CHAPTER 13
SECTION 3

PROSPECTIVE PAYMENT METHODOLOGY

ISSUE DATE: July 27, 2005
AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

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 the TRICARE Management Activity (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 Ambulatory Payment Classification (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 statewide Cost-to-Charge Ratio (CCR) is identified for each hospital's cost center ("statewide CCRs") and applied based on the from date on the claim.

(b) The statewide 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 statewide 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 could be packaged into major Healthcare Common Procedure Coding System (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
0250	Pharmacy, Drugs Requiring Specific Identification, General Class
0251	Generic
0252	Nongeneric
0253	Take Home Drugs
0254	Pharmacy Incident to Other Diagnostic
0255	Pharmacy Incident to Radiology
0257	Nonprescription Drugs
0258	IV Solutions
0259	Other Pharmacy
0260	IV Therapy, General Class
0262	IV Therapy/Pharmacy Services
0263	Supply/Delivery
0264	IV Therapy/Supplies
0269	Other IV Therapy
0270	M&S Supplies
0271	Nonsterile Supplies
0272	Sterile Supplies
0273	Take Home supplies
0275	Pacemaker Drug
0276	Intraocular Lens Source Drug
0277	Oxygen Take Home
0278	Other Implants
0279	Other M&S Supplies
0280	Oncology
0289	Other Oncology
0370	General Classification
0371	Anesthesia Incident to Radiology
0372	Anesthesia Incident to Other Diagnostic Services
0374	Acupuncture

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

REVENUE CODE	DESCRIPTION
0379	Other Anesthesia
0390	Blood Storage and Processing
0391	Blood Administration (e.g., transfusions)
0399	Other Blood Storage and Processing
0621	Supplies Incident to Radiology
0622	Supplies Incident to Other Diagnostic
0623	Surgical Dressings
0624	Investigational Device (IDE)
0631	Single Source
0632	Multiple
0633	Restrictive Prescription
0637	Self-Administered Drug (Insulin Admin. in Emergency Diabetic COMA)
0700	Cast Room
0709	Other Cast Room
0710	Recovery Room
0719	Other Recovery Room
0720	Labor Room
0721	Labor
0762	Observation Room
0770	General Classification
0771	Vaccine Administration

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, refer to the TRICARE Systems Manual (TSM), Chapter 2, Addendum O, for reporting requirements.

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. Sixty percent (60%) 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 00606 (mid-level clinic visit), Outpatient Prospective Payment System (OPPS) weights are listed on TMA's OPPS web site at http://www.tricare.mil/opps.

(j) These relative payment weights may be further adjusted for budget neutrality based on a comparison of aggregate payments using previous and current CY weights.

b. Conversion Factor Update.

(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, differences in estimated pass-through payments, and outlier payments.

(3) The market basket increase update factor of 3.6% for CY 2009, the required wage index budget neutrality adjustment of approximately 1.0013, and the adjustment of 0.02% of projected OPPS spending for the difference in the pass-through set aside resulted in a full market basket conversion factor for CY 2009 of $66.059.

3. Payment Status Indicators (SIs).

A payment SI 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 OPPS; 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, SI is assigned to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same SI as the APC to which it is assigned. The following are the payment SIs 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, CHAMPUS Maximum Allowable Charge (CMAC) reimbursement methodology for physicians, or State prevailings.

b. **B** to indicate more appropriate code required for TRICARE OPPS.

c. **C** to indicate inpatient services that are not paid under the OPPS.

d. **E** to indicate items or services are not covered 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 Certified Registered Nurse Anesthetist (CRNA) services and hepatitis B vaccines that are paid on an allowable charge basis.

f. **G** to indicate drug/biological pass-through that are paid in separate APCs under the OPPS.

g. **H** to indicate pass-through device categories and radiopharmaceutical agents allowed on a cost basis.

h. **K** to indicate non-pass-through drugs and biologicals that are paid in separate APCs under the OPPS.

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 (PHPs).

k. **Q** to indicate packaged services subject to separate payment under OPPS.

l. **Q1** to indicate packaged APC payment if billed on the same date of service as a HCPCS code assigned SI of **S**, **T**, **V**, and **X**. In all other circumstances, payment is made through a separate APC payment.

m. **Q2** to indicate APC payment if billed on the same date of service as a HCPCS code assigned SI of **T**. In all other circumstances, payment is made through a separate APC payment.

n. **Q3** to indicate composite APC payment based on OPPS composite specific payment criteria. Payment is packaged into single payment for specific combinations of service. In all circumstances, payment is made through a separate APC payment for those services.

NOTE: HCPCS codes with SI of **Q** are either separately payable or packaged depending on the specific circumstances of their billing. Outpatient Code Editor (OCE) claims processing logic will be applied to codes assigned SI of **Q** in order to determine if the service will be packaged or separately payable.

o. **R** to indicate separate APC payment for blood and blood products.

p. **S** to indicate significant procedures for which payment is allowed under the hospital OPPS, but to which the multiple procedure reduction does not apply.

q. **T** to indicate surgical services for which payment is allowed under the hospital OPPS. Services with this payment indicator are the only services to which the multiple procedure payment reduction applies.

r. **U** to indicate separate APC payment for brachytherapy sources.

s. **V** to indicate medical visits (including clinic or emergency department (ED) visits) for which payment is allowed under the hospital OPPS.

t. **W** to indicate invalid HCPCS or invalid revenue code with blank HCPCS.

u. **X** to indicate an ancillary service for which payment is allowed under the hospital OPPS.

v. **Z** to indicate valid revenue code with blank HCPCS and no other SI assigned.

w. **TB** to indicate TRICARE reimbursement not allowed for CPT/HCPCS code submitted.

NOTE: The system payment logic looks to the SIs attached to the HCPCS codes and APCs for direction in the processing of the claim. A SI, as well as an APC, must be assigned so that payment can be made for the service identified by the new code. The SIs identified for each HCPCS code and each APC listed on TMA's OPPS web site at http://www.tricare.mil/opps.

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 TMA's OPPS web site at http://www.tricare.mil/opps 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 OPPS 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 OPPS Provider File with Wage Indexes on TMA's OPPS home page at http://www.tricare.mil/opps for annual Diagnostic Related Group (DRG) wage indexes used in the payment of hospital outpatient claims, effective January 1 of each year.)

(2) Multiply the wage adjusted APC payment rate by the OPPS rural adjustment (1.071) if the provider is a Sole Community Hospital (SCH) in a rural area with 100 or more beds. Effective January 1, 2010, the OPPS rural adjustment will apply to all SCHs in rural areas.

(3) Determine any outlier amounts and add them to the sum of either paragraph III.A.4.d.(1) or (2).

(4) 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). Refer to Chapter 2, Addendum A for applicable deductible and/or cost-sharing/copayment amounts for Outpatient Hospital Departments and Ambulatory Surgery Centers (ASCs).

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 (ADFM) 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 ADFM 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% of the adjusted APC payment rate for ADFMs 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 ADFM subject to an individual $50 deductible (active duty sponsor is an E-3) and 20% cost-share.

(a) Adjusted APC payment rate: $400.

(b) Subtract any applicable deductible: $400 - $50 = $350

(c) Subtract the standard ADFM cost-share (i.e., 20% 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 with the exception of APCs with SIs of **K**, **G**, **H**, **R**, and **U**. The hospital DRG wage index will be used given the inseparable, subordinate status of the outpatient department within the hospital.

(2) The OPPS will use the same wage index changes as the TRICARE DRG-based payment system, except the effective date for the changes will be January 1 of each year instead of October 1 (refer to the OPPS Provider File with Wage Indexes on TMA's OPPS home page at http://www.tricare.mil/opps.

(3) Temporary Transitional Payment Adjustments (TTPAs) are wage adjusted. The Transitional, General, and non-network Temporary Military Contingency Payment Adjustments (TMCPAs) are not wage adjusted.

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

(5) Steps in Applying Wage Adjusts under OPPS.

(a) Calculate 60% (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 paragraph III.A.5.a.(5)(b) and (c) by the amount under paragraph III.A.5.a.(5)(a) that represents the labor-related portion of the national unadjusted payment rate.

(d) Calculate 40% (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product in paragraph III.A.5.a.(5)(d). The result is the wage index adjusted payment rate for the relevant wage index area.

(e) If a provider is a SCH in a rural area, or is treated as being in a rural area, multiply the wage adjusted payment rate by 1.071 to calculate the total payment before applying the deductible and copayment/cost-sharing amounts.

(f) 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 ADFM is $60.80 (i.e., 20% 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%), and the nonlabor-related portion of the payment rate is $120 ($300 x 40%). It is assumed that the beneficiary deductible has been met.

