

## Introducing the New TRICARE Outpatient Prospective Payment System

**T**RICARE plans to implement the Outpatient Prospective Payment System (OPPS) payment methodology by early summer 2007.

### What Is OPPS?

The OPPS is an Ambulatory Payment Classification (APC) system for covered hospital-based outpatient services. It consists of groups of covered services arranged so services within each group are comparable clinically and with respect to the use of resources. Level I Current Procedural Terminology (CPT) and Level II Healthcare Common Procedure Coding System (HCPCS) codes and descriptors are used to identify and group the services within each APC. Costs associated with items or services that are directly related and integral to performing a procedure or furnishing a service have been packaged into each procedure or service within an APC group.

While the TRICARE OPPS is modeled after the Medicare OPPS, there are some differences in the two systems, such as

covered benefits and beneficiary copayments. The TRICARE Outpatient Code Editor (OCE) will reflect these differences, allowing payment for those services that are covered under TRICARE, but not under Medicare and vice versa. In addition, TRICARE will retain its current hospital outpatient deductibles, cost-share, copayment amounts and catastrophic loss protection under its OPPS.

### What Will Change?

Currently, when sufficient coding information is provided, outpatient hospital services, including emergency services, clinical laboratory services, rehabilitation therapy, venipuncture and radiology services are paid using existing allowable charges. Such services are reimbursed under the allowable charge methodology that would also include the CHAMPUS Maximum Allowable Charge (CMAC) rates for professional services. Other services without allowable charges, such as facility charges, are paid as a percentage of billed charges.

*continued on page 2*

## Improving Surgical Site Infection Rates

**I**n 2002, the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services implemented the Surgical Care Improvement Project (SCIP) in an effort to improve surgical care in hospitals nationwide. The main goal of the SCIP initiative is to reduce surgical complications by 25 percent by the year 2010.

For surgical site infection, these measures include:

1. Prophylactic antibiotic received within one hour prior to incision
2. Appropriate prophylactic antibiotic selection for surgical patients
3. Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac patients as of Jan. 1, 2006)
4. Postoperative glucose control in non-cardiac surgical patients with diabetes
5. Cardiac surgery patients with postoperative glucose control
6. Surgical patients with appropriate hair removal
7. Surgical patients with postoperative normothermia
8. Colorectal surgical patients with peri-operative normothermia

One of the SCIP objectives is to reduce surgical site infections. The postoperative patients who develop a surgical site infection can have prolonged hospital stays and increased costs.

*continued on page 2*



## Improving Surgical Site Infection Rates

*continued from page 1*

The CDC estimates that 500,000 surgical site infections occur annually in the United States and that 40 to 60 percent are preventable. According to the SCIP, hospitals could recognize a savings of \$3,152 per patient and reduce the patient's average length of stay by seven days by implementing interventions to reduce surgical site infections.

TriWest's Clinical Quality Management Department completed a statistically significant random sample review of 382 surgical records from June 2005 to December 2005. The purpose was to identify overall physician and hospital compliance with the current best practice guidelines and to present feedback to providers. The following four measures were studied:

- Prophylactic antibiotic received within one hour prior to incision
- Prophylactic antibiotics discontinued within 24 hours

after surgery end time

- Postoperative glucose control in non-cardiac surgical patients with diabetes
- Surgical patients with post-operative normothermia

TriWest will conduct a remeasurement of the same indicators in the future.

Consider reviewing your current practices to determine if there are any barriers to success. Use best practice guidelines for compliance rate improvement with the SCIP standards to continue promoting quality care for TRICARE beneficiaries.

For more information on current guidelines, please refer to [www.jointcommission.org](http://www.jointcommission.org) or [www.medqic.org](http://www.medqic.org). ■

## New TRICARE Provider Seminars Scheduled for Spring 2007

The spring 2007 series of TRICARE provider educational seminars from TriWest is now being planned. Set throughout the 21-state West Region, these seminars will furnish providers and their staffs with the latest information on TRICARE programs and policies.

