Chapter 13 Section 2

Billing And Coding Of Services Under Ambulatory Payment Classifications (APC) Groups

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Authority: 10 USC 1079(i)(2) and 10 USC 1079(h)

1.0 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 Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

The billing and coding requirements for reimbursement under the hospital Outpatient Prospective Payment System (OPPS).

3.0 POLICY

3.1 To receive TRICARE Reimbursement under the OPPS providers must follow and contractors shall enforce all Medicare specific coding requirements.

Note: DHA will develop specific Ambulatory Payment Classifications (APCs) (those beginning with a "T") for those services that are unique to the TRICARE beneficiary population (e.g., maternity care). Reference DHA's OPPS web site at http://www.health.mil/rates for a listing of TRICARE APCs.

3.2 Packaging of Services Under APC Groups

3.2.1 The prospective payment system establishes a national payment rate, standardized for geographic wage differences, that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. These costs include, but are not limited to:

- Use of an operating suite.
- Procedure room or treatment room.
- Use of the recovery room or area.
- Use of an observation bed.

- Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations.
- Supplies and equipment for administering and monitoring anesthesia or sedation.
- Intraocular lenses (IOLs).
- Capital-related costs.
- Costs incurred to procure donor tissue other than corneal tissue.
- Incidental services.
- Implantable items used in connection with diagnostic X-ray testing, diagnostic laboratory tests, and other diagnostics.
- Implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices.
- Certain laboratory services.

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

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

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

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

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

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

3.2.2.2.1 Special transitional pass-through payments (additional payments) made for at least 2 years, but not more than three years for the following drugs and biologicals:

- Current orphan drugs, as designated under section 526 of the Federal Food, Drugs, and Cosmetic Act;
- Current drugs and biological agents used for treatment of cancer;
- Current radiopharmaceutical drugs and biological products; and
- New drugs and biologic agents in instances where the item was not being paid as a hospital outpatient service as of December 31, 1996, and where the cost of the item is "not insignificant" in relation to the hospital OPPS payment amount.

Note: The process to apply for transitional pass-through payment for eligible drugs and biological agents can be found on the Centers for Medicare and Medicaid Services (CMS) web site: http://www.cms.hhs.gov. The TRICARE contractors will not be required to review applications for pass through payment.

3.2.2.2.2 Separate APC payment for drugs and radiopharmaceuticals for which the median cost per line exceeds an amount determined each year by Medicare, and published in the Medicare final rule ($95 for CY 2015, $100 for CY 2016), with the exception of injectable and oral forms of antiemetics.

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

3.2.2.2.4 Separate payment for new drugs and biologicals that have assigned Healthcare Common Procedure Coding System (HCPCS) codes, but that do not have a reference Average Wholesale Price (AWP), approval for pass-through payment or hospital claims data.

3.2.2.2.5 Drugs and biologicals that have not been eligible for pass-through status but have been receiving nonpass-through payments since implementation of the Medicare OPPS.

3.2.2.2.6 Separate payment for new drugs, biologicals and radiopharmaceuticals enabling hospitals to begin billing for drugs and biologicals that are newly approved by the U.S. Food and Drug Administration (FDA), and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup.

3.2.2.2.7 Special APC groups that have been created to accommodate payment for new technologies. The drugs, biologicals and pharmaceuticals that are incorporated into these new technology APCs are paid separately from, and in addition to, the procedure or treatment with which they are associated yet are not eligible for transitional pass-through payment. Payment of new technology APCs is available only if the service meets the requirements of 32 CFR 199.4.

3.2.2.2.8 New drugs, biologicals, and devices which qualify for separate payment under OPPS, but have not yet been assigned to a transitional APC (i.e., assigned to a temporary APC for separate payment of an expensive drug or device) will be reimbursed under TRICARE standard allowable

charge methodology. This allowable charge payment will continue until a transitional APC has been assigned (i.e., until CMS has had the opportunity to assign the new drug, biological or device to a temporary APC for separate payment).

