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TRICARE
MANAGEMENT ACTIVITY

MB&RB

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6010.55-M
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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: NEW REIMBURSEMENT METHODOLOGY FOR
CRITICAL ACCESS HOSPITALS (CAHs)

PAGE CHANGE(S): See pages 2 and 3.

SUMMARY OF CHANGE(S): New reimbursement methodology for CAHs using a
modified version of the methodology used by Medicare.

EFFECTIVE AND IMPLEMENTATION DATE: December 1, 2009.

This change is made in conjunction with Aug 2002 TOM, Change No. 86 and Aug
2002 TSM, Change No. 74.

A handwritten signature in black ink, appearing to read "Reta Michak".

Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 75 PAGE(S)
DISTRIBUTION: 6010.55-M

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LABORATORY SERVICES

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)\(x\)](#)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are laboratory services to be reimbursed?

III. POLICY

A. For purposes of the instructions that follow, a diagnostic laboratory test, whether performed in a physician's office, in an independent laboratory, or in another laboratory, is to be treated by the contractor as a laboratory service. The term "another laboratory", refers to such examples as a reference laboratory that performs services only for other laboratories, or a hospital laboratory functioning as an independent laboratory. Also, when physicians and approved laboratories perform the same test, whether manually or with automated equipment, the services will be deemed similar and the respective charges of all physicians and approved laboratories for that test must be commingled in the computation of the prevailing charge in the state for the test.

B. Determining Prevailing Charges for Single Laboratory Tests.

1. No distinction should generally be made in determining allowable charges for laboratory services between (a) the sites where the service is performed, i.e., physicians' offices or other laboratories; or (b) the methods of the testing process used, whether manual or automated.

2. Therefore, when only one test is performed for a patient, the prevailing charge for the single laboratory test shall be derived from the charges (weighted by frequency) of both the physicians and other laboratories that perform the test in the state, including tests performed manually or with automated equipment. The automated equipment charges to be used are those for a single test that is not performed as part of a battery of tests. The charges of physicians include charges for tests performed in their own offices as well as charges billed

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for tests performed by other laboratories. The charges of other laboratories include only those charges billed to the general public but not to physicians.

C. Refer to Chapter 15, Section 1 for reimbursement requirements for laboratory services provided by a Critical Access Hospital (CAH).

IV. EXCEPTION

Effective October 1, 2008, CPT¹ procedure codes 81000 through 81003 (urinalysis), shall be separately reimbursed when billed with an Evaluation and Management (E&M) CPT code, rather than subject to any claims auditing software edit. Payment is the lesser of the billed charge, the negotiated rate, or the CHAMPUS Maximum Allowable Charge (CMAC).

- END -

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3. When separate charges are billed for specific covered ALS services, allowable charge profiles for each such service should be developed. When a claim is filed for any one or a combination of such covered services, the maximum allowable charge for the total ambulance service will be the sum of the allowable amounts for the supplier's base rate, any mileage charges, and the specific specialized service(s). When the contractor does not have a profile for the specialized service, it may use the profile for an equivalent service as a guideline for determining an appropriate allowance. For example, if an ambulance supplier submits a separate additional charge for covered EKG monitoring and the contractor does not have a prevailing profile for such charges submitted by an ambulance supplier, the contractor may use the profiles for CPT¹ procedures codes 93012 and 93270 as guidelines for determining the allowable amount.

4. Although separate charges may be allowed for specific ALS services, no separate charge can be allowed for the personnel manning the ALS, even though they are obviously more highly qualified than the personnel in a basic ambulance. Their costs are to be included in the base and mileage charges with the exception of paramedic ALS intercept services (PI) under the following conditions:

a. Be furnished in an area that is designated as a rural area by any law or regulation of the State or that is located in a rural census tract of a metropolitan area.

b. Be furnished under contract with one or more volunteer ambulance services that meet the following conditions:

- (1) Are certified to furnish ambulance services;
- (2) Furnish services only at the BLS level; and
- (3) Are prohibited by State law from billing for any service.

c. Be furnished by a paramedic ALS intercept supplier that meets the following conditions:

- (1) Is certified to furnish ALS services.
- (2) Bills all the recipients who receive ALS intercept services for the entity, regardless of whether or not those recipients are Medicare beneficiaries.

