CHAPTER 13
SECTION 1

GENERAL

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

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

I. APPLICABILITY

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

II. ISSUE

A general overview of the coverage and reimbursement of hospital outpatient services.

III. POLICY

A. Statutory Background.

Under 10 U.S.C. 1079(j)(2), the amount to be paid to hospitals, skilled nursing facilities (SNFs), and other institutional providers under TRICARE may, by regulation, be established "to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare." Similarly, under 10 U.S.C. 1079(h), the amount to be paid to health care professionals and other non-institutional health care providers "shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules used by Medicare." Based on these statutory provisions, TRICARE will adopt Medicare's prospective payment system for reimbursement of hospital outpatient services currently in effect for the Medicare program as required under the Balanced Budget Act of 1997 (the BBA 1997), (Pub. L. 105-33) which provided comprehensive provisions for establishment of a hospital outpatient prospective payment system (PPS). The Act required development of a classification system for covered outpatient services that consisted of groups arranged so that the services within each group were comparable clinically and with respect to the use of resources. The Act described the method for determining the Medicare payment amount and the beneficiary coinsurance amount for services covered under the outpatient PPS. This included the formula for calculating the conversion factor and data requirements for establishing relative payment weights.

Centers for Medicare and Medicaid Services (CMS) published a proposed rule in the

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Federal Register on September 8, 1998 (63 FR 47552) setting forth the proposed PPS for hospital outpatient services. On June 30, 1999, a correction notice was published (64 FR 35258) to correct a number of technical and typographical errors contained in the September 8, 1998 proposed rule.

Subsequent to publication of the proposed rule, the Balanced Budget Refinement Act of 1999 (the BBRA 1999 - enacted on November 29, 1999) made major changes that affected the proposed outpatient PPS. The following BBRA 1999 provisions were implemented in a final rule (65 FR 18434) published on April 7, 2000):

1. Made adjustments for covered services whose costs exceeded a given threshold (i.e., an outlier payment).

2. Established transitional pass-through payments for certain medical devices, drugs, and biologicals.

3. Placed limitations on judicial review for determining outlier payments and the determination of additional payments for certain medical devices, drugs, and biologicals.

4. Included as covered outpatient services implantable prosthetics and DME and diagnostic x-ray, laboratory, and other tests associated with those implantable items.

5. Limited the variation of costs of services within each payment classification group by providing that the highest median cost for an item or service within the group cannot be more than 2 times greater than the lowest median cost for an item or service within the group (referred to as the "2 times rule"). An exception to this requirement may be made in unusual cases, such as low volume items and services, but may not be made in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

6. Required at least annual review of the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, the addition of new services, new cost data, and other relevant information or factors.

7. Established transitional corridors that would limit payment reductions under the hospital outpatient PPS.

8. Established hold harmless provisions for rural and cancer hospitals.

B. Participation Requirement.

In order to be an authorized provider under the TRICARE OPPS, an institutional provider must be a participating provider for all claims in accordance with 32 CFR 199.6(a)(8).

C. Unbundling Provisions.

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As a prelude to implementation of the OPPS, OBRA 1996 prohibited payment for nonphysician services furnished to hospital patients (inpatients and outpatients), unless the services were furnished either directly or under arrangement with the hospital except for services of physician assistants, nurse practitioners and clinical nurse specialists. This facilitated the payment of services included within the scope of each APC. The Act provided for the imposition of civil money penalties not to exceed $2,000, and a possible exclusion from participation in Medicare, Medicaid and other Federal health care programs for any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service that violates the requirement for billing subject to the following exceptions:

1. Payment for clinical diagnostic lab may be made only to the person or entity that performed or supervised the performance of the test. In the case of a clinical diagnostic laboratory test that is provided under arrangement made by a hospital or CAH, payment is made to the hospital. The hospital is not responsible for billing for the diagnostic test if a hospital patient leaves the hospital and goes elsewhere to obtain the diagnostic test.