Note: The contractors will not be held accountable for the development of transitional APC payments for new drugs, biologicals or devices.

3.2.2.3 Corneal tissue acquisition costs.

- Corneal tissue acquisition costs not packaged into the payment rate for corneal transplant surgical procedures.
- Separate payment will be made based on the hospital's reasonable costs incurred to acquire corneal tissue.
- Corneal acquisition costs must be submitted using HCPCS code V2785 (Processing, Preserving and Transporting Corneal Tissue), indicating the acquisition cost rather than the hospital's charge on the bill.

3.2.2.4 Costs for other procedures or services not packaged in the APC payment.

- Blood and blood products, including anti-hemophilic agents.
- Casting, splinting and strapping services.
- Immunosuppressive drugs for patients following organ transplant.
- Certain other high cost drugs that are infrequently administered.

Note: New APC groups have been created for these items and services, which allows separate payment.

3.2.2.5 Reporting Requirements for Device Dependent Procedures.

Hospitals are required to bill all device-dependent procedures using the appropriate HCPCS **C**-codes for the devices. Following are provisions related to the required use of **C**-codes:

3.2.2.5.1 Hospitals are required to report device category codes on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPPS in order to improve the claims data used annually to update the OPPS payment rates.

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

3.2.2.5.2.1 These edits will be applied at the Current Procedural Terminology (CPT) and HCPCS code levels rather than at the APC level.

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

3.2.2.5.3 Composite APCs provide a single payment when more than one of a specified set of major independent services are provided in a single encounter. When HCPCS codes that meet

certain criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code. For those services considered to be a TRICARE benefit, TRICARE adopts the composite APC logic as established by Medicare. See the Medicare Claims Processing Manual, Chapter 4, Section 10.2.1 for current composite APC logic. See the TRICARE rates web site at http://www.health.mil/rates for the national unadjusted payment rates for these composite APCs.

3.2.2.5.4 Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim are packaged into payment for the primary service. With some exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service. HCPCS codes assigned to comprehensive APCs are designated with Status Indicator (SI) **J1**. When multiple **J1** services are reported on the same claim, the single payment is based on the rate associated with the highest ranking **J1** service. When certain pairs of **J1** services, or in certain cases a **J1** service and add-on code, are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family. Please see the Medicare Claims Processing Manual, Chapter 4, Section 10.2.3 for detailed logic for comprehensive APCs, including descriptions of those services included in the comprehensive APC payment, and those limited exceptions. For those services considered to be a TRICARE benefit, TRICARE adopts the comprehensive APC logic as established by Medicare. See the TRICARE rates web site at http://www.health.mil/rates for the national unadjusted payment rates for comprehensive APCs.

3.2.2.5.5 Beginning January 1, 2016, all qualifying extended assessment and management encounters will be paid through a newly created "comprehensive observation services" C-APC. Please see paragraph 3.8 for more information.

3.3 Additional Payments Under The OPPS

3.3.1 Certain clinical diagnostic testing (lab work).

3.3.2 Administration of infused drugs.

3.3.3 Therapeutic procedures including resuscitation that are furnished during the course of an emergency visit.

3.3.4 Certain high-cost drugs, such as the expensive "clotbuster" drugs that must be given within a short period of time following a heart attack or stroke.

3.3.5 Cases that fall far outside the normal range of costs. These cases will be eligible for an outlier adjustment.

3.4 Payment For Patients Who Die In The Emergency Department (ED)

3.4.1 If the patient dies in the ED, and the patient's status is outpatient, the hospital should bill for payment under the OPPS for the services furnished.

3.4.2 If the ED or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient.

- If the patient had been admitted as an inpatient, pay under the hospital DRG-based payment system.
- If the patient was not admitted as an inpatient, pay under the OPPS (an APC-based payment) for the services that were furnished.
- If the patient was not admitted as an inpatient and the procedure designated as an inpatient-only procedure (by OPPS payment SI of **C**) is performed, the hospital should bill for payment under the OPPS for the services that were furnished on that date and should include modifier -CA on the line with the HCPCS code for the inpatient procedure. Payment for all services other than the inpatient procedure designated under OPPS by the SI of **C**, furnished on the same date, is bundled into a single payment under APC 0375. Beginning January 1, 2016, APC 0375 will be renumbered to APC 5881, and all services reported on the same claim as an inpatient only procedure with modifier "-CA" will be paid through a single prospective payment for the comprehensive service.