C. The cost-sharing of ambulance services and supplies will be in accordance with the status of the patient at the time the covered services and supplies are rendered ([32 CFR 199.4\(a\)\(4\)](#)).

1. Ambulance transfers from a beneficiary's place of residence, accident scene, or other location to a civilian hospital, MTF, VA hospital, or SNF will be cost-shared on an outpatient basis. Transfers from a hospital or SNF to a patient's residence will also be considered an outpatient service for reimbursement under the program. A separate cost-

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share does not apply to ambulance transfers to or from a SNF, if the costs for ambulance transfer are included in the SNF PPS rate (see [Chapter 8, Section 2, paragraph IV.C.13.e.](#)).

2. Ambulance transfers between hospitals (acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals) and SNFs will be cost-shared on an inpatient basis. The following guidelines are consistent with the inpatient deductible and cost-sharing provisions provided in [Chapter 2, Section 1, paragraph I.B.](#) and [E.](#):

a. Deductible Amount Inpatient: None.

b. Cost-Share Amount Inpatient (Non-Network Providers).

(1) Active Duty Dependent: No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

(2) Other Beneficiary: The cost-share applicable to inpatient care for other than active duty dependent beneficiaries is 25% of the TRICARE/CHAMPUS-determined allowable amount.

3. Under the above provisions, for ambulance transfers between hospitals, a nonparticipating provider may bill the beneficiary the lower of the provider's billed charge or 115% of the TRICARE/CHAMPUS allowable charge.

4. Transfers to a MTF, VA hospital, or SNF after treatment at, or admission to, an emergency room or civilian hospital will be cost-shared on an inpatient basis, if ordered by either civilian or military personnel.

5. Medically necessary ambulance transfers from an emergency room (ER) to a hospital more capable of providing the required level of care will also be cost-shared on an inpatient basis.

NOTE: This is consistent with current policy of cost-sharing ER services as inpatient when an immediate inpatient admission for acute care follows the outpatient ER treatment.

D. Refer to [Chapter 15, Section 1](#) for reimbursement requirements for ambulance services provided by a Critical Access Hospital (CAH).

IV. POLICY CONSIDERATIONS

A. Ambulance Membership Programs.

1. Ambulance membership programs typically charge an annual fee for a subscription to an ambulance service. The ambulance provider agrees to accept assignment on all benefits from third party payers for medically necessary services. By paying the annual fee, the covered family members pay no additional fees (including third party cost-shares and deductibles) to the ambulance service.

2. When a beneficiary pays premiums to a pre-paid ambulance plan, the premiums are considered to fulfill the beneficiary's cost-share and deductible requirements. Under this

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arrangement, the ambulance membership program becomes analogous to a limited supplemental plan.

B. When an ambulance company bills a flat fee for ambulance transport within its service area, reimbursement will be at the lesser of the billed amount (flat fee) or the statewide prevailing for HCPCS A0426 through A0429 subject to applicable beneficiary cost-sharing.

C. The TRICARE/CHAMPUS national allowable charge system used to reimburse professional services does not apply to ambulance claims. The above reimbursement guidelines are to be used by the contractors.

D. Itemization requirements are dictated by the particular HCPCS codes used in filing an ambulance claim.

- END -

HOSPITAL REIMBURSEMENT - BILLED CHARGES SET RATES

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.14\(a\)](#)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by **the TRICARE Management Activity (TMA)** and specifically included in the network provider agreement.

II. ISSUE

How are billed charges/set rates to be used in determining reimbursement for hospitals?

