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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 101  
6010.55-M  
OCTOBER 8, 2009**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** MENTAL HEALTH REIMBURSEMENT FOR FISCAL YEAR (FY) 2010

**CONREQ:** 14869

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change provides the annual mental health reimbursement updates for FY 2010.

**EFFECTIVE DATE:** October 1, 2009.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

**Reta Michak  
Acting Chief, Medical Benefits and  
Reimbursement Branch**

**ATTACHMENT(S):** 35 PAGE(S)  
**DISTRIBUTION:** 6010.55-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

**REMOVE PAGE(S)**

**CHAPTER 2**

Section 1, pages 7 through 19

**CHAPTER 7**

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Addendum G (FY 2007), pages 1 through 5

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**CHAPTER 8**

Addendum E (FY 2010), pages 1 and 2

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**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 1

COST-SHARES AND DEDUCTIBLES

(Please reference daily rate chart below.) (For care provided on or after April 1, 2001, for Prime ADFMs, copayment is \$0.)

**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.

<b>PERIOD</b>	<b>DAILY CHARGE</b>
October 1, 1997 - September 30, 1998	\$10.20
October 1, 1998 - September 30, 1999	\$10.45
October 1, 1999 - September 30, 2000	\$10.85
October 1, 2000 - September 30, 2001	\$11.45
April 1, 2001 (for Prime ADFMs only)	\$0.00
October 1, 2001 - September 30, 2002 (for ADFMs not enrolled in Prime)	\$11.90
October 1, 2002 - September 30, 2003 (for ADFMs not enrolled in Prime)	\$12.72
October 1, 2003 - September 30, 2004 (for ADFMs not enrolled in Prime)	\$13.32
October 1, 2004 - September 30, 2005 (for ADFMs not enrolled in Prime)	\$13.90
October 1, 2005 - September 30, 2006 (for ADFMs not enrolled in Prime)	\$14.35
October 1, 2006 - September 30, 2007 (for ADFMs not enrolled in Prime)	\$14.80
October 1, 2007 - September 30, 2008 (for ADFMs not enrolled in Prime)	\$15.15
October 1, 2008 - September 30, 2009 (for ADFMs not enrolled in Prime)	\$15.65
<b>October 1, 2009 - September 30, 2010 (for ADFMs not enrolled in Prime)</b>	<b>\$16.30</b>

(2) Other Beneficiaries: For services exempt from the DRG-based payment system and the 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 allowable charges.

c. Cost-Shares: Maternity.

(1) Determination. Maternity care cost-share shall be determined as follows:

(a) Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded.

NOTE: Inpatient cost-share formula applies to prenatal and postnatal care provided in the office of a civilian physician or certified nurse-midwife in connection with maternity care ending in childbirth or termination of pregnancy in, or on the way to, a military treatment facility inpatient childbirth unit. ADFMs pay a per diem charge (or a \$25.00 minimum charge) for an admission and there is no separate cost-share for them for separately billed professional charges or prenatal or postnatal care.

(b) Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is

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admitted, and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

(c) Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

(d) Otherwise covered medical services and supplies directly related to "Complications of pregnancy", as defined in the Regulation, will be cost-shared on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

(2) Otherwise authorized services and supplies related to maternity care, including maternity related prescription drugs, shall be cost-shared on the same basis as the termination of pregnancy.

(3) Claims for pregnancy testing are cost-shared on an outpatient basis when the delivery is on an inpatient basis.

(4) Where the beneficiary delivers in a professional office birthing suite located in the office of a physician or certified nurse-midwife (which is not otherwise a TRICARE-approved birthing center) the delivery is to be adjudicated as an at-home birth.

(5) Claims for prescription drugs provided on an outpatient basis during the maternity episode but not directly related to the maternity care are cost-shared on an outpatient basis.

(6) Newborn cost-share. Effective for all inpatient admissions occurring on or after October 1, 1987, separate claims must be submitted for the mother and newborn. The cost-share for inpatient claims for services rendered to an beneficiary newborn is determined as follows:

(a) IN A DRG HOSPITAL:

1 Same newborn date of birth and date of admission.

2 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

3 For newborn family members of other than active duty members, unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of the number of hospital days minus three (3) multiplied by the per diem amount, OR 25% of the total billed charges (less duplicates and DRG non-reimbursables such as hospital-based professional charges).

4 Different newborn date of birth and date of admission. For family members of active duty members, there will be no cost-share during the period the

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newborn is deemed enrolled in Prime. For all other beneficiaries, the cost-share is applied to all days in the inpatient stay unless the newborn is deemed enrolled in Prime.

(b) IN DRG EXEMPT HOSPITAL:

1 Same newborn date of birth and date of admission.

2 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

3 For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

4 Different newborn date of birth and date of admission.

5 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

6 For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

(7) Maternity Related Care. Medically necessary treatment rendered to a pregnant woman for a non-obstetrical medical, anatomical, or physiological illness or condition shall be cost-shared as a part of the maternity episode when:

(a) The treatment is otherwise allowable as a benefit, and,

(b) Delay of the treatment until after the conclusion of the pregnancy is medically contraindicated, and,

(c) The illness or condition is, or increases the likelihood of, a threat to the life of the mother, or,

(d) The illness or condition will cause, or increase the likelihood of, a stillbirth or newborn injury or illness, or,

(e) The usual course of treatment must be altered or modified to minimize a defined risk of newborn injury or illness.

d. Cost-Shares: DRG-Based Payment System.

