

GENERAL

ISSUE DATE: July 27, 2005

AUTHORITY: 10 U.S.C. 1079(j)(2) and 10 U.S.C. 1079(h)

I. APPLICABILITY

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

II. ISSUE

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

III. POLICY

A. Statutory Background.

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

Centers for Medicare and Medicaid Services (CMS) published a proposed rule in the **Federal Register** (FR) on September 8, 1998 (63 FR 47552) setting forth the proposed PPS for

hospital outpatient services. On June 30, 1999, a correction notice was published (64 FR 35258) to correct a number of technical and typographical errors contained in the September 8, 1998 proposed rule.

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

1. Made adjustments for covered services whose costs exceeded a given threshold (i.e., an outlier payment).
2. Established transitional pass-through payments for certain medical devices, drugs, and biologicals.
3. Placed limitations on judicial review for determining outlier payments and the determination of additional payments for certain medical devices, drugs, and biologicals.
4. Included as covered outpatient services implantable prosthetics and Durable Medical Equipment (DME) and diagnostic x-ray, laboratory, and other tests associated with those implantable items.
5. Limited the variation of costs of services within each payment classification group by providing that the highest median cost for an item or service within the group cannot be more than two times greater than the lowest median cost for an item or service within the group (referred to as the "two times rule"). An exception to this requirement may be made in unusual cases, such as low volume items and services, but may not be made in the case of a drug or biological that has been designated as an orphan drug under Section 526 of the Federal Food, Drug and Cosmetic Act.
6. Required at least annual review of the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, the addition of new services, new cost data, and other relevant information or factors.
7. Established transitional corridors that would limit payment reductions under the hospital OPSS.
8. Established hold harmless provisions for rural and cancer hospitals.

B. Participation Requirement.

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

C. Unbundling Provisions.

As a prelude to implementation of the OPSS, the Omnibus Budget Reconciliation Act of 1996 (OBRA 1996) prohibited payment for nonphysician services furnished to hospital

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

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

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

- a. Cardiac catheterization;
- b. Computerized Axial Tomography (CAT) scans;
- c. Magnetic Resonance Imagings (MRIs);
- d. Ambulatory surgery involving the use of an operating room;
- e. Emergency Room (ER) services;
- f. Radiation therapy;
- g. Angiography; and
- h. Lymphatic and venous procedures.

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

D. Applicability and Scope of Coverage.

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

1. Provider Categories.

a. Providers Included In OPPTS:

(1) All hospitals participating in the Medicare program, except for those excluded under [paragraph III.D.1.b.](#)

(2) Hospital-based Partial Hospitalization Programs (PHPs) that are subject to the more restrictive TRICARE authorization requirements under [32 CFR 199.6\(b\)\(4\)\(xii\)](#). Following are the specific requirements for authorization and payment under the Program:

(a) Be certified pursuant to TRICARE certification standards.

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

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

(d) Has a written participation agreement with TRICARE.

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

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

(4) **Small Rural and Sole Community Hospitals (SCHs) in Rural Areas**

(a) **Currently under Medicare, small rural and SCHs in rural areas are subject to Transitional Outpatient Payments (TOPs). These TOPs will expire on December 31, 2009.**

(b) **TRICARE will delay implementation of its OPPTS for small rural hospitals with 100 or fewer beds and SCHs with 100 or fewer beds until January 1, 2010.**

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b. Providers Excluded From OPSS:

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

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

(3) CAHs. The contractors shall monitor TMA's web site at <http://www.tricare.mil/hospitalclassification> for quarterly updates to the critical access hospital list and update their systems to reflect the most current information on the list. For additional information on CAHs, refer to [Chapter 15, Section 1](#).

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

(5) Specialty care providers to include:

(a) Cancer and children's hospitals.

(b) Freestanding Ambulatory Surgery Centers (ASCs).

(c) Freestanding PHPs, Psych and Substance Use Disorder Rehabilitation Facilities (SUDRFs).

(d) Comprehensive Outpatient Rehabilitation Facilities (CORFs).

(e) Home Health Agencies (HHAs).

(f) Hospice programs.

(g) Community Mental Health Centers (CMHCs).

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

(h) Other corporate services providers (e.g., Freestanding Cardiac Catheterization, Sleep Disorder Diagnostic Centers, and Freestanding Hyperbaric Oxygen Treatment Centers).

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

(i) Freestanding Birthing Centers.

(j) Veterans Affairs (VA) hospitals.

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(k) Freestanding End Stage Renal Dialysis (ESRD) Facilities.

(l) SNFs.

2. Scope of Services.

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

(1) Physician services.

(2) Nurse practitioner and clinical nurse specialist services.

(3) Physician assistant services.

(4) Certified nurse-midwife services.

(5) Services of qualified psychologists.

(6) Clinical social worker services.

(7) Services of an anesthetist.

(8) Screening and diagnostic mammographies.

(9) Influenza and pneumococcal pneumonia vaccines.