NOTE: Units billed x APC x 60% (labor portion) x wage index (hospital specific) + APC x 40% (nonlabor portion) = adjusted payment rate.

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

= ($180 x 1.0234) = $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 and Terminating Procedures.

(1) OPPS 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 for additional guidelines on discounting of surgical procedures.

(a) Line items with a SI 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 SI of **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 should not occur, and for type **T** procedures, have the discounting factor set so as to result in the equivalent of a single procedure. Line items with terminated bilateral procedures or terminated procedure with units greater than one are denied.

(3) For non-type **T** procedures there is no multiple procedure discounting and no bilateral procedure discounting with modifier 50 performed. Line items with SI other than **T** are subject to terminated procedure discounting when modifier 52 or 73 is present. Modifier 52 or 73 on a non-type **T** procedure line will result in a 50% discount being applied to that line.

(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 13-3-2 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
9	2D/U
Where:	**D** = discounting fraction (currently 0.5) **U** = number of units **T** = terminated procedure discount (currently 0.5)
*These discount formulas are discounted prior to OPPS implementation.	

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

FIGURE 13-3-3 APPLICATION OF DISCOUNTING FORMULAS

			DISCOUNTING FORMULA NUMBER			
			TYPE "T" PROCEDURE		NON-TYPE "T" PROCEDURE	
PAYMENT AMOUNT	MODIFIER 52 OR 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	3	3
Highest	No	Yes	4	2	8*	1
Highest	Yes	Yes	3	3	3	3
Not Highest	No	No	5	5	1	1
Not Highest	Yes	No	3	3	3	3
Not Highest	No	Yes	9	5	8*	1
Not Highest	Yes	Yes	3	3	3	3
For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (**T**) any applicable offset, will be applied prior to selecting the **T** procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first before the terminated procedure discount. *If not terminated, non-type T Conditional bilateral procedures with modifier 50 will be assigned discount formula #8. Non-type T Independent bilateral procedures with modifier 50 will be assigned to formula # 8. **If modifier 50 is present on an independent or conditional bilateral line that has a composite APC or a separately paid STVX/T-packaged procedure, the modifier is ignored in assigning the discount formula.						

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.

(8) In those instances where more than one bilateral procedure and they are medically necessary and appropriate, hospitals are advised to report the procedure with a modifier -76 (repeat procedure or service by same physician) in order for the claim to process correctly.

d. Multiple discounting will not be applied to the following CPT[1] procedure codes for venipuncture, fetal monitoring and collection of blood specimens: 36400 - 36416, 36591, 36592, 59020, 59025, and 59050 - 59051.

e. Outlier Payments.

An additional payment is provided for outpatient services for which a hospital's charges, adjusted to cost, exceed the sum of the wage adjusted APC rate plus a fixed dollar threshold and a fixed multiple of the wage adjusted APC rate. Only line item services with SIs of **P**, **R**, **S**, **T**, **V**, or **X** will be eligible for outlier payment under OPPS. No outlier payments will be calculated for line item services with SIs of **G**, **H**, **K**, **N**, and **U** with the exception of blood and blood products.

(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 CY basis which requires that a hospital's cost for a service exceed the wage adjusted APC payment rate for that service by a specified multiple of the wage adjusted APC payment rate and the sum of the wage adjusted APC rate plus a fixed dollar threshold ($1,800 for CY 2009) 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.

(4) Outlier payments are not subject to cost-sharing.

(5) TTPAs and TMCPAs shall not be included in cost outlier calculations.

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(6) Example of outlier payment calculation.

EXAMPLE: Following are the steps involved in determining if services on a claim qualify for outlier payments using the appropriate CY multiple and fixed dollar thresholds.

STEP 1: Identify all APCs on the claim.

STEP 2: Determine the ratio of each wage adjusted APC payment to the total payment of the claim (assume for this example a wage index of 1.0000).

HCPCS CODE	SI	APC	SERVICE	WAGE ADJUSTED APC PAYMENT RATE	RATIO OF APC TO TOTAL PAYMENT
99285	V	0616	Level 5 Emergency Visit	$315.51	0.5107157
70481	S	0283	CT scan with contrast material	$277.48	0.4491566
93041	S	0099	Electrocardiogram	$24.79	0.0401275

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

REVENUE CODE	OPPS SERVICE OR SUPPLY	TOTAL CHARGES
0250	Pharmacy	$3,435.50
0270	Medical Supplies	$4,255.80
0350	CT scan	$3,957.00
0450	Emergency Room	$2,986.00
0730	Electrocardiogram	$336.00

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

APC	RATIO ALLOCATION	OPPS SERVICE	250 (PHARMACY)	270 (MEDICAL SUPPLIES)
0616	0.5107157	Level 5 Emergency Visit	$1,754.56	$2,173.50
0283	0.4491566	CT scan with contrast material	$1,543.08	$1,911.52
0099	0.0401275	Electrocardiogram	$137.36	$170.77

STEP 5: Calculate the total charges for each OPPS service (APC) and reduce them to costs by applying the statewide CCR. Statewide CCRs are based on the geographical CBSA (two digit = rural, five digit = urban). Assume that the outpatient CCR is 31.4%.

APC	OPPS SERVICE	TOTAL CHARGES	TOTAL CHARGES REDUCED TO COSTS (CCR = 0.3140)
0616	Level 5 Emergency Visit	$6,914.06	$2,170.01
0283	CT scan with contrast material	$7,411.60	$2,327.24
0099	Electrocardiogram	$644.63	$202.41

STEP 6: Apply the cost test to each wage adjusted APC service or procedure to determine if it qualifies for an outlier payment. If the cost of a service (wage adjusted APC) exceeds both the APC multiplier threshold (1.75 times the wage adjusted APC payment rate) and the fixed dollar threshold (wage adjusted APC rate plus $1,800), multiply the costs in excess of the wage adjusted APC multiplier by 50% to get the additional outlier payment.

APC	WAGE ADJUSTED APC RATE	COSTS	FIXED DOLLAR THRESHOLD (WAGE ADJUSTED APC RATE + $1,800)	MULTIPLIER THRESHOLD (1.75 X WAGE ADJUSTED APC RATE)	COSTS IN EXCESS OF MULTIPLIER THRESHOLD	OUTLIER PAYMENT COSTS OF WAGE ADJUSTED APC - (1.75 X WAGE ADJUSTED APC RATE) X 0.50
0616	$315.51	$2,170.01	$2,115.51	$552.14	$1,618.87	$808.43
0283	$277.48	$2,327.24	$2,077.48	$485.59	$1,841.65	$920.83
0099	$24.79	$202.41	$1,824.79	$43.38	$159.03	-0-*

*** Does not qualify for outlier payment since the APC's costs did not exceed the fixed dollar threshold (APC Rate + $1,800).**

The total outlier payment on the claim was: $1,730.26.

f. Rural SCH payments will be increased by 7.1%. This adjustment will apply to all services and procedures paid under the OPPS (SIs of **P**, **S**, **T**, **V**, and **X**), excluding drugs, biologicals and services paid under the pass-through payment policy (SIs of **G** and **H**).

(1) The adjustment amount will not be reestablished on an annual basis, but may be reviewed in the future, and if appropriate, may be revised.

(2) The adjustment is budget neutral and will be applied before calculating outliers and copayments/cost-sharing.

g. Temporary Transitional Payment Adjustments (TTPAs).

(1) On May 1, 2009 (implementation of TRICARE's OPPS), the TTPAs shall apply to all network and non-network hospitals. For network hospitals, the TTPAs will cover

a four year period. The four year transition will set higher payment percentages for the 10 APC codes 604-609 and 613-616 during the first year, with reductions in each of the transition years. For non-network hospitals, the adjustment will cover a three year period, with reductions in each of the transition years for the same 10 APC codes. Figure 13-3-4 provides the TTPA percentage adjustments for the 10 visit APC codes for network and non-network hospitals. An applicable Explanation of Benefits (EOB) message will be applied.

(2) TTPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

FIGURE 13-3-4 TTPA ADJUSTMENT PERCENTAGES FOR 10 VISIT APC CODES

	NETWORK		NON-NETWORK	
YEARS	EMERGENCY ROOM	HOSPITAL CLINIC	EMERGENCY ROOM	HOSPITAL CLINIC
Year 1	200%	175%	140%	140%
Year 2	175%	150%	125%	125%
Year 3	150%	130%	110%	110%
Year 4	130%	115%	100%	100%
Year 5	100%	100%	100%	100%

h. Temporary Military Contingency Payment Adjustments (TMCPAs).

