalization services for which payment is made to the provider.

a. Hospitals will not bill the contractor for the professional services furnished by CSWs.

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

5. Per diem is the unit of payment since it defines the structure and scheduling of partial hospitalization services. The established per diem represents the median hospital cost of furnishing a day of partial hospitalization. The following are billing instructions for submission of partial hospitalization claims/services:

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

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



**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

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

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I <sup>1</sup> AND II CODES
250	Pharmacy	HCPCS code not required
905	Intensive Outpatient Services - Psychiatric	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
906	Intensive Outpatient Services - Chemical Dependency	
911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
912	Partial Hospitalization Program - Less Intensive (Half-day PHP)	H0035
913	Partial Hospitalization Program - Intensive (Full-day PHP)	H0037
914	Individual Psychotherapy	90816- 90819, 90821- 90824, 90826-90829
915	Group Therapy	90849, 90853, 90857
916	Family Psychotherapy	90846, 90847, 90849
918	Psychiatric Testing	96100, 96115, 96117

<sup>1</sup> HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

c. To bill for partial hospitalization services under the hospital OPPS, hospitals are to use the above HCPCS and revenue codes and are to report partial hospitalization services under bill type 13X, along with condition code 41 on the HCFA-1450 claim form.

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

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**Reporting Requirements for PHP:**

- Bill Type 13x
- Mental Health (MH) Diagnosis
- Condition code 41 (yes/no)
  - **Yes**
    - Authorization on File
      - **Yes**
        - H0035/RC 912 - APC T0001 (half-day PHP)
        - H0037/RC 913 - APC 0033 (full-day PHP)
      - **No** - deny claim
  - **No** (Bill Type 12x, 13x, 14x without condition code 41)
    - Sum of Mental Health APCs >PHP APC 0033 payment amount on a given day (yes/no)
      - **Yes**
        - Assign daily MH service payment APC 0034
        - Package all other MH services
        - Apply standard APC payment rule to non-MH services
      - **No** - Apply standard APC payment rules

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

(2) Specific therapy codes (e.g., coding for family, group and individual psychotherapy) will be reported in addition to designated partial hospitalization codes H0035 and H0037 (refer to [Figure 13-2-1](#) above for specific therapy coding). Specific mental health (MH) services will be packaged into a single PHP code for the same date of service with the exception of electroconvulsive therapy (ECT).

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

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

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

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

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(5) Revenue codes 912 and 913 must be accompanied by an appropriately designated HCPCS code (refer to [Figure 13-2-1](#) for designated PHP coding). If revenue codes 912 and 913 are submitted without a HCPCS, assign status indicator "E" and edit 48 ("revenue center requires HCPCS") which will result in claim denial.

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

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

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

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

**l. Billing and Payment Requirements for Observation Services.**

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

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

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

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

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

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

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

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

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

c. Direct admission to observation will continue to be paid at a rate equal to that of a Low Level Clinic Visit (APC 600) when a beneficiary is seen by a physician in the community and then is directly admitted into a hospital outpatient department for observation care that does not qualify for separate payment under APC 0339, and under T0001.

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

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

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

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

d. Criteria for separate observation payments include:

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

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

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

1 The qualifying ICD-9-CM diagnosis code must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both, in order for the hospital to receive separate payment for APC 0339.

