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HEALTH AFFAIRS

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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 106  
6010.55-M  
DECEMBER 1, 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:** CLARIFICATIONS ON CRITICAL ACCESS HOSPITAL (CAH)  
REIMBURSEMENT

**CONREQ:** 14934

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

**SUMMARY OF CHANGE(S):** This change clarifies that CAHs are excluded from Outpatient Prospective Payment System (OPPS) reimbursement; clarifies billing for multi-day supplies of take-home drugs; and non-covered charges are not included in the billed charges when calculating the cost-to-charge cap.

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

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

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

**ATTACHMENT(S):** 5 PAGE(S)  
**DISTRIBUTION:** 6010.55-M

**CHANGE 106  
6010.55-M  
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**REMOVE PAGE(S)**

**CHAPTER 15**

Section 1, pages 3 through 7

**INSERT PAGE(S)**

Section 1, pages 3 through 7

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e. Payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients. Payment for professional medical services furnished in a CAH to CAH inpatients is made on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a Hospital Outpatient Department (HOPD). For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a Physician Assistant (PA) or a Nurse Practitioner (NP). These services are to be billed on the CMS 1500 (08/05) using the appropriate Healthcare Common Procedure Coding System (HCPCS) code or a UB-04 using the appropriate HCPCS code and professional revenue codes.

f. A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004. The CAH distinct part units must meet the following requirements:

- (1) The facility distinct part unit has been certified as a CAH by CMS;
- (2) The distinct part unit meets the conditions of participation requirements for hospitals;
- (3) The distinct part unit must also meet the requirements, other than conditions of participation requirements, that would apply if the unit were established in an acute care hospital;
- (4) Inpatient services provided in psychiatric distinct part units are subject to the CHAMPUS mental health per diem system and inpatient services provided in rehabilitation distinct part units shall be reimbursed based on billed charges or set rates.
- (5) Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;
- (6) The bed limitations for each distinct part unit is 10.

g. CAHs are not subject to the lesser of cost or charges principle.

#### 2. Outpatient Services.

a. Prior to December 1, 2009, outpatient facility services provided by CAHs were reimbursed **in accordance with the provisions in Chapter 1, Section 24. CAHs are excluded from the Outpatient Prospective Payment System (OPPS) reimbursement.**

b. Effective December 1, 2009, outpatient services including ambulatory surgery, provided by a CAH shall be reimbursed under the reasonable cost method, reference [paragraph IV.C.](#)

c. Payment to a CAH for outpatient services does not include any costs of physician services or other professional services to CAH outpatients. Payment for professional medical services furnished in a CAH to CAH outpatients is made on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a HOPD. For purposes of CAH payment, professional medical services are defined as services

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provided by a physician or other practitioner, e.g., a PA or a NP. These services are to be billed on a CMS 1500 (08/05) using appropriate HCPCS code or a UB-04 using the appropriate HCPCS code and professional revenue code.

d. Payment for clinical diagnostic laboratory tests shall be reimbursed under the reasonable cost method only if the individuals are outpatients of the CAH and are physically present in the CAH at the time the specimens are collected (bill type 85X). A CAH cannot seek reasonable cost reimbursement for tests provided to individuals in locations such as rural health clinics, the individual's home or SNF. *Individuals in these locations are non-patients of a CAH and their lab test would be categorized as "referenced lab tests" for the non-patients bill type 14X), and are paid under the **CHAMPUS Maximum Allowable Charge (CMAC)**.*

e. Multi-day supplies of take-home oral anti-cancer drugs, oral anti-emetic drugs, and immunosuppressive drugs, as well as the associated supplying fees and all inhalation drugs and the associated dispensing fees shall be paid under the **allowable charge method**. The associated supplying and dispensing fees must be billed on the same claim as the drug. Hospitals shall submit a separate claim for these services **on a CMS 1500 (08/05) identifying the specific drugs and supplies. The drugs should be identified by both the appropriate "J" code and National Drug Code (NDC).**

NOTE: When an outpatient service includes an oral anti-cancer drug, oral anti-emetic drug or immunosuppressive drug, so long as no more than one day's drug supply (i.e., only today's) is given to the beneficiary, and the beneficiary receives additional services, the claim shall be processed and paid under the reasonable cost method. Inhalation drugs that are an integral part of a hospital procedure (inpatient or outpatient) shall also be processed and paid under the reasonable cost method, when billed in conjunction with other services on the same day.

f. Authorized Partial Hospitalization Programs (PHPs) shall be reimbursed under the reasonable cost method.

g. CAHs are not subject to the lesser of cost or charges principle.

### 3. Ambulance Services.

a. Effective for services provided on or after December 1, 2009, ambulance services furnished by CAHs exempt from the allowable charge methodology, are paid under the reasonable cost method. To be exempt, the provider must "self-attest" on each claim by using the B2 condition code. This self-attestation indicates compliance with the eligibility criteria included in 42 CFR 413.70(b)(5) and requires the provider to be the only provider or supplier of ambulance services located within a 35-mile drive of the facility in question. Under TRICARE, these ambulance services shall be reimbursed using the hospital's outpatient Cost-to-Charge Ratio (CCR).

b. Reasonable cost will be determined without regard to any per-trip limits or fee schedule that would otherwise apply. The distance between the CAH or entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the nearest provider or supplier of ambulance services are garaged. An

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improved road is any road that is maintained by a local, state, or federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the CAH and the front entrance of the garage.

NOTE: CAHs that are not exempt from the allowable charge methodology may not report condition code B2.

C. Reasonable Cost Methodology. Reasonable cost is based on the actual cost of providing services and excluding any costs, that are unnecessary in the efficient delivery of services covered by the program.

