1. Hospital-Specific Per Diem. A hospital-specific per diem amount shall be calculated for each hospital or unit with a higher volume of TRICARE mental health discharges. The base period per diem amount shall be equal to the hospital's average daily charge for charges allowed by TRICARE in the base period (July 1, 1987 through May 31, 1988). The average daily charge in the base period shall be calculated by reference to all TRICARE claims paid (processed) during the base period. The base period amount, however, may not exceed the caps described in the following paragraph C.2.

a. The hospital-specific per diem rates were originally calculated based on the procedures and data referred to in the final rule which was published in the Federal Register on September 6, 1988. These rates were effective for inpatient mental health admissions occurring on or after January 1, 1989.

b. Effective October 1, 1989, the hospital-specific rates were recalculated based on more accurate TSO data.

c. As a result of the October 1, 1989, recalculation, it was determined that a few hospitals were underpaid based on the difference between the originally calculated per diems and the recalculated per diems. For these providers, the contractor will retroactively make payment adjustments back to January 1, 1989. A list of these providers were provided by TSO.

d. As published in the Federal Register March 7, 1995, changes to the mental health per diem payment system were made.

(1) Cap amount changed - the base period per diem amount may not exceed the 70th percentile of the average daily charge weighted for all discharges throughout the United States from all higher volume hospitals.

(2) Update factors - all per diems in effect at the end of fiscal year 1995 shall remain in effect, with no additional update, throughout fiscal years 1996 and 1997.

2. Cap Amount. Prior to April 6, 1995, the base period per diem amount may not exceed the eightieth percentile of the average daily charge weighted for all mental health discharges throughout the United States from all higher volume psychiatric hospitals and units. Effective for care on or after April 6, 1995, the cap amount is established at the 70th percentile.

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
$629	1/1/89 through 9/30/89
614	10/1/89 through 9/30/90
641	10/1/90 through 9/30/91
672	10/1/91 through 9/30/92
701	10/1/92 through 9/30/93
732	10/1/93 through 9/30/94
760	10/1/94 through 4/5/95
645	4/6/95 through 9/30/97

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
645	10/1/97 through 9/30/98
660	10/1/98 through 9/30/99

3. Request for Recalculation of Per Diem Amount. Any psychiatric hospital or unit which has determined TSO calculated a hospital-specific per diem which differs by more than five ($5) dollars from that calculated by the hospital or unit, may apply to the appropriate contractor for a recalculation unless the calculated rate has exceeded the cap amount described in the previous paragraph. The recalculation does not constitute an appeal, as the per diem rates are not appealable. Any hospital which has not already requested and received an administrative review determination on their hospital specific rate will have 60 days from November 28, 1989 (the date of the Federal Register notice) to request an administrative review of the per diem rates that are effective for services provided on or after October 1, 1989. Up to an additional 60 days will be allowed to provide evidence in support of the hospital's position. There is no time limit in which the recalculation must be requested for per diem rates that were effective January 1, 1989. The contractor will have 60 calendar days, including the 21 days for processing adjustments, from the date of the request to complete the requested review. Unless the provider can prove that the contractor calculation is incorrect, the contractor's calculation is final. The burden of proof shall be on the hospital or unit. The contractor shall follow these steps when verifying the hospital's or unit's calculated hospital-specific per diem.

Step 1: Data submitted by the hospital should be adjudicated against the contractor's provider history file for the base period used to calculate the hospital-specific per diem.

Step 2: Days and charges submitted by the hospital must be verified by the contractor as being covered days and allowed charges, without consideration of other health payments for mental health discharges during the base period.

Step 3: The contractor should determine that the primary diagnosis associated with the discharges during the base period were only for mental health (DRG 425 through 432) or substance use disorder (DRG 433 through 437 and DRGs 900 and 901).

Step 4: If after completing the above steps, the contractor finds that the data submitted by the hospital is correct or is partially correct, the contractor would then adjust the per diem. This means the contractor would recalculate the per diem by accumulating all allowed mental health and substance use disorder charges that were paid (processed) during the base period and dividing these charges by covered days associated with the paid (processed) charges for the base period.

EXAMPLE: The contractor is to compute a per diem based on averaged allowed charges of paid (processed) claims for the base period (7/1/87-5/31/88). This means the

contractor will average all allowed charges paid (processed) by TRICARE and other health insurance (OHI) during the base period.

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DISCHARGE	LOS	BILLED	ALLOWED	PAID/OHI	PAID/ TRICARE/ CHAMPUS	DATE OF PAYMENT
1. 4/1/87	10	$5000	$4000	$1000	$3000	7/1/87@
2. 5/15/87	15	9000	8000	2000	6000	6/25/87*
3. 7/1/87	12	8400	8000	8400	8000	8/25/87
4. 8/15/87	5	2500	2500	2500	-0-	10/1/87
5. 3/15/88	10	4000	3500	1000	2500	5/31/88
6. 4/15/88	20	14000	12000	2000	10000	6/1/88*
TOTAL	37	19900	18000	4500	13500	

Total allowed charges paid during the base period equals	$18000
Total days associated with these allowed charges equals	37
Average per diem for the base period equals ($18000 divided by 37)	$486.49
Average per diem updated by the update factor of 1.1% (Update factor brings base period per diem up to 10/1/88)	$491.84
Per diem effective 1/1/89 rounded up to the next whole dollar	$492

NOTE: *The allowed column includes the patient's cost-share and deductible amounts.*

@ Date of payment (processed), not date of discharge is the controlling factor for including or excluding allowed charges in the per diem computation.

*Allowed charges not paid (processed) during the base period were not included in the calculation.

Step 5: For per diem rates that are effective for services provided on or after October 1, 1989, an additional 5.5 percent is to be added to the base period per diem rate. In the above example, the $491.84 would be increased to $518.89 and rounded to the next whole dollar $519. ($491.84 x 1.055 = $518.89)

Step 6: If the recalculation results in a higher per diem, the contractor would then notify the hospital of the revised rate and make it retroactive to the effective date of the originally established hospital-specific per diem. (A lump-sum retroactive payment may be required if payments were made at a lower original hospital-specific per diem amount. This payment will be the result of an adjustment based upon each claim processed during the retroactive period for which an adjustment is needed, and will be subject to the 21 day time frame for processing adjustments.) If the recalculation results in a per diem lower than the original per diem, the contractor would notify the hospital that the revised rate will be applied prospectively, effective as of the date of notification to the hospital. No retroactive adjustment shall be required in this case. However, in fraud and abuse cases, the rate would be made retroactive and recoupment would be required. The contractor must maintain the revised rate, the date of the revision, and the effective date of the new contractor's rate if different from the date of the revision. For suppression of the CEOB form being sent to the beneficiary, see COM-FI Part Two, Chapter 4, Section II.B.8. and OPM Part Two, Chapter 4, Section II.C.

Step 7: After completing steps 1 through 3 above, the contractor determines that an adjustment to the hospital's or unit's original hospital-specific per diem is not necessary, the contractor should notify the hospital of the determination and why adjustment will not be made.

D. Regional Per Diems for Lower Volume Psychiatric Hospitals and Units.

1. Regional Per Diem. Hospitals and units with a lower volume of TRICARE patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and indirect medical education. Base period regional per diems shall be calculated based upon all TRICARE lower volume hospitals' and units' claims paid (processed) during the base period. Each regional per diem amount shall be the quotient of all covered charges (without consideration of other health insurance payments) divided by all covered days of care, reported on all TRICARE claims from lower volume hospitals and units in the region paid (processed) during the base period, after having been standardized for indirect medical education costs, and area wage indexes. Direct medical education costs shall be subtracted from the calculation. The regions shall be the same as the federal census regions.

REGION	STATES
Northeast:	
New England	Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut
Mid-Atlantic	New York, New Jersey, Pennsylvania
Midwest:	
East North Central	Ohio, Indiana, Illinois, Michigan, Wisconsin

REGION	STATES
West North Central	Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas
South:	
South Atlantic	Delaware, Maryland, D.C., Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida
East South Central	Kentucky, Tennessee, Alabama, Mississippi
West South Central	Arkansas, Louisiana, Texas, Oklahoma
West:	
Mountain	Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada
Pacific	Washington, Oregon, California, Alaska, Hawaii

2. Request for Recalculation of Per Diem Amount. Any hospital or unit that has determined the regional per diem amount applicable to that hospital or unit has been incorrectly calculated by TSO by more than five ($5) dollars may submit to the appropriate contractor evidence supporting a different regional per diem. The burden of proof shall be on the hospital or unit. Since regional per diem rates overlap contractor regional boundaries, a contractor which receives notification that a regional per diem is being challenged may need to obtain charge and other statistical information from other contractors in order to make a determination as to the validity of the challenge before an adjustment to the per diem can be justified. If a contractor receives notification that a regional per diem is being challenged, it should immediately inform TSO (DO). Upon receiving this information, TSO Operations Directorate (DO) will provide additional instructions to the contractor.