Even if you have previously attended a TRICARE seminar, it would be beneficial for you and your staff to attend a seminar this spring as these informational sessions will cover new TRICARE information. Additional reference tools will be provided.

Seminars are scheduled for both Medical/Surgical and Behavioral Health providers. Once the spring schedule is completed for a state, providers will be able to register online. By registering online, you will receive the following additional benefits:

- E-mail confirmation of your registration
- Reminder notice prior to the scheduled seminar
- Eligibility to participate in a drawing for a small prize

Once the spring 2007 TRICARE provider seminars schedules are completed, you can go to [www.triwest.com](http://www.triwest.com) to find out the dates, times and locations of seminars near you. For additional information, please e-mail [pseminar@triwest.com](mailto:pseminar@triwest.com). ■

## Introducing the New TRICARE Outpatient Prospective Payment System

*continued from page 1*

Under the new OPPTS, each procedure code will be assessed on a line-by-line basis in determining its appropriate reimbursement. The claims data will be processed through the TRICARE-specific OCE to determine final reimbursement. Procedure codes (HCPCS codes/CPT-4 codes) applied to a particular APC group will be reimbursed at the pre-determined, geographically wage-adjusted fee-for-service payment. Other procedure codes will either be bundled to primary procedure codes (with which they are normally associated), paid separately (under another fee schedule or payment system other than OPPTS) or denied. Total claim reimbursement will be the sum of the individual procedure payments (e.g., wage-adjusted APC amounts or

CMAC payment rates) less the beneficiary's appropriate deductible and cost-sharing.

Look to future issues of *TRICARE Provider News* for the latest information about the new TRICARE OPPTS. Future articles will include useful information about the common differences between the Medicare and the TRICARE OPPTS and identify provider categories included/excluded in the TRICARE OPPTS.

To access additional information regarding the TRICARE OPPTS program, please reference the *TRICARE Reimbursement Manual*, Chapter 13 at <http://manuals.tricare.mil>. ■

# Inpatient Cost-Shares Increase Slightly for Fiscal Year 2007

Each fiscal year (Oct. 1–Sept. 30), some TRICARE inpatient cost-share rates increase slightly. The following tables highlight the new inpatient rates for fiscal year 2007.

For additional information about cost-shares for TRICARE-covered services, visit the TRICARE Web site at [www.tricare.mil/tricarecost](http://www.tricare.mil/tricarecost). You can also visit TriWest online at [www.triwest.com](http://www.triwest.com), or call 1-888-TRIWEST (1-888-874-9378) for more information. ■

Inpatient Rates at Civilian and Military Treatment Facilities		
Program	Active Duty Family Members	Retirees, Their Families and Other Eligible Beneficiaries
<b>TRICARE Prime</b>	<i>No increase.</i> \$0 per admission	<i>No increase.</i> \$11 per day or \$25 per admission, whichever is greater; no separate copayment for separately billed professional charges.
<b>TRICARE Standard</b>	Increases from <b>\$14.35 to \$14.80</b> per day or \$25 per admission, whichever is greater. No charge for separately billed professional services.	<i>No increase.</i> \$535 per day, or 25% of the total charge, whichever is less. Plus, 25% of the allowable charge for separately billed professional services.
<b>TRICARE Extra</b>	Increases from <b>\$14.35 to \$14.80</b> per day or \$25 per admission, whichever is greater. No charge for separately billed professional services.	<i>No increase.</i> \$250 per day or 25% of total charge, whichever is less. Plus, 20% of the allowable charge for separately billed professional services.

Inpatient Rates for Behavioral Health at Civilian and Military Treatment Facilities		
Program	Active Duty Family Members	Retirees, Their Families and Other Eligible Beneficiaries
<b>TRICARE Prime</b>	<i>No increase.</i> \$0 per admission	<i>No increase.</i> \$40 per day. No charge for separately billed professional charges.
<b>TRICARE Standard</b>	<i>No increase.</i> \$20 per day or \$25 per admission, whichever is greater.	High Volume Hospitals— <i>no increase</i> —25% of hospital-specific charges. Low Volume Hospital—increases from <b>\$175 to \$181</b> per day or 25% of the billed charges, whichever is lower. RTC— 25% of the allowed amount. Partial hospitalization—25% of the allowed amount, plus 25% of the allowable charge for separately billed professional services.
<b>TRICARE Extra</b>	<i>No increase.</i> \$20 per day or \$25 per admission, whichever is greater.	<i>No increase.</i> 20% of total charge. Plus, 20% of the allowable charge for separately billed professional services.

