CHAPTER 3
SECTION 2

HOSPITAL AND OTHER INSTITUTIONAL REIMBURSEMENT

ISSUE DATE:
AUTHORITY:

I. INTRODUCTION

TRICARE reimbursement of a non-network institutional health care provider shall be determined under the TRICARE DRG-based payment system as outlined in Chapter 6 or other TRICARE-approved method. Other methodologies must be proposed in writing and approved by the Contracting Officer. The procedures below are not required for reimbursement of the network providers of care. The contractor and network providers are free to negotiate any mutually agreeable reimbursement mechanism which complies with state and federal laws. Any agreement, however, in which the methodology deviates from the accepted contract proposal methodology and which is detrimental to the TRICARE beneficiary or to the government may be rejected by the Contracting Officer, and any agreement which calls for reimbursement at higher rates than those approved for standard TRICARE must be approved by the Contracting Officer.

II. PAYMENT OF CAPITAL AND DIRECT MEDICAL EDUCATION COST

A. General

The contractor will make an annual payment to each hospital subject to the TRICARE/CHAMPUS DRG-Based Payment System (except children's hospitals) which requests reimbursement for capital and direct medical education costs, CAP/DME. The payment will be computed based on Chapter 6, Section 8. These procedures will apply to all types of CAP/DME payments (including active duty). All CAP/DME payments will be non-financially underwritten and will be made from the non-financially underwritten, bank account (see the TRICARE Operations Manual, Chapter 3, Section 2).

B. Payment Procedures

The contractor shall use the following procedures in making CAP/DME payments to hospitals:

a. Receive claim or request for payment from the hospital.

b. Compute the amount due for each hospital submitting claims during a month, stopping processing prior to check write.

c. On the first work day of the following month submit a voucher in an electronic format to TMA, CRM (see the TRICARE Operations Manual, Chapter 3, Addendum A, Figure 3-A-8). (A fax copy is not necessary.)

d. After receiving clearance from TMA, CRM, continue processing through check write and mail out checks within two calendar days.

C. Adjustments For Underpayments

The contractor shall determine the amount of the underpayment and pay any additional payment to the hospital with the next group of checks being cut and report as a payment as described in paragraph II.B. above.

D. Recoupment Of Erroneous CAP/DME Payments

If the contractor overpays a provider for CAP/DME claims, the contractor shall follow recoupment procedures as specified in the TRICARE Operations Manual, Chapter 11, Section 4 to include offsetting overpayments against future payments.

1. Offset funds shall be included as credits on the monthly CAP/DME voucher for the month the credits were processed.

2. Collections shall be included as separate lines indicating the month the collection was deposited (normally the prior month).

3. Debts established under this paragraph and related transactions shall be reported on the monthly Accounts Receivable Report (see the TRICARE Operations Manual, Chapter 3, Section 10, paragraph 2.0.).

III. TRICARE INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM

See Chapter 7, Section 1, for additional instructions. See paragraph II., for voucher preparation instructions. Effective for all admissions occurring on or after January 1, 1989, non-network inpatient mental health care shall be paid based on a per diem rate determined by TMA and provided to the contractor. Network inpatient mental health care may be paid at a rate negotiated by the contractor which is different from the inpatient mental health per diem; however, a higher rate must be approved by the Contracting Officer and the beneficiary's cost-share must be computed to be the lesser of the amount which would apply under the per diem rate or the contractor-negotiated rate. The TRICARE-determined rate shall apply to any out-of-region beneficiaries who are admitted to the facility.