III. POLICY

A. Billed charges.

In those cases in which the **Diagnosis Related Group (DRG)**-based payment system, the inpatient mental health per diem payment system, **or the reasonable cost method for Critical Access Hospitals (CAHs)** is not used, the most common method of reimbursement for covered services of hospitals is that of billed charges. The billed charge is allowable if it is reasonable and is not greater than:

1. The charge made to the general public; or
2. The allowed charge applicable to contractor policy-holders (subscribers), when extended to beneficiaries by consent or agreement; or
3. The charge set by local or state regulatory authority as applicable to citizens and extended by law or regulation, consent or agreement to TRICARE.

B. All-inclusive rates.

1. Some providers do not routinely itemize their charges or vary their charges depending upon the various services rendered. Instead, such providers have a set schedule of "all-inclusive" rates which are charged to all patients (or all patients in a given category such as surgical, medical, obstetrical, etc.) regardless of the specific services rendered to each patient. Such rates are based on a per diem or per admission amount and may consist of a

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single amount for all services or a basic "room and board" charge and a separate set charge for ancillary services. Such all-inclusive rates may be reimbursed so long as they are uniformly charged to all patients and so long as the hospital is incapable of itemizing its bills.

2. DRG amounts which hospitals have elected to use in lieu of normal billed charges also qualify as all-inclusive rates. These DRG amounts may be derived from some third-party payer such as Medicare or a Blue Cross plan. Payments based on DRG amounts are authorized only if they are the basis for the hospital's billing--not just the basis for payment by some source.

C. Room charges.

Reimbursement will be at the semi-private room rate unless there are medical indications for a private room.

D. Hospital participation.

1. Participation is required for all hospitals which participate in Medicare, whether they are reimbursed under the DRG-based payment system, the inpatient mental health per diem payment system, **the reasonable cost method for CAHs**, or under billed charges/set rates. This also applies to services of hospital-based professionals which are related to inpatient stays.

2. A hospital which is not Medicare-participating and which is exempt from the program's DRG-based payment system, the inpatient mental health per diem payment system, **or the reasonable cost method for CAHs**, may elect to participate on a claim-by-claim basis.

- END -

HOSPITAL REIMBURSEMENT - OTHER THAN BILLED CHARGES

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.14\(a\)](#)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by **the TRICARE Management Activity (TMA)** and specifically included in the network provider agreement.

II. ISSUE

What methods other than the **Diagnosis Related Group (DRG)**-based payment system, the inpatient mental health per diem payment system, **the reasonable cost method for Critical Access Hospitals (CAHs)**, and billed charges may be used to determine hospital reimbursement?

III. POLICY

A. Agreements.

1. When discount agreements are available to the contractor, the contractor shall obtain such discounts for TRICARE reimbursement. Moreover, the contractor shall determine if any state in its jurisdiction has enacted legislation which implements a rate setting system which can be applied to TRICARE. If so, the contractor shall utilize the rates. The contractor shall maintain documentation of its actions with regard to each state which shows how any discounts or state-set rates are used or the reasons they cannot be used.

2. The contractors may negotiate individual or collective agreements with providers to establish reimbursement methods.

3. The DRG-based payment system, the inpatient mental health per diem payment system, **and the reasonable cost method for CAHs**, are required for those hospitals which are subject to them. Therefore, none of the above agreements or procedures can be used for any hospital subject to the DRG, **the per diem payment system, or the reasonable cost method for CAHs**. However, when the hospital participates with the contractor as a network provider, the DRG-based amount, the mental health per diem amount, **or the reasonable cost method for CAHs**, shall be further reduced by the negotiated (discount) rate.

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B. Outside the United States. The Director, TMA, or designee, is authorized by regulation to determine appropriate reimbursement methodologies for covered medical services or supplies provided by hospitals outside the United States (see [Section 34](#) for reimbursement methodology utilized for hospital services provided in the Philippines).