2. Skilled nursing facility (SNF) consolidated billing requirements do not apply to the following exceptionally intensive hospital outpatient services:

a. Cardiac catheterization;

b. Computerized axial tomography (CAT) scans;

c. MRIs;

d. Ambulatory surgery involving the use of an operating room;

e. Emergency room services;

f. Radiation therapy;

g. Angiography; and

h. Lymphatic and venous procedures.

NOTE: The above procedures are subject to the bundling requirements while the beneficiary is temporarily absent from the SNF. The beneficiary is now considered to be a hospital outpatient and the services are subject to hospital outpatient bundling requirements.

D. Applicability and Scope of Coverage.

Following are the providers and services for which TRICARE will make payment under the OPPS.

1. Provider Categories.

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a. Providers Included In Outpatient PPS:

(1) All hospitals participating in the Medicare program, except for those excluded under paragraph (b).

(2) Hospital-based partial hospitalization programs that are subject to the more restrictive TRICARE authorization requirements under 32 CFR 199.6(b)(4)(xii). Following are the specific requirements for authorization and payment under the Program:

(a) Be certified pursuant to TRICARE certification standards.

(b) Be licensed and fully operational for a period of six months (with a minimum patient census of at least 30 percent of bed capacity) and operate in substantial compliance with state and federal regulations.

(c) Currently accredited by the Joint Commission on Accreditation of Healthcare Organizations under the current edition of the Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Development Disabilities Services.

(d) Has a written participation agreement with TRICARE.

(3) Hospitals or distinct parts of hospitals that are excluded from the inpatient DRG to the extent that the hospital or distinct part furnishes outpatient services.

NOTE: All hospital outpatient departments will be subject to the OPPS unless specifically excluded under this Chapter (TRM, Chapter 13). The marketing contractor will have responsibility for educating providers to bill under the OPPS even if they are not a Medicare participating/certified provider (i.e., not subject to the DRG inpatient reimbursement system).

b. Providers Excluded From Outpatient PPS:

(1) Outpatient services provided by hospitals of the Indian Health Service (IHS) will continue to be paid under separately established rates.

(2) Certain hospitals in Maryland that qualify for payment under the state's cost containment waiver.

(3) Critical access hospitals. The contractors are required on a monthly basis to access the critical access hospital listing at http://www.flexmonitoring.org and update their systems to reflect the most current information on the list.

(4) Hospitals located outside one of the 50 states, the District of Columbia, and Puerto Rico.

(5) Specialty care providers to include:

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(a) Cancer and children's hospitals

(b) Freestanding Ambulatory Surgery Centers (ASCs)

(c) Freestanding Partial Hospitalization Programs (PHPs)

(d) End Stage Renal Dialysis (ESRD) facilities

(e) Comprehensive Outpatient Rehabilitation Facilities (CORFs)

(f) Home Health Agencies (HHAs)

(g) Hospice programs

(h) Community Mental Health Centers (CMHCs)

NOTE: Community Mental Health Center (CMHC) PHPs have been excluded from provider authorization and payment under the OPPS due to their inability to meet the more stringent certification criteria currently imposed for hospital-based and freestanding PHPs under the Program.

(i) Other corporate services providers (e.g., Freestanding Cardiac Catheterization and Sleep Disorder Diagnostic Centers).

NOTE: Antigens, splints, casts and hepatitis B vaccines furnished outside the patient's plan of care in CORFs, HHAs and hospice programs will continue to receive reimbursement under current TRICARE allowable charge methodology.

(j) Freestanding Birthing Centers.

2. Scope of Services

a. Services excluded under the hospital OPPS and paid under the CHAMPUS Maximum Allowable Charge (CMAC) or other TRICARE recognized allowable charge methodology.

(1) Physician services.

(2) Nurse practitioner and clinical nurse specialist services.

(3) Physician assistant services.

(4) Certified nurse-midwife services.

(5) Services of qualified psychologists.

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(6) Clinical social worker services.

(7) Services of an anesthetist.

(8) Screening and diagnostic mammographies.

(9) Influenza and pneumococcal pneumonia vaccines.

NOTE: Hospitals, home health agencies (HHAs), and hospices will continue to receive CMAC payments for influenza and pneumococcal pneumonia vaccines due to considerable fluctuations in their availability and cost.