3. Adjustments to Regional Per Diem Rates. Two adjustments shall be made to the regional per diem rates when applicable.

a. Area Wage Adjustment. The same area wage indexes used for the TRICARE/CHAMPUS DRG-based payment system (see Chapter 13, Section 6.1G) shall be applied to the wage portion (wage portion percentage split will be the same used for DRGs which is currently 71.40 percent) of the applicable regional per diem rate for each day of the admission. In Fiscal Years 1989 and 1990, the percentages were 74.39 and 73.84 percent respectively. Since Fiscal Year 1990, the percentage has been 71.40 percent. For Fiscal Years 1998 and 1999, the percentage is 71.1 percent.

b. Indirect Medical Education Adjustment. The indirect medical education adjustment factors shall be calculated for teaching hospitals in the same manner as in the TRICARE/CHAMPUS DRG-based payment system (see Chapter 13, Section 6.1G) and applied to the applicable regional per diem rate for each day of the admission. For an exempt psychiatric unit in a teaching hospital, there should be a separate indirect medical education adjustment factor for the unit (separate from the rest of the hospital) when medical education applies to the unit.

c. The adjusted regional per diem rate is not to be rounded up to the next whole dollar.

4. Reimbursement of Direct Medical Education Costs. In addition to payments made to lower volume hospitals and units, TRICARE shall annually reimburse hospitals for actual direct medical education costs associated with TRICARE beneficiaries. The first payment may cover a period of less than a full year--from the effective date of the TRICARE per diem payment system to the end of the hospital's fiscal year end. This reimbursement shall be done pursuant to the same procedures as are applicable to the TRICARE/CHAMPUS DRG-based payment system (see Chapter 13, Section 6.1H).

NOTE: *No additional payment is to be made for capital costs. Such costs have been covered in the regional per diem rates which are based on charges.*

E. Base Period and Update Factors.

1. Hospital-Specific Per Diem Calculated Using Date of Payment. The base period for calculating the hospital-specific and regional per diems, as described above is federal fiscal year 1988. The base period calculations shall be based on actual claims paid (processed) during the period July 1, 1987 through May 31, 1988, trended forward to September 30, 1988, using a factor of 1.1 percent.

2. Hospital-Specific Per Diem Calculated Using Date of Discharge. Upon application by a higher volume hospital or unit to the appropriate contractor, the hospital or unit may have its hospital-specific base period calculations based on TRICARE claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988, if it has generally experienced unusual delays in TRICARE claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least $5.00 with the revised per diem not exceeding the cap amount. For this purpose, the unusual delays mean that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations (204 days) longer than the national average (94 days). The burden of proof shall be on the hospital.

3. Updating Hospital-Specific and Regional Per Diems. The hospital-specific per diems and the regional per diems calculated for the base period shall be in effect for admissions on or after January 1, 1989; there will be no additional update for fiscal year 1989. For subsequent fiscal years, each per diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system. In accordance with the final rule published March 7, 1995, in the Federal Register, all per diems in effect at the end of fiscal year 1995 shall remain frozen through fiscal year 1997. Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each federal fiscal year by the contractors. New hospitals shall be notified by the contractor at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the Federal Register prior to the start of that fiscal year and will be furnished to contractors by TSO.

UPDATE FACTOR	FISCAL YEAR	DATE PUBLISHED
5.5 percent	1990	11/28/89
4.2545 percent	1991	12/14/90
4.7 percent	1992	10/30/91
4.2 percent	1993	12/16/92
4.3 percent	1994	9/30/93
3.7 percent	1995	10/3/94
-0- percent	1996	Frozen
-0- percent	1997	Frozen
-0- percent	1998	10/6/97
2.4 percent	1999	

4. Claims priced by day of service. All claims reimbursed under the TRICARE mental health per diem payment system are to be priced for each day of service (using the rate in effect on the day of service) regardless of when the claim is submitted. Any adjustments to such claims will also be priced as of the day of service. In order to do this, contractors shall maintain at least three (3) iterations of per diem rates, including indirect medical education adjustment factors, wage indexes, etc., in the contractor's on-line system. If the claim filing deadline has been waived and the day of service is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest per diem rate on the contractor's system.

F. Higher Volume Hospitals and Units.

1. Higher Volume of TRICARE Mental Health Discharges During the Base Period. Any hospital or unit that had an annual rate of 25 or more TRICARE mental health discharges during the period July 1, 1987 through May 31, 1988, shall be considered a higher volume hospital or unit during federal fiscal year 1989 and all subsequent fiscal years. The intent of this provision is to "annualize" the discharge rate during the eleven (11) month base period, to a full twelve (12) months. As a result, any hospital or unit establishing a record of 23 or more actual TRICARE mental health discharges during the base period, would qualify as a high volume provider.

EXAMPLE: 23 actual TRICARE mental health (MH) discharges July 1, 1987-May 31, 1988.

$$\frac{23 \text{ MH Discharges}}{11 \text{ months}} = 2.09 \text{ MH discharges/month}$$

$2.09 \times 12 \text{ months} = 25.08$ MH discharges/year.

All other hospitals and units covered by the TRICARE inpatient mental health per diem payment system shall be considered lower volume hospitals and units.

2. Higher Volume of TRICARE Mental Health Discharges in Subsequent Fiscal Years and Hospital-Specific Per Diem Calculation. In any federal fiscal year in which a hospital or unit not previously classified as a higher volume hospital or unit has 25 or more TRICARE mental health discharges, that hospital or unit shall be considered to be a higher volume

hospital or unit during the next federal fiscal year and all subsequent fiscal years. If TRICARE discharges group into DRG 424 or any other non-mental health DRG, these discharges will not count toward meeting the 25 or more TRICARE mental health discharges. TRICARE mental health discharges that are not covered under standard TRICARE will not count toward meeting the 25 or more TRICARE mental health discharges. In addition, TRICARE mental health discharges for benefits covered under a demonstration program would not be counted toward meeting the 25 or more TRICARE mental health discharges. Managed Care Support Contract for CA/HI in-system mental health discharges are not to be included in the counting of mental health discharges. However, services provided to a Managed Care Support Contract for CA/HI beneficiary outside the Managed Care Support Contract for CA/HI contracted area is considered to be Standard TRICARE business. This means that any such beneficiary discharged from a psychiatric hospital or unit outside the Managed Care Support Contract for CA/HI contracted area would be included in the determination for high volume status for that hospital. If a TRICARE discharge is paid in part or in full by other insurance, yet the admission would have been covered by TRICARE had there not been other health insurance, this discharge would be counted toward meeting the 25 or more TRICARE mental health discharges.

NOTE: *Only standard TRICARE mental health discharges reimbursed under the mental health per diem payment system for mental health and substance use disorder services provided by DRG-exempt psychiatric hospitals and DRG-exempt psychiatric units are to be included in the determination of high or low volume provider status.*

The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE mental health discharges and the base period. The base period amount, however, can not exceed the cap described above. Once a statistically valid rate is established based on a year in which the hospital or unit had at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem. When a hospital-specific per diem is retroactively implemented and the calculated hospital-specific per diem results in a lower rate than the regional rate which had been paid during the interim period, recoupment of the difference would not be made.

To illustrate, suppose a hospital or unit has 15 TRICARE admissions in the base period, 20 in FY-1989 and 25 in FY-1990. Payments during FY-1989 and FY-1990 would have been based on the applicable regional rates. The hospital-specific per diem for that hospital, which will begin to apply in FY-1991, will be calculated by taking the hospital's or unit's average daily charge in FY-1990, adjusting it back to the base period by the percent of change in average daily charges for all high volume hospitals and units from the base period to FY-1990, applying the cap (if applicable), and updating the base period per diem to FY-1991 by the same update factors as apply to other higher volume hospitals and units.

a. Percent of change and deflator factor (DF).

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 1989	14.98%	1.1498
September 30, 1990	31.69%	1.3169
September 30, 1991	63.18%	1.6318
September 30, 1992	85.81%	1.8581
September 30, 1993	94.48%	1.9448
September 30, 1994	106.94%	2.0694
September 30, 1995	117.20%	2.1720
September 30, 1996	123.83%	2.2383

EXAMPLE: A hospital that did not have the required number of TRICARE mental health discharges during the base period, but does have 25 or more TRICARE mental health discharges for the 12 month period ended September 30, 1993, would be eligible for a hospital-specific per diem rate. If this is not a new provider, the hospital-specific per diem rate would be effective for services provided on or after October 1, 1993. The calculated numbers that follow are based on actual TRICARE charge data and have been used to establish the percent of change.

-The average daily charge for base period (July 1, 1987, through May 31, 1988, trended forward to September 30, 1988, using an update factor of 1.1 percent for all higher volume hospitals & units) is $484.81.

-The average daily charge for 12 month ended September 30, 1993 (All higher volume hospitals & units) is $942.88.

-The change in average daily charges is reflected in an increase in average daily charges ($942.88-$484.81) is $458.07.

-The percent of change ($458.07 divided by $484.81) is 94.48%.

The contractor shall follow the subsequent steps in establishing the hospital-specific rate.

Step 1: To reflect the percent of change and show the above hospital-specific per diem at the base year value, the per diem rate is divided by 1.9448, the deflator factor. $411.35 ($800 divided by 1.9448 = $411.35)

Step 2: Hospital-specific per diem rate for a hospital that had 25 or more TRICARE mental health discharges during the 1993 federal fiscal year. (Allowed billed charges processed during the period, October 1, 1992, through September 30, 1993, divided by allowed days associated with these charges.) $800

Step 3: $411.35 would be rounded and would be the hospital's specific per diem rate at January 1, 1989. $412

Step 4: $412 would be updated by the update factors for fiscal years 1990, 1991, 1992, 1993, and 1994 of 5.5 percent, 4.2545 percent, 4.7 percent, 4.2 percent, and 4.3 percent respectively. The hospital-specific per diem rate for the hospital in this example would be ($412 x 1.055 = $434.66, $435 x 1.042545 = $453.51, $454 x 1.047 = $475.34, $476 x 1.042 = $495.99, $496 x 1.043 = $517.33) rounded to $518, effective October 1, 1993. The contractor should note that all per diems are to be rounded to the next whole dollar, i.e., $520.01 would be rounded to $521.

