



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

MB&RS

CHANGE 70  
6010.55-M  
FEBRUARY 11, 2008

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/  
revision(s) to the 6010.55-M, issued August 2002.

**CHANGE TITLE:** ROUTINE TPM/TRM CHANGE FEBRUARY 2008  
(FORMERLY TITLED SEPTEMBER 2007)

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

**SUMMARY OF CHANGE(S):** This change clarifies cost-sharing for hearing aids  
and adds a reference to the TRICARE Operations Manual (TOM) chapter for CAP/  
DME payments.

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

This change is made in conjunction with Aug 2002 TPM, Change No. 70.

  
Reta Michak  
Chief, Office of Medical Benefits  
and Reimbursement Systems

ATTACHMENT(S): 17 PAGE(S)  
DISTRIBUTION: 6010.55-M

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

**CHANGE 70**  
**6010.55-M**  
**FEBRUARY 11, 2008**

**REMOVE PAGE(S)**

**CHAPTER 2**

Addendum A, pages 1 through 8  
Addendum B, page 1

**CHAPTER 3**

Section 2, pages 1 through 6

**CHAPTER 10**

Addendum A, pages 3 and 4

**INSERT PAGE(S)**

Addendum A, pages 1 through 8  
Addendum B, page 1

Section 2, pages 1 through 6

Addendum A, pages 3 and 4

## **SUMMARY OF CHANGES**

### **CHAPTER 2**

1. Addendum A (Benefits and Beneficiary Payments under the TRICARE Program). This change clarifies cost-sharing for hearing aids.

### **CHAPTER 3**

2. Section 2 (Hospital and Other Institutional Reimbursement). This change removes the incorrect timing reference found in paragraph II.B. and provides a cross reference to the CAP/DME electronic filing details found in the TRICARE Operations Manual (TOM).



## BENEFITS AND BENEFICIARY PAYMENTS UNDER THE TRICARE PROGRAM

NOTE 1: Beneficiary copayments (i.e., beneficiary payments expressed as a specified amount) and enrollment fees may be updated for inflation annually (cumulative effect applied and rounded to the nearest whole dollar) by the national CPI-U medical index (the medical component of the Urban Consumer Price Index). Beneficiary cost shares (i.e., beneficiary payments expressed as a percentage of the provider's fee) will not be similarly updated.

### I. TRICARE PRIME PROGRAM ANNUAL ENROLLMENT FEES

Does not apply to the TRICARE Extra Program (Also see "Point of Service Option", paragraph IV., below.):

TRICARE PRIME PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFMs)		RETIRES, THEIR FAMILY MEMBERS, ELIGIBLE FORMER SPOUSES & SURVIVORS
E1 - E4	E5 & ABOVE	
None	None	<p>\$230 per Retiree or Family Member                      \$460 Maximum per Family</p> <p>EXCEPTION: Effective March 26, 1998, the enrollment fee is waived for those beneficiaries who are eligible for Medicare on the basis of disability or end stage renal disease and who maintain enrollment in Part B of Medicare.</p>

### II. TRICARE EXTRA PROGRAM ANNUAL FISCAL YEAR DEDUCTIBLE

Applies to all outpatient services, does not apply to the TRICARE Prime Program. (Also see "Point of Service Option".)

TRICARE EXTRA PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFMs)		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS
E1 - E4	E5 & ABOVE	
\$50 per Individual \$100 Maximum per Family	\$150 per Individual \$300 Maximum per Family	\$150 per Individual \$300 Maximum per Family

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III. TRICARE STANDARD PROGRAM ANNUAL FISCAL YEAR DEDUCTIBLE

Applies to all outpatient services, does not apply to the TRICARE Prime or Extra Programs:

TRICARE STANDARD PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFM's)		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS
E1 - E4	E5 & ABOVE	
\$50 per Individual \$100 Maximum per Family	\$150 per Individual \$300 Maximum per Family	\$150 per Individual \$300 Maximum per Family

NOTE 2: These charts are not intended to be a comprehensive listing of all services covered under TRICARE. All care is subject to review for medical necessity and appropriateness:

NOTE 3: An eligible former spouse is responsible for payment of copayment/cost-sharing amounts identical to those required for beneficiaries other than family members of active duty members.

IV. OUTPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
	ADFM's		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
<b>INDIVIDUAL PROVIDER SERVICES</b> Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; medical supplies used within the office including casts, dressings, and splints.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit.	<b>ADFM's:</b> Cost-share--15% of the fee negotiated by the contractor.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>ADFM's:</b> Cost-share--20% of the allowable charge.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--25% of the allowable charge.