3.4.3 Billing and Payment Rules for Using Modifier -CA. Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission.

3.4.3.1 All the following conditions must be met in order to receive payment for services billed with modifier -CA:

- The status of the patient is outpatient;
- The patient has an emergent, life-threatening condition;
- A procedure on the inpatient list (designated by payment SI of **C**) is performed on an emergency basis to resuscitate or stabilize the patient; and
- The patient dies without being admitted as an inpatient.

3.4.3.2 If all of the conditions for payment are met, the claim should be submitted using a 013X bill type for all services that were furnished, including the inpatient procedure (e.g., a procedure designated by OPPS payment SI of **C**). The hospital should include modifier -CA on the line with the HCPCS code for the inpatient procedure.

Note: When a line with a procedure code that has a SI of **C** assigned and has a patient status of "20" (deceased) and one of the modifiers is "CA" (patient dies). The OCE software will change the SI of the procedure to **S** and price the line using the adjusted APC rate formula.

3.4.3.3 Payment for all services on a claim that have the same date of service as the HCPCS billed with modifier -CA is made under APC 0375. Separate payment is not allowed for other services furnished on the same date.

3.4.3.4 Beginning January 1, 2016, APC 0375 will be renumbered to APC 5881, and all services reported on the same claim as an inpatient only procedure with modifier "-CA" will be paid through a single prospective payment for the comprehensive service.

3.5 Medical Screening Examinations

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

3.5.2 If no treatment is furnished, medical screening examinations would be billed with a low-level ED code.

3.6 HCPCS/Revenue Coding Required Under OPPS

Hospital Outpatient Departments (HOPDs) should use the CMS 1450 UB-04 Editor as a guide for reporting HCPCS and revenue codes under the OPPS.

3.7 Treatment of Partial Hospitalization Services

Hospital-based Partial Hospitalization Programs (PHPs) (psych and Substance Use Disorder Rehabilitation Facilities (SUDRFs)) will be reimbursed a per diem payment under the OPPS. Freestanding PHPs (psych and SUDRFs) are reimbursed under the existing PHP per diem payment. See Chapter 7. Separate TRICARE certification of hospital-based psychiatric PHPs is not required, making all hospital-based PHPs eligible for payment under TRICARE's OPPS.

3.7.1 Services of physicians, clinical psychologists, Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs), and Physician Assistants (PAs) furnished to partial hospitalization patients are billed separately as professional services and are not considered to be partial hospitalization services.

3.7.2 Payment for PHP (psych) services represents the provider's overhead costs, support staff, and the services of Clinical Social Workers (CSWs) and Occupational Therapists (OTs), whose professional services are considered to be included in the PHP per diem rate. For SUDRFs, the costs of alcohol and addiction counselor services would also be included in the per diem.

- Hospitals will not bill the contractor for the professional services furnished by CSWs, OTs, and alcohol and addiction counselors.

- Rather, the hospital's costs associated with the services of CSWs, OTs, and alcohol and addiction counselors will continue to be billed to the contractor and paid through the PHP per diem rate.

3.7.3 PHP should be a highly structured and clinically-intensive program, usually lasting most of the day. Since a day of care is the unit that defines the structure and scheduling of partial hospitalization services, a two-tiered payment approach has been retained, one for days with three services (APC 0175) and one for days with four or more services (APC 0176) to provide PHPs scheduling flexibility and to reflect the lower costs of a less intensive day. PHP programs offering "Intensive Outpatient Therapy" or IOP, provided less than five days per week, at least three hours per day but less than six hours per day, may be appropriate for patients who do not require the

more intensive level of care, or for those who have completed a more intense inpatient or partial hospitalization stay.

