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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 94
6010.55-M
JUNE 11, 2009

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: CONSOLIDATED CHANGES - JANUARY 2009

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

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

This change is made in conjunction with Aug 2002 TOM, Change No. 80 and Aug
2002 TPM, Change No. 97.

Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 7 PAGE(S)
DISTRIBUTION: 6010.55-M

CHANGE 94
6010.55-M
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REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 30, page 1

Section 30, page 1

CHAPTER 4

Section 1, pages 3 and 4

Section 1, pages 3 and 4

CHAPTER 6

Section 8, pages 13 and 14

Section 8, pages 13 and 14

CHAPTER 11

Section 4, pages 23 and 24

Section 4, pages 23 and 24

SUMMARY OF CHANGES

CHAPTER 1

1. Section 30. Redundant language “with the patient’s approval” was deleted.

CHAPTER 4

2. Section 1. Obsolete language was deleted.

CHAPTER 6

3. Section 8. Updated the flat rate of \$18,671 to \$20,185.

CHAPTER 11

4. Section 4. Removed reference to FY06 hospice rates and added reference to FY09 rates.

REIMBURSEMENT OF CERTAIN PRIME TRAVEL EXPENSES

ISSUE DATE: December 21, 2001

AUTHORITY: [32 CFR 199.17\(n\)\(2\)\(vi\)](#)

I. POLICY

TRICARE Prime enrollees referred for necessary specialty care over 100 miles from their Primary Care Manager's (PCM's) office to the nearest specialist's office may be eligible to receive reimbursement for reasonable travel expenses. Entitlement is limited to those specialty referrals when no other specialist (i.e., Military Treatment Facility (MTF), network or non-network specialists) is available within 100 miles of the PCM's office. The only exception is when the beneficiary agrees to a referral to a center of excellence or MTF. Travel orders and reimbursement are also authorized for one non-medical attendant to accompany a non-active duty TRICARE Prime patient referred for medically necessary specialty care more than 100 miles from the patient's primary care manager location.

MTFs will be responsible for validation of travel expense entitlement and issuing travel orders for specialty referrals issued by military PCMs, while the Regional Directors or designated government representatives will assume responsibility for travel entitlement determinations and orders for specialty referrals from civilian PCMs. Travel expenses will be reimbursed in accordance with the Joint Federal Travel Regulations (JFTR). The Managed Care Support Contractors (MCSCs) will refer civilian travel requests for MTF-enrolled beneficiaries to the MTFs and civilian-enrolled requests to the Regional Director or designated Government representative for validation, orders and payment if it appears that the beneficiary may be entitled to the new travel benefit. Beneficiaries with questions about the Prime travel benefit and the non-medical attendant entitlement should contact their local Military Treatment Facility or Regional Director travel representative on Beneficiary Counseling and Assistance Coordination (BCAC) for assistance. Telephone numbers and addresses for BCAC are available on the TRICARE website at <http://www.tricare.osd.mil>.

II. EFFECTIVE DATE October 30, 2000.

- END -

(2) Health care delivery systems not considered within the definition of either an insurance plan, medical service or health plan including the Veterans Administration, the Maternal and Child Health Program, the Indian Health Services, and entitlement to receive care from the designated provider. These programs are designed to provide benefits to a distinct beneficiary population, and they require no premium payment or monetary contribution prior to obtaining care.

E. No Waiver of Benefit From Other Insurer. Beneficiaries may not waive benefits due from any plan which meets the above definitions. If a double coverage plan provides, or may provide, benefits for the services, a claim must be filed with the double coverage plan. Refusal by the beneficiary to claim benefits from the other coverages must result in a denial of TRICARE benefits. Benefits are considered to be the services available. For example, if the other plan includes psychotherapy as a benefit, but only by a psychiatrist, the beneficiary cannot elect to waive this benefit in order to receive services from a psychologist. For TRICARE for Life claims, an exception exists for mental health counselors and pastoral counselors as well as for services received under a private contract (see Chapter 4, Section 4, [paragraph I.C.1.e.](#)).