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

(10) Clinical diagnostic laboratory services.

(11) Take home surgical dressings.

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

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

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

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

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

(15) Services excluded by statute (excluded from the definition of “covered Outpatient Department (OPD) Services”):

- (a) Ambulance services;
- (b) Physical therapy;
- (c) Occupational therapy;
- (d) Speech-language pathology.

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

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

b. Costs excluded under the hospital OPDS:

- (1) Direct cost of medical education activities.
- (2) Costs of approved nursing and allied health education programs.
- (3) Costs associated with interns and residents not in approved teaching programs.
- (4) Costs of teaching physicians.
- (5) Costs of anesthesia services furnished to hospital outpatients by qualified non-physician anesthetists (Certified Registered Nurse Anesthetists (CRNA) and Anesthesiologists' Assistants (AAs)) employed by the hospital or obtained under arrangements, for hospitals.
- (6) Bad debts for uncollectible and coinsurance amounts.
- (7) Organ acquisition costs.
- (8) Corneal tissue acquisition costs incurred by hospitals that are paid on a reasonable cost basis.

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

(1) Hospital-based full- and half-day PHPs (psych and SUDRFs) which are paid a per diem OPSS. Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients who have profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

(2) All hospital outpatient services, except those that are identified as excluded. The following are services that are included in OPSS:

(a) Surgical procedures.

NOTE: Hospital-based ASC procedures will be included in the OPSS/APC system even though they are currently paid under the ASC grouper system. The new OPSS/APC system covers procedures on the ASC list when they are performed in a hospital outpatient department, hospital ER, or hospital-based ASC. ASC group payment will still apply when they are performed in freestanding ASCs.

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

(b) Radiology, including radiation therapy.

(c) Clinic visits.

(d) Emergency department visits.

(e) Diagnostic services and other diagnostic tests.

(f) Surgical pathology.

(g) Cancer chemotherapy.

(h) Implantable medical items.

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

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

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

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

(i) Specific hospital outpatient services furnished to a beneficiary who is admitted to a Medicare-participating SNF but who is not considered to be a SNF resident, for purposes of SNF consolidated billing, with respect to those services that are beyond the scope of SNF comprehensive care plans. They include:

- 1 Cardiac catheterization;
- 2 CAT scans;
- 3 MRIs;
- 4 Ambulatory surgery involving the use of an operating room;
- 5 ER services;
- 6 Radiation therapy;
- 7 Angiography;
- 8 Lymphatic and venous procedures.

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

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

(l) ESRD Services. Since TRICARE does not have an ESRD composite rate, ESRD services are included in TRICARE's OPSS.

E. Description of APC Groups.

Group services identified by Healthcare Common Procedure Coding System (HCPCS) codes and descriptors within APC groups are the basis for setting payment rates under the hospital OPSS.

1. Grouping of Procedures/Services Under APC System.

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

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

(1) *Resource Homogeneity* - The amount and type of facility resources (e.g., operating room time, medical surgical supplies, and equipment) that are used to furnish or

perform the individual procedures or services within each APC should be homogeneous. That is, the resources used are relatively constant across all procedures or services even though resource use may vary somewhat among individual patients.

(2) *Clinical Homogeneity* - The definition of each APC group should be “clinically meaningful”; that is, the procedures or services included within the APC group relate generally to a common organ system or etiology, have the same degree of extensiveness, and utilize the same method of treatment - for example, surgical, endoscopic, etc.

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

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

F. Basic Reimbursement Methodology.

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

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

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

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

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

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

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

6. A wage adjustment factor will be used to adjust the portion of the payment rate that is attributable to labor-related costs for relative differences in labor and non-labor-related costs across geographical regions.

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

NOTE: The ASC cost-sharing provision (i.e., assessment of a single copayment for both the professional and facility charge for a Prime beneficiary) will be adopted as long as it is administratively feasible. This will not apply to Extra and Standard beneficiaries since their cost-sharing is based on a percentage of the total bill. The copayment is based on site of service, except for CPT¹/HCPCS 36400-36416, 36591, 36592, 59020, 59025, and 59050, for venipuncture and fetal monitoring. Reference [Chapter 2, Section 1, paragraph I.B.5.e.](#) and [g.](#)

G. Reimbursement Hierarchy For Procedures Paid Outside The OPPTS.

1. CMAC Facility Pricing Hierarchy (No Technical Component (TC) Modifier).

a. The following tables includes the list of rate columns on the CMAC file. The columns are number 1 through 6 by description. The pricing hierarchy for facility CMAC is 8, 6, 4, then 2.

COLUMN	DESCRIPTION
1	Non-facility CMAC for physician/LLP class
2	Facility CMAC for physician/LLP class
3	Non-facility CMAC for non-physician class
4	Facility CMAC for non-physician class
5	Physician class Professional Component (PC) rate
6	Physician class Technical Component (TC) rate

Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the physician class TC rate. Otherwise, if the Facility CMAC for non-physician class > 0, then pay the Facility CMAC for non-physician class. Otherwise, pay Facility CMAC for physician/LLP class.