Under the authority of the last paragraph of 32 CFR 199.14(a)(6)(ii), the following OPPS adjustments are authorized.

(1) Transitional TMCPAs. In view of the ongoing military operations in Afghanistan and Iraq, the TMA Director has determined that it is impracticable to support military readiness and contingency operations without adjusting OPPS payments for network hospitals that provide a significant portion of the health care of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs). Therefore effective May 1, 2009, network hospitals that have received OPPS payments of $1.5 million or more for care provided to ADSMs and ADDs during an OPPS year (May 1 through April 30), shall be granted a Transitional TMCPA in addition to the TTPAs for the first four years of the OPPS implementation. At the end of the first year of OPPS implementation, i.e., April 30, 2010, the total TRICARE OPPS payments for these qualifying hospitals will be increased by 20%. Second and subsequent year adjustments (assuming a hospital continues to meet the $1.5 million threshold) will be reduced by 5% per year until the OPPS payment levels are reached; (i.e., 15% year two, 10% year three, and 5% year four). The adjustment will be applied to the total year OPPS payment amount received by the hospital for all active duty members and all TRICARE beneficiaries (including ADDs, retirees and their family members, but excluding TRICARE For Life (TFL) beneficiaries) for whom TRICARE is primary payer. These year-end adjustments will be paid approximately four months following the end of the OPPS year. In year five, the OPPS payments will be at established APC levels.

(a) TMA will run a query of claims history to determine which network hospitals qualify for Transitional TMCPAs at year end; i.e., those network hospitals receiving OPPS payments of $1.5 million or more for care of ADSMs and ADDs during the previous OPPS year (May 1 through April 30).

(b) These queries will be run in subsequent Transitional TMCPA years to determine those network hospitals qualifying for Transitional TMCPAs.

(c) The year end adjustment will be paid approximately four months following the end of the OPPS year. Each year, subsequent adjustments will be issued to the qualifying hospitals for the prior OPPS year to ensure claims that were not Processed To Completion (PTC) the previous year are adjusted. This adjustment payment is separate from the applicable TMCPA percentage in effect during the current transitional year.

EXAMPLE: At the end of the second OPPS year, a qualifying hospital's total TRICARE OPPS payments will be increased by 15%. The hospital will also receive an additional adjustment for the first OPPS year for those claims that were not PTC and included in the prior year's payment. This subsequent adjustment would be paid at the first year's TMCPA percentage of 20%.

(d) The TMA Medical Benefits and Reimbursement Branch (MB&RB) shall verify the accuracy of the Transitional TMCPA amounts and provide the Managed Care Support Contractor (MCSC) with a copy of the report noting which hospitals in their region qualify for the Transitional TMCPAs and the amounts to pay. MB&RB shall also provide a copy of the report to Contract Resource Management (CRM).

(e) The MCSCs shall submit the Transitional TMCPAs amounts on a voucher in accordance with the requirements of the TRICARE Operations Manual (TOM), Chapter 3, Section 4. The voucher shall be sent electronically to RM.Invoices@tma.osd.mil at the TMA CRM Office and to OPPS.MBRB@tma.osd.mil at the MB&RB before releasing payments. The vouchers should contain the following information: hospital name, address, Medicare number or provider number, Tax Identification Number (TIN), and the amount to be paid. Listings shall separate payments for prior OPPS years and the current OPPS year. Additional vouchers shall be submitted, as needed, for voided/staledated checks and/or for reissued or adjusted payments.

(f) CRM shall send an approval to the contractors to issue Transitional TMCPA payments out of the non-financially underwritten bank account based on fund availability.

(g) Hospitals that previously qualified for Transitional TMCPAs but subsequently fell below $1.5 million revenue threshold would no longer be eligible for the adjustment. However, if a subsequent adjustment for the prior OPPS year results in a hospital exceeding the $1.5 million revenue threshold, the hospital shall receive the Transitional TMCPA for the prior year.

(h) New hospitals that meet the $1.5 million revenue threshold would be eligible for the Transitional TMCPA percentage adjustment in effect during the transitional year in which the revenue threshold was met.

EXAMPLE: A hospital that meets the $1.5 million revenue threshold in year three of the transition but failed to meet it in year one and two, would receive a percentage adjustment of 10%.

(2) General TMCPAs. The TMA Director, or designee at any time after OPPS implementation, has the authority to adopt, modify and/or extend temporary adjustments for TRICARE network hospitals located within MTF Prime Service Areas (PSAs) and deemed essential for military readiness and support during contingency operations. The TMA Director may approve a General TMCPA for hospitals that serve a disproportionate share of ADSMs and ADDs. In order for a hospital to be considered for a General TMCPA, the hospital's outpatient revenue received for services provided to TRICARE ADSMs and ADDs must have been at least 10% of the hospital's total outpatient revenue received during the previous OPPS year (May 1 through April 30); or the number of outpatient visits by ADSMs and ADDs during that same 12-month period must have been at least 50,000. Billed charges will not be used as the basis for determining a hospital's eligibility for a General TMCPA.

(a) General TMCPA Process.

1 The Director, TRICARE Regional Office (DTRO), shall conduct a thorough analysis and recommend the appropriate year end adjustment to total OPPS payments for a network hospital qualifying for a General TMCPA.

2 In analyzing and recommending the appropriate year end percentage adjustment, the DTRO will ensure the General TMCPA adjustment does not exceed 95% of the amount that would have been paid prior to implementation of OPPS. Although, the maximum amount that a hospital can receive is 95% of the pre-OPPS amount, this does not infer the hospital is entitled to receive the full 95%. It is the DTRO's discretion on what percentage adjustment is appropriate to ensure access to care (ATC) in a facility requesting a General TMCPA. This applies to TRICARE beneficiaries when TRICARE is the primary payer. The MCSCs shall provide the history of pre-OPPS payments for the analysis to the DTRO.

3 Total TRICARE OPPS payments (including the TTPAs) and transitional TMCPA's, if applicable, of the qualifying hospital will be increased by the Director TMA, or designee, approved adjustment percentage by way of an additional payment after the end of the OPPS year (May 1 through April 30). Each year, subsequent adjustments will be issued to the qualifying hospitals for the prior OPPS year to ensure claims that were not PTC the previous year are adjusted. This adjustment payment is separate from the applicable General TMCPA percentage approved for the current OPPS year.

EXAMPLE: Assume a hospital was approved for a General TMCPA of 5% for the first year of OPPS and a General TMCPA of 8% for the second year of OPPS. At the end of the second year, the hospital's total TRICARE OPPS payments will be increased by 8%. The hospital will also receive an additional adjustment of 5% for the first OPPS year for those claims that were not PTC and included in the prior year's payment. The

General TMCPA is applied to the total OPPS payment amount at year end.

4 General TMCPAs will be reviewed and approved on an annual basis; i.e., General TMCPAs will have to be evaluated on a yearly basis by the DTRO in order to determine if the hospital continues to serve a disproportionate share of ADSMs and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities. This will include a recommendation for the appropriate OPPS year end adjustment to total OPPS payments.

5 The hospital's initial and all subsequent requests for a General TMCPA shall include the data requirements in paragraph III.A.5.h.(2)(b), and a full 12 months of claims payment data from the year the General TMCPA is requested.

6 The TMA MB&RB shall verify the accuracy of the General TMCPA amounts and provide the MCSC's with a copy of the report noting which hospitals in their region qualify for the General TMCPAs and the amounts to pay. MB&RB shall also provide a copy of the report to CRM.

7 The MCSCs shall submit the General TMCPA amounts on a voucher in accordance with requirements of the TOM, Chapter 3, Section 4. The voucher shall be sent electronically to RM.Invoices@tma.osd.mil at the TMA CRM Office and to OPPS.MBRB@tma.osd.mil at the MB&RB before releasing payments. The vouchers should contain the following information: hospital name, address, Medicare number or provider number, TIN, and the amount to be paid. Listings shall separate payments for prior OPPS years and the current OPPS year.

8 CRM shall send an approval to the contractors to issue General TMCPA payments out of the non-financially underwritten bank account based on fund availability.

(b) Annual Data Requirements for General TMCPAs. Hospital required data submissions to the MCSC for review and consideration:

1 The hospital's percent of outpatient revenue derived from ADSM plus ADD outpatient visits (e.g., Emergency Room (ER) and HOPD); i.e., the outpatient revenue from TRICARE ADSM plus ADD visits divided by total outpatient revenue (TRICARE and non-TRICARE) derived from all other third party payers and private pay during the previous OPPS year; i.e., May 1 through April 30. Reference paragraph III.A.5.h.(2).