(10) Services for patients with ESRD along with related drugs and supplies, will be paid under the current TRICARE allowable charge methodology. Refer to TRICARE Policy Manual, Chapter 7, Section 4.2 for coverage guidelines.

(a) Hospital ESRD facilities must submit ESRD dialysis, and those items and services directly related to the dialysis (e.g., drugs and supplies), on a claim separate from non-related ESRD dialysis services.

(b) Items and services not related to the dialysis are required to be billed by the hospital using the hospital bill type. This requirement is necessary to properly pay the non-related ESRD services under OPPS.

(11) Clinical diagnostic laboratory services.

(12) Take home surgical dressings.

(13) Non-implantable DME, orthotics, prosthetics, and prosthetic devices and supplies (DMEPOS) paid under the DMEPOS fee schedule when the hospital is acting as a supplier of these items.

(a) An item such as crutches or a walker that is given to the patient to take home, but that may also be used while the patient is at the hospital, would be paid for under the hospital outpatient PPS.

(b) Payment may not be made for items furnished by a supplier of medical equipment and supplies unless the supplier obtains a supplier number. However, since there is no reason to split a claim for DME payment under TRICARE, a separate supplier number will not be required for a hospital to receive reimbursement for DME.

(14) Hospital outpatient services furnished to SNF inpatients as part of his or her resident assessment or comprehensive care plan that are furnished by the hospital "under arrangements" but billable only by the SNF.

(15) Services and procedures designated as requiring inpatient care.

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(16) Services excluded by statute (excluded from the definition of "covered Outpatient Department (OPD) Services"):

(a) Ambulance services

(b) Physical therapy

(c) Occupational therapy

(d) Speech-language pathology

NOTE: The above services are subject to the CMAC or other TRICARE recognized allowable charge methodology (e.g., statewide prevailings).

(17) Ambulatory surgery procedures performed in Freestanding ASCs will continue to be reimbursed under the per diem system established in Chapter 9, Section 1 of this manual.

b. Costs excluded under the hospital outpatient PPS:

(1) Direct cost of medical education activities.

(2) Costs of approved nursing and allied health education programs.

(3) Costs associated with interns and residents not in approved teaching programs.

(4) Costs of teaching physicians.

(5) Costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (certified registered nurse anesthetists (CRNA) and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals.

(6) Bad debts for uncollectible and coinsurance amounts.

(7) Organ acquisition costs.

(8) Corneal tissue acquisition costs incurred by hospitals that are paid on a reasonable cost basis.

c. Services included in payment under the OPPS (not an all-inclusive list).

(1) Hospital-based full- and half-day partial hospitalization programs which are paid a per diem outpatient PPS. Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients who

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have profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

(2) All hospital outpatient services, except those that are identified as excluded. They include the following:

(a) Surgical procedures

NOTE: Hospital-based ambulatory surgery center (ASC) procedures will be included in the OPPS/APC system even though they are currently paid under the ASC grouper system. The new OPPS/APC system covers procedures on the ASC list when they are performed in a hospital outpatient department, hospital emergency room, or hospital based ambulatory surgery center. ASC group payment will still apply when they are performed in free-standing ASCs.

(b) Radiology, including radiation therapy

(c) Clinic visits

(d) Emergency department visits

(e) Diagnostic services and other diagnostic tests

(f) Surgical pathology

(g) Cancer chemotherapy

(h) Implantable medical items

1 Prosthetic implants (other than dental) that replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care and including replacement of these devices);

2 Implantable DME (e.g., pacemakers, defibrillators, drug pumps, and neurostimulators)

3 Implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

NOTE: Because implantable items are now packaged into the APC payment rate for the service or procedure with which they are associated, certain items may be candidates for the transitional pass-through payment.