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COLUMN	DESCRIPTION
7	Non-physician class PC rate
8	Non-physician class TC rate
Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the physician class TC rate. Otherwise, if the Facility CMAC for non-physician class > 0, then pay the Facility CMAC for non-physician class. Otherwise, pay Facility CMAC for physician/LLP class.	

NOTE: Hospital-based therapy services, i.e., Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST), shall be reimbursed at the non-facility CMAC for physician/LLP class.

b. If there is no CMAC available, the contractor shall reimburse the procedure under DMEPOS.

2. DMEPOS. If there is no DMEPOS available, the contractor shall reimburse the procedure using state prevailings.

3. State Prevailing Rate. If there is no state prevailing rate available, the contractor shall reimburse the procedure based on billed charges.

H. Outpatient Code Editor (OCE).

1. The OCE with APC program edits patient data to help identify possible errors in coding and assigns APC numbers based on HCPCS codes for payment under the OPPS. The OPPS is an outpatient equivalent of the inpatient, DRG-based PPS. Like the inpatient system based on DRGs, each APC has a pre-established prospective payment amount associated with it. However, unlike the inpatient system that assigns a patient to a single DRG, multiple APCs can be assigned to one outpatient record. If a patient has multiple outpatient services during a single visit, the total payment for the visit is computed as the sum of the individual payments for each service. Updated versions of the OCE (MF cartridge) and data files CD, along with installation and user manuals, will be shipped from the developer to the contractors. The contractors will be required to replace the existing OCE with the updated OCE within 21 calendar days of receipt. See [Chapter 13, Addendum A1](#), for quarterly review/update process.

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

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

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

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

I. PRICER Program.

1. The APC PRICER will be straightforward in that the site-of-service wage index will be used to wage adjust the payment rate for the particular APC HCPCS Level I and II code (e.g., a HCPCS code with a designated Status Indicator (SI) of S, T, V, or X) reported off of the hospital outpatient claim. The PRICER will also apply discounting for multiple surgical procedures performed during a single operative session and outlier payments for extraordinarily expensive cases. TMA will provide the contractor's a common TRICARE PRICER to include quarterly updates. The contractors will be required to replace the existing PRICER with the updated PRICER within 21 days of receipt.

NOTE: Claims received with service dates on or after the OPSS quarterly effective dates (i.e., January 1, April 1, July 1 and October 1 of each calendar year) but prior to 21 days from receipt of either the OPSS OCE or PRICER update cartridge may be considered excluded claims as defined by the TOM, [Chapter 1, Section 3, paragraph 1.3.2](#).

2. The contractors shall provide 3M with those pricing files to maintain and update the TRICARE OPSS PRICER within five weeks prior to the quarterly update. For example, statewide prevailings for ambulance services and state specific non-professional component birthing center rates. Appropriate deductible, cost-sharing/copayment amounts and catastrophic caps limitations will be applied outside the PRICER based on the eligibility status of the TRICARE beneficiary at the time the outpatient services were rendered.

J. Geographical Wage Adjustments.

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

K. Provider-Based Status for Payment Under OPSS.

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

L. Implementing Instructions.

Since this issuance only deals with a general overview of the OPSS reimbursement methodology, the following cross reference is provided to facilitate access to specific

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implementing instructions within [Chapter 13, Section 1](#) through 5:

IMPLEMENTING INSTRUCTIONS/SERVICES	
POLICIES	
General Overview	Chapter 13, Section 1
Billing and Coding of Services under APC Groups	Chapter 13, Section 2
Reimbursement Methodology	Chapter 13, Section 3
Claims Submission and Processing Requirements	Chapter 13, Section 4
Medical Review And Allowable Charge Review Under The Hospital OPPS	Chapter 13, Section 5
ADDENDA	
Development Schedule for TRICARE OCE/APC - Quarterly Update	Chapter 13, Addendum A1
OPPS OCE Notification Process for Quarterly Updates	Chapter 13, Addendum A2
Approval Of OPPS - OCE/APC And NGPL Quarterly Update Process	Chapter 13, Addendum A3

M. OPPS Data Elements Available on TMA's web site.

The following data elements are available on TMA's OPPS web site at <http://www.tricare.mil/opps>.

1. APCs with SIs and Payment Rates.
2. Payment SI by HCPCS Code.
3. Payment SIs/Descriptions.
4. CPT Codes That Are Paid Only as Inpatient Procedures.
5. Statewide Cost-to-Charge Ratios (CCRs).
6. OPPS Provider File with Wage Indexes for Urban and Rural Areas, uses same wage indexes as TRICARE's DRG-based payment system, except effective date is January 1 of each year for OPPS.
7. Zip to Wage Index Crosswalk.

IV. EFFECTIVE DATE May 1, 2009.

- END -