3.7.3.1 However, it was never the intention of this two-tiered per diem system that only three units of service should represent the number of services provided in a typical day. The intention of the two-tiered system was to cover days that consisted of three units of service only in certain limited circumstances; e.g., three-service days may be appropriated when a patient is transitioning towards discharge or days when a patient who is transitioning at the beginning of his or her PHP stay.

3.7.3.2 Programs that provide four or more units of service should be paid an amount that recognizes that they have provided a more intensive day of care. A higher rate for more intensive days is consistent with the goal that hospitals provide a highly structured and clinically-intensive program.

3.7.3.3 The OCE logic will require that hospital-based PHPs provide a minimum of three units of service per day in order to receive PHP payment. Payment will be denied for days when fewer than three units of therapeutic services are provided. The three units of service are a minimum threshold that permits unforeseen circumstances, such as medical appointments, while allowing payment, but still maintains the integrity of a comprehensive program. An exception to the requirement for three units for service is made for programs billing with HCPCS codes S9480 or H0015. However, because these codes represent comprehensive programs, they must represent a program providing at a minimum three hours of service per day.

3.7.3.4 PHPs may provide IOP services for either psychiatric or substance use disorder treatment. Hospital-based PHPs or SUDRFs may provide partial hospitalization services, also referred to as IOP, provided less than five days per week, at least three hours per day but less than six hours per day. Hospital-based PHPs providing psychiatric or substance use disorder IOP services, may submit reimbursement for one unit of HCPCS codes S9480 or H0015 for each day of service to represent these services. These codes will be assigned to an APC with the same payment rate as APC 0175. Reimbursement is only allowed for hospital-based PHP programs that provide IOP services; reimbursement is not available for hospital-based IOPs that are not PHPs. Also, see the TRICARE Policy Manual (TPM), Chapter 7, Sections 3.4 and 3.5. For hospital-based services rendered in a non-PHP program, see paragraph 3.7.4.

3.7.3.5 The following are billing instructions for submission of partial hospitalization claims/ services:

3.7.3.5.1 Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services. This means that each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

3.7.3.5.2 A complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services or other mental health services outside partial hospitalization is available in the Medicare Claims Processing Manual, Chapter 4, Section 260.1.

3.7.3.5.3 To bill for partial hospitalization services under the hospital OPPS, hospitals are to report partial hospitalization services under bill type 013X, along with Condition Code **41** on the CMS 1450 UB-04 claim form.

3.7.3.5.4 The claim must include a mental health diagnosis and an authorization on file for each day of service. Since there is no HCPCS code that specifies a partial hospitalization related service, partial hospitalizations are identified by means of a particular bill type and condition code (i.e., 13X Type of Bill (TOB) with Condition Code **41**) along with HCPCS codes specifying the individual services that constitute PHPs. In order to be assigned payment under Level II Partial Hospitalization Payment APC (0176) there must be four or more codes from PHP List B of which at least one code must come from PHP List A. In order to be assigned payment under Level I Partial Hospitalization Payment APC (0175) there must be a least three codes from PHP List B of which at least one code must come from PHP List A. List A is a subset of List B and contains only psychotherapy codes, while List B includes all PHP codes. (Refer to PHP Lists A and B in Figure 13.2-1). All other PHP services rendered on the same day will be packaged into the PHP APCs (0175 and 0176). All PHP lines will be denied if there are less than three codes/service appearing on the claim.

FIGURE 13.2-1 PHP AS OF CY 2015

PHP LIST A	PHP LIST B			PHP LIST C*
90832	90785	90845	96119	90785
90834	90791	90846	96120	90833
90837	90792	90847	96129	90836
90845	90832	90865	G0176	90838
90846	90833	96101	G0177	
90847	90834	96102	G0410	
90865	90836	96103	G0411	
G0410	90837	96116		
G0411	90838	96118		

* Add-on codes that are not counted in meeting the numerical requirement for APC assignment.