2 The number of outpatient visits by ADSMs and ADDs during the previous OPPS year; i.e., May 1 through April 30.

3 Hospital-specific Medicare outpatient CCR based on the hospital's most recent cost reporting period.

4 Hospital's Medicare outpatient payment to charge ratio based on the corresponding Medicare cost reporting period.

5 The hospital's recommended percentage adjustment as supported by the above data requirement submissions.

(c) Annual MCSC data review requirements.

1 Data Requirements for Evaluation of Network Adequacy Necessary to Support Military Contingency Operations:

a Number of available primary care and specialist providers in the network locality;

b Availability (including reassignment) of military providers in the locations or nearby;

c Appropriate mix of primary care and specialists needed to satisfy demand and meet appropriate patient access standards (appointment/waiting time, travel distance, etc.);

d Efforts that have been made to create an adequate network, and

e Other cost effective alternatives and other relevant factors.

2 If upon initial evaluation, the MCSC determines the hospital meets the disproportionate share criteria in paragraph III.A.5.h.(2), and is essential for continued network adequacy, the request from the hospital along with the above supporting documentation shall be submitted to the TRICARE Regional Office (TRO) for review and determination.

(d) The DTRO shall conduct a thorough analysis and recommend the appropriate percentage adjustments to be applied for that year; i.e., the General TMCPAs will be reviewed and approved on an annual basis. The recommendation with a cost estimate shall be submitted to the MB&RB to be forwarded to the Director, TMA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RB for TMA Director review and approval.

(e) TMA Director, or designee review.

1 The Director, TMA or designee is the final approval authority.

2 A decision by the Director TMA or designee to adopt, modify, or extend General TMCPAs is not subject to appeal.

(3) Non-Network TMCPAs.

TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that the procedures cannot be obtained timely enough from a network hospital. This determination will be based on the MCSC's and TRO's evaluation of network adequacy data related to the specific procedures for which the TMCPA is being requested as outlined under paragraph III.A.5.h.(2)(c). Non-network TMCPAs will be adjusted on a claim-by-claim basis.

(4) Application of Cost-Sharing.

(a) Transitional and General TMCPAs are not subject to cost-sharing.

(b) Non-network TMCPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

(5) Reimbursement of Transitional, General, and Non-Network TMCPA costs shall be paid as pass-through costs. The MCSC does not financially underwrite these costs.

i. Hold Harmless TRICARE Transitional Outpatient Payments (TTOPs).

(1) Effective January 1, 2010, TRICARE adopted Medicare's hold harmless provision for rural hospitals with 100 or fewer beds and all SCHs regardless of bed size. TRICARE will apply the hold harmless provision to these hospitals as long as the provision remains in effect under Medicare.

(2) TTOPs will be made to qualifying hospitals that have OPPS costs that are greater than their TRICARE allowed amounts. The 7.1% increase for SCHs, the TTPAs for ER and clinic visits, Transitional and General TMCPAs, if applicable, will be included in the allowed amounts when determining if a hospital's OPPS costs are greater than their TRICARE allowed amounts.

(3) TRICARE will use a method similar to Medicare to reimburse these hospitals their TTOPs. TRICARE will pay qualifying hospitals an amount equal to 85% of the difference between the estimated OPPS costs and the OPPS payment.

(4) Process for TTOPs Year One (Effective January 1, 2010, through December 31, 2010) and Subsequent Years.

(a) TMA will run query reports of claims history to determine which hospitals qualify for TTOPs at year end; i.e., those hospitals whose costs exceeded their allowed amounts during the previous TTOPs year (January 1 through December 31).

(b) These query reports will be run in subsequent TTOPs years to determine those hospitals qualifying for TTOPs.

(c) The year end adjustment will be paid approximately six months following the end of the TTOPs year. Each year, subsequent adjustments will be issued to the

qualifying hospitals for the prior TTOPs year to ensure claims that were not PTC the previous year are adjusted.

(d) The TMA MB&RB shall provide the MCSC with a copy of the query report noting which hospitals in their region qualify for the TTOPs and the amounts to pay. A copy of the report shall also be provided to TMA's CRM.

(e) The contractor shall process the adjustment payments per the instructions in Section G of their contracts under Invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No payments will be sent out without approval from TMA-Aurora (TMA-A), CRM, Budget.

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.

NOTE: Orphan drugs will be paid separately at the Average Sales Price (ASP) + 6%, which represents a combined payment for acquisition and overhead costs associated with furnishing these products. Orphan drugs will no longer be paid based on the use of drugs because all orphan drugs, both single-indication and multi-indication, will be paid under the same methodology. The TRICARE contractors will not be required to calculate orphan drug payments.

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, will be subject to transitional pass-through payment 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 OPPS 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 SI **H**.

b. Pass-through drugs and biological agents are identified by SI **G**.

3. Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2009.

a. Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug Competitive Acquisition Program (CAP) at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Social Security Act (SSA) rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug or biological.

b. Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug CAP at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Act, rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug and biological.

c. The difference between ASP + 4% and ASP + 6%, therefore would be the CY 2009 pass-through payment amount for these drugs and biologicals.

d. Considering diagnostic radiopharmaceuticals to be drugs for pass-through purposes which will be reimbursed based on the ASP methodology; i.e., ASP + 6%.

e. Therapeutic radiopharmaceuticals with pass-through status in CY 2009 will be paid at hospital charges adjusted to cost, the same payment methodology as other therapeutic radiopharmaceuticals in CY 2009.

f. If a drug or biological that has been granted pass-through status for CY 2009 becomes covered under the Part B drug CAP (if the program is reinstituted) the Centers for Medicare and Medicaid Services (CMS) will provide payment for Part B Drugs that are granted pass-through status and are covered under the Part B drug CAP at the Part B drug CAP rate.

g. Beneficiary copayments/cost-sharing will be based on the entire ASP of the transition pass-through drug or biological.

h. Drugs and biologicals that are continuing pass-through status or have been granted pass-through status as of January 2009 for CY 2009 are displayed in Figure 13-3-5.

FIGURE 13-3-5 DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2009

CY 2008	CY 2009			
HCPCS	HCPCS	SHORT DESCRIPTOR	SI	APC
C9238	J1953	Levetiracetam injection	G	9238
C9239	J9330	Temsirolimus injection	G	1168
C9240*	J9207	Exabepilone injection	G	9240
C9241	J1267	Doripenem injection	G	9241
C9242	J1453	Fosaprepitant injection	G	9242
C9243	J9033	Bendamustine injection	G	9243
C9244	J2785	Injection, regadenoson	G	9244
C9354	C9354	Veritas collagen matrix, cm2	G	9354
C9355	C935	Neuromatrix nerve cuff, cm	G	9355
C9356	C9356	TendoGlide Tendon prot, cm2	G	9356
C9357	Q4114	Integra flowable wound matri	G	1251
C9358	C9358	SurgiMend, 0.5cm2	G	9358
C9359	C9359	Implant, bone void filler	G	9359
J1300	J1300	Eculizumab injection	G	9236
J1571	J1571	Hepagam b im injection	G	0946
J1573	J1573	Hepagam b intravenous, inj	G	1138
J3488*	J3488	Reclast injection	G	0951
J9225*	J9225	Vantas implant	G	1711
J9226	J9226	Supprelin LA implant	G	1142
J9261	J9261	Nelarabine injection	G	0825
Q4097	J1459	Inj IVIG privigen 500 mg	G	1214
	C9245	Injection, romiplostim	G	9245
	C9246	Inj, gadoxetate	G	9246
	C9248	Inj, clevidipine butyrate	G	9248

*** Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology (prior to January 1, 2009) while identified as pass-through under the OPPS.**

4. Reduction of Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals to Offset Costs Packaged Into APC Groups.

a. Prior to CY 2008, certain diagnostic radiopharmaceuticals were paid separately under the OPPS if their mean per day cost were greater than the applicable year's drug packaging threshold.

b. In CY 2008, CMS payment for all non-pass-through diagnostic radiopharmaceuticals were packaged as ancillary and supportive items and service.

c. In CY 2009, continued to package payment for all non-pass-through diagnostic radiopharmaceuticals.

d. For OPPS pass-through purposes, radiopharmaceuticals are considered to be "drugs" where the transitional pass-through for the drugs and biologicals is the difference between the amount paid ASP + 4% or the Part B drug CAP rate and the otherwise applicable OPPS payment amount of ASP + 6%.

e. There is currently one radiopharmaceutical with pass-through status under OPPS.

f. New pass-through diagnostic radiopharmaceuticals with no ASP information or CAP rate will be paid at ASP + 6%, while those without ASP information will be paid based on Wholesale Acquisition Cost (WAC) or, if WAC is not available, based on 95% of the product's most recently published Average Wholesale Price (AWP).

g. Offset Calculations.