(1) General. These special cost-sharing procedures apply only to claims paid under the DRG-based payment system.

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(2) TRICARE Standard.

(a) Cost-shares for ADFMs.

1 Except in the case of mental health services, ADFMs 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.

2 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.

(b) Cost-shares for beneficiaries other than ADFMs.

1 The cost-share will be the lesser of:

ⓐ An amount based on a single, specific per diem amount which will not vary regardless of the DRG involved. The following is the DRG inpatient TRICARE Standard cost-sharing per diems for beneficiaries other than ADFMs.

For FY 2005, the daily rate is \$512.

For FY 2006, the daily rate is \$535.

For FY 2007, the daily rate is capped at the FY 2006 level of \$535, per Section 704 of NDAA FY 2007.

For FY 2008, the daily rate is \$535.

For FY 2009, the daily rate is \$535.

(1) The per diem amount will be calculated as follows:

(a) Determine the total allowable DRG-based amounts for services subject to the DRG-based payment system and for beneficiaries other than ADFMs during the same database period used for determining the DRG weights and rates.

(b) Add in the allowance for capital and direct medical education which have been paid to hospitals during the same database period used for determining the DRG weights and rates.

(c) Divide this amount by the total number of patient days for these beneficiaries. This amount will be the average cost per day for these beneficiaries.

(d) Multiply this amount by 0.25. In this way total cost-sharing amounts will continue to be 25% of the allowable amount.

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(e) Determine any cost-sharing amounts which exceed 25% of the billed charge (see [paragraph I.C.3.d.\(2\)\(b\)1b](#)) and divide this amount by the total number of patient days in [paragraph I.C.3.d.\(2\)\(b\)1a](#). Add this amount to the amount in [paragraph I.C.3.d.\(2\)\(b\)1a](#). This is the per diem cost-share to be used for these beneficiaries.

(2) The per diem amount will be required for each actual day of the beneficiary's hospital stay which the DRG-based payment covers except for the day of discharge. When the payment ends on a specific day because eligibility ends on either a long-stay or short-stay outlier day, the last day of eligibility is to be counted for determining the per diem cost-sharing amount. For claims involving a same-day discharge which qualify as an inpatient stay (e.g., the patient was admitted with the expectation of a stay of several days, but died the same day) the cost-share is to be based on a one-day stay. (The number of hospital days must contain one day in this situation.) Where long-stay outlier days are subsequently determined to be not medically necessary by a PRO, no cost-share will be required for those days, since payment for such days will be the beneficiary's responsibility entirely.

b Twenty-five percent (25%) of the billed charge. The billed charge to be used includes all inpatient institutional line items billed by the hospital minus any duplicate charges and any charges which can be billed separately (e.g., hospital-based professional services, outpatient services, etc.). The net billed charges for the cost-share computation include comfort and convenience items.

2 Under no circumstances can the cost-share exceed the DRG-based amount.

3 Where the dates of service span different fiscal years, the per diem cost-share amount for each year is to be applied to the appropriate days of the stay.

#### (3) TRICARE Extra.

(c) Cost-shares for ADFMs. The cost-sharing provisions for ADFMs are the same as those for TRICARE Standard.

(b) Cost-shares for beneficiaries other than ADFMs. The cost-sharing provisions for beneficiaries other than ADFMs is the same as those for TRICARE Standard, except the per diem copayment is \$250.

(4) TRICARE Prime. Cost-shares for ADFMs. The cost-sharing provision for ADFMs is the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or a per diem rate of \$11, whichever is greater. For care provided on or after April 1, 2001, for Prime ADFMs, cost-share is \$0. See attached Table 1 of this Policy for further information.

(5) Maternity Services. See [paragraph I.C.3.c.](#), for the cost-sharing provisions for maternity services.

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e. Cost-Shares: Inpatient Mental Health Per Diem Payment System.

(1) General. These special cost-sharing procedures apply only to claims paid under the inpatient mental health per diem payment system. For inpatient claims exempt from this system, the procedures in [paragraph I.C.3.b.](#) or [paragraph I.C.3.d.](#) are to be followed.

(2) Cost-shares for ADFMs. Effective for care on or after October 1, 1995 and care on or prior to March 31, 2001, 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 PHP providing mental health or substance use disorder rehabilitation services. For Prime ADFMs care provided on or after April 1, 2001, cost-share is \$0 per day. See Table 1 of this Policy for further information.

(3) Cost-shares for beneficiaries other than ADFMs.

(a) 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% of the hospital specific per diem amount.

(b) 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 [paragraph I.C.3.e.\(3\)\(b\)1](#) or [paragraph I.C.3.e.\(3\)\(b\)2](#):

1 A fixed daily amount multiplied by the number of covered days. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the 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 7, Section 1](#). This fixed daily amount will also be furnished to contractors by TMA. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

a Fiscal Year 1998 - \$137 per day.

b Fiscal Year 1999 - \$140 per day.

c Fiscal Year 2000 - \$144 per day.

d Fiscal Year 2001 - \$149 per day.

e Fiscal Year 2002 - \$154 per day.

f Fiscal Year 2003 - \$159 per day.

g Fiscal Year 2004 - \$164 per day.

h Fiscal Year 2005 - \$169 per day.

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- i Fiscal Year 2006 - \$175 per day.
- j Fiscal Year 2007 - \$181 per day.
- k Fiscal Year 2008 - \$187 per day.
- l Fiscal Year 2009 - \$193 per day.
- m Fiscal Year 2010 - \$197 per day.