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

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

FIGURE 13-2-2 REQUIRED DIAGNOSES FOR CHEST PAIN

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

FIGURE 13-2-3 REQUIRED DIAGNOSES FOR ASTHMA

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

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

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

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

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

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY

ICD-9-CM	DESCRIPTION
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

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

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

ICD-9-CM	DESCRIPTION
V23.2	Pregnancy with history of abortion
V23.3	Grand multiparity
V23.4	Pregnancy with other poor obstetric history
V23.41	Pregnancy with history of pre-term labor
V23.49	Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor reproductive history
V23.7	Insufficient prenatal care
V23.8	Other high-risk pregnancy
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	Ectopic pregnancy
633.0	Abdominal pregnancy
633.00	Abdominal pregnancy without intrauterine pregnancy
633.01	Abdominal pregnancy with intrauterine pregnancy
633.1	Tubal pregnancy
633.10	Tubal pregnancy without intrauterine pregnancy
633.11	Tubal pregnancy with intrauterine pregnancy
633.2	Ovarian pregnancy
633.20	Ovarian pregnancy without intrauterine pregnancy
633.21	Ovarian pregnancy with intrauterine pregnancy
633.8	Other ectopic pregnancy
633.80	Other ectopic pregnancy without intrauterine pregnancy
633.81	Other ectopic pregnancy with intrauterine pregnancy
633.9	Unspecified ectopic pregnancy
633.90	Unspecified ectopic pregnancy without intrauterine pregnancy
633.91	Unspecified ectopic pregnancy with intrauterine pregnancy

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
640	Hemorrhage in early pregnancy
640.0	Threatened abortion
640.00	Unspecified as to episode of care or not applicable
640.01	Delivered, with or without mention of antepartum condition
640.03	Antepartum condition or complication
640.8	Other specified hemorrhage in early pregnancy
640.80	Unspecified as to episode of care or not applicable
640.81	Delivered, with or without mention of antepartum condition
640.83	Antepartum condition or complication
640.9	Unspecified hemorrhage in early pregnancy
640.90	Unspecified as to episode of care or not applicable
640.91	Delivered, with or without mention of antepartum condition
640.93	Antepartum condition or complication
641	Antepartum hemorrhage, abruption placentae, and placenta previa
641.0	Placenta previa without hemorrhage
641.00	Unspecified as to episode of care or not applicable
641.01	Delivered, with or without mention of antepartum condition
641.03	Antepartum condition or complication
641.1	Hemorrhage from placenta previa
641.10	Unspecified as to episode of care or not applicable
641.11	Delivered, with or without mention of antepartum condition
641.13	Antepartum condition or complication
641.2	Premature separation of placenta
641.20	Unspecified as to episode of care or not applicable
641.21	Delivered, with or without mention of antepartum condition
641.23	Antepartum condition or complication
641.3	Antepartum hemorrhage associated with coagulation defects
641.30	Unspecified as to episode of care or not applicable
641.31	Delivered, with or without mention of antepartum condition
641.33	Antepartum condition or complication
641.8	Other antepartum hemorrhage
641.80	Unspecified as to episode of care or not applicable
641.81	Delivered, with or without mention of antepartum condition



TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
641.83	Antepartum condition or complication
641.9	Unspecified antepartum hemorrhage
641.90	Unspecified as to episode of care or not applicable
641.91	Delivered, with or without mention of antepartum condition
641.93	Antepartum condition or complication
642	Hypertension complicating pregnancy, childbirth, and the puerperium
642.0	Benign essential hypertension complicating pregnancy, childbirth and the puerperium
642.00	Unspecified as to episode of care or not applicable
642.01	Delivered, with or without mention of antepartum condition
642.02	Delivered, with mention of postpartum complication
642.03	Antepartum condition or complication
642.04	Postpartum condition or complication
642.1	Hypertension secondary to renal disease, complicating pregnancy, childbirth and the puerperium
642.10	Unspecified as to episode of care or not applicable
642.11	Delivered, with or without mention of antepartum condition
642.12	Delivered, with mention of postpartum complication
642.13	Antepartum condition or complication
642.14	Postpartum condition or complication
642.2	Other pre-existing hypertension complicating pregnancy, childbirth and the puerperium
642.20	Unspecified as to episode of care or not applicable
642.21	Delivered, with or without mention of antepartum condition
642.22	Delivered, with mention of postpartum complication
642.23	Antepartum condition or complication
642.24	Postpartum condition or complication
642.3	Transient hypertension of pregnancy
642.30	Unspecified as to episode of care or not applicable
642.31	Delivered, with or without mention of antepartum condition
642.32	Delivered, with mention of postpartum complication
642.33	Antepartum condition or complication
642.34	Postpartum condition or complication
642.4	Mild or unspecified pre-eclampsia