NOTE: *The contractor should consult provider history to determine that a provider has not had the necessary number of TRICARE mental health discharges in the base period or in a previous federal fiscal year for high volume status. This will ensure that the provider is classified as a high volume in the proper period of time and will prevent a provider from obtaining high volume status in a period of time when it has been able to raise its charges for a higher hospital-specific per diem rate.*

3. New Hospitals and Units. The TRICARE inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under TEFRA rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are PPS-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE mental health discharges. This provision also applies to the preceding fiscal year (<u>if it had any</u> TRICARE <u>patients during the preceding fiscal year</u>). A retrospective payment shall be required if payments were originally made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the 21 day time frame for processing adjustments.

By definition, a new hospital is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the Medicare and or TRICARE programs under the present and previous ownership for less than 3 full years. A change in ownership in itself does not constitute a new hospital.

NOTE: *A psychiatric hospital or unit that is currently classified as a high volume provider will remain high volume when there is a change of ownership. A change of ownership would not be sufficient reason to honor a request by a hospital or hospital unit to have its high volume hospital-specific rate recalculated. A psychiatric hospital and unit that is currently a low volume provider which has a change in ownership will remain low volume until it can show that it has the required number of TRICARE mental health discharges during a federal fiscal year.*

A newly-established mental health unit which is a distinct part of an acute

medical hospital that is excluded from the prospective payment system does not qualify for the exemption afforded to a new hospital unless the distinct unit is located in a new hospital. New hospitals must provide the contractor with proof that they meet these requirements. This may be a written statement by the hospital official to the contractor supporting this fact. Using this definition, the earliest date a hospital would be considered a new provider under this payment system would be October 1, 1986.

To illustrate how the contractor is to use this data, the following illustration is provided.

Hospital opens October 1, 1986, earliest date for a new hospital under the per diem payment system. If a hospital opened on September 30, 1986, it would not be considered a new hospital.

This hospital does not have the required number of TRICARE mental health discharges during the base period. (23 or more mental health discharges during the period July 1, 1987, through May 31, 1988). The contractor should verify this.

This hospital notifies the contractor that during the period October 1, 1988, through September 30, 1989, it had 25 or more TRICARE mental health discharges. It also provides the contractor with the appropriate data which will aid the contractor in making a determination whether this hospital should be classified as high volume. The contractor will search its provider history for this time period and will either confirm or deny this provider as a high volume provider. If the provider is found to have 25 or more TRICARE mental health discharges for this period of time, the contractor will compute a hospital-specific per diem rate retroactive back to January 1, 1989. The per diem rate will be computed as follows:

Hospital-specific per diem rate for this hospital. (Allowed billed charges processed during the period, October 1, 1988, through September 30, 1989, divided by allowed days associated with these charges.)	$500
To reflect the percent of change and show the above hospital-specific per diem at the base year value, the per diem rate is divided by 1.1498. ($500 divided by 1.1498 = $434.86)	$434.86
$434.86 would be rounded and would be the hospital's specific per diem rate effective retroactive to January 1, 1989.	$435
To update the per diem, the base year value is updated by the update factors previously discussed in this section.	

Such new hospitals must agree not to bill TRICARE beneficiaries for any additional cost-share beyond that determined initially based on the regional rate. For suppression of the CEOB from being sent to the beneficiary, see COM-FI Part Two, Chapter 1, Section VI.H. and OPM Part Two, Chapter 1, Section VI.G.

NOTE: *If the hospital-specific per diem calculated for a new psychiatric hospital or unit is less than the regional per diem rate which the new psychiatric hospital or unit has been paid since becoming a TRICARE authorized provider, no recoupment action is to be initiated.*

4. Request for a Review of Higher or Lower Volume Classification. Any hospital or unit which TSO improperly fails to classify as a higher or lower volume hospital or unit may apply to the appropriate contractor for such a classification. The hospital or unit shall have the burden of proof. The contractor should take the following steps to determine why a hospital or unit may not have qualified as a higher or lower volume hospital or unit.

Step 1: Is the hospital or unit a Medicare-participating provider? If not, has this hospital or unit signed an agreement to participate on all TRICARE inpatient claims and meets TRICARE standards as an authorized provider of mental health services? (A hospital or unit must be a Medicare-participating provider or have signed a TRICARE agreement to participate on all TRICARE inpatient claims and meet the TRICARE standards as an authorized provider of mental health services.)

Step 2: Is the hospital or unit a Medicare-exempt psychiatric specialty hospital or unit? If not, does the hospital or unit meet the criteria in Chapter 13, Section 6.1D? (If the answer to all of the above questions is “no”, then the contractor is not required to proceed any further. A letter explaining why the hospital did not qualify should be sent to the hospital.)

Step 3: If the answer to either of the questions in each of the above steps is yes, then the discharge data for the base period must be reviewed. The hospital must submit to the contractor data which identifies the mental health discharges during the base period. This data should include the patient's name, the sponsor's social security number, the patient's date of birth, the date of admission, the date of discharge, the length of stay, the allowed charges, and corresponding dates of payment or note that payment has not been received.

Step 4: The hospital's submitted data must be verified against the contractor's provider history data file and the UB-92 charge file. If the contractor finds that a discharge reported by the hospital is not appropriate, the reasons should be documented as to why it was not appropriate. However, if at least 25 mental health discharges reported by the hospital are found to be appropriate for the base period the contractor should calculate a hospital-specific per diem for the hospital or unit, and notify the hospital or unit of its hospital-specific per diem (see paragraph C. and paragraph F.1.). This per diem should become effective retroactive to January 1, 1989. The contractor shall maintain the name of the hospital, its location, the provider's billing number and the date it was determined to be a high volume provider. For a hospital that was classified by TSO as a high volume provider, but can not be supported and verified as such for the base period by the contractor, it should be classified as a low volume provider retroactive to January 1, 1989. For a provider that was

improperly classified, the contractor will make additional payments for underpayments, but will not recoup overpayments.

G. Payment for Hospital Based Professional Services

1. Lower Volume Hospitals and Units. Lower volume hospitals and units may not bill separately for hospital based professional services; payment for those services is included in the per diems.

2. Higher Volume Hospitals and Units. Higher volume hospitals and units, whether they billed TRICARE separately for hospital based professional services or included those services in the hospital's or unit's charges to TRICARE, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to the appropriate contractor notice of its request to change its billing procedures for hospital-based professional services. The contractor has 90 days from the first of the month following the month after the request is received by the contractor to make the change prospective.

The hospital or unit requesting a change in the billing of hospital-based professional services must submit verifiable data including the ratio of average hospital-based professional billed charges to average total billed charges for the fiscal year in which the request to change its billing procedures. This ratio will be used to adjust the hospital's or unit's hospital specific rate. To illustrate how the contractor would make this adjustment the following examples are provided.

EXAMPLE 1: For a hospital or unit that currently has hospital-based professional services included in its hospital-specific per diem rate and wants to bill separately for these services.

(1) Hospital-specific per diem rate. $500

(2) Average hospital-based professional per diem charges. $100

(3) Adjusted hospital-specific per diem rate. $400 ($500 - $100 = $400)

EXAMPLE 2: For a hospital or unit that currently does not have hospital-based professional services included in its hospital-specific per diem rate and wants to include these services in its hospital-specific per diem rate.

(1) Hospital-specific per diem rate. $400

(2) Average hospital-based professional per diem charges. $100

(3) Adjusted hospital-specific per diem rate. $500

EXAMPLE 3: For those hospitals and units that are limited to the cap who request a change in the billing of hospital-based professional services, the hospital-specific rate (the cap amount) would be adjusted as follows:

(1) Hospital-specific per diem rate. $701

(2) Total average charges including hospital-based professional services. $1025

(3) Average hospital-based professional per diem charges. $320

(4) Adjusted hospital-specific per diem rate. $701 ($1025-$320=$705 limited to cap of $701)

(5) Hospital could now bill for the hospital-based professional services separately although the hospital-specific per diem rate would remain at $701.

EXAMPLE 4: Same as example 3 except the amounts are changed.

(1) Hospital-specific per diem rate. $701

(2) Total average charges including hospital-based professional services. $750

(3) Average hospital-based professional per diem charges. $150

(4) Adjusted hospital-specific per diem rate. $600 ($750-$150=$600)

3. Basis and Approval of Request to Change Billing of Hospital-Based Professional Services. A request to change the way hospital-based professional services were traditionally billed in the base period should be the result of an operating change by the hospital such as going from a closed staff to an open staff. After receiving the request from the hospital, the contractor will send the request and the contractor's calculations to TSO (Program Development Branch) for approval of the adjusted per diem. TSO Operations Directorate will inform the contractor of the approved adjusted per diem rate and its effective date.

4. Professional Services not Included in Hospital-Specific Per Diem. Each hospital's-specific rate shall reflect the total Form UB-92 charges submitted and paid (processed) during the base period for all inpatient mental health and substance use disorder services which group into DRGs 425 through 432, DRGs 433 through 437, and DRGs 900 and 901. Claims for inpatient professional mental health service charges routinely submitted separately by the hospital were not included in the per diem calculation, and this practice can continue.

5. Concurrent Care inpatient psychotherapy Limits and Review Requirements. High volume hospitals and units that bill for professional mental health services shall not be subject to the concurrent care inpatient psychotherapy limit of five (5) sessions per week nor review requirements.