F. Beneficiary Liability. In all double coverage situations, a beneficiary's liability is limited by all TRICARE provisions. As a result, a provider cannot collect from a CHAMPUS beneficiary any amount that would result in total payment to the provider that exceeds CHAMPUS limitations. For example, a beneficiary is not liable for any cost-sharing or deductible amounts required by the primary payer, if the sum of the primary payer's and TRICARE's payments are at least equal to 115% of the TRICARE allowable amount for a nonparticipating provider. This is true whether TRICARE actually makes any payment or not. This also applies to claims from participating non-network providers and from network providers. Because of the payment calculations, the provider usually will receive payments from the primary payer and from TRICARE that equal the billed charges. In those rare cases where this does not occur, the provider cannot collect any amount from the beneficiary that would result in payment that exceeds the TRICARE allowable amount.

NOTE: It is important to note that this paragraph addresses beneficiary liability and does not change in any way the amounts TRICARE will pay based on provisions elsewhere in this chapter.

G. Claims Processed Under the TRICARE/CHAMPUS DRG-Based Payment System or the Inpatient Mental Health Per Diem Payment System. When double coverage exists on a claim processed under the TRICARE/CHAMPUS DRG-based payment system or the inpatient mental health per diem payment system, the TRICARE payment cannot exceed an amount that, when combined with the primary payment, equals the lesser of the TRICARE/CHAMPUS DRG-based amount, the inpatient mental health per diem based amount, or the hospital's charges for the services. Thus, when the DRG-based amount or the inpatient mental health per diem based amount is greater than the hospital's actual billed charge, and the primary payer has paid the full billed charge, TRICARE will make no additional payment. Similarly, when the DRG-based amount or the inpatient mental health per diem based amount is less than the hospital's actual billed charge, and the primary payer has paid the full DRG-based amount or inpatient mental health per diem based amount, no additional payment can be made. Nor can the hospital bill the beneficiary for any additional amounts in these cases.

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CHAPTER 4, SECTION 1

DOUBLE COVERAGE

H. No Legal Obligation to Pay. Payment should not be extended for services and supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary was not an eligible TRICARE beneficiary. Whenever possible, all double coverage claims should be accompanied by an explanation of benefits (EOB) from the primary insurer. If the existence of a participating agreement limiting liability of a beneficiary is evident on the EOB, payment is to be limited to that liability; however, if it is not clearly evident, the claim is to be processed as if no such agreement exists.

- END -

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CHAPTER 6, SECTION 8

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM
(ADJUSTMENTS TO PAYMENT AMOUNTS)

indirect medical education adjustment factor. For admissions occurring on or after October 1, 1997, the costs for indirect medical education are no longer standardized.

(b) Cost outliers will be reimbursed the DRG-based amount plus 80% effective October 1, 1994 of the standardized costs exceeding the threshold.

(c) For admissions occurring on or after October 1, 1997, the following steps shall be followed when calculating cost outlier payments for all cases other than neonates and children's hospitals:

$$\text{Standard Cost} = (\text{Billed Charges} \times \text{CCR})$$

$$\text{Outlier Payment} = 80\% \text{ of } (\text{Standard Cost} - \text{Threshold})$$

$$\text{Total Payments} = \text{Outlier Payments} + (\text{DRG Base Rate} \times (1 + \text{IDME}))$$

NOTE: Noncovered charges should continue to be subtracted from the billed charges prior to multiplying the billed charges by the CCR.

(d) The CCR for admissions occurring on or after October 1, 2006, is 0.3967. The CCR for admissions occurring on or after October 1, 2007, is 0.3888. The CCR for admissions occurring on or after October 1, 2008, is 0.3796.

(e) The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2007 is 0.925, for FY 2008 is 0.925, and for FY 2009 is 0.925.