(i) Specific hospital outpatient services furnished to a beneficiary who is admitted to a Medicare-participating SNF but who is not considered to be a SNF resident,

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for purposes of SNF consolidated billing, with respect to those services that are beyond the scope of SNF comprehensive care plans. They include:

1 Cardiac catheterization

2 Computerized axial tomography (CAT) scans

3 MRIs

4 Ambulatory surgery involving the use of an operating room

5 Emergency room services

6 Radiation therapy

7 Angiography

8 Lymphatic and venous procedures

(j) Certain preventive services furnished to healthy persons, such as colorectal cancer screening.

(k) Acute dialysis (e.g., dialysis for poisoning).

E. Description of Ambulatory Payment Classification (APC) Groups.

Group services identified by HCPCS codes and descriptors within APC groups are the basis for setting payment rates under the hospital outpatient PPS.

1. Grouping of Procedures/Services Under APC System.

The APC system establishes groups of covered services so that the services within each group are comparable clinically and with respect to the use of resources.

a. Fundamental criteria for grouping procedures/services under the APC system:

(1) *Resource Homogeneity* - The amount and type of facility resources (e.g., operating room time, medical surgical supplies, and equipment) that are used to furnish or perform the individual procedures or services within each APC should be homogeneous. That is, the resources used are relatively constant across all procedures or services even though resource use may vary somewhat among individual patients.

(2) *Clinical Homogeneity* - The definition of each APC group should be "clinically meaningful"; that is, the procedures or services included within the APC group relate generally to a common organ system or etiology, have the same degree of

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extensiveness, and utilize the same method of treatment - for example, surgical, endoscopic, etc.

(3) *Provider Concentration* - The degree of provider concentration associated with the individual services that comprise the APC is considered. If a particular service is offered only in a limited number of hospitals, then the impact of payment for the services is concentrated in a subset of hospitals. Therefore, it is important to have an accurate payment level for services with a high degree of provider concentration. Conversely, the accuracy of payment levels for services that are routinely offered by most hospitals does not bias the payment system against any subset of hospitals.

(4) *Frequency of Service* - Unless there is a high degree of provider concentration, creating separate APC groups for services that are infrequently performed is avoided. Since it is difficult to establish reliable payment rates for low volume APC groups, HCPCS codes are assigned to an APC that is most similar in terms of resource use and clinical coherence.

F. Basic Reimbursement Methodology.

1. Under the OPPS, hospital outpatient services are paid on a rate-per-service basis that varies according to the APC group to which the service is assigned.

2. The APC classification system is composed of groups of services that are comparable clinically and with respect to the use of resources. Level I and Level II Healthcare Common Procedure Coding System (HCPCS) codes and descriptors are used to identify and group the services within each APC. Costs associated with items or services that are directly related and integral to performing a procedure or furnishing a service have been packaged into each procedure or service within an APC group with the exception of:

a. New temporary technology APCs for certain approved services that are structured based on cost rather than clinical homogeneity.

b. Separate APCs for certain medical devices, drugs, biologicals, radiopharmaceuticals and devices of brachytherapy under transitional pass-through provisions.

3. Each APC weight represents the median hospital cost of the services included in the APC relative to the median hospital cost of services included in APC 0601, Mid-Level Clinic Visits. The APC weights are scaled to APC 0601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

4. The items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median cost for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group. However, exceptions may be made to the 2 times rule “in unusual cases, such as low volume items and services.”

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5. The prospective payment rate for each APC is calculated by multiplying the APC's relative weight by the conversion factor.

6. 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 non-labor-related costs across geographical regions.

7. Applicable deductible and/or cost-sharing/copayment amounts will be subtracted from the adjusted APC payment rate based on the eligibility status of the beneficiary at the time outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra and Standard beneficiary categories). TRICARE will retain its current hospital outpatient deductibles, cost-sharing/copayment amounts and catastrophic loss protection under the OPPS.

NOTE: The ASC cost-sharing provision (i.e., assessment of a single copayment for both the professional and facility charge for a Prime beneficiary) will be adopted as long as it is administratively feasible. This will not apply to Extra and Standard beneficiaries since their cost-sharing is based on a percentage of the total bill.