Professional mental health services billed by professionals outside the hospital shall be subject to the limit and all review requirements.

6. Non-Mental Health Professional Services and Services Billed by Individual Professional Providers. Under both the hospital-specific and the regional rate reimbursement systems, hospitals may bill separately for non-mental health related professional services. Also, individual professional providers not employed or under contract

to the hospital may continue to bill for their professional services provided to hospital inpatients.

H. Leave Days

1. No Payment. TRICARE shall not pay (including holding charges) for days where the patient is absent on leave (including therapeutic absences) from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement.

2. Does not Constitute a Discharge/Do not Count Toward Day Limit. TRICARE shall not count a patient's departure for a leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital pursuant to this section. Leave days shall not count toward the TRICARE day limit pursuant to Chapter 1, Section 12.1B.

I. Exemptions from the TRICARE Inpatient Mental Health Per Diem Payment System.

1. Providers Subject to the TRICARE/CHAMPUS DRG-Based Payment System. Providers of inpatient care which are neither psychiatric hospitals nor psychiatric units as described earlier in this section, or which otherwise qualify under that discussion, are exempt from the TRICARE inpatient mental health per diem payment system. Such providers should refer to Chapter 13, Section 6.1D for provisions pertinent to the TRICARE/CHAMPUS DRG-based payment system.

2. Services Which Group into DRG 424. Admissions to psychiatric hospitals and units for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424) are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

3. Non-Mental Health Procedures. Admissions for non-mental health procedures that group into DRGs 1 through 423, DRGs 438 through 494, and DRGs 600 through 636 in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges. Since it is very unusual for a psychiatric hospital/unit to have an admission for a non-mental health procedure, Contractors should ensure that the claim is correct as submitted--especially the procedures and the provider number--before paying the claim.

4. Sole Community Hospital. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt.

5. Hospital Outside the Fifty (50) States, D.C. or Puerto Rico. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia, or Puerto Rico.

NOTE: *Currently, Puerto Rico is exempt from the per diem payment system. Puerto Rico is not included in any of the current regions for making payment for lower volume providers. There are no high volume providers in Puerto Rico. Due to the small number of mental health claims from psychiatric hospitals and units in Puerto Rico, TSO has decided to pay as billed mental health claims from psychiatric hospitals and psychiatric units in Puerto Rico. Until further notice, claims from these hospitals will be paid as billed for admissions on or after January 1, 1989.*

6. Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized TRICARE provider. However, any hospital which is subject to the TRICARE/CHAMPUS DRG-based payment system in Chapter 13, Section 6.1D or the TRICARE inpatient mental health per diem payment system and which otherwise meets TRICARE requirements but which is not a Medicare-participating provider (having completed a HCFA-1561, Health Insurance Benefit Agreement, and a HCFA-1514, Hospital Request for Certification in the Medicare/Medicaid Program) must complete a participation agreement with the contractor. By completing the participation agreement, the hospital agrees to accept the TRICARE-determined allowable amount as payment in full for its services. The participation agreements will be completed only upon request of the hospital to the contractor. A copy of the participation agreement is in Chapter 13, Addendum 1. Any hospital which does not participate in Medicare and does not complete a participation agreement with the contractor will not be authorized to provide services to TRICARE beneficiaries. TRICARE beneficiaries admitted prior to the effective date of the TRICARE inpatient mental health per diem payment system will be paid through the episode of care based on billed charges if the hospital chooses not to participate. However, services of new admissions by such nonparticipating hospitals and units will not be reimbursed by TRICARE.

7. TRICARE Demonstration Programs. For those states where a TRICARE demonstration program has been implemented, the TRICARE inpatient mental health per diem payment system will not apply unless services are provided under the standard TRICARE program or services are provided outside the geographic region of the demonstration.

8. TRICARE limits. Unless otherwise noted, all limitations such as the day limit pursuant to Chapter 1, Section 12.1B and the 21 day limit pursuant to Chapter 8, Section 21.1 still apply under the TRICARE inpatient mental health per diem payment system.

9. Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the TRICARE/CHAMPUS DRG-based payment system or the TRICARE inpatient mental health per diem payment system shall be determined on the basis of billed charges or set rates as found in Chapter 13, Section 6.2.

- END -

b. If the period of time away from the facility is more than 10 days, admission approval is required including an updated treatment plan and progress report.

2. Authorization for Geographically Distant Family Therapy.

a. All geographically distant family therapy must be authorized and approved by the TRICARE/CHAMPUS mental health review contractor at the time the treatment plan is submitted. The RTC is required to submit a detailed treatment plan for each TRICARE/CHAMPUS patient within 30 days of admission. The contractor will send authorizations to the geographically responsible contractor. For cases in which there are two contractors because of differing geographical locations, a copy of the authorization will be sent to each. The authorization must be on file at the contractor before coverage can be extended. (Refer to Chapter 1, Section 12.8, FAMILY THERAPY.)

b. Cost-Share. Payment for geographically distant family therapy will be cost-shared on an inpatient basis, subject to the prevailing charge in the state in which the service was rendered.

3. Authorization for Coverage of Educational Services. A Public Official's Statement (POS) must be submitted to the TRICARE/CHAMPUS mental health review contractor demonstrating that the school district in which the TRICARE/CHAMPUS beneficiary was last enrolled refuses to pay for the educational component of the child's RTC care. The contractor will review the Public Official's Statements on a case by case basis and make a decision on whether they meet the exception for coverage under the program. The authorization for educational services must be on file at the geographical contractor before coverage can be extended. (Refer to Chapter 11, Section 12.1.)

4. Authorization for Therapeutic Absences. Prior to July 1, 1995, all therapeutic absences must be planned and documented in the treatment plan submitted to the TRICARE/CHAMPUS mental health review contractor for approval. Passes that do not involve an overnight stay away from the facility do not require specific authorization by the mental health review contractor or Managed Care Support contractor.

a. Prior to July 1, 1995, all therapeutic absences must be reviewed individually by the TRICARE/CHAMPUS mental health review contractor, and an authorization must be submitted to the appropriate geographical contractor before payment can be made.

b. Therapeutic absences on or after July 1, 1995, may not be reimbursed.

E. Reimbursement of Therapeutic Absences.

1. Admissions on or After December 1, 1988. For all admissions on or after December 1, 1988, the first three days of each approved therapeutic absence will be allowed at 100 percent of the TRICARE/CHAMPUS all-inclusive rate. Beginning with the fourth day of a therapeutic absence, reimbursement will be at 75 percent of the rate.

2. Admissions Prior to December 1, 1988. For those RTCs that continue to participate under the terms of the new agreement, the contractors will continue to allow RTC charges for authorized therapeutic absences for patients admitted prior to December 1, 1988, at 100 percent of billed charges until the patient is discharged or transferred, or until

the care is no longer determined medically necessary. RTCs that choose not to participate will be allowed RTCs charges for authorized therapeutic absences for patients admitted prior to December 1, 1988, at 100 percent of billed charges until the patient is discharged, transferred, or until January 31, 1989, whichever occurs first. If the patient is still in the RTC on February 1, 1989, coverage will cease.

3. Care on or after July 1, 1995. Therapeutic leave of absence days may not be reimbursed by TRICARE/CHAMPUS.

F. Dates Applicable to RTC Prospective Payment Methodology.

July 1, 1987 - June 30, 1988 - base period used in calculation of rebased individual RTC per diem rates and capped amount.

November 30, 1988 - beneficiaries admitted on or before this date are subject to the grandfathering provisions in paragraph A. below.

December 1, 1988 - date that prospective payment rates went into effect for TRICARE/CHAMPUS beneficiaries admitted on or after December 1, 1988.

December 1, 1988 - September 30, 1989 - subject to retroactive adjustment of all claims for services provided TRICARE/CHAMPUS beneficiaries admitted on or after December 1, 1988, based on rebased per diem amounts (rates retired from Appendix B).

October 1, 1989 - updated rates for payment of claims for services rendered on or after October 1, 1989, for TRICARE/CHAMPUS patients admitted to RTCs on or after December 1, 1988 (rates retired from Appendix B).

October 1, 1990 - September 30, 1994 - updated rates for payment of claims for services rendered during this period have been retired from Appendix B.

October 1, 1994 - updated rates for payment of claims for services rendered on or after October 1, 1994 (refer to rates in Appendix B-1).

April 6, 1995 - updated rates for payment of claims for services rendered on or after April 6, 1995, (refer to rates in Appendix B-2).

October 1, 1995 - updated rates for payment of claims for services rendered on or after October 1, 1995 (refer to bracketed rates in Appendix B-3).

October 1, 1996 - updated rates for payment of claims for services rendered on or after October 1, 1996 (refer to bracketed rates in Appendix B-4).

October 1, 1997 - updated rates for payment of claims for services rendered on or after October 1, 1997 (refer to rates in Appendix B-5).

October 1, 1998 - updated rates for payment of claims for services rendered on or after October 1, 1998 (refer to rates in Appendix B-6).

CONSIDERATIONS

A. Grandfathering Provisions.

1. RTCs that continue to participate under the terms of the new agreement will be reimbursed for TRICARE/CHAMPUS patients admitted up through November 30, 1988, on the same basis and at the same rates as were in effect prior to the December 1, 1988, effective date, until discharge or until the care is no longer determined medically necessary or appropriate by TRICARE/CHAMPUS in standard utilization and quality review procedures.