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
642.40	Unspecified as to episode of care or not applicable
642.41	Delivered, with or without mention of antepartum condition
642.42	Delivered, with mention of postpartum complication
642.43	Antepartum condition or complication
642.44	Postpartum condition or complication
642.5	Severe pre-eclampsia
642.50	Unspecified as to episode of care or not applicable
642.51	Delivered, with or without mention of antepartum condition
642.52	Delivered, with mention of postpartum complication
642.53	Antepartum condition or complication
642.54	Postpartum condition or complication
642.6	Eclampsia
642.60	Unspecified as to episode of care or not applicable
642.61	Delivered, with or without mention of antepartum condition
642.62	Delivered, with mention of postpartum complication
642.63	Antepartum condition or complication
642.64	Postpartum condition or complication
642.7	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension
642.70	Unspecified as to episode of care or not applicable
642.71	Delivered, with or without mention of antepartum condition
642.72	Delivered, with mention of postpartum complication
642.73	Antepartum condition or complication
642.74	Postpartum condition or complication
642.9	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium
642.90	Unspecified as to episode of care or not applicable
642.91	Delivered, with or without mention of antepartum condition
642.92	Delivered, with mention of postpartum complication
642.93	Antepartum condition or complication
642.94	Postpartum condition or complication
643	Excessive vomiting in pregnancy
643.0	Mild hyperemesis gravidarum
643.00	Unspecified as to episode of care or not applicable

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
643.01	Delivered, with or without mention of antepartum condition
643.03	Antepartum condition or complication
643.1	Hyperemesis gravidarum with metabolic disturbance
643.10	Unspecified as to episode of care or not applicable
643.11	Delivered, with or without mention of antepartum condition
643.13	Antepartum condition or complication
643.2	Late vomiting of pregnancy
643.20	Unspecified as to episode of care or not applicable
643.21	Delivered, with or without mention of antepartum condition
643.23	Antepartum condition or complication
643.8	Other vomiting complicating pregnancy
643.80	Unspecified as to episode of care or not applicable
643.81	Delivered, with or without mention of antepartum condition
643.83	Antepartum condition or complication
643.9	Unspecified vomiting of pregnancy
643.90	Unspecified as to episode of care or not applicable
643.91	Delivered, with or without mention of antepartum condition
643.93	Antepartum condition or complication
644	Early or threatened labor
644.0	Threatened premature labor
644.00	Unspecified as to episode of care or not applicable
644.03	Antepartum condition or complication
644.1	Other threatened labor
644.10	Unspecified as to episode of care or not applicable
644.13	Antepartum condition or complication
644.2	Early onset of delivery
644.20	Unspecified as to episode of care or not applicable
644.21	Delivered, with or without mention of antepartum condition
645	Late pregnancy
645.1	Post term pregnancy
645.10	Unspecified as to episode of care or not applicable
645.11	Delivered, with or without mention of antepartum condition
645.13	Antepartum condition or complication