(2) For FY 2007, a fixed loss cost-outlier threshold is set of \$22,649. Effective October 1, 2006, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$22,649 (also wage-adjusted).

(3) For FY 2008, a fixed loss cost-outlier threshold is set of \$22,649. Effective October 1, 2007, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$22,649 (also wage-adjusted).

(4) For FY 2009, a fixed loss cost-outlier threshold is set of \$20,185. Effective October 1, 2008, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$20,185 (also wage-adjusted).

The cost-outlier threshold shall be calculated as follows:

$$\{[\text{Fixed Loss Threshold} \times ((\text{Labor-Related Share} \times \text{Applicable wage index}) + \text{Non-labor-related share}) \times \text{NOSCASTC}] + (\text{DRG Base Payment (wage-adjusted)} \times (1 + \text{IDME}))\}$$

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HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM
(ADJUSTMENTS TO PAYMENT AMOUNTS)

EXAMPLE: Using FY 1999 figures $\{[10,129 \times ((0.7110 \times \text{Applicable wage index}) + 0.2890) \times 0.913] + (\text{DRG Based Payment (wage-adjusted)} \times (1 + \text{IDME}))\}$

f. Burn outliers. Burn outliers generally will be subject to the same outlier policies applicable to the CHAMPUS DRG-based payment system except as indicated below. For admissions prior to October 1, 1998, there are six DRGs related to burn cases. They are:

- 456 - Burns, transferred to another acute care facility
- 457 - Extensive burns w/o O.R. procedure
- 458 - Non-extensive burns with skin graft
- 459 - Non-extensive burns with wound debridement or other O.R. procedure
- 460 - Non-extensive burns w/o O.R. procedure
- 472 - Extensive burns with O.R. procedure

Effective for admissions on or after October 1, 1998, the above listed DRGs are no longer valid.

For admissions on or after October 1, 1998, there are eight DRGs related to burn cases. They are:

- 504 - Extensive 3rd degree burn w skin graft
- 505 - Extensive 3rd degree burn w/o skin graft
- 506 - Full thick burn w sk graft or inhal inj w cc or sig tr
- 507 - Full thick burn w sk graft or inhal inj w/o cc or sig tr
- 508 - Full thick burn w/o sk graft or inhal inj w cc or sig tr
- 509 - Full thick burn w/o sk graft or inhal inj w/o cc or sig tr
- 510 - Non-extensive burns w cc or significant trauma
- 511 - Non-extensive burns w/o cc or significant trauma

Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.

(1) For burn cases with admissions occurring prior to October 1, 1988, there are no special procedures. The marginal cost factor for outliers for all such cases will be 60%.

(2) Burn cases which qualify as short-stay outliers, regardless of the date of admission, will be reimbursed according to the procedures for short-stay outliers.

(3) Burn cases with admissions occurring on or after October 1, 1988, which qualify as cost outliers will be reimbursed using a marginal cost factor of 90%.

(4) Burn cases which qualify as long-stay outliers will be reimbursed as follows.

(o) Admissions occurring from October 1, 1988, through September 30, 1990 will be reimbursed using a marginal cost factor of 90%.

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CHAPTER 11, SECTION 4

HOSPICE REIMBURSEMENT - GUIDELINES FOR PAYMENT OF DESIGNATED LEVELS OF CARE

intervals. This requirement applies to both the institutional and hospice-based physician claims.

15. Updated Hospice Rates.

a. The rates in [Chapter 11, Addendum A \(FY 2007\)](#) will be used for payment of claims for services rendered on or after October 1, 2006, through September 30, 2007. The hospice cap amount applies to the cap year ending October 31, 2006.

b. The rates in [Chapter 11, Addendum A \(FY 2008\)](#) will be used for payment of claims for services rendered on or after October 1, 2007, through September 30, 2008. The hospice cap amount applies to the cap year ending October 31, 2007.

c. The rates in [Chapter 11, Addendum A \(FY 2009\)](#) will be used for payment of claims for services rendered on or after October 1, 2008, through September 30, 2009. The hospice cap amount applies to the cap year ending October 31, 2008.