- END -

HOSPITAL REIMBURSEMENT - OUTPATIENT SERVICES

ISSUE DATE: March 10, 2000

AUTHORITY: 32 CFR 199.14(a)(3) and (a)(5)

I. APPLICABILITY

A. This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

B. Hospital reimbursement - outpatient services for all services prior to implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of the Outpatient Prospective Payment System (OPPS), and thereafter, for services not otherwise reimbursed under hospital OPPS.

II. POLICY

A. When professional services or diagnostic tests (e.g., laboratory, radiology, EKG, EEG) that have CHAMPUS Maximum Allowable Charge (CMAC) pricing ([Chapter 5, Section 3](#)) are billed, the claim must have the appropriate [Current Procedural Terminology \(CPT\)](#) coding and modifiers, if necessary. Otherwise, the service shall be denied. If only the technical component is provided by the hospital, the technical component of the appropriate CMAC shall be used.

B. For all other services, payment shall be made based on allowable charges when the claim has [Healthcare Common Procedure Coding System \(HCPCS\)](#) (Level I, II, III) coding information (these may include ambulance, Durable Medical Equipment (DME) and supplies, drugs administered other than oral method, and oxygen and related supplies). For claims development, see TRICARE Operations Manual (TOM), [Chapter 8, Section 6](#). Other services without allowable charges, such as facility charges, shall be paid as billed. For reimbursing drugs administered other than oral method, see [Chapter 1, Section 15, paragraph III.E](#).

NOTE: All line items on the Centers of Medicare and Medicaid Services (CMS) 1450 UB-04 claim form must be submitted with a specific date of service. The header date of the CMS 1450 UB-04 may span dates of services. However, each line item date of service must fall within the span date billed or the claim will be denied.

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C. When coding information is provided, outpatient hospital services including emergency and clinical services, clinical laboratory services, rehabilitation therapy, venipuncture, and radiology services are paid using existing allowable charges. Such services are reimbursed under the allowable charge methodology that would also include the CMAC rates. In addition, venipuncture services provided on an outpatient basis by institutional providers other than hospitals are also paid on this basis. Professional services billed on a CMS 1450 UB-04 will be paid at the professional CMAC if billed with the professional service revenue code and enough information to identify the rendering provider.

D. Freestanding Ambulatory Surgical Center (ASC) services are to be reimbursed in accordance with [Chapter 9, Section 1](#).

NOTE: All hospital based ASC claims that are submitted to be paid under OPSS must be submitted with a Type Of Bill (TOB) 13X. If a claim is submitted to be paid with a TOB 83X the claim will be denied.

E. Outpatient hospital services including professional services, provided in the state of Maryland are paid at the rates established by the Maryland Health Services Cost Review Commission (HSCRC). Since hospitals are required to bill these rates, reimbursement for these services is to be based on the billed charge.

F. Surgical outpatient procedures which are not otherwise reimbursed under the hospital OPSS will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under OPSS for services rendered on or after implementation of OPSS. Refer to [Chapter 1, Section 16, paragraph III.A.1.a. through c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b. and c.](#) for further detail.

G. Industry standard modifiers and condition codes may be billed on outpatient hospital claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers and condition codes are essential for ensuring accurate processing and payment of these claims.

H. Effective December 1, 2009, hospital outpatient services provided in a CAH, including ambulatory surgery services, shall be paid under the reasonable cost method, reference [Chapter 15, Section 1](#).

- END -

LEGAL OBLIGATION TO PAY

ISSUE DATE: February 9, 1987

AUTHORITY: [32 CFR 199.4\(g\)\(11\)](#), [\(g\)\(12\)](#) and [\(g\)\(13\)](#)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by all providers.

II. ISSUE

Under what circumstances can TRICARE make no payment for services or supplies because the beneficiary has no legal obligation to pay for them?