## Prior Authorization Requirements Updated

TriWest updated its prior authorization requirements on Nov. 1, 2006.

Here are some important points about the Prior Authorization List:

- The Prior Authorization List replaced the Medical Necessity Review List.
- Services on the Prior Authorization List will require prior authorization. Providers will need to submit requests with supporting clinical documentation for these services only.
- Please keep in mind that prior authorization is not a guarantee of payment. Covered services are subject to eligibility and all applicable terms and conditions of the TRICARE program, including any exclusions, limitations and benefits in effect at

the time services are rendered. Some of these provisions may not be readily identifiable at the time prior authorization is given, but they still apply if discovered later in the claims processes after services have been provided.

- The Prior Authorization List posted on the TriWest Web site has links to lists of codes. For example, a provider can go to [www.triwest.com](http://www.triwest.com), Provider Connection, click on “Cosmetic Procedures” and review a list of codes for which prior authorization is required.

For further information, refer to [www.triwest.com](http://www.triwest.com) or at 1-888-TRIWEST (1-888-874-9378). ■

TriWest Healthcare Alliance  
P.O. Box 42049  
Phoenix, AZ 85080

## CONTACTS

**TriWest Customer Service**  
1-888-TRIWEST  
[www.triwest.com](http://www.triwest.com)

**TRICARE Alaska Office**  
1-907-743-1800

**Wisconsin Physicians Service**  
(Electronic claims set up)  
1-800-782-2680  
[www.wpsic.com](http://www.wpsic.com)

**Express Scripts, Inc. (ESI)**  
(Pharmacy inquiries)  
1-866-DoD-TRRX  
1-866-DoD-TMOP  
[www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE)



## Prior Authorization Required for ADSMs

**A**ctive duty service members (ADSMs) using TRICARE Prime or TRICARE Prime Remote (TPR) must have prior authorization for inpatient and outpatient services, except most ancillary services (laboratory and X-ray), from a TRICARE network or non-network civilian provider.

**Note:** TPR ADSMs can obtain primary care outpatient services and clinical preventive care from a local TRICARE-authorized provider without a prior authorization.

If you don't obtain a prior authorization when one is required, or you exceed the scope of an approved prior authorization, you risk not being paid or being assessed a penalty.

**Network Providers:** TRICARE claims submitted by network providers to Wisconsin Physicians Service (WPS) without the required authorization are reviewed, and if determined to be

medically necessary and a covered benefit, reimbursed at the TRICARE allowable charge with an assessed penalty. Providers may not bill the beneficiary the penalty amount. If the beneficiary did not advise the provider of TRICARE coverage before services were rendered, the provider can request a post-service, prepayment review. Requests for review should be sent, along with documentation, to WPS, P.O. Box 77028, Madison, WI 53707-1028.

**Non-network Providers:** TRICARE claims submitted to WPS without the required authorization may be denied.

To request a prior authorization, fax a completed TRICARE Patient Referral/Authorization form to 1-866-269-5892 for TRICARE Prime beneficiaries or to 1-866-312-5831 for TPR beneficiaries. Forms are available at [www.triwest.com](http://www.triwest.com) by clicking on

the "Find a Form" tab at the top of the home page and selecting "Provider Forms."

You can help TriWest process your authorization request by following these easy guidelines:

- Fax your authorization request only once. Re-faxing causes duplication and may delay processing your request.
- Send only one completed TRICARE Patient Referral/Authorization form per fax. Sending multiple requests under one fax cover sheet increases the processing time.
- Fill out the form completely and accurately. Incomplete forms will be returned.

Approved authorizations are faxed to provider offices between midnight and 3 a.m. daily, so it's important to leave fax machines on after hours. ■