3.7.3.5.5 In order to assign the partial hospitalization APC to one of the line items the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC. All other partial hospital services on the same day are packaged; (i.e., the SI is changed from **Q** to **N**.) Partial hospitalization services with SI **E** (items or services that are not covered by TRICARE) or **B** (more appropriate code required for TRICARE OPPS) are not packaged and are ignored in the PHP processing. See the Medicare Claims Processing Manual, Chapter 4, Section 260.1 for additional details on PHP claims processing in hospitals subject to OPPS.

3.7.3.5.6 Each day of service will be assigned to a partial hospitalization APC, and the partial hospitalization per diem will be paid. Only one PHP APC will be paid per day.

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

3.7.3.5.8 Hospitals must report the number of times the service or procedure was rendered, as defined by the HCPCS code.

3.7.3.5.9 Dates of service per revenue code line for partial hospitalization claims that span two or more dates. Each service (revenue code) provided must be repeated as a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are

reported in "Service Date." Following are examples of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

FIGURE 13.2-2 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - HIPAA 837 FORMAT

RECORD TYPE	REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGE
61	0915	90849	19980505	1	$80
61	0915	90849	19980529	2	$160

FIGURE 13.2-3 REPORTING OF PARTIAL HOSPITALIZATION SERVICES SPANNING TWO OR MORE DATES - CMS 1450 FORMAT

REVENUE CODE	HCPCS	DATES OF SERVICE	UNITS	TOTAL CHARGES
0915	90849	050598	1	$80
0915	90849	052998	2	$160

Note: Each line item on the 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.

3.7.4 Reimbursement for a day of outpatient mental health services in a non-PHP program (i.e., those mental health services that are not accompanied with a Condition Code **41**) will be capped at the partial hospital per diem rate. The payments for all of the designated Mental Health (MH) services will be totaled with the same date of service. If the sum of the payments for the individual MH services standard APC rules, for which there is an authorization on file, exceeds the Level II Partial Hospitalization APC (0176), a special MH services composite payment APC (APC 0034) will be assigned to one of the line items that represent MH services. All other MH services will be packaged. The MH services composite payment APC amount is the same as the Level II Partial Hospitalization APC per diem rate. MH services with SI **E** or **B** are not included in payments that are totaled and are not assigned the daily mental health composited APC amount.

3.7.5 Beginning January 1, 2016, APC 0175 and 0176 are renumbered to 5861 and 5862, respectively.

3.7.6 Freestanding psychiatric partial hospitalization services will continue to be reimbursed under all-inclusive per diem rates established under Chapter 7, Section 2.

3.8 Payment Policy for Observation Services

3.8.1 Beginning January 1, 2014, in certain circumstances when observation care is billed in conjunction with a clinical visit, high level Type **A** ED visit (level 4 or 5), high level type **B** ED visit (level 5), critical care services, or a direct referral as an integral part of a patients extended encounter of care, payment may be made for the entire encounter through APC 8009. APCs 8002 and 8003 were deleted as of January 1, 2014. APC 8009 is deleted effective January 1, 2016. See the Medicare Claims Processing Manual, Chapter 4, Sections 10.2.1, 290.5.1. and 290.5.2 for observation stays for non-maternity conditions.

3.8.2 Beginning January 1, 2016, all qualifying extended assessment and management encounters will be paid through a "Comprehensive Observation Services" Comprehensive -APC (C-APC), 8011, and will assign the services within this APC to SI of **J2**. In order to be eligible for payment under this C-APC, claims must meet the following criteria:

- The claims do not contain a procedure described by a HCPCS code with assigned SI of **T** that is reported with a date of service on the same day or one day earlier than the date of service associated with services described by HCPCS code G0378;
- The claims contain eight or more units of services described by HCPCS code G0378 (Observation services, per hour);
- The claims contain services described by one of the following codes: HCPCS code G0379 on the same date of service as services described by HCPCS code G0378; CPT[1] code 99284; CPT[1] code 99285 or HCPCS code G0384; CPT[1] code 99291; or HCPCS code G0463 provided on the same date of service or one day before the date of service for services described by HCPCS code G0378; and
- The claims do not contain services described by a HCPCS code with assigned SI of **J1**.
- Observations for maternity conditions that meet the above criteria will be reimbursed utilizing this logic. See paragraph 3.8.3 for all other maternity observation services.