2 Twenty-five percent (25%) of the hospital's billed charges (less any duplicates).

(4) Claim which spans a period in which two separate per diems exist. A claim subject to the 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.

(5) 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.

(6) 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 cannot 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 an 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.

#### f. Cost-Shares: Partial Hospitalization.

Cost-sharing for partial hospitalization is on an inpatient basis. The inpatient cost-share also applies to the associated psychotherapy billed separately by the individual professional provider. These providers will have to identify on the claim form that the psychotherapy is related to a partial hospitalization stay so the proper inpatient cost-sharing can be applied. Effective for care on or after October 1, 1995 and on or prior to March 31, 2001, the cost-share for ADFMs for inpatient mental health services is \$20 per day for each day of the inpatient admission. For care provided on or after April 1, 2001, the cost-share for ADFMs enrolled in Prime for inpatient mental health services is \$0. For retirees and their family members, the cost-share is 25% of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for ADFMs is to be taken from the PHP claim.

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g. Cost-Shares: Ambulatory Surgery.

For the basis of payment of ambulatory surgery, see [Chapter 9, Section 1](#).

(1) ADFMs or Authorized NATO Beneficiary. For all services reimbursed as ambulatory surgery, the cost-share will be \$25 and will be assessed on the facility claim. No cost-share is to be deducted from a claim for professional services related to ambulatory surgery. This applies whether the services are provided in a freestanding ASC, a hospital outpatient department or a hospital emergency room. So long as at least one procedure on the claim is reimbursed as ambulatory surgery, the claim is to be cost-shared as ambulatory surgery as required by this section-- that is, a \$25 cost-share is to be assessed to the claim for the facility charges, and no cost-share is to be taken from any claim for related professional services.

(2) Other Beneficiaries. Since the cost-share for other beneficiaries is based on a percentage rather than a set amount, it is to be taken from all ambulatory surgery claims. For professional services, the cost-share is 25% of the allowed amount. For the facility claim, the cost-share is the lesser of:

(a) Twenty-five percent (25%) of the applicable group payment rate (see [Chapter 9, Section 1](#)); or

(b) Twenty-five percent (25%) of the billed charges; or

(c) Twenty-five percent (25%) of the allowed amount as determined by the contractor.

(d) The special cost-sharing provisions for beneficiaries other than ADFMs will ensure that these beneficiaries are not disadvantaged by these procedures. In most cases, 25% of the group payment rate will be less, but because there is some variation within each group, 25% of billed charges could be less in some cases. This will ensure that the beneficiaries get the benefit of the group payment rates when they are more advantageous, but they will never be disadvantaged by them. If there is no group payment rate for a procedure, the cost-share will simply be 25% of the allowed amount.

h. Cost-Shares and Deductible: Former Spouses.

(1) Deductible. In accordance with the FY 1991 Appropriations and Authorization Acts, Sections 8064 and 712 respectively, beginning April 1, 1991, an eligible former spouse is responsible for payment of the first one hundred and fifty dollars (\$150.00) of the reasonable costs/charges for otherwise covered outpatient services and/or supplies provided in any one fiscal year. Although the law defines former spouses as family members of the member or former member, there is no legal familial relationship between the former spouse and the member or former member. Moreover, any TRICARE-eligible children of the former spouse will be included in the member's or former member's family deductible. Therefore, the former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of that of any TRICARE-eligible children. In other words, a former spouse must independently meet the \$150.00 deductible in any fiscal year.

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(2) Cost-Share. An eligible former spouse is responsible for payment of cost-sharing amounts identical to those required for beneficiaries other than ADFMs.

i. Cost-Share Amount: Under Discounted Rate Agreements. Under managed care, where there is a negotiated (discounted) rate agreed to by the network provider, the cost-share shall be based on the following:

(1) For noninstitutional providers providing outpatient care, and for institution-based professional providers rendering both inpatient and outpatient care; the cost-share (20%) for outpatient care to ADFMs, (25%) for care to all others) shall be applied to, (after duplicates and noncovered charges are eliminated), the lowest of the billed charge, the prevailing charge, the maximum allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge.

(2) For institutional providers subject to the DRG-based reimbursement methodology, the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

(a) The single, specific per diem supplied by TMA after the application of the agreed upon discount rate; OR,

(b) Twenty-five percent (25%) of the billed charge.

(3) For institutional providers subject to the Mental Health Per Diem Payment System (high volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be 25% of the hospital per diem amount after it has been adjusted by the discount.

(4) For institutional providers subject to the Mental Health per diem payment system (low volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

(a) The fixed daily amount supplied by TMA after the application of the agreed upon discount rate; OR,

(b) Twenty-five percent (25%) of the billed charge.

(5) For Residential Treatment Centers (RTC), the cost-share for other than ADFMs shall be 25% of the TRICARE rate after it has been adjusted by the discount.

(6) For institutions and for institutional services being reimbursed on the basis of the TRICARE-determined reasonable costs, the cost-share for beneficiaries other than ADFMs shall be 25% of the allowable billed charges **after** it has been adjusted by the discount.

NOTE: For all inpatient care for ADFMs, the cost-share shall continue to be either the daily charge or \$25 per stay, whichever is higher. There is no change to the requirement for the ADFM's cost-share to be applied to the institutional charges for inpatient services. If the contractor learns that the participating provider has billed a beneficiary for a

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greater cost-share amount, based on the provider's usual billed charges, the contractor shall notify the provider that such an action is a violation of the provider's signed agreement. (Also, see [paragraph I.C.3.d.](#)) For Prime ADFMs, the cost-share is \$0 for care provided on or after April 1, 2001.

j. Preventive Services.