2. The grandfathering provision applicable to participating RTCs will be applied as follows:

a. Grandfathering will continue when a patient, otherwise eligible for the grandfathering provision, is discharged and admitted without any break from the RTC to a hospital and directly back to the RTC. Any break (including a break of one day) in inpatient status nullifies grandfathering.

b. Any patient, otherwise eligible for the grandfathering provision, absent without leave (AWOL) for a period which exceeds 10 days shall lose grandfathering status.

c. In neither case (a or b above) will TRICARE/CHAMPUS cost-share any days of absence from the RTC.

B. Termination of Participation by RTC

1. Addendum 6, Exhibit 1, Article 8 of the RTC participation agreement sets forth the following provisions for termination of participation under the TRICARE/CHAMPUS program:

a. Notice is not required for changes or modifications to the participation agreement resulting from amendments to the TRICARE/CHAMPUS regulation through rulemaking procedures.

b. Changes or modifications resulting from amendments to the Regulation will become effective on the date the regulation amendment is effective or the date the agreement is amended, whichever date is earlier.

c. If the RTC does not wish to accept the proposed changes, it may terminate its participation by giving the agency written notice of such intent to terminate at least 60 calendar days in advance of the effective date of termination (Addendum 6, Exhibit 1, Article 8 of the RTC participation agreement).

d. If the RTC's notice of intent to terminate its participation is not given at least 60 days prior to the effective date of the proposed changes/modifications, then the proposed changes/modifications will be incorporated into its agreement for care furnished between the effective date of the changes/modifications and the effective date of the termination of this agreement.

2. In other words, signing of the participation agreement simply acknowledges modifications/changes resulting from an amendment to the TRICARE/CHAMPUS regulation through rulemaking procedures prescribed in Addendum 6, Exhibit 1, Article 8 of the participation agreement. If the RTC does not want to participate, it can terminate its agreement by giving written notice 60 calendar days in advance of the effective date of the

changes/modifications. However, in the interim, the RTC will be subject to the changes/modifications between the effective date of the changes/modifications and the effective date of termination of the agreement; i.e., 60 days from the notification of the RTC.

C. Retroactive Adjustment of RTC Claims.

1. Retroactive adjustment of RTC claims will only apply for those TRICARE/CHAMPUS patients admitted on or after December 1, 1988. TRICARE/CHAMPUS patients admitted prior to December 1, 1988, will not be affected by the rebasing and will continue to participate under the same conditions and rates as were in effect prior to the December 1, 1988, effective date, until discharge or until the care is no longer determined medically necessary or appropriate.

2. If the rebased rate is higher than the rate originally established on December 1, 1988, the contractor will retroactively adjust all claims for patients admitted on or after December 1, 1988, for services provided up through September 30, 1989.

a. A retroactive payment will be required if payments were made at a lower per diem rate. This payment will be the result of an adjustment based upon each claim processed during the retroactive period for which an adjustment is needed, and will be subject to the 21-day time frame for processing adjustments.

b. The retroactive adjustment will reflect the difference between the total amount that would have been paid to the RTC for those patients admitted on or after December 1, 1988, had the rebased rates been in use from December 1, 1988, through September 30, 1989, and the total amount that was paid based on the December 1, 1988, per diem rates.

c. In those situations where an RTC's per diem rate is adjusted upward as a result of the rebasing and payment was originally made at a lower per diem, the contractor is responsible for ensuring that the EOB to the beneficiary is suppressed to insure the beneficiary is not held responsible for additional payment(s).

d. The beneficiary and Federal Government will be held harmless for any additional cost-sharing beyond that determined initially for claims originally paid at the lower per diem amount. A message will appear on the provider's EOB prohibiting collection of additional cost-sharing as a result of rebasing. (Refer to COM-FI Part Two, Chapter 1, Section VI.G.3.d.(19)(c) and OPM Part Two, Chapter 1, Section VI.H.3.d.(22)(c).)

e. Increases in cost-sharing will not be applied toward the catastrophic limit since there is no additional liability to the beneficiary.

3. RTCs may provide lists of TRICARE/CHAMPUS beneficiaries admitted to their facilities on or after December 1, 1988, to facilitate the identification of claims requiring retroactive adjustment; however, each claim must be verified prior to adjustment/payment.

D. If rebasing results in a per diem rate lower than the per diem rate implemented on December 1, 1988, a retroactive adjustment will not be required and no recoupment action will be initiated.

E. The goal of preauthorization and concurrent review for residential treatment is to assure that the RTC level of care is medically necessary and appropriate, that a reasonable and specific treatment plan is developed and carried out, and that the length of stay is as brief as is consistent with the needs of the individual TRICARE/CHAMPUS beneficiary. The TRICARE/CHAMPUS mental health review contractor or appropriate Managed Care Support contractor, will conduct the review function. For reviews conducted by the mental health review contractor, the necessary authorizations are submitted to the appropriate contractor for adjudication of RTC claims. The contractors must not make payment without the mental health review contractor's authorization. The TRICARE/CHAMPUS mental health review contractor will develop appropriate forms for transmittal of authorizations to the contractors.

F. Payment for RTC care will be made by the contractors only for claims from authorized RTCs, and with the TRICARE/CHAMPUS mental health review contractor's or Managed Care Support contractor's authorization for RTC care on file.

G. Updated RTC Rates.

1. Once a statistically valid rate is established for each RTC from the base year data (July 1, 1987 through June 30, 1988), it becomes the basis for all future rates. The change in mix of third party payor days thereafter will have no bearing on the TRICARE/CHAMPUS RTC per diem.

2. TSO/OCHAMPUS will provide the contractors with annual rate updates prior to the start of each fiscal year. The RTC rates were updated on October 1 of each year using the annual CPI-U for medical care for the reporting period of the previous July to July. This reporting period was used due to the 2- to 3-month lag in publication of CPI-U statistics.

3. All claims reimbursed under the TRICARE/CHAMPUS RTC per diem payment system are to be priced for each day of service (using the rate in effect on the day of service) regardless of when the claim is submitted. Any adjustments to such claims will also be priced as of the day of service. In order to do this, contractors shall maintain at least three (3) iterations of per diem rates in the contractor's on-line system. If the claims filing deadline has been waived and the day of service is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest per diem rate on the contractor's system.

4. The rates in Appendix B-1 will be used for payment of claims for services rendered on or after October 1, 1994. The updated capped amount for services rendered on or after October 1, 1994, is $530 per patient day.

5. The rates in Appendix B-2 will be used for payment of claims for services rendered on or after April 6, 1995. The updated capped amount for services rendered on or after April 6, 1995, is $515 per patient day.

6. For fiscal years 1996 and 1997, the cap shall remain unchanged for any RTC whose 1995 rate was at or above the 30th percentile of all established fiscal year 1995 RTC rates normally weighted by total TRICARE/CHAMPUS days provided at each rate during the first half of fiscal year 1994. For any RTC whose 1995 rate was below the 30th percentile level as determined under this paragraph, the rate shall be adjusted by the lesser of the CPI-

U for medical care, or the amount that brings the rate up to the 30th percentile level. For fiscal years after fiscal year 1997, the cap shall be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

7. The rates in Appendix B-3 reflect the rate adjustments for those RTCs whose 1995 per diems were below the 30th percentile of all established fiscal year 1995 rates. The rates were adjusted by the lesser of the CPI-U for medical care for the annual reporting period of July 1, 1994 to July 1995 (4.4 percent) or the amount that brought the rate up to the 30th percentile level of $429.

8. The rates in Appendix B-4 reflect the rate adjustments for those RTCs whose FY 1996 per diems were still below the 30th percentile of all established FY 1995 rates. The rates adjusted by the lesser of the CPI-U for medical care for the annual reporting period of July 1995 to July 1996 (3.6 percent) or the amount that brought the rate up to the 30th percentile level of $429.

9. As allowed by 32 Code of Federal Regulations (CFR), Section 199.14, paragraph (f)(5)(iii), individual facility rates and cap amount are to be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment for fiscal years after FY 1997. Since the FY 1998 Medicare update factor is zero (0), individual facility per diems and cap amount will remain at previous FY 1997 levels. The rates in Appendix B-5 will be used for payment of services rendered on or after October 1, 1997. The cap amount for services rendered on or after October 1, 1997 will continue to be $515.

(For further information, see COM-FI Part Two, Chapter 17, Section II.H. and OPM Part Two, Chapter 1, Section IV.H.4.)

10. The rates in Appendix B-6 will be used for payment of claims for services rendered on or after October 1, 1998. The rates were adjusted by the lesser of the FY 1999 Medicare update factor (2.4 percent) or the amount that brought the rates up to the new cap amount of $528.

- END -

Subject: AMBULATORY SURGICAL CENTER REIMBURSEMENT	Chapter: 13
Authority: DoD 6010.8-R, Chapter 14, D.	Section: 9.1
	Issue Date: August 26, 1985

ISSUE

How are ambulatory surgery procedures to be reimbursed under TRICARE?

BACKGROUND

A. Background

1. Effective December 19, 1980, services provided by authorized hospital-based or freestanding ambulatory surgery centers became covered TRICARE benefits. These services have been paid as billed.

2. Ambulatory surgery procedures provided on or after November 1, 1994, are no longer to be reimbursed based on billed charges. Reimbursement is to follow the procedures described below.

B. Reimbursement System

1. General. Payment for ambulatory surgery procedures will be made using prospectively determined rates. The rates will be: established on a cost-basis, divided into eleven payment groups representing ranges of costs, and adjusted for area labor costs based on Metropolitan Statistical Areas (MSAs).

