



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 96
6010.55-M
JUNE 22, 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: ADOPTING MEDICARE'S ADJUSTMENTS FOR
REPLACEMENT OF IMPLANTED DEVICES

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change follows Medicare's adjustments by
reducing TRICARE payments when an implanted device is replaced.

EFFECTIVE DATE: October 1, 2009.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TSM, Change No. 72.

Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 3 PAGE(S)
DISTRIBUTION: 6010.55-M

CHANGE 96
6010.55-M
JUNE 22, 2009

REMOVE PAGE(S)

CHAPTER 6

Section 8, pages 19 and 20

INSERT PAGE(S)

Section 8, pages 19 through 21

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, SECTION 8

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

U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.

1 = Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.

c. HACs. TRICARE shall adopt those HACs adopted by CMS. On or about September 2009, the HACs, and their respective diagnosis codes will be posted at <http://www.tricare.mil/drgrates>.

d. Provider responsibilities and reporting requirements. For non-exempt providers, issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

e. The TRICARE/CHAMPUS contractor shall accept, validate, retain, pass, and store the POA indicator.

f. Exempt Providers

(1) The following hospitals are exempt from POA reports for TRICARE:

(a) Critical Access Hospitals (CAHs)

(b) Long Term Care (LTC) Hospitals

(c) Maryland Waiver Hospitals

(d) Cancer Hospitals

(e) Children's Inpatient Hospitals

(f) Inpatient Rehabilitation Hospitals

(g) Psychiatric Hospitals

(h) Sole Community Hospitals (SCHs)

(i) Veterans Administration (VA) Hospitals

(2) Contractors shall identify claims from those hospitals that are exempt from POA reporting, and shall take the actions necessary to be sure that the TRICARE grouper software does not apply HAC logic to the claim.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, SECTION 8

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

g. The DRG payment is considered payment in full, and the hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complication or charges because the DRG was demoted to a lesser-severity level.

h. Effective October 1, 2009, claims will be denied if a non-exempt hospital does not report a valid POA indicator for each diagnosis on the claim.

i. Reports. Contractors shall create a monthly report listing all TRICARE Encounter Data (TED) records that had HACs. The report shall include, at a minimum, the TED Record Indicator, each HAC reported, the POA indicator for each HAC, the dates of service/admission, the DRG that was paid, the total amount paid by TRICARE, and the following provider data: Taxpayer Identification Number (TIN), Sub-Identifier (SUBID), Zip Code, Type of Institution, and National Provider Identifier (NPI). The report shall be provided to TMA by the 10th of each month in an Excel file and submitted via the E-Commerce Extranet. The first monthly report shall be due no later than November 10, 2009.

9. Replacement Devices.

a. TRICARE is not responsible for the full cost of a replaced device if a hospital receives a partial or full credit, either due to a recall or service during the warranty period. Reimbursement in cases in which an implanted device is replaced shall be made:

- (1) At reduced or no cost to the hospital; or
- (2) With partial or full credit for the removed device.

b. The following condition codes 49 and 50 allow TRICARE to identify and track claims billed for replacement devices:

(1) Condition Code 49. Product replacement within product lifecycle. Condition code 49 is used to describe replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly - warranty.

(2) Condition Code 50. Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly. Condition code 50 is used to describe that the manufacturer or the U.S. Food and Drug Administration (FDA) has identified the product for recall and, therefore, replacement.

c. When a hospital receives a credit for a replaced device that is 50% or greater than the cost of the device, hospitals are required to bill the amount of the credit in the amount portion for value code **FD**.

d. Beginning with admissions on or after October 1, 2009, the contractor shall reduce hospital reimbursement for those DRGs subject to the replacement device policy, by the full or partial credit a provider received for a replaced device. The specific DRGs subject to the replacement device policy will be posted on TRICARE's DRG web page at

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, SECTION 8

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

<http://www.tricare.mil/drgrates/>. As necessary, the DRGs subject to the replacement device policy will be updated as part of the annual DRG update.

e. Hospitals must use the combination of condition code 49 or 50, along with value code **FD** to correctly bill for a replacement device that was provided with a credit or no cost. The condition code 49 or 50 will identify a replacement device while value code **FD** will communicate to TRICARE the amount of the credit, or cost reduction, received by the hospital for the replaced device.

f. The contractor shall deduct the partial/full credit amount, reported in the amount for value code **FD** from the final DRG reimbursement when the assigned DRG is one of the DRGs subject to the replacement device policy.

g. Once a DRG rate is determined, any full/partial credit amount is deducted from the DRG reimbursement rate. The beneficiary copayment/cost-share is then determined based on the reduced rate.

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