(1) Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TPM, [Chapter 7, Sections 2.1](#) and [2.5](#):

- (a) Colorectal cancer screening.
- (b) Breast cancer screening.
- (c) Cervical cancer screening.
- (d) Prostate cancer screening.
- (e) Immunizations.
- (f) Well-child visits for children under six years of age.

(g) Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in [paragraph I.C.3.j.\(1\)\(a\)](#) through [\(e\)](#). If one or more of the procedure codes described in the TPM, [Chapter 7, Section 2.1](#) for those preventive services listed in [paragraph I.C.3.j.\(1\)\(a\)](#) through [\(e\)](#) is billed on a claim, then the cost-share is waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit are subject to appropriate cost-sharing and deductibles.

(2) A beneficiary is not required to pay any portion of the cost of these preventive services even if the beneficiary has not satisfied the deductible for that year.

(3) This waiver does not apply to any TRICARE beneficiary who is a Medicare-eligible beneficiary.

(4) Appropriate cost-sharing and deductibles will apply for all other preventive services under TRICARE Standard. See [Chapter 7, Sections 2.1](#) and [2.5](#).

(5) The contractor shall process claims for reimbursement of copayments paid for those services exempted from copayments rendered from October 14, 2008 through the implementation date of this change as prescribed in the Underpayments provisions in the TOM. Contractors will add a message to the Explanation of Benefits (EOB) to advise the provider that this is a retroactive adjustment to the copayment to alert the provider regarding a refund to the beneficiary of the copayment amount.

D. TRICARE Extra.

1. For Extra deductibles and cost-shares, see [Chapter 2, Addendum A](#).

2. If non-enrolled TRICARE beneficiary receives care from a network provider out of the region of residence, and if the beneficiary has not met the Fiscal Year Catastrophic Cap, the beneficiary shall pay the Extra cost-share to the provider. The contractor for the beneficiary's residence shall process the claim under TRICARE Extra claims processing procedures if the TRICARE Encounter Provider Record (TEPRV) shows the provider to be contracted.

3. Preventive Services.

a. Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TPM, [Chapter 7, Sections 2.1 and 2.5](#):

(1) Colorectal cancer screening.

(2) Breast cancer screening.

(3) Cervical cancer screening.

(4) Prostate cancer screening.

(5) Immunizations.

(6) Well-child visits for children under six years of age.

(7) Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in [paragraph I.D.3.a.\(1\)](#) through (5). If one or more of the procedure codes described in the TPM, [Chapter 7, Section 2.1](#) for those preventive services listed in [paragraph I.D.3.a.\(1\)](#) through (5) is billed on a claim, then the cost-share is waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit are subject to appropriate cost-sharing and deductibles.

b. A beneficiary is not required to pay any portion of the cost of these preventive services even if the beneficiary has not satisfied the deductible for that year.

c. This waiver does not apply to any TRICARE beneficiary who is a Medicare-eligible beneficiary.

d. Appropriate cost-sharing and deductibles will apply for all other preventive services under TRICARE Standard. See [Chapter 7, Sections 2.1 and 2.5](#).

e. The contractor shall process claims for reimbursement of copayments paid for those services exempted from copayments rendered from October 14, 2008 through the

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implementation date of this change as prescribed in the Underpayments provisions in the TOM. Contractors shall add a message to the EOB to advise the provider that this is a retroactive adjustment to the copayment to alert the provider regarding a refund to the beneficiary of the copayment amount.

#### E. Cost-Shares: Ambulance Services.

For the basis of payment of ambulance services, see [Chapter 1, Section 14](#).

1. Outpatient. The following are beneficiary copayment/cost-sharing requirements for medically necessary ambulance services when paid on an outpatient basis:

##### a. TRICARE Prime:

(1) For care provided prior to April 1, 2001, for ADFMs in pay grades E-1 through E-4, \$10. For care provided on or after April 1, 2001, for ADFMs in pay grades E-1 through E-4, \$0. See [Chapter 2, Addendum A](#) for further information.

(2) For care provided prior to April 1, 2001, for ADFMs in pay grades E-5 and above, \$15. For care provided on or after April 1, 2001, for ADFMs in pay grades E-5 and above, \$0. See [Chapter 2, Addendum A](#) for further information.

(3) For retirees and their family members, \$20.

##### b. TRICARE Extra:

(1) A cost-share of 15% of the fee negotiated by the contractor for ADFMs.

(2) A cost-share of 20% of the fee negotiated by the contractor for retirees, their family members, and survivors.

##### c. TRICARE Standard:

(1) A cost-share of 20% of the allowable charge for ADFMs.

(2) A cost-share of 25% of the allowable charge for retirees, their family members, and survivors.

#### 2. Inpatient: Non-Network Providers:

a. ADFMs: No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

b. Other Beneficiary: The cost-share applicable to inpatient care for beneficiaries other than ADFMs is 25% of the allowable amount.

F. Exceptions.

1. Inpatient cost-share applicable to each separate admission. A separate cost-share amount is applicable to each separate beneficiary for each inpatient admission EXCEPT:

a. Any admission which is not more than 60 days from the date of the last inpatient discharge shall be treated as one inpatient confinement with the last admission for cost-share amount determination.

b. Certain heart and lung hospitals are excepted from cost-share requirements. See [Chapter 1, Section 28](#), entitled "Legal Obligation To Pay".