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IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ADFMS		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
<b>OUTPATIENT HOSPITAL DEPARTMENTS</b> Clinics visits; therapy visits; medical supplies; consultations; treatment room; etc. NOTE: Use other parts of this table for cost-sharing of ASC services, ER services, DME, etc.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit.  No separate copayment/cost-share for separately billed professional charges.	<b>ADFMS:</b> Cost-share--15% of the fee negotiated by the contractor.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>ADFMS:</b> Cost-share--20% of the allowable charge.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--25% of the allowable charge.
<b>LABORATORY AND X-RAY SERVICES</b>	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit. (See Note 4)	<b>ADFMS:</b> Cost-share--15% of the fee negotiated by the contractor.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>ADFMS:</b> Cost-share--20% of the allowable charge.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--25% of the allowable charge.
<b>ANCILLARY SERVICES</b> Refer to <a href="#">Chapter 2, Section 1</a> for specific CPT code ranges	\$0 copayment per visit.	\$0 copayment per visit.	No copayment (See Note 3.)	<b>ADFMS:</b> Cost-share--15% of the fee negotiated by the contractor.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>ADFMS:</b> Cost-share--20% of the allowable charge.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--25% of the allowable charge.
NOTE 4: If these services are performed by the office visit provider on a date different from the office visit or performed by a different provider such as an independent laboratory or radiology facility (even if performed on the same day as the related office visit) the beneficiary will owe a separate copayment for the services. Also, no copayment will be collected for these services when they are billed and provided as clinical preventive services to TRICARE Prime Enrollees.					
NOTE 5: For dates of service on or after March 26, 1998, under TRICARE Prime, services defined as "ancillary services" in <a href="#">Chapter 2, Section 1</a> require no copayment.					

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IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
	ADFM's		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
TYPE OF SERVICE (SEE NOTE 10.)					
<b>ROUTINE PAP SMEARS</b> Frequency to depend on physician recommendations based on the published guidelines of the American Academy of Obstetrics and Gynecology. (See Note 4.)	No copayment.	No copayment.	No copayment.	<b>ADFM's:</b> Cost-share--15% of the fee negotiated by the contractor.	<b>ADFM's:</b> Cost-share--20% of the allowable charge.
<b>AMBULANCE SERVICES</b> When medically necessary as defined in this Policy Manual and the service is a covered benefit.	\$0 copayment per visit.	\$0 copayment per visit.	\$20 copayment per occurrence.	<b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--25% of the allowable charge.
<b>EMERGENCY SERVICES</b> Emergency and urgently needed care obtained on an outpatient basis, both network and non-network, and in and out of the Region.	\$0 copayment per visit.	\$0 copayment per visit.	\$30 copayment per emergency room visit.		
<b>DME (e.g., HEARING AIDS), PROSTHETIC DEVICES, HEARING AIDS FOR ADFM's, AND MEDICAL SUPPLIES PRESCRIBED BY AN AUTHORIZED PROVIDER WHICH ARE COVERED BENEFITS</b> (If dispensed for use outside of the office or after the home visit.)	\$0 copayment per visit.	\$0 copayment per visit.	Cost-share - 20% of the fee negotiated by the contractor.		

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IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ADFMs		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
<p><b>HOME HEALTH CARE</b>                      Part-time or intermittent skilled nursing and home health aide services, physical, speech, &amp; occupational therapy, medical social services, routine and non-routine medical services.</p> <p>NOTE: DME, osteoporosis drugs, pneumococcal pneumonia, influenza virus and hepatitis B vaccines, oral cancer drugs, antiemetic drugs, orthotics, prosthetics, enteral and parenteral nutritional therapy and drugs/biologicals administered by other than oral methods are services that can be paid in addition to the prospective payment amount subject to applicable copayment/cost-sharing and deductible amounts.</p>	\$0 copayment.	\$0 copayment.	\$0 copayment.	\$0 cost-share.	\$0 cost-share.
<p><b>HOSPICE CARE</b>                      NOTE: A separate cost-share <u>may be</u> (optional) collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.</p>					