IV. INPATIENT MENTAL HEALTH HOSPITAL, PARTIAL HOSPITALIZATION AND RESIDENTIAL TREATMENT CENTER (RTC) FACILITY RATES

Effective with Fiscal Year 1998, contractors shall submit three iterations of inpatient mental health, partial hospitalization (Half Day three to five hours and full day six or more hours) and RTC rates by facility to the TMA, Office of Medical Benefits and Reimbursement Systems-Aurora (MB&RS). This data shall be reported in ASCII Format on a 3.5 floppy disc. The information shall include the Name of the Facility, Provider Number and the Location of

the Facility. For inpatient mental health facilities indicate whether the facility is high volume or low volume and if high volume, the date when the facility became high volume. In addition, if a high volume inpatient mental health facility or RTC has been limited to a cap amount, so indicate. (See 32 CFR 199.14 and Chapter 7, Section 1 and 4) For those psychiatric hospitals affected by the deflator computation, the contractor shall submit the high volume rate no later than 30 days from the date the deflator factor is received. The data shall be submitted using the following format:

NOTE: After year 2000 change number of iterations to submit only current year.

	A	B	C
1	**Field Name**	**Picture**	**Comments**
2	Provider/Facility Number	X(9)	Employer Identification Number
3	Fiscal Year	9(2)	Current Fiscal Year plus the two previous Fiscal Year Iterations
4	Facility Type	9(1)	1=Inpatient 2=Half Day Partial 3=Full Day Partial 4=RTC
5	Facility Name	X(40)	Name of the Facility Providing the Treatment
6	Facility Street Address	X(30)	Street Address of the Facility
7	Facility City	X(18)	City Where the Facility is Located
8	Facility State or Country Code	X(2)	State or Country Where Facility is Located (Alpha Code) (TRICARE Systems Manual, Chapter 2)
9	Facility Zip Code	X(9)	Zip Code Where Facility is Located
10	Per Diem Rate (Separate Record for each Per Diem Rate)	9(7)v99	1=Inpatient High Volume Per Diem Rate 2=Inpatient Low Volume Per Diem Rate - Adjusted by Wage Index and IDME Factors 3=Half Day Partial Hospitalization Per Diem Rate 4=Full Day Partial Hospitalization Per Diem Rate 5=RTC Per Diem Rate
11	High Volume Indicator	X(1)	Indicates if Facility is High Volume (1=True, 0=False)
12	High Volume Date	9(8)	If High Volume Indicator is True - Date Facility Became High Volume YYYYMMDD
13	High Volume Per Diem or RTC at Cap Amount	9(7)v99	If Per Diem has been Limited by Cap Amount, Provide Capped Amount

V. BILLED CHARGES/SET RATES

When a beneficiary is not enrolled in TRICARE Prime, the contractor shall reimburse for institutional care received from non-network providers on the basis of billed charges, if reasonable for the area and type of institution, or on the basis of rates set by statute or some other arrangement. The basic guidance shall be that the beneficiary's share shall not be increased above that which would have been required by payment of a reasonable billed charge.

A. Verification Of Billed Services

Reimbursement of billed charges should be subjected to tests of reasonableness performed by the contractor. These tests should be used to protect against both inadvertent and intentional practices of overbilling and/or supplying of excessive services. The contractor should verify that no mathematical errors have been made in the bill.

B. Use Of Local Or State Regulatory Authority Allowed Charges

There are instances in which a local or state regulatory authority, in an attempt to control costs, has established allowable charges for the citizens of a community or state. If such allowable charges have been extended to TRICARE beneficiaries by consent, agreement, or law, and if they are generally (not on a case by case basis) less than TRICARE would otherwise reimburse, the contractor should use such rates in determining TRICARE reimbursement. However, if a state creates a reimbursement system which would result in payments greater than the hospital's normal billed charges, the contractor should not use the state-determined amounts.

C. Discounts Or Reductions

Contractors should attempt to take advantage of all available discounts or rate reductions when they do not conflict with other requirements of the Program. When such a discount or charge reduction is available but the contractor is uncertain whether it would conform to its TRICARE contract, TMA should be contacted for direction.