2. Inpatient Cost-Share: Maternity care. See [paragraph I.C.3.c](#). All admissions related to a single maternity episode shall be considered one confinement regardless of the number of days between admissions. For ADFMs, the cost-share will be applied to the first institutional claim received.

3. Special Cost-Share Provisions. Effective October 1, 1987, the inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories cannot exceed that which would have been imposed if the service were subject to the DRG-based payment system. This will not affect ADFMs. For all other beneficiaries, the cost-share shall be the lesser of (1) that calculated according to [paragraph I.C.3.b.\(2\)](#), or (2) that calculated according to [paragraph I.C.3.d.\(2\)](#).

a. Child bone marrow transplant. All services related to discharges involving bone marrow transplant for a beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis code V42.8 and ICD-9-CM procedure codes 41.0 through 41.04, 41.06, and 41.91.

b. Child HIV Seropositivity. All services related to discharges involving HIV seropositive beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis codes 042, 079.53 and 795.71.

c. Child Cystic Fibrosis. All services related to discharges involving beneficiary less than 18 years old with ICD-9-CM principle or secondary diagnosis code 277.0 (cystic fibrosis).

4. Cost-Sharing for Family Members of a Member who Dies While on Active Duty. Those in Transitional Survivor status, are not distinguished from other ADFMs for cost-sharing purposes. After the Transitional Survivor status ends, eligible TRICARE beneficiaries may be placed in Survivor status and will be responsible for retiree cost-shares. See the Transitional Survivor Status policy in [Chapter 10, Section 7.1](#).

G. Catastrophic Loss Protection.

See [Chapter 2, Section 2](#).

- END -



## MENTAL HEALTH

SECTION	SUBJECT
1	Hospital Reimbursement - TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System
2	Psychiatric Partial Hospitalization Program (PHP) Reimbursement
3	Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement
4	Residential Treatment Center (RTC) Reimbursement
ADDENDUM A	Table Of Regional Specific Rates For Psychiatric Hospitals And Units With Low TRICARE Volume (FY 2008 - FY 2010)
ADDENDUM B	Table Of Maximum Rates For Partial Hospitalization Programs (PHPs) Before May 1, 2009 (Implementation Of OPPS), And Thereafter, Freestanding Psychiatric PHP Reimbursement (FY 2008 - FY 2010)
ADDENDUM C	Participation Agreement For Substance Use Disorder Rehabilitation Facility (SUDRF) Services For TRICARE/CHAMPUS Beneficiaries
ADDENDUM D	TRICARE/CHAMPUS Standards For Inpatient Rehabilitation And Partial Hospitalization For The Treatment Of Substance Use Disorders (SUDRFs)
ADDENDUM E	Participation Agreement For Residential Treatment Center (RTC)
ADDENDUM F	Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates
ADDENDUM G	(FY 2008) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2007
ADDENDUM G	(FY 2009) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2008
ADDENDUM G	(FY 2010) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2009
ADDENDUM H	TRICARE/CHAMPUS Standards For Residential Treatment Centers (RTCs) Serving Children And Adolescents
ADDENDUM I	Participation Agreement For Hospital-Based Psychiatric Partial Hospitalization Program Services

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**  
CHAPTER 7 - MENTAL HEALTH

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SECTION	SUBJECT
ADDENDUM J	Participation Agreement For Freestanding Psychiatric Partial Hospitalization Program Services

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 1

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS INPATIENT MENTAL HEALTH  
PER DIEM PAYMENT SYSTEM

<b>CAP PER DIEM AMOUNT</b>	<b>FOR SERVICES RENDERED</b>
679	10/01/1999 through 09/30/2000
702	10/01/2000 through 09/30/2001
725	10/01/2001 through 09/30/2002
750	10/01/2002 through 09/30/2003
776	10/01/2003 through 09/30/2004
802	10/01/2004 through 09/30/2005
832	10/01/2005 through 09/30/2006
860	10/01/2006 through 09/30/2007
889	10/01/2007 through 09/30/2008
917	10/01/2008 through 09/30/2009
936	10/01/2009 through 09/30/2010

3. Request for Recalculation of Per Diem Amount. Any psychiatric hospital or unit which has determined TMA calculated a hospital-specific per diem which differs by more than five 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. 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.

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 IDME. 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 IDME 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. See [Chapter 7, Addendum A](#), for the regional per diems used for hospitals and units with a lower volume of TRICARE patients.

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

a. Wage Portion or Labor-Related Share. The wage portion or labor-related share is adjusted by the DRG-based area wage adjustment. See [Chapter 7, Addendum A](#), for area wage adjustment rates. The calculated adjusted regional per diem is not to be rounded up to the next whole dollar.

# TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

## CHAPTER 7, SECTION 1

### HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM

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b. IDME Adjustment. The IDME adjustment factors shall be calculated for teaching hospitals in the same manner as in the DRG-based payment system 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 IDME adjustment factor for the unit (separate from the rest of the hospital) when medical education applies to the unit.

3. Reimbursement of Direct Medical Education Costs. In addition to payments made to lower volume hospitals and units, the government shall annually reimburse hospitals for actual direct medical education costs associated with TRICARE beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the DRG-based payment system.

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 (FY) 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%.