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IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
	ADFM's		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
TYPE OF SERVICE (SEE NOTE 10.)					
<b>FAMILY HEALTH SERVICES</b> Family planning and well baby care (up to 24 months of age). The exclusions listed in this Policy Manual will apply.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit. (See Note 4.)	<b>Active Duty Family Members:</b> Cost-share--15% of the fee negotiated by the contractor.	<b>Active Duty Family Members:</b> Cost-share--20% of the allowable charge.
<b>OUTPATIENT MENTAL HEALTH TO INCLUDE HOME</b> One hour of therapy, no more than two times each week (when medically necessary).	\$0 copayment per visit.	\$0 copayment per visit.	\$25 copayment for individual visits.  \$17 copayment for group visits.	<b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--25% of the allowable charge.
<b>PRESCRIPTION DRUGS</b> See Addendum B.					
NOTE 6: If medically necessity is established for a non-formulary drug, patients may qualify for the \$9 copayment for up to a 30-day supply in the TRRx or a 90-day supply in the TMOP program.					
<b>AMBULATORY SURGERY (same day)</b> Authorized hospital-based or freestanding ambulatory surgical center that is TRICARE certified.	\$0 copayment per visit.	\$0 copayment per visit.	\$25 copayment	<b>ADFM's:</b> Cost-share--\$25. for Ambulatory Surg.	<b>ADFM's:</b> \$25.
<b>OTHER NON-ASC SURGICAL PROCEDURES</b> With the exclusion of those surgical procedures referenced in Chapter 2, Section 1, paragraph I.B.5.e. and f.			No separate copayment/cost-share for separately billed professional charges.	<b>Retirees, their Family Members &amp; Survivors:</b> Cost-share --20% of the institutional fee negotiated by the contractor.	<b>Retirees, their Family Members &amp; Survivors:</b> Lesser of 25% of group rate or 25% of billed charge.
<b>BIRTHING CENTER</b> Prenatal care, outpatient delivery, and postnatal care provided by TRICARE authorized birthing center.	\$0 copayment.	\$0 copayment.	\$25 copayment.	<b>ADFM's:</b> \$25.	<b>ADFM's:</b> \$25.
				<b>Retirees, their Family Members &amp; Survivors:</b> Cost-share --20% of the fee negotiated by the contractor.	<b>Retirees, their Family Members &amp; Survivors:</b> Lesser of 25% of birthing center rate or 25% of billed charge.

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IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POINT OF SERVICE)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ADFMS		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
<b>IMMUNIZATIONS (See Note 7.)</b> Immunizations required for active duty family members whose sponsors have permanent change of station orders to overseas locations.	\$0 copayment per visit.	\$0 copayment per visit.	Not covered under Prime.	<b>ADFMS:</b> Cost-share--15% of the fee negotiated by the contractor.  <b>Retirees, their Family Members &amp; Survivors:</b> Not covered under TRICARE Extra.	<b>ADFMS:</b> Cost-share--20% of the allowable charge.  <b>Retirees, their Family Members &amp; Survivors:</b> Not covered under TRICARE Standard.
<b>EYE EXAMINATIONS (See Note 7.)</b> One routine examination per year for family members of active duty sponsors.	\$0 copayment per visit.	\$0 copayment per visit.	Not covered under Prime. (See Note 7.)	Not covered under TRICARE Extra.	Not covered under TRICARE Standard.
NOTE 7: Additional immunizations and eye examinations are covered under the TRICARE Prime Program's "clinical preventive services". See the TRICARE Policy Manual, <a href="#">Chapter 7, Section 2.2</a> .					
<b>CLINICAL PREVENTIVE SERVICES</b> Includes those services listed in the TRICARE Policy Manual, Chapter 7, <a href="#">Sections 2.1 and 2.2</a> .	\$0 copayment	\$0 copayment	\$0 copayment	<b>ADFMS:</b> Cost-share--15% of the fee negotiated by contractor.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--20% of the fee negotiated by the contractor.	<b>ADFMS:</b> Cost-share--20% of the allowable charge.  <b>Retirees, their Family Members &amp; Survivors:</b> Cost-share--25% of the allowable charge.
NOTE 8: No copayment may be collected for these services when they are billed and provided as specified in the TRICARE Policy Manual, <a href="#">Chapter 7, Section 2.2</a> .					
NOTE 9: No enhanced outpatient benefits under the TRICARE Extra Program.					