III. POLICY

TRICARE Management Activity (TMA) cannot pay for services or supplies for which the beneficiary or sponsor has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor was not eligible under TRICARE. An obligation to pay is defined as a legal debt which is enforceable through a court action. The beneficiary's obligation to pay for services can be abrogated by a number of circumstances which must be judged on the merits of each situation.

IV. EXCEPTIONS

A. Amounts may be paid for which there is no legal obligation to pay in situations involving claims paid under the TRICARE **Diagnosis Related Group (DRG)**-based payment system, the inpatient mental health per diem payment system, **or the reasonable cost method for Critical Access Hospitals (CAHs)** where the allowable amount exceeds the provider's billed charge.

B. Hospitals Which Do Not Charge.

1. According to Section 1079(m) of Chapter 55, Title 10, United States Code (**USC**), certain hospitals can be excepted from the requirement that a beneficiary cost-share be collected for every claim. In order to qualify for this exception the hospital must certify in writing to the responsible contractor that it will:

a. Not impose a legal obligation of any kind on any of its patients; and

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b. Accept and treat TRICARE beneficiaries to the same extent as any other patient or category of patients; and

c. Provide evidence that it has sources of revenue to cover unbilled costs.

2. The contractor is to ensure that payments to such hospitals do not exceed the average amount paid for comparable services in the area and that the hospital's practice of not billing patients does not result in increased costs to TRICARE.

3. Claims for professional services may qualify for this exception only when they are billed through a facility meeting the above criteria. Professional claims billed under a different Employment Identification Number (EIN) or Social Security Number (SSN) will not be exempt from imposing a legal obligation on patients for payment of their cost share or deductible.

- END -

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 **Diagnosis Related Group (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 (**CO**). 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 **CO**, and any agreement which calls for reimbursement at higher rates than those approved for standard TRICARE must be approved by the **CO**.

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](#).

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. REASONABLE COST METHOD FOR CAHs

Effective for admissions on or after December 1, 2009, non-network inpatient care provided in CAHs shall be paid under the reasonable cost method. See [Chapter 15, Section 1](#) for additional instructions.

IV. 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 CO 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.

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

Effective with Fiscal Year (FY) 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 Branch-Aurora (MB&RB). This data shall be reported in an Excel spreadsheet. 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 (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

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HOSPITAL AND OTHER INSTITUTIONAL REIMBURSEMENT

	A	B	C
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

VI. 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](#).)

VII. SPECIAL REIMBURSEMENT PROCEDURES FOR CERTAIN 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](#).

VIII. REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS (ASCs)

A. General

1. Payment for facility charges for ambulatory surgical services will be made using prospectively determined rates **except for ambulatory surgery services performed in CAHs that are subject to the reasonable cost method on or after December 1, 2009, reference [Chapter 15, Section 1](#); or in a hospital outpatient clinic or in a hospital Emergency Room (ER) that are subject to the OPSS on or after May 1, 2009**. The rates will be divided into 11 payment groups representing ranges of costs and will apply to all ambulatory surgical procedures identified by TMA and provided in a freestanding ASC.

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](#)

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III.A.5.b. and c. for services rendered on or after May 1, 2009 (implementation of the Outpatient Prospective Payment System (OPPS)).

C. Claims Form Requirements. Claims for facility charges must be submitted on a **Centers of Medicare and Medicaid Services (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.

IX. 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. Facilities should not submit claims on bill type 135 as this bill type is not allowed under TRICARE and will be denied.

X. 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 **ER** 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 -

DISCOUNTS

ISSUE DATE:

AUTHORITY:

I. PROVIDER DISCOUNTS

The contractor may negotiate agreements or contracts with providers which include reductions or discounts in the TRICARE reimbursement, however, the provider must agree to participate on all TRICARE claims. This section provides direction concerning processing of claims subject to such reductions in reimbursement.