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 FY 1989. For subsequent fiscal years, each per diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare DRG 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 FY 1995 shall remain frozen through FY 1997. For FY 1998 and thereafter the per diems shall be updated by the Medicare update factor. 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

TABLE OF REGIONAL SPECIFIC RATES FOR PSYCHIATRIC  
 HOSPITALS AND UNITS WITH LOW TRICARE VOLUME  
 (FY 2008 - FY 2010)

UNITED STATES CENSUS REGIONS	FY 2008 REGIONAL RATES 10/01/07 - 09/30/08	FY 2009 REGIONAL RATES 10/01/08 - 09/30/09	FY 2010 REGIONAL RATES 10/01/09 - 09/30/10
<b>Northeast:</b>			
New England (ME, NH, VT, MA, RI, CT)	\$707	\$730	\$745
Mid-Atlantic (NY, NJ, PA)	\$681	\$703	\$717
<b>Midwest:</b>			
East North Central (OH, IN, IL, MI, WI)	\$588	\$607	\$619
West North Central (MN, IA, MO, ND, SD, NE, KS)	\$555	\$573	\$585
<b>South:</b>			
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	\$701	\$723	\$738
East South Central (KY, TN, AL, MS)	\$750	\$774	\$790
West South Central (AR, LA, TX, OK)	\$639	\$659	\$672
<b>West:</b>			
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	\$638	\$658	\$671
Pacific (WA, OR, CA, AK, HI)	\$754	\$778	\$794
Puerto Rico	\$481	\$496	\$506

NOTE: This table reflects maximum rates.

FOR FY 2009: For wage index values greater than 1.0, the wage portion or labor related share subject to the area wage adjustment is 69.7%. The non-labor related share is 30.3%. For wage index values less than or equal to 1.0, the wage portion or labor related share subject to the area wage adjustment is 62%. The non-labor related share is 38%. Utilize the appropriate year DRG wage index file for area wage adjustment calculations.

FOR FY 2009/BENEFICIARY COST-SHARE: Beneficiary cost-share (other than active duty members) for care paid on a basis of a regional per diem rate is the lower of \$193 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2008.

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 7, ADDENDUM A

TABLE OF REGIONAL SPECIFIC RATES FOR PSYCHIATRIC HOSPITALS AND UNITS WITH LOW TRICARE

FOR FY 2010: For wage index values greater than 1.0, the wage portion or labor related share subject to the area wage adjustment is 68.8%. The non-labor related share is 31.2%. For wage index values less than or equal to 1.0, the wage portion or labor related share subject to the area wage adjustment is 62%. The non-labor related share is 38%. Utilize the appropriate year DRG wage index file for area wage adjustment calculations.

FOR FY 2010/BENEFICIARY COST-SHARE: Beneficiary cost-share (other than active duty members) for care paid on a basis of a regional per diem rate is the lower of \$197 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2009.

- END -

TABLE OF MAXIMUM RATES FOR PARTIAL HOSPITALIZATION PROGRAMS (PHPs) BEFORE MAY 1, 2009 (IMPLEMENTATION OF OPPS), AND THEREAFTER, FREESTANDING PSYCHIATRIC PHP REIMBURSEMENT (FY 2008 - FY 2010)

UNITED STATES CENSUS REGIONS	FULL-DAY RATE (6 HOURS OR MORE)			HALF-DAY RATE (3-5 HOURS)		
	10/01/07-09/30/08	10/01/08-09/30/09	10/01/09-09/30/10	10/01/07-09/30/08	10/01/08-09/30/09	10/01/09-09/30/10
<b>Northeast:</b>						
New England (ME, NH, VT, MA, RI, CT)	\$284	\$293	\$299	\$214	\$221	\$222
Mid-Atlantic (NY, NJ, PA)	\$308	\$318	\$324	\$232	\$239	\$244
<b>Midwest:</b>						
East North Central (OH, IN, IL, MI, WI)	\$271	\$280	\$285	\$203	\$209	\$213
West North Central (MN, IA, MO, ND, SD, NE, KS)	\$271	\$280	\$285	\$203	\$209	\$213
<b>South:</b>						
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	\$292	\$301	\$307	\$219	\$226	\$230
East South Central (KY, TN, AL, MS)	\$315	\$325	\$331	\$237	\$245	\$250
West South Central (AR, LA, TX, OK)	\$315	\$325	\$331	\$237	\$245	\$250
<b>West:</b>						
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	\$318	\$328	\$334	\$240	\$248	\$253
Pacific (WA, OR, CA, AK, HI)	\$312	\$322	\$328	\$234	\$241	\$246
Puerto Rico	\$203	\$209	\$213	\$153	\$158	\$161
<b>Days of 3 hours or less: no payment authorized.</b>						

NOTE: This table reflects maximum rates.

- END -



CHAPTER 7  
 ADDENDUM G (FY 2010)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR  
 PAYMENT OF SERVICES PROVIDED ON OR AFTER 10/01/2009

The rates in this Addendum will be used for payment of claims for services rendered on or after October 1, 2009. The rates were adjusted by the lesser of the FY 2009 Medicare update factor (2.1%) or the amount that brought the rate up to the new cap amount of \$758.

NOTE: This listing is for residential treatment center per diem rates only. It does not reflect a facility's status as a TRICARE-authorized residential treatment center. Information regarding a facility's current status as an authorized provider can be obtained from the appropriate contractor.