(1) An established methodology will be employed to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment (the APC device offset).

(2) New pass-through device categories will be evaluated individually to determine if there are device costs packaged into the associated procedural APC payment rate - suggesting that a device offset amount would be appropriate.

h. Effective April 1, 2009, diagnostic radiopharmaceutical HCPCS code C9247, Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries, has been granted pass-through status under the OPPS and will be assigned SI of **G**.

(1) Beginning April 1, 2009, payment for HCPCS code C9247 will be made at 106% of ASP if ASP data are submitted by the manufacturer. Otherwise, payment will be made based on the product's WAC. Further if WAC data is not available, payment will be made at 95% of the AWP.

(2) Effective for nuclear medicine services furnished on and after April 1, 2009, when HCPCS code C9247 is billed on the same claims with a nuclear medicine procedure, the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 will be reduced by the corresponding nuclear medicine procedure's portion of its APC payment (offset amount) associated with diagnostic radiopharmaceutical; i.e., the payment for HCPCS code C9247 will be reduced by the estimated amount of payment that is attributable to the predecessor radiopharmaceutical that is package into payment for the associated nuclear medicine procedure reported on the same claim as HCPCS code C9247.

(3) When C9247 is billed on a claim with one or more nuclear medicine procedures, the OPPS Pricer will identify the offset amount or amounts that apply to the nuclear medicine procedures that are reported on the claim.

(4) Where there is a single nuclear medicine procedure reported on the claim with a single occurrence of C9247, the OPPS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index that applies to the hospital submitting the bill.

(5) Where there are multiple nuclear medicine procedures on the claim with a single occurrence of the pass-through radiopharmaceutical, the OPPS Pricer will select the nuclear medicine procedure with the single highest offset amount, and will adjust the selected offset amount by the wage index of the hospital submitting the claim.

(6) When a claim has more than one occurrence of C9247, the OPPS Pricer will rank potential offset amounts associated with the units of nuclear medicine procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-though radiopharmaceutical on the claims and adjust the total offset amount by the wage index of the hospital submitting the claim.

(7) The adjusted offset will be subtracted from the APC payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247.

(8) The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status.

5. 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 Durable Medical Equipment (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 Food and Drug Administration (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 via a natural or surgically created orifice on incision, 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.

(10) The new device category must demonstrate that utilization of its devices provide substantial clinical improvement for beneficiaries compared with currently available treatments, including procedures utilizing devices in existing or previously existing device categories.

d. Duration of Transitional Pass-Through Payments.

(1) The duration of transitional pass-through payments for devices is for at least two, but not more than three 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.

(a) 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.

(b) HCPCS codes that describe devices without pass-through status and that are packaged in kits with other items used in a particular procedure, hospitals may consider all kit costs in their line-item charge for the associated device/device category HCPCS code that is assigned SI of **N** for packaged payment (i.e., hospitals may report the total charge for the whole kit with the associated device/device category HCPCS code. Payment for device/device category HCPCS codes without pass-through status is packaged into payment for the procedures in which they are used, and these codes are assigned SI of **N**. In the case of a device kit, should a hospital choose to report the device charge alone under a device/device category HCPCS code with SI of **N**, the hospital should report charges for other items that may be included in the kit on a separate line on the claim.

(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 FDA relating to the reprocessing of devices applicable at the time the service is delivered.

f. Current Device Categories Subject to Pass-Through Payment. Two device categories were established for pass-through payment as a January 1, 2007, HCPCS code C1821 (interspinous process distraction device (implantable)) and HCPCS code L8690 (auditory osseointegrated device, includes all internal and external components), will be active categories for pass-through payment for two years as of January 1, 2007, i.e., these categories will expire from pass-through payment as of December 31, 2008.

g. Reduction of Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups.

(1) Each new device category will be reviewed on a case-by-case basis to determine whether device costs associated with the new category were packaged into the existing APC structure.

(2) If it is determined that, for any new device category, no device costs associated with the new category were packaged into existing APCs, the offset amount for the new category would be set to $0 for CY 2008.

h. Calculation of Transitional Pass-Through Payment for a Pass-Through Device.

(1) Device pass-through payment is calculated by applying the statewide CCR to the hospital's charges on the claim and subtracting any appropriate pass-through offset. Statewide CCRs are based on the geographical CBSA (two digit = rural, five digit = urban).

(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 CCR (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[2].

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[2] code 92982 (APC0083)

Payment rate = $3,289.42

Coinsurance amount = $657.88 (standard ADFM 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 from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph III.B.5.h.(4) for detailed application of discounting factors to offset amounts.) 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:

$3,289.42 - $657.88 = $2,631.54

TRICARE payment for pass-through device C1884 = $397.94

Beneficiary cost-share liability for APC 0083 = $657.88

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

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$2,631.54	TRICARE program payment for HCPCS Level I[3] code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I[3] code 92982
397.94	Transitional pass-through payment for device
$3,687.36	Total amount received by the provider

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[3] code 92982 (APC0083)

Payment rate = $3,289.42

Coinsurance amount = $657.88 (standard ADFM 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 from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to paragraph III.B.5.h.(4) for detailed application of discounting factors to offset amounts.) 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:

$3,289.42 - $657.88 = $2,631.54

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

Beneficiary cost-share liability for APC 0083 = $657.88

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

$2,631.54	TRICARE program payment for HCPCS Level I[3] code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I[3] code 92982
1,500.00	Transitional pass-through payment for device
$4,789.42	Total amount received by the provider

NOTE: Transitional payments for devices (SI=H) are not subject to beneficiary cost-sharing/copayments.

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(4) Steps involved in applying multiple discounting factors to offset amounts prior to subtracting from the device cost.

STEP 1: For each APC with an offset multiply the offset by the discount percent (whether it is 50%, 75%, 100%, or 200%) and the units of service.

(Offset x Discount Rate x Units of Service)

STEP 2: Sum the products of Step 1.

STEP 3: Wage adjust the sum of the products calculated in Step 2.

(Step 2 Amount x Labor % x Wage Index) + Step 2 Amount x Nonlabor %)

STEP 4: If the units of service from the procedures with offsets are greater than the device units of service, then Step 3 is adjusted by device units divided by procedure offset units.

[(Step 2 Amount x Labor % x Wage Index) + (Step 2 Amount x Nonlabor %) x (Device Units ÷ Offset Procedure Units)]

otherwise

(Step 2 Amount x Labor % x Wage Index) Step 2 Amount x Non-Labor %)

EXAMPLE: If there are two procedures with offsets but only one device, then the final offset is reduced by 50%.

STEP 5: If there is only one line item with a device, then the amount calculated in Step 4 is subtracted from the line item charge adjusted to cost.

[Step 4 Amount - (Line Item Charge x State CCR)]

If there are multiple devices, then the amount from Step 4 is allocated to the line items with devices based on their charges.

(Line Item Device Charge ÷ Sum of Device Charges)

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 day for the drug or radiopharmaceutical is less than $60. Separate APC payment is established for drugs and radiopharmaceuticals for which the median cost per day exceeds $60.

3. An exception to the packaging rule is being made for injectable oral forms of antiemetics, listed in Figure 13-3-6.

FIGURE 13-3-6 ANTIEMETICS EXEMPTED FROM CY 2008 $60 PACKAGING THRESHOLD

HCPCS CODE	SHORT DESCRIPTOR
J1260	Dolasetron mesylate
J1626	Granisetron HCl Injection
J2405	Ondansetron HCl Injection
J2469	Palonosetron HCl
Q0166	Granisetron HCl 1 mg oral
Q0179	Ondansetron HCl 8 mg oral
Q0180	Dolasetron Mesylate oral

4. Continuing to package payment for all non-pass-through diagnostic radiopharmaceuticals and contrast agents, regardless of their per day costs for CY 2009.

5. 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 HCPCS code has been assigned.

(c) Orphan drugs.

b. Payment of Specified Outpatient Drugs, Biological, and Radiopharmaceuticals.

(1) Specified outpatient drugs and biologicals will be paid a combined rate of the ASP + 4% which is reflective of the present hospital acquisition and overhead costs for separately payable drugs and biologicals under the OPPS. In the absence of ASP data, the WAC will be used for the product to establish the initial payment rate. If the WAC is also unavailable, then payment will be calculated at 95% of the most recent AWP.

(2) Since there is no ASP data for separately payable specified radiopharmaceuticals, reimbursement will be based on charges converted to costs. Refer to Section 2, Figure 13-2-15, for a list of therapeutic radiopharmaceuticals that will continue to be reimbursed under the cost-to-charge methodology up through December 31, 2009.