G. Outpatient Code Editor (OCE).

1. The Outpatient Code Editor with Ambulatory Payment Classification (APC) program edits patient data to help identify possible errors in coding and assigns Ambulatory Payment Classification numbers based on Healthcare Common Procedure Coding System (HCPCS) codes for payment under the outpatient prospective payment system (OPPS). The OPPS is an outpatient equivalent of the inpatient, DRG-based PPS. Like the inpatient system based on Diagnosis Related Groups (DRGs), each APC has a pre-established prospective payment amount associated with it. However, unlike the inpatient system that assigns a patient to a single DRG, multiple APCs can be assigned to one outpatient record. If a patient has multiple outpatient services during a single visit, the total payment for the visit is computed as the sum of the individual payments for each service. Updated versions of the OCE (MF cartridge) and data files CD, along with installation and user manuals, will be shipped from the developer to the contractors. The contractors will be required to replace the existing OCE with the updated OCE within 21 calendar days of receipt.

2. The OCE incorporates the National Correct Coding Initiatives (NCCI) edits used by the Centers for Medicare and Medicaid Services (CMS) to check for pairs of codes that should not be billed together for the same patient on the same day. Claims reimbursed under the OPPS methodology are exempt from the claims auditing software referenced in Chapter 1, Section 3.

3. Under certain circumstances (e.g., active duty claims), the contractor may override claims that are normally not payable.

4. CMS has agreed to the use of 900 series numbers (900-999) within the OCE for TRICARE specific edits.

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NOTE: The questionable list of covered services may be different among the contractors. Providers will need to contact the contractor directly concerning these differences.

H. PRICER Program.

The APC PRICER will be straightforward in that the site-of-service wage index will be used to wage adjust the payment rate for the particular APC HCPCS Level I and II code (e.g., a HCPCS code with a designated status indicator of S, T, V, or X) reported off of the hospital outpatient claim. The PRICER will also apply discounting for multiple surgical procedures performed during a single operative session and outlier payments for extraordinarily expensive cases. The contractor shall develop, update and maintain the TRICARE PRICER. Appropriate deductible, cost-sharing/copayment amounts and catastrophic caps limitations will be applied outside the PRICER based on the eligibility status of the TRICARE beneficiary at the time the outpatient services were rendered.

I. Geographical Wage Adjustments.

DRG wage indexes will be used for adjusting the OPPS standard payment amounts for labor market differences. Refer to the Provider File with Wage Indexes on TMA's DRG home page at http://www.tricare.osd.mil/drgrates/ for annual DRG wage index updates. The annual DRG wage index updates will be effective January 1 of each year for the OPPS.

J. Provider-Based Status for Payment Under OPPS.

An outpatient department, remote location hospital, satellite facility, or provider-based entity must be either created or acquired by a main provider (hospital) for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial/administrative control of the main provider, in order to qualify for payment under the OPPS. The CMS will retain sole responsibility for determining provider-based status under the OPPS.

K. Implementing Instructions.

Since this issuance only deals with a general overview of the OPPS reimbursement methodology, the following cross reference is provided to facilitate access to specific implementing instructions within Chapter 13, Section 1 through 5:

IMPLEMENTING INSTRUCTIONS/SERVICES	
POLICIES	
General Overview	Chapter 13, Section 1
Billing and Coding of Services under APC Groups	Chapter 13, Section 2
Reimbursement Methodology	Chapter 13, Section 3
Claims Submission and Processing Requirements	Chapter 13, Section 4

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IMPLEMENTING INSTRUCTIONS/SERVICES	
Medical Review Under the Hospital OPPS	Chapter 13, Section 5
ADDENDA	
Ambulatory Payment Classifications (APCs) with Status Indicators, Relative Weights and Payment Rates	Chapter 13, Addendum A (FY 2006)
Payment Status by HCPCS Code and Related Information Calendar Year 2005	Chapter 13, Addendum B1 (FY2006) - Chapter 13, Addendum B7 (FY2006)
Payment Status Indicators For Hospital OPPS	Chapter 13, Addendum C
CPT Codes That Are Paid Only As Inpatient Procedures	Chapter 13, Addendum D
Statewide Cost-to-Charge Ratios	Chapter 13, Addendum E (FY2006)

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