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
645.2	Prolonged pregnancy
645.20	Unspecified as to episode of care or not applicable
645.21	Delivered, with or without mention of antepartum condition
645.23	Antepartum condition or complication
646	Other complications of pregnancy, not otherwise classified
646.0	Papyraceous fetus
646.00	Unspecified as to episode of care or not applicable
646.01	Delivered, with or without mention of antepartum condition
646.03	Antepartum condition or complication
646.1	Edema or excessive weight gain in pregnancy, without mention of hypertension
646.10	Unspecified as to episode of care or not applicable
646.11	Delivered, with or without mention of antepartum condition
646.12	Delivered, with mention of postpartum complication
646.13	Antepartum condition or complication
646.14	Postpartum condition or complication
646.2	Unspecified renal disease in pregnancy, without mention of hypertension
646.20	Unspecified as to episode of care or not applicable
646.21	Delivered, with or without mention of antepartum condition
646.22	Delivered, with mention of postpartum complication
646.23	Antepartum condition or complication
646.24	Postpartum condition or complication
646.3	Habitual aborter
646.30	Unspecified as to episode of care or not applicable
646.31	Delivered, with or without mention of antepartum condition
646.33	Antepartum condition or complication
646.4	Peripheral neuritis in pregnancy
646.40	Unspecified as to episode of care or not applicable
646.41	Delivered, with or without mention of antepartum condition
646.42	Delivered, with mention of postpartum complication
646.43	Antepartum condition or complication
646.44	Postpartum condition or complication
646.5	Asymptomatic bacteriuria in pregnancy

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
646.50	Unspecified as to episode of care or not applicable
646.51	Delivered, with or without mention of antepartum condition
646.52	Delivered, with mention of postpartum complication
646.53	Antepartum condition or complication
646.54	Postpartum condition or complication
646.6	Infections of genitourinary tract in pregnancy
646.60	Unspecified as to episode of care or not applicable
646.61	Delivered, with or without mention of antepartum condition
646.62	Delivered, with mention of postpartum complication
646.63	Antepartum condition or complication
646.64	Postpartum condition or complication
646.7	Liver disorders in pregnancy
646.70	Unspecified as to episode of care or not applicable
646.71	Delivered, with or without mention of antepartum condition
646.73	Antepartum condition or complication
646.8	Other specified complications of pregnancy
646.80	Unspecified as to episode of care or not applicable
646.81	Delivered, with or without mention of antepartum condition
646.82	Delivered, with mention of postpartum complication
646.83	Antepartum condition or complication
646.84	Postpartum condition or complication
646.9	Unspecified complication of pregnancy
646.90	Unspecified as to episode of care or not applicable
646.91	Delivered, with or without mention of antepartum condition
646.93	Antepartum condition or complication
647	Infectious and parasitic conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium
647.0	Syphilis
647.00	Unspecified as to episode of care or not applicable
647.01	Delivered, with or without mention of antepartum condition
647.02	Delivered, with mention of postpartum complication
647.03	Antepartum condition or complication
647.04	Postpartum condition or complication

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
647.1	Gonorrhea
647.10	Unspecified as to episode of care or not applicable
647.01	Delivered, with or without mention of antepartum condition
647.02	Delivered, with mention of postpartum complication
647.03	Antepartum condition or complication
647.04	Postpartum condition or complication
647.2	Other venereal diseases
647.20	Unspecified as to episode of care or not applicable
647.21	Delivered, with or without mention of antepartum condition
647.22	Delivered, with mention of postpartum complication
647.23	Antepartum condition or complication
647.24	Postpartum condition or complication
647.3	Tuberculosis
647.30	Unspecified as to episode of care or not applicable
647.31	Delivered, with or without mention of antepartum condition
647.32	Delivered, with mention of postpartum complication
647.33	Antepartum condition or complication
647.34	Postpartum condition or complication
647.4	Malaria
647.40	Unspecified as to episode of care or not applicable
647.41	Delivered, with or without mention of antepartum condition
647.42	Delivered, with mention of postpartum complication
647.43	Antepartum condition or complication
647.44	Postpartum condition or complication
647.5	Rubella
647.50	Unspecified as to episode of care or not applicable
647.51	Delivered, with or without mention of antepartum condition
647.52	Delivered, with mention of postpartum complication
647.53	Antepartum condition or complication
647.54	Postpartum condition or complication
647.6	Other viral diseases
647.60	Unspecified as to episode of care or not applicable
647.61	Delivered, with or without mention of antepartum condition