2. Applicability. This payment system applies to all ambulatory surgery procedures identified in the list in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15. (Creation and updating of Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 is the responsibility of TSO, and the inclusion or omission of any given procedure in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 cannot be the basis for appealing any claim. Changes to Addendum 1, Section 1 through Section 15 will be provided to the contractors whenever they are made.) The payment system is to be used regardless of where the ambulatory surgery procedures are provided--that is, in a freestanding ambulatory surgery center (ASC), in a hospital outpatient department, or in a hospital emergency room. (Throughout this instruction, ASC refers only to freestanding ambulatory surgery centers.) The payment rates established under this system apply only to the facility charges for ambulatory surgery. The facility rate is a standard overhead amount that includes nursing and technician services; use of the facility; drugs including take-home drugs for less than $40; biologicals; surgical dressings, splints, casts and equipment directly related to provision of the surgical procedure; materials for anesthesia; intra-ocular lenses (IOLs); and administrative, recordkeeping and housekeeping items and services. The rate does not include items such as physicians' fees (or fees of other professional providers authorized to render the services identified in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 and to bill independently for them); laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure);

prosthetic devices (except IOLs); ambulance services; leg, arm, and back braces; artificial limbs; and durable medical equipment for use in the patient's home.

3. Ambulatory Surgery Payment Rates.

a. TSO, or its data contractor, will calculate the payment rates and will provide them (on magnetic media) to the claims processing contractors. The magnetic media will include the locally-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. Additions or deletions to the list of procedures will be given to the contractors as they occur, but the magnetic media will be provided only on an annual basis. The MSAs and corresponding wage indexes will be those used by Medicare for ambulatory surgery centers.

b. In addition to the payment rates, the contractors will be provided a zip code to MSA crosswalk, so that they can determine which payment rate to use for each ambulatory surgery provider. For this purpose the zip code of the facility (as opposed to its billing address) is to be used. This crosswalk will be updated periodically throughout the year and sent to the contractors.

c. In order to calculate payment rates, only those procedures with at least twenty-five claims nationwide during the database period will be used.

d. The rates will be calculated using the following steps.

(1) For each ambulatory surgery procedure, a median standardized cost will be calculated on the basis of all ambulatory surgery charges nationally under TRICARE during the one-year database period. The steps in this calculation include:

(a) Standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare;

(b) Applying the cost-to-charge ratio using the Medicare cost-to-charge ratio for freestanding ambulatory surgery centers for ASCs and the Medicare cost-to-charge ratio for hospital outpatient settings for all charges from hospitals;

(c) Calculating a median cost for each procedure; and

(d) Updating to the year for which the payment rates will be in effect by the Consumer Price Index--Urban.

(2) Procedures will then be placed into one of ten groups by their median per procedure cost, starting with $0 to $299 for Group 1 and ending with $1,000 to $1,299 for Group 9 and $1,300 and above for Group 10. Groups 2 through 8 will be set on the basis of $100 fixed intervals.

(3) The Director, TSO, may make adjustments to the groupings resulting from step 2 to account for any ambulatory surgery procedures for which there were insufficient data to allow a grouping or to correct for any anomalies resulting from data or statistical factors or other special factors that fairness requires be specially recognized. In

making any such adjustments, the Director may take into consideration the placing of particular procedures in the ambulatory surgery groups under Medicare.

(4) The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

e. Procedures for which there is no or insufficient (less than 25 claims) data will be assigned to groups by:

(1) Calculating a volume-weighted ratio of TRICARE payment rates to Medicare payment rates for those procedures with sufficient data;

(2) Applying the ratio to the Medicare payment rate for each procedure; and

(3) Assigning the procedure to the appropriate payment group.

f. The amount paid for any ambulatory surgery service under these procedures cannot exceed the amount that would be allowed if the services were provided on an inpatient basis. The allowable inpatient amount equals the applicable DRG relative weight multiplied by the national large urban adjusted standardized amount. This amount will be adjusted by the applicable hospital wage index.

g. As of November 1, 1998, an eleventh payment group is added to this payment system. This group will include extracorporeal shock wave lithotripsy.

4. Payments.

a. General. The payment for a procedure will be the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the same labor/non-labor-related cost ratio and hospital wage index as used for ambulatory surgery centers by Medicare. This calculation will be done by TSO, or its data contractor. For participating claims, the ambulatory surgery payment rate will be reimbursed regardless of the actual charges made by the facility--that is, regardless of whether the actual charges are greater or smaller than the payment rate. For nonparticipating claims, reimbursement (TRICARE payment plus beneficiary cost-share plus any double coverage payments, if applicable) cannot exceed the lower of the billed charge or the group payment rate.

b. Procedures Which are Not in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 and Are Provided by an ASC. Only those procedures contained in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 are to be reimbursed under this reimbursement process. If a claim is received from an ASC for a procedure which is not in Addendum 1, Section 1 through Section 15, the facility charges are to be denied using EOB message 8, Provider not TRICARE-authorized for this service. These charges are the responsibility of the beneficiary. Claims for the related professional services can be processed and reimbursed as outpatient services.

c. Procedures Which Are Not in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 and Are Provided by a Hospital. If an ambulatory surgery procedure not contained in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 is provided by a hospital (either in an emergency room or in an outpatient department), the

claim is to be reimbursed based on the billed charges and cost-shared as outpatient services.

d. Multiple Procedures. The following rules are to be followed whenever more than one procedure is included on an ambulatory surgery claim. The claim for professional services, regardless of what type of ambulatory surgery facility provided the services and regardless of what procedures were provided, is to be reimbursed according to the multiple surgery guidelines in Chapter 13, Section 3.7. For the facility charges, the following rules apply:

(1) If all the procedures on the claim are included in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15, the claim is to be reimbursed at 100 percent of the group payment rate for the major procedure (the procedure which allows the greatest payment) and 50 percent of the group payment rate for each of the other procedures. This applies regardless of the groups to which the procedures are assigned--i.e., if all the procedures are assigned to the same group, payment is to be made for each procedure.

(2) If the claim includes procedures included in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 as well as procedures not included in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15, the following rules are to be followed.

(a) If the services are provided in an ASC, all procedures which are not on the list are to be denied. If more than one procedure on the list is on the facility claim, reimbursement is to be 100 percent of the group payment rate for the major procedure (the procedure which allows the greatest payment) and 50 percent of the group payment rate for each of the other procedures.

(b) If the services are provided in a hospital, each service is to be reimbursed according to the method appropriate to it. That is, the allowable amount for procedures in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 is to be based on the appropriate group payment amount while the allowable amount for procedures not in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 is to be based on the billed charge for that procedure. Regardless of the method used for determining the reimbursement for each procedure, only one procedure (the procedure which allows the greatest payment) is to be reimbursed at 100 percent. All other procedures are to be reimbursed at 50 percent. If the contractor is unable to determine the charges for each procedure (i.e., a single billed charge is made for all procedures), the contractor is to develop the claim for the charges using the steps contained in the COM-FI Part Two, Chapter 1, Section V.B. and OPM Part Two, Chapter 1, Section V.B. If development does not result in usable charge data, the contractor is to reimburse the major procedure (the procedure for which the greatest amount is allowed) if that can be determined (e.g., the major procedure is in Addendum 1, Section 1 through Section 15 or is identified on the claim) and deny the other procedures using EOB message "Requested information not received". If the major procedure cannot be determined, the entire claim is to be denied.

(3) Unbundling of Procedures. Contractors should ensure that reimbursement for claims involving multiple procedures conforms to the unbundling

guidelines contained in Chapter 13, Section 1.4, COM-FI Part Two, Chapter 1, Section VI.B.5., and OPM Part Two, Chapter 1, Section VI.B.6.

(4) Incidental Procedures. The rules for reimbursing incidental procedures as contained in Chapter 13, Section 3.7, are to be applied to ambulatory surgery procedures reimbursed under the rules set forth in this section. That is, no reimbursement is to be made for incidental procedures performed in conjunction with other procedures which are not classified as incidental. This limitation applies to payments for facility claims as well as to professional services.

5. Updating Payment Rates.

a. The rates will be updated annually by TSO by the same update factor as is used in the Medicare annual updates for ambulatory surgery center payments. Periodically the rates will be recalculated using the steps in paragraph B.3.d. above.

b. The rates were updated by 3.2 percent effective November 1, 1995. This update included the wage indexes as updated by Medicare.

c. The rates were updated by 2.6 percent effective November 1, 1996. This update included the wage indexes as updated by Medicare.

d. The rates were updated by .6 percent effective November 1, 1997. This update included the wage indexes as updated by Medicare.

e. There was no update to the rates effective November 1, 1998.

C. Claims for Ambulatory Surgery

1. Claim Forms. The claim forms used for ambulatory surgery services are to conform to the requirements of the COM-FI Part Two, Chapter 1, Section I.E. and the OPM Part Two, Chapter 1, Section I.C.

2. Claim Data.

a. Billing Data. The claim must identify all procedures which were performed (by CPT-4 or HCPCS code) and indicate if the bill is for facility charges or professional charges. (If the claim is submitted on a UB-92, the procedure code will be shown in FL 44.) If any of this information is missing, the contractor is required to develop the claim for the missing information in accordance with the COM-FI Part Two, Chapter 1, Section V. or the OPM Part Two, Chapter 1, Section V.

b. HCSR Data. All ambulatory surgery services are to be reported on the HCSR using the appropriate CPT-4 code. The only exception is services which are billed using a HCPCS code and for which no CPT-4 code exists. These services are to be reported on the HCSR using one of the TSO-assigned codes in the ADP Manual, Chapter 2, Addendum F, Figure 2-F-1.

