CHAPTER 1
SECTION 24

HOSPITAL REIMBURSEMENT - OUTPATIENT SERVICES FOR ALL SERVICES ON OR BEFORE MAY 1, 2009 (IMPLEMENTATION OF OPPS), AND THEREAFTER, FOR SERVICES NOT OTHERWISE REIMBURSED UNDER HOSPITAL OPPS

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

I. APPLICABILITY

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

II. ISSUE

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

III. POLICY

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

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

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

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

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

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

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

G. Industry standard modifiers and condition codes may be billed on outpatient hospital claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers are essential for ensuring accurate processing and payment of these claims.

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