D. All-Inclusive Rate Providers

All-inclusive rates may be reimbursed if the contractor verifies that the provider cannot adequately itemize its bills to provide the normally required TRICARE Encounter Data. Further, the contractor must ensure that appropriate revenue codes are included on the claim (as well as all other required UB-92 information), even though itemized charges are not required to be associated with the revenue codes. When a contractor reimburses a provider based on an all-inclusive rate, the contractor shall maintain documentation of its actions in approving the all-inclusive rate. The documentation must be available to TMA upon request. (Also, see Chapter 1, Section 22.)

VI. SPECIAL REIMBURSEMENT PROCEDURES FOR CERTAIN RESIDENTIAL TREATMENT CENTERS (RTCs)

The contractor shall pay the network RTCs based on agreements as negotiated by the

contractor. Non-network RTCs (see the TRICARE Operations Manual, Chapter 4) shall be reimbursed based on the rate established by TMA, using the methodology specified in Chapter 7, Section 4.

VII. REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS

A. General

1. Payment for facility charges for ambulatory surgical services will be made using prospectively determined rates. The rates will be divided into 11 payment groups representing ranges of costs and will apply to all ambulatory surgical procedures identified by TMA regardless of whether they are provided in a freestanding ambulatory surgical center (ASC), in a hospital outpatient clinic, or in a hospital emergency room.

2. TMA will provide the facility payment rates to the contractors on magnetic media and will provide updates each year. The magnetic media will include the locality-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. In addition, the contractors will be provided a zip code to MSA crosswalk.

3. Contractors are required to maintain only two sets of rates on their on-line systems at any time.

4. Professional services related to ambulatory surgical procedures will be reimbursed under the instructions for individual health care professionals and other non-institutional health care providers in Chapter 3, Section 1.

5. See Chapter 9, Section 1 for additional instructions.

B. Payment Procedures. All rate calculations will be performed by TMA (or its data contractor) and will be provided to each contractor. In pricing a claim, the contractor will be required to identify the zip code of the facility which provided the services (for the actual location, not the billing address, etc.) and the procedure(s) performed. The contractor shall use the zip code to MSA crosswalk to identify the rates applicable to that facility and then will select the rate applicable to the procedure(s) performed. Multiple procedures are to be reimbursed in accordance with the instructions in the TRICARE Policy Manual (TPM). Surgical and bilateral procedures (both institutional and professional) will be subject to the multiple surgery discounting guidelines and modifier requirement as prescribed under Chapter 1, Section 16, paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for services rendered on or after implementation of the Outpatient Prospective Payment System (OPPS).

C. Claims Form Requirements. Claims for facility charges must be submitted on a CMS 1450 UB-04. Claims for professional charges may be submitted on either a CMS 1450 UB-04 or a CMS 1500 (08/05) claim form. The preferred form is the CMS 1500 (08/05). When professional services are billed on a CMS 1450 UB-04, the information on the CMS 1450 UB-04 should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

VIII. CLAIM ADJUSTMENTS

Facilities may not submit a late charge bill (frequency 5 in the third position of the bill type). They must submit an adjustment bill for any services required to be billed with HCPCS codes, units, and line item dates of service by reporting frequency 7 (replacement of a prior claim) or frequency 8 (void/cancel of a prior claim). Claims submitted with a frequency code of 7 or 8 should report the original claim number in Form Locator 64 on the CMS 1450 UB-04 claim form.

IX. PROPER REPORTING OF CONDITION CODES

Hospitals should report valid Condition Codes on the CMS 1450 UB-04 claim form as necessary.

A. Condition Codes are reported in FLs 18-28 when applicable.

B. The following are two examples of condition code reporting:

1. **Condition Code G (zero)** identifies when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day - in the morning for a broken arm and later for chest pain.

a. Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim.

b. Claims with condition code G0 should not be automatically rejected as a duplicate claim.

2. **Condition Code 41** identifies a claim being submitted for Partial Hospitalization Program (PHP) Services.

- END -