3. Claim submission/processing. If facility submits a single claim which includes charges for services included in the prospective group rate as well as for services not included in the group rate (i.e., facility charges for services not included in the group rate or

physicians' fees) otherwise allowable charges are not to be denied simply because they are submitted on a single claim. In such cases, the Contractor is to:

a. Split the claim and process each type of allowable charge as a separate claim with a separate claim number; or

b. Process the claim reimbursing each type of charge using the appropriate methodology and using different suffixes to report each type of charge.

D. Cost-Sharing for Ambulatory Surgery. Please refer to Chapter 13, Section 11.8.

POLICY CONSIDERATIONS

A. Wage Index Changes. If, during the year, Medicare revises any of the wage indexes used for ambulatory surgery reimbursement, such changes will not be incorporated into the TRICARE payment rates until the next routine update. These changes will not be incorporated regardless of the reason Medicare revised the wage index.

B. Contractors' On-Line Data. Contractors are required to maintain two years' payment rates on their systems at all times. Since no changes will be made to the payment rates between annual updates, this means that the contractors will need to maintain only two sets of rates on their on-line system at any time.

C. Double Coverage. Ambulatory surgery claims which involve payments by another third-party payer are to be processed under the three step double coverage computation which apply to claims other than those processed under the TRICARE/CHAMPUS DRG-Based Payment System. See the COM-FI Part Two, Chapter 3, Section III.B.2. and the OPM Part Two, Chapter 3, Section III.B.2.

D. Subsequent Hospital Admissions. If a beneficiary is admitted to a hospital subject to the DRG-based payment system as a result of complications, etc. of ambulatory surgery, the ambulatory surgery procedures are to be billed and reimbursed separately from the hospital inpatient services. The same rules applicable to emergency room services are to be followed.

EFFECTIVE DATE

The payment system described in this section is effective for all listed ambulatory surgery procedures provided on or after November 1, 1994.

- END -

URINARY SYSTEM

KIDNEY

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
50561	2	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50570	2	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
50572	2	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50574	2	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50576	2	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50578	2	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration
50580	2	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
OTHER PROCEDURES		
50590[11]	11	Lithotripsy, extracorporeal shock wave

URINARY SYSTEM

URETER

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
INTRODUCTION		
50684	2	Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter
50688	2	Change of ureterostomy tube
50690	2	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service
ENDOSCOPY		
50951	2	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
50953	2	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter

URINARY SYSTEM

URETER

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
50955	2	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50957	2	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50959	2	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of material)
50961	2	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50970	2	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
50972	2	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
50974	2	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50976	2	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
50978	2	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of material)
50980	2	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus

URINARY SYSTEM

BLADDER

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
INCISION		
51005	2	Aspiration of bladder; by trocar or intracatheter
51010	2	Aspiration of bladder; with insertion of suprapubic catheter
51020	6	Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material
51030	6	Cystotomy or cystostomy; with cryosurgical destruction of intravesical lesion
51040[2]	6	Cystostomy, cystotomy with drainage
51045	6	Cystotomy, with insertion of ureteral catheter or stent (separate procedure)

URINARY SYSTEM

BLADDER

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
EXCISION		
51500	6	Excision of urachal cyst or sinus, with or without umbilical hernia repair
INTRODUCTION		
51600	1	Injection procedure for cystography or voiding urethrocystography
51605	2	Injection procedure and placement of chain for contrast and/or chain urethrocystography
51610	2	Injection procedure for retrograde urethrocystography
51710	2	Change of cystostomy tube; complicated
URODYNAMICS		
51725	2	Simple cystometrogram (CMG)(eg, spinal manometer)
51726	1	Complex cystometrogram (eg, calibrated electronic equipment)
51772	2	Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique
51785	2	Electromyography studies (EMG) of anal or urethral sphincter, any technique
REPAIR		
51865	6	Cystorrhaphy, suture of bladder wound, injury or rupture; complicated
51880	2	Closure of cystostomy (separate procedure)
51900	6	Closure of vesicovaginal fistula, abdominal approach
51920	5	Closure of vesicouterine fistula
ENDOSCOPY-SYSTOSCOPY, URETHROSCOPY, CYSTOURETHROSCOPY		
52000	2	Cystourethroscopy (separate procedure)
52005	5	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
52007	4	Cystourethroscopy with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis
52010	4	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service
TRANSURETHRAL SURGERY (URETHRA AND BLADDER)		
52204	5	Cystourethroscopy, with biopsy
52214	4	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224	4	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
52234	6	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)
52235	6	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240	5	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)

URINARY SYSTEM

BLADDER

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
52250	6	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
52260	5	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52270	4	Cystourethroscopy, with internal urethrotomy; female
52275	4	Cystourethroscopy, with internal urethrotomy; male
52276	5	Cystourethroscopy with direct vision internal urethrotomy
52277	4	Cystourethroscopy, with resection of external sphincter (sphincterotomy)
52281	4	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female
52283	4	Cystourethroscopy, with steroid injection into stricture
52285	6	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52290	4	Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral
52300	4	Cystourethroscopy; with resection or fulguration of ureterocele(s), unilateral or bilateral
52305	4	Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple
52310	4	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52315	4	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated
52317	2	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments, simple; small (less than 2.5 cm)
52318	4	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments, simple; complicated or large (over 2.5 cm)
TRANSURETHRAL SURGERY (URETER AND PELVIS)		
52320	7	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
52325	6	Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)
52330	4	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus
52332	6	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
52334	5	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde
52335	5	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method)

URINARY SYSTEM

BLADDER

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
52336	6	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method); with removal or manipulation of calculus (uretheral catheterization is included)
52337	6	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method); with lithotripsy (ureteral catheterization is included)
52338	6	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method); with biopsy and/or fulguration of lesion
TRANSURETHRAL SURGERY (VESICAL NECK AND PROSTATE)		
52340	5	Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic mucosal folds)
52450[2]	5	Transurethral incision of prostate
52500	5	Transurethral resection of bladder neck (separate procedure)
52601	6	Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
52606	2	Transurethral fulguration for postoperative bleeding occurring after the usual follow-up time
52612	4	Transurethral resection of prostate; first stage of two-stage resection (partial resection)
52614	2	Transurethral resection of prostate; second stage of two-stage resection (resection completed)
52620	2	Transurethral resection; of residual obstructive tissue after 90 days postoperative
52630	4	Transurethral resection; of regrowth of obstructive tissue longer than one year postoperative
52640	4	Transurethral resection; of postoperative bladder neck contracture
52650[3]	4	Transurethral cryosurgical removal of prostate (postoperative irrigations and aspiration of sloughing tissue included)
52700	4	Transurethral drainage of prostatic abscess

URINARY SYSTEM

URETHRA

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
INCISION		
53000	2	Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra
53010	2	Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external
53020	1	Meatotomy, cutting of meatus (separate procedure); except infant
53040	4	Drainage of deep periurethral abscess

URINARY SYSTEM

URETHRA

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
EXCISION		
53200	2	Biopsy of urethra
53210	7	Urethrectomy, total, including cystostomy; female
53215	7	Urethrectomy, total, including cystostomy; male
53220	4	Excision or fulguration of carcinoma of urethra
53230	4	Excision of urethral diverticulum (separate procedure); female
53235	5	Excision of urethral diverticulum (separate procedure); male
53240	4	Marsupialization of urethral diverticulum, male or female
53250	4	Excision of bulbourethral gland (Cowper's gland)
53260	4	Excision or fulguration; urethral polyp(s), distal urethra
53265	4	Excision or fulguration; urethral caruncle
53275	4	Excision or fulguration; urethral prolapse
REPAIR		
53400	5	Urethroplasty; first stage, for fistula, diverticulum, or stricture, (eg, Johannsen type)
53405	4	Urethroplasty; second stage (formation of urethra), including urinary diversion
53410	4	Urethroplasty, one-stage reconstruction of male anterior urethra
53420	5	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	4	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	4	Urethroplasty, reconstruction of female urethra
53440	4	Operation for correction of male urinary incontinence, with or without introduction of prosthesis
53442	2	Removal of perineal prosthesis introduced for continence
53447	2	Removal, repair or replacement of inflatable sphincter including pump and/or reservoir and/or cuff
53449	2	Surgical correction of hydraulic abnormality of inflatable sphincter device
53450	2	Urethromeatoplasty, with mucosal advancement
53460	2	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
SUTURE		
53502	4	Urethrorrhaphy, suture of urethral wound or injury; female
53505	4	Urethrorrhaphy, suture of urethral wound or injury; penile
53510	4	Urethrorrhaphy, suture of urethral wound or injury; perineal
53515	4	Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous
53520	4	Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)
MANIPULATION		
53605	4	Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia
53665	2	Dilation of female urethra, general or conduction (spinal) anesthesia

CHAPTER 13 SECTION 9.1	ADDENDUM 1, SECTION 8

Except as provided below, all procedures are effective as of November 1, 1994

1 Code added for services performed on or after January 1, 1995
2 Code added for services performed on or after February 27, 1995
3 Code deleted for services performed on or after April 1, 1995
4 Code deleted for services performed on or after April 26, 1995
5 Payment group changed for services performed on or after February 27, 1995
6 Code added October 1995 effective for services performed on or after November 1, 1994
7 Code deleted for services performed on or after March 31, 1996
8 Code added for services performed on or after January 1, 1996
9 Code added for services performed on or after January 1, 1997
10 Code deleted for services performed on or after January 1, 1997
11 Code added for services performed on or after November 1, 1998

TRICARE-APPROVED AMBULATORY SURGERY PROCEDURES

The number following the procedure code is the TRICARE payment group.