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V. INPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 10.)	ACTIVE DUTY FAMILY MEMBERS (ADFM's)	RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
<b>Note 10:</b> No enhanced inpatient benefits under the TRICARE Prime or Extra programs.				
<b>HOSPITALIZATION</b> Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and their surgical services, meals including special diets, drugs and medications while an inpatient, operating and recovery room, anesthesia, laboratory tests, x-ray and other radiology services, necessary medical supplies and appliances, blood and blood products.	\$0 copayment per visit.	\$11 per diem charge (\$25 minimum charge per admission).  No separate copayment/cost-share for separately billed professional charges.	<b>ADFM's:</b> Per diem charge (\$25 minimum charge per admission). No separate cost-share for separately billed professional charges.  <b>Retirees, their Family Members &amp; Survivors:</b> \$250 per diem copayment or 25% cost-share of total charges (based on the fee schedule negotiated by the contractor), whichever is less, for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).	<b>ADFM's:</b> Per diem charge (\$25 minimum charge per admission). No separate cost-share for separately billed professional charges.  <b>Retirees, their Family Members &amp; Survivors:</b> DRG per diem copayment or 25% cost-share of billed charges for institutional services, whichever is less, plus 25% cost-share of allowable for separately billed professional charges.
<b>MATERNITY</b> Hospital and professional services (prenatal, delivery, postnatal).				

PHARMACY BENEFITS PROGRAM - COST-SHARES

I. COST-SHARES

PHARMACY PAYMENT MATRIX

TRICARE PHARMACY COPAYMENTS/COST SHARES IN THE UNITED STATES (INCLUDING PUERTO RICO, GUAM, AND THE U.S. VIRGIN ISLANDS)			
PLACE OF SERVICE	FORMULARY		NON-FORMULARY (TIER 3)
	GENERIC (TIER 1)	BRAND NAME (TIER 2)	
Military Treatment Facility (MTF) Pharmacy (up to a 90-day supply)	\$0	\$0	Not Applicable
TRICARE Mail Order Pharmacy (TMOP) (up to a 90-day supply)	\$3	\$9	\$22*
TRICARE Retail Pharmacy Network Pharmacy (TRRx) (up to a 30-day supply)	\$3	\$9	\$22*
Non-network Retail Pharmacy (up to a 30-day supply)  Note: Beneficiaries using non-network pharmacies may have to pay the total amount of their prescription first and then file a claim to receive partial reimbursement.	<p><b>For those who are not enrolled in TRICARE Prime:</b> \$9 or 20% of total cost, whichever is greater, after deductible is met (D1-E4: \$50/person; \$100/family; all others, including retirees, \$150/person, \$300/family)</p> <p><b>TRICARE Prime:</b> 50% cost share after point-of-service deductibles (\$300 per person/\$600 per family deductible)</p>		<p><b>For those who are not enrolled in TRICARE Prime:</b> \$22 or 20% of total cost, whichever is greater, after deductible is met (E1-E4: \$50/person; \$100/family; all others, including retirees, \$150/person, \$300/family)</p> <p><b>TRICARE Prime:</b> 50% cost share after point-of-service deductibles (\$300 per person/\$600 per family deductible)</p>
* If medical necessity is established for a non-formulary drug, patients may qualify for the \$9 copayment for up to a 30-day supply in the TRRx or a 90-day supply in the TMOP program.			

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## HOSPITAL AND OTHER INSTITUTIONAL REIMBURSEMENT

ISSUE DATE:

AUTHORITY:

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### 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 (CAP/DME) 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 ([TOM](#)), [Chapter 3, Section 2](#)).

#### B. Payment Procedures

The contractor shall use the following procedures **and the procedures in the TOM, Chapter 3**, in making CAP/DME payments to hospitals:

1. Receive claim or request for payment from the hospital.
2. Compute the amount due for each hospital submitting claims during a month, stopping processing prior to check write.

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3. Submit a voucher in an electronic format to the TRICARE Management Activity (TMA), Contract Resource Management (CRM) (see the TOM, Chapter 3, Addendum A, Figure 3-A-8). (A fax copy is not necessary.)

4. 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 TOM, 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 TOM, 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

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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.

<b>A</b>	<b>B</b>	<b>C</b>
<b>1</b>	<b>Field Name</b>	<b>Picture</b> <b>Comments</b>
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 (TSM), 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 (TED). 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 [TOM, 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 (ASCs)