(a) Therapeutic radiopharmaceuticals must have a mean per day cost of more than $60 in order to be paid separately.

(b) Diagnostic radiopharmaceuticals and contrast agents are packaged regardless of per day cost since they are ancillary and supportive of the therapeutic procedures in which they are used.

c. Designated SI.

The HCPCS codes for the above three categories of "specified covered outpatient drugs" are designated with the SI **K** - non-pass-through drugs, biologicals, and radiopharmaceuticals paid under the hospital OPPS (APC Rate). Refer to TMA's OPPS web site at http://www.tricare.mil/opps for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

6. Payment for Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data.

a. These new drugs and biologicals with HCPCS codes as of January 1, 2008, but which do not have pass-through status and are without OPPS hospital claims data, will be paid at ASP + 4% consistent with its final payment methodology for other separately payable non-pass-through drugs and biologicals.

b. Payment for all new non-pass-through diagnostic radiopharmaceuticals will be packaged.

c. In the absence of ASP data, the WAC will be used for the product to establish the initial payment rate for new non-pass-through drugs and biologicals with HCPCS codes, but which are without OPPS claims data. If the WAC is also unavailable, payment will be made at 95% of the product's most recent AWP.

d. SI K will be assigned to HCPCS codes for new drugs and biologicals for which pass-through application has not been received.

e. Payment for new therapeutic radiopharmaceuticals with HCPCS codes as of January 1, 2008, but which do not have pass-through status, will be assigned SI H and continue to be reimbursed under the cost-to-charge methodology up through December 31, 2009.

f. In order to determine the packaging status of these items for CY 2008 an estimate of the per day cost of each of these items was calculated by multiplying the payment rate for each product based on ASP + 4%, by a estimated average number of units of each product that would typically be furnished to a patient during one administration in the hospital outpatient setting. Items for which the estimated per day cost is less than or equal to $60 will be packaged. For drugs currently covered under the CAP the payment rates calculated under that program that were in effect as of April 1, 2008 will be used for purposes of packaging decisions.

7. Drugs and Biologicals Not Eligible for Pass-Through Status and Receiving Separate Non-Pass-Through Payment.

a. Payment will be based on median costs derived from CY claims data for drugs and biologicals that have been:

(1) Separately paid since implementation of the OPPS under Medicare, 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 $60 packaging threshold.

b. Payment based on median costs should be adequate for hospitals since these products are generally older or low-cost items.

8. 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) When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.

(3) The new drug, biological and/or radiopharmaceutical will be priced at 95% of its AWP from a schedule of allowable charges based on the AWP, and process the claim for payment.

(4) The above approach enables hospitals to bill and receive payment for a new drug, biological or radiopharmaceutical concurrent with it's approval by the FDA.

b. Hospitals will discontinue billing C9399 and the NDC upon implementation of a HCPCS code, SI, and appropriate payment amount with the next quarterly OPPS update.

9. Package payment for any biological without pass-through status that is surgically inserted or implanted (through a surgical incision or a natural orifice) into the payment for the associated surgical procedure.

a. As a result, HCPCS codes C9352, C9353, and J7348 are packaged and assigned SI of **N**.

b. Any new biologicals without pass-through status that are surgically inserted or implanted will be packaged beginning in CY 2009.

10. Drugs and non-implantable biologicals with expiring pass-through status.

a. CY 2009 payment methodology of packaged or separate payment based on their estimated per day costs, in comparison with the CY 2009 drug packaging threshold.

b. Packaged drugs and biologicals are assigned SI of **N** and drugs and biologicals that continue to be separately paid as non-pass-through products are assigned SI of **K**.

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 13-3-7 CROSSWALK FROM HCPCS LEVEL I[1] CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCS

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion pump	S	0440
90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	S	0437
90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	S	0438
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	S	0437
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	S	0438
90776	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	N	
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	S	0436
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0438
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0438
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0438
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0438
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0441
96420	Chemotherapy administration, intra-arterial; push technique	S	0439
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0441
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	S	0438
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0441
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0441
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0441

FIGURE 13-3-7 CROSSWALK FROM HCPCS LEVEL I[1] CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCS (CONTINUED)

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0441
96521	Refilling and maintenance of portable pump	S	0440
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	S	0440
96523	Irrigation of implanted venous access device for drug delivery systems	Q	0624
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0438
96549	Unlisted chemotherapy procedure	S	0436

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2. The following non-chemotherapy HCPCS codes have also been created that are similar to CPT codes for initiation of prolonged chemotherapy infusion requiring a pump and pump maintenance and refilling codes so hospitals can bill for services when provided to patients who require extended infusions for non-chemotherapy medications including drugs for pain (see Figure 13-3-8).

FIGURE 13-3-8 NON-CHEMOTHERAPY PROLONGED INFUSION CODES THAT REQUIRE A PUMP

HCPCS LEVEL I[1] CODE	DESCRIPTION	SI	APC
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0441

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3. Packaged HCPCS Level I codes for drug administration should continue to be billed to ensure accurate payment in the future. These are bill changes for HCPCS Level I codes with SI of **N** that will be used as the basis for setting median costs for each drug administration HCPCS Level I code in the future.

4. HCPCS Level I[4] codes 90772-90774 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.

5. Drugs for which the median cost per day is greater than $60 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 $60 will result in more equitable payment for both the drugs and their administration.

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F. Coding and Payment Policies for Drugs and Supplies.

1. Drug Coding.

a. Drugs for which separate payment is allowed are designated by SI **K** and must be reported using the appropriate HCPCS code.

b. Drugs that are reported without a HCPCS code will be packaged under the revenue center code, under OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633.

c. Drugs billed using revenue code 636 ("Drugs requiring detailed coding") require use of the appropriate HCPCS code, or they will be denied.

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

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.

3. Recognition of Multiple HCPCS Codes for Drugs.

a. Prior to January 1, 2008, the OPPS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPPS assigned a SI **B** indicating that another code existed for OPPS purposes. For example, if drug X has two HCPCS codes, one for a 1 ml dose and another for a 5 ml dose, the OPPS would assign a payable status indicator to the 1 ml dose and SI **B** to the 5 ml dose.

b. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under OPPS.

c. Beginning January 1, 2008, the OPPS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor.

d. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

4. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices.

a. When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriated HCPCS code for the product.

b. Separate payment will be made for an implanted biological when it has pass-through status.

c. If the implantable device does not have pass-through status it will be packaged into the payment for the associated procedure.

5. Correct Reporting of Units for Drugs.

a. Units of drugs administered to patients should be accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

b. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patients, the units bill should be one. If the description for the drug code is 50 mg, but 200 mg of the drug was administered, the units billed should be four.

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

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% of AWP or 106 of the ASP, whichever is higher.

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

H. Vaccines.

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

2. Separately payable vaccines other than influenza, pneumococcal pneumonia and hepatitis B will be paid under their own APC.

3. See Figure 13-3-9 for vaccine administration codes and SIs.

FIGURE 13-3-9 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS

HCPCS LEVEL 1[1] CODE	DESCRIPTION	SI	APC
G0008	Influenza vaccine administration	S	0350
G0009	Pneumococcal vaccine administration	S	0350
G0010	Hepatitis B vaccine administration	B	--
90465	Immunization admin, under 8 yrs old, with counseling; first injection	N	--
90466	Immunization admin, under 8 yrs old, with counseling; each additional injection	N	--
90467	Immunization admin, under 8 yrs old, with counseling; first intranasal or oral	N	--
90468	Immunization admin, under 8 yrs old, with counseling; each additional intranasal or oral	N	--
90471	Immunization admin, one vaccine injection	S	0437
90472	Immunization admin, each additional vaccine injections	S	0436
90473	Immunization admin, one vaccine by intranasal or oral	N	
90474	Immunization admin, each additional vaccine by intranasal or oral	N	--

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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 $60.

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% 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. SI **R** was created in CY 2009 to denote blood and blood products.

2. The OPPS provider also should report charges for processing and storage services on a separate line using Revenue Code 0390 (General Classification), 0392 (Blood Processing/ Storage), or 0399 (Blood Processing/Storage; Other Blood Storage and Processing), along with appropriate blood HCPCS code, the number of units transfused, and the Line Item Date Of Service (LIDOS).

3. 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.

4. 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).

5. Payment rates for blood and blood products will be determined based on median costs. Refer to Figure 13-3-10 for APC assignment of blood and blood product codes.