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
647.62	Delivered, with mention of postpartum complication
647.63	Antepartum condition or complication
647.64	Postpartum condition or complication
647.8	Other specified infectious and parasitic diseases
647.80	Unspecified as to episode of care or not applicable
647.81	Delivered, with or without mention of antepartum condition
647.82	Delivered, with mention of postpartum complication
647.83	Antepartum condition or complication
647.84	Postpartum condition or complication
648	Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium
648.0	Diabetes mellitus
648.00	Unspecified as to episode of care or not applicable
648.01	Delivered, with or without mention of antepartum condition
648.02	Delivered, with mention of postpartum complication
648.03	Antepartum condition or complication
648.04	Postpartum condition or complication
648.1	Thyroid dysfunction
648.10	Unspecified as to episode of care or not applicable
648.11	Delivered, with or without mention of antepartum condition
648.12	Delivered, with mention of postpartum complication
648.13	Antepartum condition or complication
648.14	Postpartum condition or complication
648.2	Anemia
648.20	Unspecified as to episode of care or not applicable
648.21	Delivered, with or without mention of antepartum condition
648.22	Delivered, with mention of postpartum complication
648.23	Antepartum condition or complication
648.24	Postpartum condition or complication
648.3	Drug dependence
648.30	Unspecified as to episode of care or not applicable
648.31	Delivered, with or without mention of antepartum condition
648.32	Delivered, with mention of postpartum complication

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
648.33	Antepartum condition or complication
648.34	Postpartum condition or complication
648.4	Mental disorders
648.40	Unspecified as to episode of care or not applicable
648.41	Delivered, with or without mention of antepartum condition
648.42	Delivered, with mention of postpartum complication
648.43	Antepartum condition or complication
648.44	Postpartum condition or complication
648.5	Congenital cardiovascular disorders
648.50	Unspecified as to episode of care or not applicable
648.51	Delivered, with or without mention of antepartum condition
648.52	Delivered, with mention of postpartum complication
648.53	Antepartum condition or complication
648.54	Postpartum condition or complication
648.6	Other cardiovascular diseases
648.60	Unspecified as to episode of care or not applicable
648.61	Delivered, with or without mention of antepartum condition
648.62	Delivered, with mention of postpartum complication
648.63	Antepartum condition or complication
648.64	Postpartum condition or complication
648.7	Bone and joint disorders of back, pelvis, and lower limbs
648.70	Unspecified as to episode of care or not applicable
648.71	Delivered, with or without mention of antepartum condition
648.72	Delivered, with mention of postpartum complication
648.73	Antepartum condition or complication
648.74	Postpartum condition or complication
648.8	Abnormal glucose tolerance
648.80	Unspecified as to episode of care or not applicable
648.81	Delivered, with or without mention of antepartum condition
648.82	Delivered, with mention of postpartum complication
648.83	Antepartum condition or complication
648.84	Postpartum condition or complication
648.9	Other current conditions classifiable elsewhere



TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
648.90	Unspecified as to episode of care or not applicable
648.91	Delivered, with or without mention of antepartum condition
648.92	Delivered, with mention of postpartum complication
648.93	Antepartum condition or complication
648.94	Postpartum condition or complication
651	Multiple gestation
651.0	Twin pregnancy
651.00	Unspecified as to episode of care or not applicable
651.01	Delivered, with or without mention of antepartum condition
651.03	Antepartum condition or complication
651.1	Triplet pregnancy
651.10	Unspecified as to episode of care or not applicable
651.11	Delivered, with or without mention of antepartum condition
651.13	Antepartum condition or complication
651.2	Quadruplet pregnancy
651.20	Unspecified as to episode of care or not applicable
651.21	Delivered, with or without mention of antepartum condition
651.23	Antepartum condition or complication
651.3	Twin pregnancy with fetal loss and retention of one fetus
651.30	Unspecified as to episode of care or not applicable
651.31	Delivered, with or without mention of antepartum condition
651.33	Antepartum condition or complication
651.4	Triplet pregnancy with fetal loss and retention of one or more fetus(es)
651.40	Unspecified as to episode of care or not applicable
651.41	Delivered, with or without mention of antepartum condition
651.43	Antepartum condition or complication
651.5	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es)
651.50	Unspecified as to episode of care or not applicable
651.51	Delivered, with or without mention of antepartum condition
651.53	Antepartum condition or complication
651.6	Other multiple pregnancy with fetal loss and retention of one or more fetus(es)
651.60	Unspecified as to episode of care or not applicable
651.61	Delivered, with or without mention of antepartum condition