B. Beneficiary cost-sharing. There are no deductibles under the hospice benefit. TRICARE pays the full cost of all covered services for the terminal illness, except for small cost-share amounts which may be collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.

NOTE: The collection of cost-share amounts are optional under the hospice program.

1. The patient is responsible for 5 percent of the cost of outpatient drugs, or \$5 toward each prescription, whichever is less. Additionally, the cost of prescription drugs (drugs or biologicals) may not exceed that which a prudent buyer would pay in similar circumstances; that is, a buyer who refuses to pay more than the going price for an item or service and also seeks to economize by minimizing costs.

2. For inpatient respite care, the cost-share for each respite care day is equal to 5 percent of the amount TRICARE has estimated to be the cost of respite care, after adjusting the national rate for local wage differences.

EXAMPLE: Calculation of the cost-share for respite care in Denver, Colorado.

Wage Component Subject to Index	x Index for Denver	= Adjusted Wage Component
\$50.68	x 1.2141	= \$61.53
Adjusted Wage Component	+ Nonwage Component	= Adjusted Rate
\$61.53	+ \$42.95	= \$104.48
Adjusted/.95 (Rate to Include Rate Cost-Share)	x % Cost-Share	= Cost-Share Amount
\$104.48/.95	x 0.05	= \$5.50

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CHAPTER 11, SECTION 4

HOSPICE REIMBURSEMENT - GUIDELINES FOR PAYMENT OF DESIGNATED LEVELS OF CARE

3. The cost-sharing provisions established under [paragraph III.B.](#) are applicable to all beneficiaries regardless of the sponsor's status (active duty or retired).

4. Hospice cost-sharing is not subject to the catastrophic cap provisions since it is optional and already offset in the established national rates.

5. The amount of the individual cost-share liability for respite care during a hospice cost-share period may not exceed the Medicare inpatient hospital deductible applicable for the year in which the hospice cost-share period began. The individual hospice cost-share period begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

EXAMPLE: Mr. Brown elected an initial 90-day period of hospice care. Five days after the initial period of hospice care ended, Mr. Brown began another period of hospice care under a subsequent election. Immediately after that period ended, he began a third period of hospice care. Since these election periods were not separated by 14 consecutive days, they constitute a single hospice cost-share period. Therefore, the maximum cost-share for respite care during the three periods of hospice care may not exceed the amount of the inpatient deductible for the year in which the first period began.

6. The TRICARE payment rates are not reduced when the individual is liable for coinsurance payments. Instead, when establishing the payment rates, TRICARE offsets the estimated cost of services by an estimate of average coinsurance amounts hospices collect.

NOTE: Since the services and supplies associated with the palliative treatment of beneficiaries electing hospice care under TRICARE are included in the all-inclusive rates and the rates are already reduced/offset by the estimated average cost-sharing, the contractors will not be responsible for monitoring whether or not the hospice has waived cost-sharing for a particular service. The cost-sharing calculation will not be a part of the reimbursement methodology for payment of hospice claims.

7. Since TRICARE payment rates are not to be reduced when beneficiary liability is reported by the hospice (i.e., when the provider indicates that a cost-share was collected from the beneficiary), the following guidelines should be applied when beneficiary cost-sharing is reported on the hospice claim form:

- a. List a cost-share amount of \$0.00 on CEOB for all services;
- b. Do not retain a history of any cost-share payments reported on the claim form by the hospice; and
- c. Do not apply any amount of the reported cost-share to the catastrophic cap.

C. Medical review of hospice claims. The contractor will request and review medical records (post-payment medical review), including written plans of care, to make sure that appropriate payments are made for services provided to individuals electing hospice care.