MALE GENITAL SYSTEM

PENIS

PROCEDURE CODE	PAYMENT GROUP	DESCRIPTION
INCISION		
54000	4	Slitting of prepuce, dorsal or lateral (separate procedure); newborn
54001	4	Slitting of prepuce, dorsal or lateral (separate procedure); except newborn
54015[2]	6	Incision and drainage of penis, deep
DESTRUCTION		
54057	2	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery
54060	2	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
54065	2	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method
EXCISION		
54100	2	Biopsy of penis; cutaneous (separate procedure)
54105	2	Biopsy of penis; deep structures
54110	4	Excision of penile plaque (Peyronie disease)
54115	2	Removal foreign body from deep penile tissue (eg, plastic implant)
54120	4	Amputation of penis; partial
54125	4	Amputation of penis; complete
54150	1	Circumcision, using clamp or other device; newborn
54152	2	Circumcision, using clamp or other device; except newborn
54160	2	Circumcision, surgical exicison other than clamp, device or dorsal slit; newborn
54161	4	Circumcision, surgical excision other than clamp device or dorsal slit; except newborn
INTRODUCTION		
54205[2]	6	Injection procedure for Peyronie disease; with surgical exposure of plaque
54220	2	Irrigation of corpora cavernosa for priapism
REPAIR		
54300	5	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
54360	5	Plastic operation on penis to correct angulation
54420	6	Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral
54435	6	Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism
54440	6	Plastic operation of penis for injury

than active duty or authorized NATO dependent beneficiaries, including all related pre- and post-surgical services and supplies, is as follows:

(1) Facility Charges. The cost-share is the lesser of twenty-five percent (25%) of the applicable group payment rate or twenty-five percent (25%) of the billed charges. If the claim involves multiple services, some of which are reimbursed based on a group payment rate and some of which are reimbursed based on billed charges, the cost-share for the services reimbursed based on a group payment rate is to be determined as provided in the previous sentence. The cost-share for those services reimbursed based on billed charges is to be twenty-five percent (25%) of the applicable billed charges.

(2) Professional Charges. The cost share is twenty-five percent (25%) of the TRICARE-determined allowable amount in excess of the annual fiscal year deductible.

2. Maternity Care. See Chapter 13, Section 11.4.

3. Other Outpatient Care: Active Duty Dependent or Authorized NATO Beneficiary. The cost-share for all other outpatient care is twenty percent (20%) of the TRICARE-determined allowable amount in excess of the annual deductible amount. This includes the professional charges of a TRICARE-approved individual professional provider for services rendered in a non-TRICARE-approved ambulatory surgery center or birthing center.

4. Other Outpatient Care: Other Beneficiary. The cost-share applicable to all other outpatient care for other than active duty and authorized NATO dependent beneficiaries is twenty-five percent (25%) of the TRICARE-determined allowable amount in excess of the annual deductible amount. This includes: partial hospitalization for alcohol rehabilitation; professional charges of a TRICARE-approved individual professional provider for services rendered in a non-TRICARE-approved ambulatory surgery.

D. Cost-Share Amount: Inpatient Care.

1. Active Duty Dependent: Except in the case of mental health services, dependents of active duty members or their sponsors are responsible for the payment of the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater. (Please reference daily rate chart below.)

Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is $20 per day for each day of the inpatient admission. This $20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any residential treatment facility, any substance use disorder rehabilitation facility, and any partial hospitalization program providing mental health or substance use disorder rehabilitation services. For care prior to October 1, 1995, no changes will be made to the cost-sharing requirements for dependents of active duty members.

UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS

Use the daily charge (per diem rate) in effect for each day of the stay to calculate a cost-share for a stay which spans periods.

PERIOD		DAILY CHARGE
January 1, 1977	- December 31, 1977	$4.10
January 1, 1978	- September 30, 1978	$4.40
October 1, 1978	- September 30, 1979	$4.65
October 1, 1979	- September 30, 1980	$5.00
October 1, 1980	- September 30, 1981	$5.50
October 1, 1981	- September 30, 1982	$6.30
October 1, 1982	- December 31, 1983	$6.55
January 1, 1984	- December 31, 1984	$6.80
January 1, 1985	- September 30, 1985	$7.10
October 1, 1985	- September 30, 1986	$7.30
October 1, 1986	- December 31, 1987	$7.55
January 1, 1988	- December 31, 1988	$7.85
January 1, 1989	- December 31, 1989	$8.05
January 1, 1990	- September 30, 1990	$8.35
October 1, 1990	- September 30, 1991	$8.55
October 1, 1991	- September 30, 1992	$8.95
October 1, 1992	- September 30, 1993	$9.30
October 1, 1993	- September 30, 1994	$9.30 (No change from FY 93)
October 1, 1994	- September 30, 1995	$9.50
October 1, 1995	- September 30, 1996	$9.70
October 1, 1996	- September 30, 1997	$9.90
October 1, 1997	- September 30, 1998	$10.20
October 1, 1998	- September 30, 1999	$10.45

2. Other Beneficiaries: For the cost-share applicable to inpatient care for other than active duty dependent beneficiaries, please reference Chapter 13, Section 11.2 (DRG-based payment system) and Chapter 13, Section 11.5 (mental health per diem payment system). For services exempt from the TRICARE/CHAMPUS DRG-based payment system and the TRICARE mental health per diem payment system and services provided by institutions other than hospitals (i.e. RTCs), the cost-share shall be 25% of the TRICARE-determined allowable charges.

E. Cost-Share Amount: Under Discounted Rate Agreements. Under special programs approved by the TSO Director (e.g., the Health Care Finder and Participating Provider Program), where there is a negotiated (discounted) rate agreed to by the provider, the cost-share shall be based on the provisions found in the COM-FI Part Two, Chapter 1, Section VI.C.8. or the OPM Part Two, Chapter 1, Section VI.C.7.

POLICY CONSIDERATIONS

The deductible amounts identified in this Section shall be deemed to have been satisfied if the Catastrophic Cap amounts identified in Chapter 13, Section 14.1 have been met for the same fiscal year in which the deductible applies.

Subject: COST-SHARES AND DEDUCTIBLES: TRICARE/ CHAMPUS INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM	Chapter: 13
Authority: DoD 6010.8-R, Chapter 4, F.	Section: 11.5
	Issue Date: November 28, 1988

ISSUE

What are the special cost-sharing provisions under the TRICARE/CHAMPUS inpatient mental health per diem payment system?

POLICY

A. General. These special cost-sharing procedures apply only to claims paid under the TRICARE/CHAMPUS inpatient mental health per diem payment system. For inpatient claims exempt from this system, the procedures in Chapter 13, Section 11.1 or Section 11.2 are to be followed.

B. Cost-shares for dependents of active duty members. Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is $20 per day for each day of the inpatient admission. This $20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any residential treatment facility, any substance use disorder rehabilitation facility, and any partial hospitalization program providing mental health or substance use disorder rehabilitation services.

For care prior to October 1, 1995, no changes will be made to the cost-sharing requirements for dependents of active duty members.

C. Cost-shares for beneficiaries other than dependents of active duty members.

1. Higher volume hospitals and units. With respect to care paid for on the basis of a hospital specific per diem, the cost-share shall be 25 percent of the hospital specific per diem amount.

2. Lower volume hospitals and units. For care paid for on the basis of a regional per diem, the cost-share shall be the lower of a. or b. below:

a. A fixed daily amount multiplied by the number of covered days. The fixed daily amount shall be 25 percent of the per diem adjusted so that total beneficiary cost-shares will equal 25 percent of total payments under the TRICARE/CHAMPUS inpatient mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to Chapter 13, Section 6.5. This fixed daily amount will also be furnished to contractors by TSO. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

(1) Fiscal Year 1989 - $142 per day.

(2) Fiscal Year 1990 - $109 per day.

(3) Fiscal Year 1991 - $114 per day.

(4) Fiscal Year 1992 - $120 per day.

(5) Fiscal Year 1993 - $126 per day.

(6) Fiscal Year 1994 - $132 per day.

(7) Fiscal Year 1995 - $137 per day.

(8) Fiscal Year 1996 - $137 per day.

(9) Fiscal Year 1997 - $137 per day.

(10) Fiscal Year 1998 - $137 per day.

(11) Fiscal Year 1999 - $140 per day.

(In accordance with the final rule published March 7, 1995, in the Federal Register, all per diems/cost-shares in effect at the end of fiscal year 1995 shall remain frozen through fiscal year 1997.)

b. 25 percent of the hospital's billed charges (less any duplicates).

D. Claim which spans a period in which two separate per diems exist. A claim subject to the TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System which spans a period in which two separate per diems exist shall have the cost share computed on the actual per diem in effect for each day of care.

E. Cost-share whenever leave days are involved. There is no patient cost-share for leave days when such days are included in a hospital stay. See Chapter 13, Section 6.5.

F. Claims for services that are provided during an inpatient admission which are not included in the per diem rate are to be cost-shared as an inpatient claim if the contractor can not determine where the service was rendered and the status of the patient when the service was provided. The contractor would need to examine the claim for place of service and type of service to determine if the care was rendered in the hospital while the beneficiary was in inpatient of the hospital. This would include non-mental health claims and mental health claims submitted by individual professional providers rendering medically necessary services during the inpatient admission.

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