3.8.3 Observations For Maternity Conditions

3.8.3.1 Maternity observation stays will continue to be paid separately under TRICARE APC T0002 using HCPCS code G0378 (Hospital observation services by hour) if the following criteria are met:

3.8.3.1.1 The maternity observation claim must have a maternity diagnosis as Principal Diagnosis (PDX) or Reason Visit Diagnosis (VRDX). Refer to DHA's OPPS web site (http://www.health.mil/rates) for the listing of maternity diagnoses.

3.8.3.1.2 The number of units reported with HCPCS code G0378 must be at a minimum four hours per observation stay; and

3.8.3.1.3 No procedure with a SI of **T** can be reported on the same day or day before observation care is provided.

3.8.3.2 If the above criteria are not met, the maternity observation will remain bundled (i.e., the SI for HCPCS code G0378 will remain **N**).

3.8.3.3 Multiple maternity observations on a claim are paid separately if the required criteria are met for each observation and Condition Code **G0** is present on the claim or modifier 27 is present on additional lines with HCPCS code G0378.

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3.8.3.4 If multiple payable maternity observations are submitted without Condition Code **G0** or modifier 27, the first encountered is paid and additional observations for the same day are denied.

3.9 Inpatient Only Procedures

3.9.1 The inpatient list on DHA's OPPS web site at http://www.health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/Inpatient-Procedures specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient.

3.9.1.1 The list is updated quarterly and reflects CMS changes. The Director may make exceptions to Medicare's Inpatient Only List and include those exceptions in the April or October quarterly updates for those inpatient procedures, which upon medical review, may be safely and efficaciously rendered in an outpatient setting due to TRICARE's younger, healthier beneficiary population. Exceptions will be made based on standardized utilization review criteria used by the Managed Care Support Contractors (MCSCs).

3.9.1.1.1 The Contractor shall identify those procedures that they believe should be removed from or added to the list of inpatient procedures, along with support from standardized utilization management (UM) review criteria. Requests shall be submitted to the Medical Benefits & Reimbursement Section (MB&RS) through the applicable Contracting Officer's Representative. If standardized UM criteria are not provided with the request, the Director will not consider the procedure for modification. Contractors may submit procedures for consideration at any time; however, to be considered for the following April or October update, procedures and supporting criteria must be submitted by January 15 to be considered for the April update, and by July 15, to be considered for the following October update.

3.9.1.1.2 If the Director's review determines a modification to the inpatient list is warranted, the procedure will be assigned to an appropriate APC and rate. If there is a similar procedure, with an assigned APC under OPPS, the Director will assign the newly-approved procedure to that APC with corresponding status indicator (SI) and rate. If there is no appropriate APC, the Director will create a TRICARE-specific APC based on a method similar to that of Medicare, which identifies the geometric mean for all costs for the procedure, and then standardize those costs to the geometric mean cost of APC 5012 to provide an APC weight. This weight is then scaled by the Budget Neutrality Factor required by the Social Security Act, as specified in the annual CMS OPPS Final Rule. The final APC weight is multiplied by the appropriate conversion factor to determine the TRICARE-specific APC payment amount. In the case that no APC amount can be determined based on claims data, APC T9999 and SI of T will be assigned to the procedure. When sufficient claims data exist, an APC amount shall be determined based on the provisions of this paragraph. The final APC weight and payment amount will be provided to the contractor building the OPPS pricer for inclusion in the software.

3.9.1.1.3 Effective April 1, 2017, individuals who have dual eligibility under both TRICARE and Medicare are not eligible for cost-sharing for TRICARE exceptions to Medicare's Inpatient Only List.