FIGURE 13-3-10 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9010		R	Whole blood for transfusion	0950
P9011		R	Split unit of blood	0967
P9012		R	Cryoprecipitate each unit	0952
P9016		R	RBC leukocytes reduced	0954
P9017		R	Plasma 1 donor frz w/in 8 hr	9508
P9019		R	Platelets, each unit	0957
P9020		R	Platelet rich plasma unit	0958
P9021		R	Red blood cells unit	0959
P9022		R	Washed red blood cells unit	0960
P9023		R	Frozen plasma, pooled, sd	0949
P9031		R	Platelets leukocytes reduced	1013
P9032		R	Platelets, irradiated	9500
P9033		R	Platelets leukoreduced irradiated	0968
P9034		R	Platelets, pheresis	9507
P9035		R	Platelets pheresis leukoreduced	9501
P9036		R	Platelet pheresis irradiated	9502
P9037		R	Platelet pheresis leukoreduced irradiated	1019
P9038		R	RBC irradiated	9505
P9039		R	RBC deglycerolized	9504
P9040		R	RBC leukoreduced irradiated	0969
P9043		R	Plasma protein fract, 5%, 50 ml	0956
P9044		R	Cryoprecipitate reduced plasma	1009
P9048		R	Granulocytes, pheresis unit	9506

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FIGURE 13-3-10 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES (CONTINUED)

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9051	C1010	R	Blood, L/R, CMV-NEG	1010
P9052	C1011	R	Platelets, HLA-m, L/R, unit	1011
P9053	C1015	R	Plt, pher, L/R, CMV, irradiated	1020
P9054	C1016	R	Blood, L/R, Froz/Degly/Washed	1016
P9055	C1017	R	Plt, Aph/Pher, L/R, CMV-Neg	1017
P9056	C1018	R	Blood, L/R, Irradiated	1018
P9057	C1020	R	RBC, frz/deg/wash, L/R irradiated	1021
P9058	C1021	R	RBC, L/R, CMV-Neg, irradiated	1022
P9059	C1022	R	Plasma, frz within 24 hours	0955
P9060	C9503	R	Fresh frozen plasma, ea unit	9503

6. For CY 2009, blood clotting factors will be paid at ASP + 4%, plus an additional payment for the furnishing fee that is also a part of the payment for blood clotting factors furnished in physician's offices.

K. Adjustment to Payment in Cases of Devices Replaced with Partial Credit for the Replaced Device.

1. Hospitals will be required to append the modifier "FC" to the HCPCS code for the procedure in which the device was inserted on claims when the device that was replaced with partial credit under warranty, recall, or field action is one of the devices in Figure 13-3-11. Hospitals should not append the modifier to the HCPCS procedure code if the device is not listed in Figure 13-3-11.

2. Claims containing the "FC" modifier will not be accepted unless the modifier is on a procedure code with SI **S**, **T**, **V**, or **X**.

3. If the APC to which the procedure is assigned is one of the APCs listed in Figure 13-3-12, the Pricer will reduce the unadjusted payment rate for the procedure by an amount equal to the percent in Figure 13-3-12 for partial credit device replacement (i.e., 50% of the device offset when both a device code listed in Figure 13-3-11 is present on the claim and the procedure code maps to an APC listed in Figure 13-3-12) multiplied by the unadjusted payment rate.

4. The partial credit adjustment will occur before wage adjustment and before the assessment to determine if the reductions for multiple procedures (signified by the presence of more than on procedure on the claim with a SI of **T**), discontinued service (signified by modifier 73) or reduced service (signified by modifier 52) apply.

L. Payment When Devices Are Replaced Without Cost or Where Credit for a Replacement Device is Furnished to the Hospital.

1. Payments will be reduced for selected APCs in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. The

amount of the reduction to the APC rate will be calculated in the same manner as the offset amount that would be applied if the implanted device assigned to the APC has pass-through status.

2. This permits equitable adjustments to the OPPS payments contingent on meeting all of the following criteria:

a. All procedures assigned to the selected APCs must require implantable devices that would be reported if device replacement procedures are performed;

b. The required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedures, at least temporarily; and

c. The offset percent for the APC (i.e., the median cost of the APC without device costs divided by the median cost of the APC with device costs) must be significant--significant offset percent is defined as exceeding 40%.

3. The presence of the modifier "FB" ["Item Provided Without Cost to Provider, Supplier, or Practitioner or Credit Received for Replacement (examples include, but are not limited to devices covered under warranty, replaced due to defect, or provided as free samples)"] would trigger the adjustment in payment if the procedure code to which modifier "FB" was amended appeared in Figure 13-3-11 and was also assigned to one of the APCs listed in Figure 13-3-12. OPPS payments for implantation procedures to which the "FB" modifier is appended are reduced to 100% of the device offset for no-cost/full credit cases.

FIGURE 13-3-11 DEVICES FOR WHICH "FC" AND "FB" MODIFIERS MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL OR PARTIAL CREDIT FOR A REPLACEMENT DEVICE

DEVICE HCPCS CODE	SHORT DESCRIPTOR
C1721	AICD, dual chamber
C1722	AICS, single chamber
C1728	Cath, brachytx seed adm
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep Dev urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual rate-resp
C1786	Pmkr, single rate-resp
C1789	Prosthesis, breast, imp
C1813	Prostheses, penile, inflatab
C1815	Pros, urinary sph, imp

FIGURE 13-3-11 DEVICES FOR WHICH "FC" AND "FB" MODIFIERS MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL OR PARTIAL CREDIT FOR A REPLACEMENT DEVICE (CONTINUED)

DEVICE HCPCS CODE	SHORT DESCRIPTOR
C1820	Generator, neuro, rechg bat sys
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Pmkr, other than sing/dual
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8600	Implant breast silicone/eq
L8614	Cochlear device/system
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

FIGURE 13-3-12 ADJUSTMENTS TO APCS IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED FOR CY 2009

APC	SI	APC GROUP TITLE	DEVICE OFFSET PERCENTAGE FOR NO-COST/FULL CREDIT CASE	DEVICE OFFSET PERCENTAGE FOR PARTIAL CREDIT CASE
0039	S	Level I Implantation of Neurostimulator	84	42
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	57	29
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes	62	31
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	72	36
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74	37
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes	43	21
0107	T	Insertion of Cardioverter-Defibrillator	89	45
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	89	44
0222	S	Level II Implantation of Neurological Device	85	42

FIGURE 13-3-12 ADJUSTMENTS TO APCS IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL OR PARTIAL CREDIT IS RECEIVED FOR CY 2009 (CONTINUED)

APC	SI	APC GROUP TITLE	DEVICE OFFSET PERCENTAGE FOR NO-COST/FULL CREDIT CASE	DEVICE OFFSET PERCENTAGE FOR PARTIAL CREDIT CASE
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	62	31
0227	T	Implantation of Drug Infusion Devices	82	41
0229	T	Transcatheter Placement of Intravascular Shunts	84	42
0259	T	Level IV ENT Procedures	88	44
0315	S	Level III Implantation of Neurostimulator	59	29
0385	S	Level I Prosthetic Urological Procedures	69	34
0386	S	Level II Prosthetic Urological Procedures	71	36
0418	T	Insertion of Left Ventricular Pacing Elect	59	29
0425	T	Level II Arthroplasty or Implantation with Prosthesis	46	23
0648	T	Level IV Breast Surgery	77	38
0625	T	Level IV Vascular Access Procedures	76	38
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	71	36
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	71	35
0680	S	Insertion of Patient Activated Event Recorders	71	36
0681	T	Knee Arthroplasty	71	35

4. If the APC to which the device code (i.e., one of the codes in Figure 13-3-11) is assigned is on the APCs listed in Figure 13-3-12, the unadjusted payment rate for the procedure APC will be reduced by an amount equal to the percent in Figure 13-3-12 times the unadjusted payment rate.

5. In cases in which the device is being replaced without cost, the hospital will report a token device charge. However, if the device is being inserted as an upgrade, the hospital will report the difference between its usual charge for the device being replaced and the credit for the replacement device.

6. Multiple procedure reductions would also continue to apply even after the APC payment adjustment to remove payment for the device cost, because there would still be the expected efficiencies in performing the procedure if it was provided in the same operative session as another surgical procedure. Similarly, if the procedure was interrupted before administration of anesthesia (i.e., there was modifier 52 or 73 on the same line as the procedure), a 50% reduction would be taken from the adjusted amount.

M. 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 SI **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 OPPS.

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 SI 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 SI.

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 $50 in increments of $10.

(2) From $50 to $100 in a single $50 increment.

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

(4) 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). (Refer to Chapter 2, Addendum A for applicable deductible cost-sharing/copayment amounts for outpatient hospital services.)

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.