FACILITY	TRICARE/CHAMPUS RATE
<b>ALASKA</b>	
DeBarr Residential Treatment Center Frontline Hospital, LLC 1500 DeBarr Circle Anchorage, AK 99508 EIN: 72-1539254	758.00
<b>ARKANSAS</b>	
BHC Pinnacle Pointe Hospital 11501 Financial Center Parkway Little Rock, AR 72211 EIN: 62-1658502	753.00
<b>COLORADO</b>	
PSI Cedar Springs Hospital, Inc. Cedar Springs Behavioral Health Systems, Inc. 2135 Southgate Road Colorado Springs, CO 80906 EIN: 74-3081810	758.00
CBR Youth Connect 28071 Hwy 109 La Junta, CO 81050 EIN: 84-0500375	697.00
<b>FLORIDA</b>	
LaAmistad Behavioral Health Services 1650 Park Avenue North Maitland, FL 32751 EIN: 58-1791069	719.00

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

## CHAPTER 7, ADDENDUM G (FY 2010)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR PAYMENT OF SERVICES PROVIDED ON  
OR AFTER 10/01/2009

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
Ten Broeck Ocala Behavioral 3130 SW 27th Ave Ocala, FL 34474 EIN: 32-0235544	387.00
River Point Behavioral Health TBJ Behavioral, LLC 6300 Beach Blvd Jacksonville, FL 32216 EIN: 20-4865566	584.00
Tampa Bay Academy Youth & Family Centered Services of Florida, Inc 12012 Boyette Road Riverview, FL 33569 EIN: 52-1955335	590.00
Manatee Palms Youth Service 4480 51st Street West Bradenton, FL 34210 EIN: 65-0816927	675.00
<b>GEORGIA</b>	
Costal Harbor Treatment Center UHS of Savannah, LLC 1150 Cornell Avenue Savannah, GA 31406 EIN: 20-0931196	419.00
Inner Harbour Hospitals, Inc 4685 Dorsett Shoals Road Douglasville, GA 30135 EIN: 58-0873694	758.00
<b>HAWAII</b>	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	758.00
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	731.00

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

## CHAPTER 7, ADDENDUM G (FY 2010)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR PAYMENT OF SERVICES PROVIDED ON  
OR AFTER 10/01/2009

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
<b>INDIANA</b>	
Michiana Behavioral Health Center HHC Indiana, Inc 1800 North Oak Road Plymouth, IN 46563 EIN: 20-0768028	427.00
Valle Vista Hospital, LLC Valle Vista Health System 898 East Main Street Greenwood, IN 46143 EIN: 62-1740366	453.00
<b>KENTUCKY</b>	
Ten Broeck Hospital -- Louisville KMI Acquisition, LLC 8521 LaGrange Road Louisville, KY 40242 EIN: 20-5048153	682.00
Ten Broeck Hospital -- Dupont TBD Acquisition, LLC Louisville, KY 40207 EIN: 20-5048087	641.00
<b>MISSOURI</b>	
Heartland Behavioral Health Services, Inc Great Plains Hospital, Inc 1500 W. Asland Nevada, MO 64772 EIN: 43-1328523	399.00
Lakeland Regional Hospital Lakeland Hospital Acquisition Corporation 440 South Market Avenue Springfield, MO 65806 EIN: 58-2291915	408.00
Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 EIN: 44-0545808	\$326.00

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 7, ADDENDUM G (FY 2010)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR PAYMENT OF SERVICES PROVIDED ON  
OR AFTER 10/01/2009

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
<b>MONTANA</b>	
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	436.00
<b>NEVADA</b>	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	758.00
<b>NEW MEXICO</b>	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	320.00
<b>NORTH CAROLINA</b>	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 561317433	464.00
<b>SOUTH CAROLINA</b>	
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	435.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	727.00
<b>TENNESSEE</b>	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	451.00

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

## CHAPTER 7, ADDENDUM G (FY 2010)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR PAYMENT OF SERVICES PROVIDED ON  
OR AFTER 10/01/2009

<b>FACILITY</b>	<b>TRICARE/CHAMPUS RATE</b>
Dickson Recovery Center 222 Church Street Dickson, TN 37055 EIN: 20-4990101	413.00
<b>TEXAS</b>	
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	758.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	632.00
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	711.00
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	653.00
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	696.00
<b>VIRGINIA</b>	
Poplar West HHC Poplar Springs, Inc. 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	730.00
The Pines Residential Treatment Center - Kempsville 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	632.00

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 7, ADDENDUM G (FY 2010)

TRICARE-AUTHORIZED RESIDENTIAL TREATMENT CENTERS - FOR PAYMENT OF SERVICES PROVIDED ON  
OR AFTER 10/01/2009

FACILITY	TRICARE/CHAMPUS RATE
<b>WASHINGTON</b>	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	628.00

WAGE INDEXES FOR URBAN AREAS FOR SNFs BASED ON  
 CBSA LABOR MARKET AREAS - FISCAL YEAR 2010

SOURCE: 74 FR 40365; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Final Rule. August 11, 2009.