3.9.1.1.4 Exceptions to the Inpatient Only List shall not be made on a case-by-case basis. The Director's determination of whether a procedure is removed from the Inpatient Only List is not

based on medical review of individual beneficiary claims, but on generally accepted medical standards of practice as substantiated by standardized utilization management review criteria.

3.9.1.2 Denial of payment for procedures on the Inpatient Only List is appealable under the Appeal of Factual (Non-Medical Necessity) Determinations. Refer to the TRICARE Operations Manual (TOM), Chapter 12, Section 5 for appeal procedures.

3.9.1.3 Refer to Chapter 1, Section 16, for additional information regarding TRICARE's Inpatient Only List.

3.9.2 Under the hospital outpatient PPS, payment will not be made for procedures that are designated as "inpatient only". Refer to DHA's Inpatient Procedures web site at http://www.health.mil/rates for a list of "inpatient only" procedures.

3.9.3 There are three exceptions to the policy of not paying for outpatient services furnished on the same day with an "inpatient-only" service that would be paid under the OPPS if the inpatient service had not been furnished:

3.9.3.1 For outpatients who undergo inpatient-only procedures on an emergency basis and who expire before they can be admitted to the hospital, a specified APC payment is made to the provider as reimbursement for all services on that day. The presence of modifier -CA on the inpatient-only procedure line assigns the specified payment APC and associated status and payment indicators to the line. The packaging flag is turned on for all other lines on that day. Payment is only allowed for one procedure with modifier -CA. If multiple inpatient-only procedures are submitted with the modifier -CA, only one procedure is paid and all others are packaged. If multiple units are submitted on a payable inpatient-only procedure line, the OCE resets the service units to one. If modifier -CA is submitted with an inpatient-only procedure for a patient who did not expire (patient status code is not 20), the claim is suspended for data validation. Beginning January 1, 2016, APC 0375 will be renumbered to APC 5881, and all services reported on the same claim as an inpatient only procedure with modifier "-CA" will be paid through a single prospective payment for the comprehensive service. Also, beginning January 1, 2016, the assignment of the C-APC will be across the claim, rather than the day. See paragraph 3.4.3.4.

3.9.3.2 Inpatient-only procedures that are on the separate-procedure list are bypassed when performed incidental to a surgical procedure with SI of **T**. The line(s) with the inpatient-separate procedure is denied and the claim is processed according to usual OPPS rules.

3.9.3.3 Inpatient-only procedures are allowed on outpatient claims for Supplemental Health Care Program (SHCP) beneficiaries. If a line item with an inpatient-only procedure (SI = **C**) is reported, the inpatient-only logic is bypassed for the day and all procedures with SI = **C** on the same date of service have their SI changed to **T** (and assigned to APC T9999).

3.10 Billing Of Condition Codes Under OPPS

The CMS 1450 UB-04 Claim Form allows 11 values for condition codes, however, the OCE can only accommodate seven, therefore, OPPS hospitals should list those condition codes that affect outpatient pricing first.

3.11 Billing for Wound Care Services

3.11.1 A list of CPT codes are classified as "sometimes therapy" services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care is located at http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html.

3.11.2 Hospitals would receive separate payment under the OPPS when they bill for wound care services listed as "sometimes therapy" codes that are furnished to hospital outpatients by individuals independent of a therapy plan of care.

3.11.3 When these services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, **GP** for Physical Therapy (PT), **GO** for Occupational Therapy (OT), and **GN** for Speech-Language Pathology (SLP)) or report their charges under a therapy revenue code (that is, 0420, 0430, or 0440) or both, to receive payment under the professional fee schedule.

3.11.4 The OCE logic assigns these services to the appropriate APC for payment under the OPPS if the services are not provided under a certified therapy plan of care or directs contractors to the fee schedule payment rates if the services are identified on hospital claims with therapy modifier or therapy revenue code as a therapy service.

3.11.5 See the Medicare Claims Processing Manual, Chapter 4, Section 200.9 for more information on "sometimes therapy" codes.

4.0 EFFECTIVE DATE

May 1, 2009.

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