OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 111
6010.55-M
MARCH 17, 2010

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: **PARTIAL HOSPITALIZATION PROGRAMS (PHPs)/PSYCHIATRIC HOSPITAL RATE CORRECTIONS**

CONREQ: 14994

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides rate corrections for PHPs, freestanding psychiatric PHP reimbursement, and psychiatric hospitals and units with low TRICARE volume. These rates are corrected to be consistent with Federal Register mental health notice.

EFFECTIVE DATE: October 1, 2009.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

John A. D'Alessandro
Chief, Medical Benefits and
Reimbursement Branch

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

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

REMOVE PAGE(S)	**INSERT PAGE(S)**
CHAPTER 6	
Section 4, pages 3 and 4	Section 4, pages 3 and 4
CHAPTER 7	
Addendum A, pages 1 and 2	Addendum A, pages 1 and 2
Addendum B, page 1	Addendum B, page 1

7. All services related to Combined Liver-Kidney (CLKT) and Combined Heart-Kidney Transplant (CHKT) through July 31, 2003. Effective August 1, 2003, CLKTs and CHKTs shall be paid under the assigned DRG based on the procedure performed.

8. All services related to TRICARE/CHAMPUS covered solid organ transplants for which there is no DRG assignment.

9. All services provided by hospital-based professionals (physicians, psychologists, etc.) which, under normal TRICARE/CHAMPUS requirements, would be billed by the hospital. This does not include any therapy services (physical, speech, etc.), since these are included in the DRG-based payment. For radiology and pathology services provided by hospital-based physicians, any related non-professional (i.e., technical) component of these services is included in the DRG-based payment and cannot be billed separately. The services of hospital-based professionals which are employed by, or under contract to, a hospital must still be billed by the hospital and must be billed on a participating basis.

10. Anesthesia services provided by nurse anesthetists. This may be separately billed only when the nurse anesthetist is the primary anesthetist for the case.

NOTE: As a general rule, TRICARE/CHAMPUS will only pay for one anesthesia claim per case. When an anesthesiologist is paid for anesthesia services, a nurse anesthetist is not authorized to bill for those same services. Services which support the anesthesiologist in the operating room fall within the DRG allowed amount and are considered to be already included in the facility fee, even if the support services are provided by a nurse anesthetist. Charging for such services is considered an inappropriate billing practice.

11. All outpatient services related to inpatient stays.

NOTE: Payment for trauma services (e.g., revenue code 068X), is included in the TRICARE/CHAMPUS DRG-based payment system.

12. All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) bone marrow transplants which would otherwise be paid under DRG 009.

13. All services related to discharges involving children (beneficiary less than 18 years old upon admission) who have been determined to be HIV seropositive.

14. All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) cystic fibrosis.

15. For admissions occurring on or after October 1, 1997, an additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a TRICARE/CHAMPUS patient who is a hemophiliac. Payment will be made for blood clotting factor when one of the following hemophilia ICD-9-CM diagnosis codes is listed on the claim:

286.0 Congenital Factor VIII Disorder;

286.1 Congenital Factor IX Disorder;
286.2 Congenital Factor XI Deficiency;
286.3 Congenital Deficiency of Other Clotting Factors;
286.4 Von Willebrand's Disease;
286.5 Hemorrhagic Disorder Due to Circulating Anticoagulants; and
286.7 Acquired Coagulation Factor Deficiency.

a. For admissions occurring on or after October 1, 1994, and prior to admissions occurring on or after October 1, 1997, the cost of the blood clotting factor for hemophilia inpatients is no longer eligible for separate reimbursement.

b. Each unit billed on the hospital claim represents 100 payment units except Q0187, Factor VIIa. For example, if the hospital indicates that 25 units of Factor VIII were provided, this would represent 2,500 actual units of factor, and the payment would be $1,600 (paid at $0.64/unit - Factor VIII). For HCPCS Q0187, one billing unit represents 1.2mg.

NOTE: Since the costs of blood clotting factor are reimbursed separately for admissions occurring on or after October 1, 1997, for these claims all charges associated with the factor are to be subtracted from the total charges in determining applicability of a cost outlier. However, the charges for the blood clotting factor are to be included when calculating the cost-share based on billed charges.

c. For admissions occurring on or after October 1, 2000, through September 30, 2001, the following HCPCS codes and payment rates shall be used for blood clotting factors:

J7190 Factor VIII (antihemophilic factor - human)	$0.85 per unit
J7191 Factor VIII (antihemophilic factor - porcine)	2.09 per unit
J7192 Factor VIII (antihemophilic factor - recombinant)	1.12 per unit
J7194 Factor IX (complex)	0.31 per unit
J7198 Anti-Inhibitor	1.43 per unit
Q0160 Factor IX (antihemophilic factor, purified, non-recombinant)	1.05 per unit
Q0161 Factor IX (antihemophilic factor, recombinant)	1.12 per unit

NOTE: HCPCS billing code J7198 replaces code J7196 (Other hemophilia clotting factors (e.g., anti-inhibitors)).

d. For admissions occurring on or after October 1, 2001, through September 30, 2002, the following HCPCS codes and payment rates shall be used for blood clotting factors:

J7190 Factor VIII (antihemophilic factor - human)	$0.86 per unit
J7191 Factor VIII (antihemophilic factor - porcine)	2.09 per unit
J7192 Factor VIII (antihemophilic factor - recombinant)	1.12 per unit
J7194 Factor IX (complex)	0.31 per unit
J7198 Anti-Inhibitor	1.43 per unit
Q0160 Factor IX (antihemophilic factor, purified, non-recombinant)	1.05 per unit
Q0161 Factor IX (antihemophilic factor, recombinant)	1.12 per unit

CHAPTER 7
ADDENDUM A

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
Northeast:			
New England (ME, NH, VT, MA, RI, CT)	$707	$730	$745
Mid-Atlantic (NY, NJ, PA)	$681	$703	$718
Midwest:			
East North Central (OH, IN, IL, MI, WI)	$588	$607	$620
West North Central (MN, IA, MO, ND, SD, NE, KS)	$555	$573	$585
South:			
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	$673
West:			
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	$638	$658	$672
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.

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.

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CHAPTER 7
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)

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
Northeast:						
New England (ME, NH, VT, MA, RI, CT)	$284	$293	$299	$214	$221	$222
Mid-Atlantic (NY, NJ, PA)	$308	$318	$325	$232	$239	$244
Midwest:						
East North Central (OH, IN, IL, MI, WI)	$271	$280	$286	$203	$209	$213
West North Central (MN, IA, MO, ND, SD, NE, KS)	$271	$280	$286	$203	$209	$213
South:						
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	$292	$301	$307	$219	$226	$231
East South Central (KY, TN, AL, MS)	$315	$325	$332	$237	$245	$250
West South Central (AR, LA, TX, OK)	$315	$325	$332	$237	$245	$250
West:						
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	$318	$328	$335	$240	$248	$253
Pacific (WA, OR, CA, AK, HI)	$312	$322	$329	$234	$241	$246
Puerto Rico	$203	$209	$213	$153	$158	$161
Days of 3 hours or less: no payment authorized.						

NOTE: This table reflects maximum rates.

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