### 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 (FL) 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 -

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 10, ADDENDUM A

BIRTHING CENTER RATE NON-PROFESSIONAL COMPONENT

FIGURE 10-A-3 BIRTHING CENTER RATE NON-PROFESSIONAL COMPONENT - FY 2006

FISCAL YEAR 2006			
TRICARE-AUTHORIZED BIRTHING CENTER PROVIDER			
NON-PROFESSIONAL COMPONENT FOR ALL-INCLUSIVE PRICING FORMULA			
Alabama	\$2,965.78	Montana	\$1,399.53
Alaska	\$3,156.82	Nebraska	\$1,894.80
Arizona	\$1,604.68	Nevada	\$2,849.86
Arkansas	\$3,788.53	New Hampshire	\$1,879.12
California	\$3,533.86	New Jersey	\$5,726.79
Colorado	\$2,214.47	New Mexico	\$2,149.67
Connecticut	\$3,045.34	New York	\$1,451.65
Delaware	\$2,578.53	North Carolina	\$2,483.29
District of Columbia	\$2,614.79	North Dakota	\$893.46
Florida	\$2,768.17	Ohio	\$2,316.77
Georgia	\$2,381.60	Oklahoma	\$3,055.18
Hawaii	\$2,318.61	Oregon	\$1,887.67
Idaho	\$1,669.21	Pennsylvania	\$2,927.86
Illinois	\$2,056.84	Puerto Rico	\$802.83
Indiana	\$2,115.11	Rhode Island	\$3,160.76
Iowa	\$1,720.53	South Carolina	\$2,604.70
Kansas	\$2,107.07	South Dakota	\$1,443.10
Kentucky	\$2,115.30	Tennessee	\$1,713.33
Louisiana	\$2,650.81	Texas	\$2,595.58
Maine	\$1,689.12	Utah	\$1,548.56
Maryland	\$1,700.66	Vermont	\$1,972.22
Massachusetts	\$2,678.64	Virginia	\$2,307.44
Michigan	\$2,432.86	Washington	\$2,291.03
Minnesota	\$2,665.68	West Virginia	\$1,503.66
Mississippi	\$2,308.79	Wisconsin	\$1,612.33
Missouri	\$2,244.08	Wyoming	\$1,785.16

These state specific non-professional component amounts are to be used in creating the maximum allowable all-inclusive TRICARE-authorized birthing center prices during Fiscal Year 2006. The all-inclusive prices are to be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update. (See Chapter 10, Section 1, for instruction for the use of these amounts.)

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 10, ADDENDUM A

BIRTHING CENTER RATE NON-PROFESSIONAL COMPONENT

FIGURE 10-A-4 BIRTHING CENTER RATE NON-PROFESSIONAL COMPONENT - FY 2007

FISCAL YEAR 2007			
TRICARE-AUTHORIZED BIRTHING CENTER PROVIDER			
NON-PROFESSIONAL COMPONENT FOR ALL-INCLUSIVE PRICING FORMULA			
Alabama	\$3,686.88	Montana	\$1,466.57
Alaska	\$3,040.73	Nebraska	\$2,024.74
Arizona	\$1,946.13	Nevada	\$2,920.62
Arkansas	\$3,807.75	New Hampshire	\$2,551.56
California	\$3,548.31	New Jersey	\$5,010.10
Colorado	\$2,303.01	New Mexico	\$2,501.06
Connecticut	\$3,701.71	New York	\$1,451.56
Delaware	\$2,736.36	North Carolina	\$2,662.36
District of Columbia	\$2,504.93	North Dakota	\$1,373.26
Florida	\$3,411.22	Ohio	\$2,557.72
Georgia	\$2,420.48	Oklahoma	\$3,077.71
Hawaii	\$2,591.73	Oregon	\$1,892.26
Idaho	\$1,772.36	Pennsylvania	\$2,770.11
Illinois	\$2,337.80	Puerto Rico	\$784.50
Indiana	\$2,481.09	Rhode Island	\$3,533.74
Iowa	\$2,050.04	South Carolina	\$2,806.01
Kansas	\$2,641.96	South Dakota	\$1,408.77
Kentucky	\$2,180.78	Tennessee	\$2,032.68
Louisiana	\$2,303.50	Texas	\$2,863.58
Maine	\$1,829.51	Utah	\$1,511.88
Maryland	\$2,002.51	Vermont	\$1,565.74
Massachusetts	\$2,647.58	Virginia	\$2,568.48
Michigan	\$2,651.53	Washington	\$2,339.51
Minnesota	\$2,631.52	West Virginia	\$1,395.96
Mississippi	\$3,232.74	Wisconsin	\$1,665.50
Missouri	\$2,221.82	Wyoming	\$2,544.07

These state specific non-professional component amounts are to be used in creating the maximum allowable all-inclusive TRICARE-authorized birthing center prices during Fiscal Year 2007. The all-inclusive prices are to be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update. (See Chapter 10, Section 1, for instruction for the use of these amounts.)