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
10180	Abilene, TX	0.7946		Grant, LA			Henderson, NC	
	Callahan, TX			Rapides, LA			Madison, NC	
	Jones, TX		10900	Allentown-Bethlehem-Easton, PA-NJ	0.9611	12020	Athens-Clarke, GA	0.9492
	Taylor, TX			Warren, NJ			Clarke, GA	
10380	Aguadilla-Isabela-San Sebastian, PR	0.3462		Carbon, PA			Madison, GA	
	Aguada, PR			Lehigh, PA			Oconee, GA	
	Aguadilla, PR			Northampton, PA		12060	Atlanta-Sandy Springs-Marietta, GA	0.9591
	Anasco, PR		11020	Altoona, PA	0.8863		Barrow, GA	
	Isabela, PR			Blair, PA			Bartow, GA	
	Lares, PR		11100	Amarillo, TX	0.8689		Butts, GA	
	Moca, PR			Armstrong, TX			Carroll, GA	
	Rincon, PR			Carson, TX			Cherokee, GA	
	San Sebastian, PR			Potter, TX			Clayton, GA	
10420	Akron, OH	0.8850		Randall, TX			Cobb, GA	
	Portage, OH		11180	Ames, IA	0.9493		Coweta, GA	
	Summit, OH			Story, IA			Dawson, GA	
10500	Albany, GA	0.8899	11260	Anchorage, AK	1.2013		DeKalb, GA	
	Baker, GA			Anchorage Municipality, AK			Douglas, GA	
	Dougherty, GA			Matanuska-Susitna Borough, AK			Fayette, GA	
	Lee, GA		11300	Anderson, IN	0.9052		Forsyth, GA	
	Terrell, GA			Madison, IN			Fulton, GA	
	Worth, GA			Anderson, SC	0.9023		Gwinnett, GA	
10580	Albany-Schenectady-Troy, NY	0.8777	11340	Anderson, SC	0.9023		Haralson, GA	
	Albany, NY			Anderson, SC			Henry, GA	
	Rensselaer, NY		11460	Ann Arbor, MI	1.0293		Jasper, GA	
	Saratoga, NY			Washtenaw, MI			Lamar, GA	
	Schenectady, NY		11500	Anniston-Oxford, AL	0.7643		Meriwether, GA	
	Schoharie, NY			Calhoun, AL			Newton, GA	
10740	Albuquerque, NM	0.9399	11540	Appleton, WI	0.9289		Paulding, GA	
	Bernalillo, NM			Calumet, WI			Pickens, GA	
	Sandoval, NM			Outagamie, WI			Pike, GA	
	Torrance, NM		11700	Asheville, NC	0.9057		Rockdale, GA	
	Valencia, NM			Buncombe, NC			Spalding, GA	
10780	Alexandria, LA	0.8012		Haywood, NC				

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 8, ADDENDUM E (FY 2010)

WAGE INDEXES FOR URBAN AREAS FOR SNFs BASED ON CBSA LABOR MARKET  
AREAS - FISCAL YEAR 2010

CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX	CBSA CODE	URBAN AREA (CONSTITUENT COUNTIES)	WAGE INDEX
12100	Walton, GA Atlantic City-Hammonton, NJ Atlantic, NJ	1.1554	12980	Battle Creek, MI Calhoun, MI	1.0000	14060	Bloomington-Normal, IL McLean, IL	0.9378
12220	Auburn-Opelika, AL Lee, AL	0.8138	13020	Bay City, MI Bay, MI	0.9267	14260	Boise City-Nampa, ID Ada, ID Boise, ID	0.9318
12260	Augusta-Richmond, GA-SC Burke, GA Columbia, GA McDuffie, GA Richmond, GA Aiken, SC Edgefield, SC	0.9409	13140	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.8383	14484	Boston-Quincy, MA Norfolk, MA Plymouth, MA Suffolk, MA	1.2186
12420	Austin-Round Rock, TX Bastrop, TX Caldwell, TX Hays, TX Travis, TX Williamson, TX	0.9518	13380	Bellingham, WA Whatcom, WA	1.1395	14500	Boulder, CO Boulder, CO	1.0266
12540	Bakersfield, CA Kern, CA	1.1232	13460	Bend, OR Deschutes, OR	1.1446	14540	Bowling Green, KY Edmonson, KY Warren, KY	0.8469
12580	Baltimore-Towson, MD Anne Arundel, MD Baltimore, MD Carroll, MD Harford, MD Howard, MD Queen Anne's, MD Baltimore City, MD	1.0214	13644	Bethesda-Frederick-Gaithersburg, MD Frederick, MD Montgomery, MD	1.0298	14600	Bradenton-Sarasota-Venice, FL Manatee, FL Sarasota, FL	0.9735
12620	Bangor, ME Penobscot, ME	1.0154	13740	Billings, MT Carbon, MT Yellowstone, MT	0.8781	14740	Bremerton-Silverdale, WA Kitsap, WA	1.0755
12700	Barnstable Town, MA Barnstable, MA	1.2618	13780	Binghamton, NY Broome, NY Tioga, NY	0.8780	14860	Bridgeport-Stamford-Norwalk, CT Fairfield, CT	1.2792
12940	Baton Rouge, LA Ascension, LA East Baton Rouge, LA East Feliciana, LA Iberville, LA Livingston, LA Pointe Coupee, LA St. Helena, LA West Baton Rouge, LA West Feliciana, LA	0.8180	13820	Birmingham-Hoover, AL Bibb, AL Blount, AL Chilton, AL Jefferson, AL St. Clair, AL Shelby, AL Walker, AL	0.8554	15180	Brownsville-Harlingen, TX Cameron, TX	0.9020
			13900	Bismarck, ND Burleigh, ND Morton, ND	0.7637	15260	Brunswick, GA Brantley, GA Glynn, GA McIntosh, GA	0.9178
			13980	Blacksburg-Christiansburg-Radford, VA Giles, VA Montgomery, VA Pulaski, VA Radford City, VA	0.8394	15380	Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	0.9740
			14020	Bloomington, IN Greene, IN Monroe, IN Owen, IN	0.9043	15500	Burlington, NC Alamance, NC	0.8749
						15540	Burlington-South Burlington, VT Chittenden, VT Franklin, VT Grand Isle, VT	1.0106

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