1. TMA shall calculate an overall inpatient CCR and overall outpatient CCR, obtained from data on the hospital's most recently filed Medicare cost report as of July 1 of each year.

2. The inpatient and outpatient CCRs are calculated using Medicare charges, e.g., Medicare costs for outpatient services are derived by multiplying an overall hospital outpatient CCR (by department or cost center) by Medicare charges in the same category.

3. The following methods are used by TMA to calculate the CCRs for CAHs. The worksheet and column references are to the CMS Form 2552-96 (Cost Report for Electronic Filing of Hospitals).

4. To reimburse the vast majority of CAHs for all their costs in an administratively

#### **Inpatient CCRs**

**Numerator** Medicare costs were defined as Worksheet D-1, Part II, line 49 MINUS (worksheet D, Part III, Column 8, sum of lines 25-30 PLUS Worksheet D, Part IV, line 101).

**Denominator** Medicare charges were defined as Worksheet D-4, Column 2, sum of lines 25-30 and 103.

#### **Outpatient CCRs**

**Numerator** Outpatient costs were taken from Worksheet D, Part V, line 104, the sum of Columns 6, 7, 8, and 9.

**Denominator** Total outpatient charges were taken from the same Worksheet D, Part V, line 104, sum of Columns 2, 3, 4, and 5 for the same breakdowns.

feasible manner, TRICARE will identify CCRs that are outliers using the method used by Medicare to identify outliers in its Outpatient Prospective Payment System (OPPS) reimbursement methods. Specifically, Medicare classifies CCR outliers as values that fall outside of three standard deviations from the geometric mean. Applying this method to the CAH data, those limits will be considered the threshold limits on the CCR for reimbursement purposes. For Fiscal Year (FY) 2010, this calculation resulted in an inpatient CCR cap of 2.31 and outpatient CCR cap of 1.26; these will be re-calculated each year with the CCR update. Thus, for FY 2010, TRICARE will pay the lesser of 2.31 multiplied by the billed charges or 101% of costs (using the hospital's CCR and billed charges) for inpatient services and the lesser of 1.26 multiplied by the billed charges or 101% of costs for outpatient services. Following is the two step comparison of costs.

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STEP 1: Inpatient, pay the lesser of:

FY cap x billed charges (minus non-covered charges) OR  
1.01 x (hospital-specific CCR x billed charges (minus non-covered charges))

STEP 2: Outpatient, pay the lesser of:

FY cap x billed charges OR  
1.01 x (hospital-specific CCR x billed charges)

5. TMA shall provide a list of CAHs to the Managed Care Support Contractors (MCSCs) with their corresponding inpatient and outpatient CCRs by November 1 each year. The CCRs shall be updated on an annual basis using the second quarter CMS Hospital Cost Report Information System (HCRIS) data. The updated CCRs shall be effective as of December 1 of each respective year, with the first update occurring December 1, 2009.

6. TMA shall also provide the MCSCs the State median inpatient and outpatient CAH CCRs to use when a hospital specific CCR is not available.

D. CAH Listing.

1. TMA will maintain the CAH listing on the TMA's web site at <http://www.tricare.mil/hospitalclassification/>, and will update the list on a quarterly basis and will notify the contractors by e-mail when the list is updated.

2. For payment purposes for those facilities that were listed on both the CAH and SCH lists prior to June 1, 2006, the contractors shall use the implementation date of June 1, 2006, as the effective date for reimbursing CAHs under the DRG-based payment system. The June 1, 2006, effective date is for admissions on or after June 1, 2006. For admissions prior to June 1, 2006, if a facility was listed on both the CAH and SCH lists, the SCH list took precedence over the CAH list. The contractors shall not initiate recoupment action for any claims paid billed charges where the CAH was also on the SCH list, prior to the June 1, 2006, effective date. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

3. The effective date on the CAH list is the date supplied by CMS upon which the facility began receiving reimbursement from Medicare as a CAH, however, if a facility was listed on both the CAH and SCH lists prior to June 1, 2006, the effective date for TRICARE DRG reimbursement is June 1, 2006. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

4. After June 1, 2006, if a CAH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

5. If the contractor receives documentation from a CAH indicating their status is different than what is on the CAH listing on TMA's web site, the contractor shall send the

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information to TMA, Medical Benefits & Reimbursement Branch (MB&RB) to update the listings on the web.

E. CAHs participating in the demonstration in the state of Alaska, from July 1, 2007 through November 30, 2009, are exempt from the DRG-based payment system and are subject to the payment rates under the TRICARE Demonstration Project. For information on the demonstration, refer to the TRICARE Operations Manual (TOM), [Chapter 20, Section 9](#).

F. Prior to December 1, 2009, the contractor's shall update their institutional provider files to include CAH's and their Indirect Medical Education (IDME) factors, if applicable, as the CMS Inpatient Provider Specific File used to update the annual DRG Provider File does not contain CAH information.

G. Billing and Coding Requirements.

1. The contractors shall use type of institution 91 for CAHs.
2. CAHs shall utilize bill type 11X for inpatient services.
3. CAHs shall utilize bill type 85X for all outpatient services including services approved as Ambulatory Surgery Center (ASC) services.
4. CAHs shall utilize bill type 12X for ancillary/ambulance services.
5. CAHs shall utilize bill type 14X for non-patient diagnostic services.
6. CAHs shall use bill type 18X for swing bed services.

H. Beneficiary Liability. Applicable TRICARE deductible and cost-sharing provisions apply to CAH inpatient and outpatient services.

V. EFFECTIVE DATE

Implementation of the CAH reasonable cost methodology is effective for admissions and outpatient services occurring on or after December 1, 2009.

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