N. Coding And Payment Of ED Visits.

1. CPT defines an ED as "an organized hospital based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must available 24 hours a day."

2. Prior to CY 2007, under the OPPS the billing of ED CPT codes was restricted to services furnished at facilities that met this CPT definition. Based on the above definition, facilities open less than 24 hours a day could not report ED CPT codes.

3. Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on Medicare-participating hospitals that offer emergency services. These obligations concern individuals who come to a hospital's Dedicated Emergency Department (DED) and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. Section 1867(h) of the Act specifically phohibits a delay in providing required screening or stabilization services in order to inquire about the individual's payment method or insurance status.

4. These provisions are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA). The EMTALA regulations define DED as any department or facility of the hospital, regardless of whether it is located on or off the main campus, that meets at least one of the following requirements:

a. It is licensed by the State in which it is located under applicable State law as an ER or ED;

b. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

c. During the calendar year immediately preceding the calendar year in which a determination under the regulations is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring previously scheduled appointment.

5. There are some departments or facilities of hospitals that met the definition of a dedicated ED under the EMTALA regulations, but did not meet the more restrictive CPT definition of ED. For example, a hospital department or facility that met the definition of a DED might not have been available 24 hours a day, seven days a week.

6. To determine whether visits to EDs of facilities (referred to as Type B ED) that incur EMTALA obligations, but do not meet the more prescriptive expectations that are consistent with the CPT definition of an ED (referred to as Type A ED) have different resource costs than visits to either clinics or Type A EDs, five G codes were developed for use by hospitals to report visits to all entities that meet the definition of a DED under the EMTALA regulations, but that are not Type A EDs. These codes are called "Type B ED visit codes." EDs meeting the definition of a DED under the EMTALA regulations, but which are not Type A EDs (i.e., they may meet the DED definition but are not available 24 hours a day, seven days a week).

FIGURE 13-3-13 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDS

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0380	Level 1 Hosp Type B Visit	Level 1 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0381	Level 2 Hosp Type B Visit	Level 2 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

FIGURE 13-3-13 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDS

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0382	Level 3 Hosp Type B Visit	Level 3 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0383	Level 4 Hosp Type B Visit	Level 4 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0384	Level 5 Hosp Type B Visit	Level 5 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an ER or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

7. The five new Type B ED visit codes for services provided in a Type B ED will be assigned to the five newly established Clinical Visit APCs 0604, 0605, 0606, 0607, and 0608.

8. For CY 2007, the five CPT E/M ED visit codes for services provided in a Type A ED were assigned to the five newly-created ED Visit APCs 0609, 0613, 0614, 0615, and 0616.

9. The definition of Type A and Type B EDs was not modified for CY 2008 because its current definition accurately distinguished between these two types of ED.

10. For CY 2008, Type A ED visits will continue to be paid based on the five ED Visit APCs, while Type B ED visits would continue to be paid based on the five Clinic Visit APCs.

11. A new **G** code (G0390 - Trauma response team activation associated with hospital critical care services) was also created (effective January 1, 2007) to be used in addition to CPT[6] procedure codes 99291 and 99292 to address the meaningful cost difference between critical care when billed with and without trauma activation.

a. If critical care is provided without trauma activation, the hospital will bill with either CPT[6] procedure code 99291, receiving payment for APC 0617.

b. However if trauma activation occurs, the hospital would be called to bill one unit of "G" code (G0390), report with revenue code 68x on the same date of service, thereby receiving payment for APC 0618.

12. The CPT Evaluation and Management (E/M) codes and other HCPCS codes currently assigned to the clinic visit APCs have been mapped in Figure 13-3-14 to 11 new APCs; five for clinic visits; five for ED visits; and one for critical care services, based on median costs and clinical consideration.

FIGURE 13-3-14 ASSIGNMENT OF CPT E/M CODES AND OTHER HCPCS CODES TO NEW VISIT APCS FOR CY 2007

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 1 Hospital Clinic Visits	0604	92012	Eye exam, established pat
		99201	Office/outpatient visit, new (Level 1)
		99211	Office/outpatient visit, est (Level 1)
		99241	Office consultation
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam Pt lops
		G0379	Direct admit hospital observ
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level 2)
		99212	Office/outpatient visit, est (Level 2)
		99213	Office/outpatient visit, est (Level 3)
		99243	Office consultation (Level 3)
		99242	Office consultation (Level 2)
		99273	Confirmatory consultation (Level 3)
		99272	Confirmatory consultation (Level 2)
		99431	Initial care, normal newborn
		G0246	Follow-up eval of foot pt lop
		G0344	Initial preventive exam
Level 3 Hospital Clinic Visits	0606	90862	Medication management
		92004	Eye exam, new patient
		99203	Office/outpatient visit, new (Level 3)
		99214	Office/outpatient visit, est (Level 4)

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FIGURE 13-3-14 ASSIGNMENT OF CPT E/M CODES AND OTHER HCPCS CODES TO NEW VISIT APCS FOR CY 2007 (CONTINUED)

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 3 Hospital Clinic Visits (Continued)	0606	99274	Confirmatory consultation (Level 4)
		99244	Office consultation (Level 4)
		M0064	Visit for drug monitoring
Level 4 Hospital Clinic Visits	0607	99204	Confirmatory consultation (Level 1)
		99215	Office/outpatient visit, est (Level 5)
		99245	Office consultation (Level 5)
		99275	Confirmatory consultation (Level 5)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level 5)
		G0175	OPPS service, sched team conf
Level 1 Type A Emergency Visits	0609	99281	Emergency department visit
Level 2 Type A Emergency Visits	0613	99282	Emergency department visit
Level 3 Type A Emergency Visits	0614	99283	Emergency department visit
Level 4 Type A Emergency Visits	0615	99284	Emergency department visit
Level 5 Type A Emergency Visits	0616	99285	Emergency department visit
Critical Care	0617	99291	Critical care, first hour
Trauma Activation	0618	G0390	Trauma Respon. w/hosp criti

O. OPPS PRICER.

1. Common PRICER software will be provided to the contractor that includes the following data sources:

a. National APC amounts

b. Payment status by HCPCS code

c. Multiple surgical procedure discounts

d. Fixed dollar threshold

e. Multiplier threshold

f. Device offsets

g. Other payment systems pricing files (CMAC, DMEPOS, and statewide prevailings)

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

a. Units;

b. HCPCS/Modifiers;

c. APC;

d. Status payment indicator;

e. Line item date of service;

f. Primary diagnosis code; and

g. Other necessary OCE output.

3. The following data elements will be passed into the PRICER by the contractors:

a. Wage indexes (same as DRG wage indexes);

b. Statewide CCRs as provided in the CMS Final Rule and listed on TMA's OPPS web site at http://www.tricare.mil/opps;

c. Locality Code: Based on CBSA - two digit = rural and five digit = urban;

d. Hospital Type: Rural SCH = 1 and All Others = 0

4. The outpatient PRICER will return the line item APC and cost outlier pricing information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary EOB with exception for an electronic 835 transaction. Paper EOBs and remits will reflect APCs at the line level and will also include indication of outlier payments and pricing information for those services reimbursed under other than OPPS methodology's, e.g., CMAC (SI of **A**) when applicable.

5. If a claim has more than one service with a SI of **T** or a SI of **S** within the coding range of 10000 - 69999, and any lines with SI of **T** or a SI within the coding range of 10000 - 69999 have less than $1.01 as charges, charges for all lines will be summed and the charges will then be divided up proportionately to the payment rates for each line (refer to Figure 13-3-15). The new charge amount will be used in place of the submitted charge amount in the line item outlier calculator.

FIGURE 13-3-15 PROPORTIONAL PAYMENT FOR "T" LINE ITEMS

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
T	$19,999	$6,000	$12,000
T	$1	$3,000	$6,000
T	$0	$1,000	$2,000
Total	$20,000	$10,000	$20,000

NOTE: Because total charges here are $20,000 and the first SI of T gets $6,000 of the $10,000 total payment, the new charge for that line is $6,000/$10,000 x $20,000 = $12,000.

P. TRICARE Specific Procedures/Services.

1. TRICARE specific APCs have been assigned for half-day PHPs.

2. Other procedures that are normally covered under TRICARE but not under Medicare will be assigned SI of **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.

Q. Validation Reviews.

OPPS claims are not subject to validation review.

R. Hospital-Based Birthing Centers.

Hospital-based birthing centers will be reimbursed the same as freestanding birthing centers except the all inclusive rate consisting of the CMAC for CPT[7] procedure code 59400 and the state specific non-professional component, will lag two months (i.e., April 1 instead of February 1).

IV. EFFECTIVE DATE May 1, 2009.

- END -

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