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
651.63	Antepartum condition or complication
651.8	Other specified multiple gestation
651.80	Unspecified as to episode of care or not applicable
651.81	Delivered, with or without mention of antepartum condition
651.83	Antepartum condition or complication
651.9	Unspecified multiple gestation
651.90	Unspecified as to episode of care or not applicable
651.91	Delivered, with or without mention of antepartum condition
651.93	Antepartum condition or complication
655	Known or suspected fetal abnormality affecting management of mother
655.0	Central nervous system malformation in fetus
655.00	Unspecified as to episode of care or not applicable
655.01	Delivered, with or without mention of antepartum condition
655.03	Antepartum condition or complication
655.1	Chromosomal abnormality in fetus
655.10	Unspecified as to episode of care or not applicable
655.11	Delivered, with or without mention of antepartum condition
655.13	Antepartum condition or complication
655.2	Hereditary disease in family possibly affecting fetus
655.20	Unspecified as to episode of care or not applicable
655.21	Delivered, with or without mention of antepartum condition
655.23	Antepartum condition or complication
655.3	Suspected damage to fetus from viral disease in the mother
655.30	Unspecified as to episode of care or not applicable
655.31	Delivered, with or without mention of antepartum condition
655.33	Antepartum condition or complication
655.4	Suspected damage to fetus from other disease in the mother
655.40	Unspecified as to episode of care or not applicable
655.41	Delivered, with or without mention of antepartum condition
655.43	Antepartum condition or complication
655.5	Suspected damage to fetus from drugs
655.50	Unspecified as to episode of care or not applicable
655.51	Delivered, with or without mention of antepartum condition

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
655.53	Antepartum condition or complication
655.6	Suspected damage to fetus from radiation
655.60	Unspecified as to episode of care or not applicable
655.61	Delivered, with or without mention of antepartum condition
655.63	Antepartum condition or complication
655.7	Decreased fetal movements
655.70	Unspecified as to episode of care or not applicable
655.71	Delivered, with or without mention of antepartum condition
655.73	Antepartum condition or complication
655.8	Other known or suspected fetal abnormality, not elsewhere classified
655.80	Unspecified as to episode of care or not applicable
655.81	Delivered, with or without mention of antepartum condition
655.83	Antepartum condition or complication
655.9	Unspecified
655.90	Unspecified as to episode of care or not applicable
655.91	Delivered, with or without mention of antepartum condition
655.93	Antepartum condition or complication
656	Other fetal and placental problems affecting management of mother
656.0	Fetal-maternal hemorrhage
656.00	Unspecified as to episode of care or not applicable
656.01	Delivered, with or without mention of antepartum condition
656.03	Antepartum condition or complication
656.1	Rhesus isoimmunization
656.10	Unspecified as to episode of care or not applicable
656.11	Delivered, with or without mention of antepartum condition
656.13	Antepartum condition or complication
656.2	Isoimmunization from other and unspecified blood-group incompatibility
656.20	Unspecified as to episode of care or not applicable
656.21	Delivered, with or without mention of antepartum condition
656.23	Antepartum condition or complication
656.3	Fetal distress
656.30	Unspecified as to episode of care or not applicable
656.31	Delivered, with or without mention of antepartum condition

