Chapter 1 Section 24

Hospital Reimbursement - Outpatient Services

Issue Date: March 10, 2000
Authority: 32 CFR 199.4(a)(3) and (a)(5)

1.0 APPLICABILITY

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

1.2 Hospital reimbursement - outpatient services for all services prior to implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of the Outpatient Prospective Payment System (OPPS), and thereafter, for services not otherwise reimbursed under hospital OPPS.

2.0 POLICY

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

2.2 For all other services, payment shall be made based on allowable charges when the claim has Healthcare Common Procedure Coding System (HCPCS) (Level I, II, III) coding information (these may include ambulance, Durable Medical Equipment (DME) and supplies, drugs administered other than oral method, and oxygen and related supplies). For claims development, see TRICARE Operations Manual (TOM), Chapter 8, Section 6. Other services without allowable charges, such as facility charges, shall be paid as billed. Facility charges shall have an HCPCS code on the claim for the specific service provided, e.g., Evaluation and Management (E&M) code if a visit, or surgical code if surgery. Only one facility charge (payment at billed charges), e.g., 510 and 760 series revenue codes on the same day, is allowed for a procedure or visit. For reimbursing drugs administered other than oral method, see Section 15, paragraph 3.3.1.

Note: Each line item on the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 claim form must be submitted with a specific date of service to avoid claim denial. The header dates of service on the CMS 1450 UB-04 may span, as long as all lines include specific dates of service within the span on the header.

2.3 When coding information is provided, outpatient hospital services including emergency and clinical services, clinical laboratory services (lab codes with one level of CMAC pricing, commonly referred to as the global rate, i.e., the same payment rate regardless of the site of service, e.g., doctor's office, hospital or lab), rehabilitation therapy, venipuncture, and radiology services are paid using existing allowable charges. Such services are reimbursed under the allowable charge methodology that would also include the CMAC rates. In addition, venipuncture services provided on an outpatient basis by institutional providers other than hospitals are also paid on this basis. Professional services billed on a CMS 1450 UB-04 will be paid at the professional CMAC if billed with the professional service revenue code and enough information to identify the rendering provider, or the claim will be denied.

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

Note: All hospital based ASC claims that are submitted to be paid under OPPS must be submitted with a Type Of Bill (TOB) 13X. If a claim is submitted to be paid with a TOB 83X the claim will be denied.

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

2.6 Surgical outpatient procedures which are not otherwise reimbursed under the hospital OPPS will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under OPPS for services rendered on or after implementation of OPPS. Refer to Section 16, paragraph 3.1.1.1 through 3.1.1.3 and Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3 for further detail.

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

2.8 Effective December 1, 2009, hospital outpatient services provided in a CAH, including ambulatory surgery services, shall be paid under the reasonable cost method, reference Chapter 15, Section 1.

2.9 Effective January 1, 2011, radiology services for cancer and children's hospitals will be reimbursed using a blend of facility-specific costs and the CMAC. The blend is based on a 42% weight for costs and a 58% weight for the technical portion of the CMAC (calculated as 62% of the global fee). TMA will calculate adjustment amounts that are due to cancer and children's hospitals from January 1, 2011 to June 30, 2012, and will provide the contractor with a list of authorized discretionary payment adjustments for processing. TMA will run a final report in 2013 to capture any claims filed within the one year claims filing deadline for this same time period and will provide the contractor with a list of payment adjustments for processing.

2.9.1 For hospital outpatient radiology services provided on or after July 1, 2012, the contractor shall use the following formula to calculate the TRICARE allowed amount for each hospital outpatient radiology claim:

0.42 (lower of costs or charges) + 0.58 (0.62 x global CMAC)

Costs = BC multiplied by the CCR;

BC = billed charge for that line item;

CCR = the hospital-specific outpatient Cost-to-Charge Ratio;

Global CMAC = the global CMAC for the CPT code (line item)

Note: The formula uses billed charges if they are lower than costs, which essentially caps the CCR at 1.0.

2.9.2 TMA will provide the contractor with the hospital outpatient Cost-to-Charge Ratio (CCR) file annually around the beginning of the calendar year. The CCR file will be effective on the same day as the annual CMAC update. The file will include the name of the hospital, the Medicare provider number, and the hospital outpatient CCR.

2.9.3 Applicable discount and cost-sharing shall be applied.

2.9.4 If there is no global CMAC fee, the allowed amount shall be equal to the lesser of billed charges or costs (billed charges multiplied by the CCR).

2.9.5 The blended rate methodology applies to CPT, Fourth Edition (CPT-4)[1] radiology codes 70010-79999 and HCPCS radiology codes G0130 and G0202-G0235.

2.9.6 Claims auditing software bundling edits shall be applied prior to calculating the blended rate.

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