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
656.33	Antepartum condition or complication
656.4	Intrauterine death
656.40	Unspecified as to episode of care or not applicable
656.41	Delivered, with or without mention of antepartum condition
656.43	Antepartum condition or complication
656.5	Poor fetal growth
656.50	Unspecified as to episode of care or not applicable
656.51	Delivered, with or without mention of antepartum condition
656.53	Antepartum condition or complication
656.6	Excessive fetal growth
656.60	Unspecified as to episode of care or not applicable
656.61	Delivered, with or without mention of antepartum condition
656.63	Antepartum condition or complication
656.7	Other placental conditions
656.70	Unspecified as to episode of care or not applicable
656.71	Delivered, with or without mention of antepartum condition
656.73	Antepartum condition or complication
656.8	Other specified fetal and placental problems
656.80	Unspecified as to episode of care or not applicable
656.81	Delivered, with or without mention of antepartum condition
656.83	Antepartum condition or complication
656.9	Unspecified fetal and placental problem
656.90	Unspecified as to episode of care or not applicable
656.91	Delivered, with or without mention of antepartum condition
656.93	Antepartum condition or complication
657	Polyhydramnios
657.0	Unspecified as to episode of care or not applicable
657.1	Delivered, with or without mention of antepartum condition
657.3	Antepartum condition or complication
658	Other problems associated with amniotic cavity and membranes
658.0	Oligohydramnios
658.00	Unspecified as to episode of care or not applicable
658.01	Delivered, with or without mention of antepartum condition

Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.

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

ICD-9-CM	DESCRIPTION
658.03	Antepartum condition or complication
658.1	Premature rupture of membranes
658.10	Unspecified as to episode of care or not applicable
658.11	Delivered, with or without mention of antepartum condition
658.13	Antepartum condition or complication
658.2	Delayed delivery after spontaneous or unspecified rupture of membranes
658.20	Unspecified as to episode of care or not applicable
658.21	Delivered, with or without mention of antepartum condition
658.23	Antepartum condition or complication
658.3	Delayed delivery after artificial rupture of membrane
658.30	Unspecified as to episode of care or not applicable
658.31	Delivered, with or without mention of antepartum condition
658.33	Antepartum condition or complication
658.4	Infection of amniotic cavity
658.40	Unspecified as to episode of care or not applicable
658.41	Delivered, with or without mention of antepartum condition
658.43	Antepartum condition or complication
658.8	Other
658.80	Unspecified as to episode of care or not applicable
658.81	Delivered, with or without mention of antepartum condition
658.83	Antepartum condition or complication
658.9	Unspecified
658.90	Unspecified as to episode of care or not applicable
658.91	Delivered, with or without mention of antepartum condition
658.93	Antepartum condition or complication

(2) Observation time requirements.

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

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

(c) A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care

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furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

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

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

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

- 1 An emergency department visit (APC 0310, 0611, or 0612); or
- 2 A clinic visit (APC 0600, 0601, or 0602); or
- 3 Critical care (APC 0620); or
- 4 Direct admission to observation services using HCPCS code

G0379 (APC 0600).

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

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

(4) Ongoing physician evaluation.

(c) The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

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

e. Additional billing requirements.

(1) Separate payment for observation stays that meet the required conditions are only allowed when billed as a 13X bill type.

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

**Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.**

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

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

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

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

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

#### J. Inpatient Only Procedures.

1. The inpatient list found in [Chapter 13, Addendum D](#) 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.

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 OPFS:

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.

**Note: This reimbursement system is tentatively scheduled to become effective on February 1, 2007.**

3. Under the hospital outpatient PPS, payment will not be made for procedures that are designated as "inpatient only" (list of "inpatient only" procedures found in [Chapter 13, Addendum D](#)).

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 status indicator "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 status indicator "C" that is performed on an elective basis or scheduled to be performed on a patient whose status is that of an outpatient.

#### **K. APC For Vaginal Hysterectomy**

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

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