II. AGREEMENTS

Agreements must meet the following conditions:

A. The provider must be TRICARE-authorized. If the provider is not currently certified, the contractor shall certify the provider through the normal provider certification process. If the provider is non-certifiable, the contractor shall notify both the provider and the **Military Treatment Facility (MTF)** if the MTF is involved. Contractors must ensure that clinics, **Preferred Provider Organizations (PPOs)**, and other multi-member groups provide a list of the providers within the organization, along with their **Employer Identification Numbers (EINs)/Social Security Numbers (SSNs)**. Contractors shall review these lists, making sure that each individual provider in the groups is authorized under TRICARE.

B. For all contractor negotiated agreements, the effective dates will be the first day of the month following the month the agreement was signed.

C. The agreement must contain date parameters (effective and termination dates). For multi-member groups, the effective date of each member will be the same unless otherwise indicated. Groups must identify the rendering physician on the claim.

D. The agreement must list specific procedure codes and the method and amount of discount, for example, a general description such as gynecological procedures is not acceptable.

E. Providers must agree to participate on all charges, whether the services provided are subject to the negotiated discount or not.

F. Providers cannot balance bill the beneficiary.

G. Provider must agree to bill the patient's OHI prior to billing TRICARE.

H. Providers must be able to fluently speak, read, and write the English language.

III. METHODS

At a minimum, the following negotiated reimbursement reduction methods are authorized:

A. Agreements using a percent reduction method. Under the percent reduction method, provider reimbursement is reduced by a percentage rate (e.g., 20%) applied to the allowable amount for professional services, the **Diagnosis Related Group (DRG)** allowance for an inpatient episode, the TRICARE mental health per diem for hospitalization or **Residential Treatment Center (RTC)** care per diem, **the reasonable cost method for Critical Access Hospitals (CAHs)**, or the billed charge. If the billed charge minus the discount amount exceeds the CHAMPUS Maximum Allowable Charge (CMAC), payment is limited to the CMAC unless an exception is allowed under demonstration authority. The discount will be taken from the applicable reimbursement methodology used for the provider, i.e., DRG, mental health per diem, RTC per diem, etc. The cost-share is always applied after calculation of the discounted amount.

B. Agreements may include a discount for the initial 1,000 claims processed (does not include adjustments) during a stated period of time (e.g., 10%) and a higher discount for claims exceeding 1,000, (e.g., 15%). In this case the contractor must have counters to tally the number of claims processed by individual, provider or group.

C. Agreements using negotiated per diems are authorized for hospitalization and RTC care, but the established method of payment cannot be altered, i.e., a DRG hospital cannot revert to using a per diem, unless an exception is allowed under demonstration authority. The cost-share is applied after calculation of the new allowed amount.

D. Agreements on which each procedure code listed in the agreement could have a different percentage discount or fee schedule.

E. Agreements which have different discounts for inpatient and outpatient services. This can be for both professional and institutional providers.

F. Agreements with provider groups when only some of the members of the group will honor the participation/discount agreement. Groups must identify the rendering physician on the claim.

IV. CONTRACTOR RESPONSIBILITIES

A. The contractor shall load the name of the provider and EIN, the applicable negotiated reimbursement, and the effective date parameters within 45 days of receipt of the agreement/contract.

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DISCOUNTS

B. The contractor shall ensure, by implementing an automated payment mechanism, that claims from affiliated providers with agreements or contracts which include negotiated reimbursements are processed using an authorized and correct reimbursement method.

C. The contractor shall report the discounted amount as the allowed amount.

V. SAMPLE NEGOTIATED REIMBURSEMENT METHODS

A. Negotiated per diems or negotiated percent reduction in the standard TRICARE mental health or RTC per diem (e.g., 20% reduction in the TRICARE per diem). Negotiated per diems are subject to the adjustments applied to regional TRICARE per diems (i.e., wage index factor, indirect medical education costs, etc.). A negotiated per diem for a provider shall be paid by the contractor until expiration, renewal, or renegotiation of the contract or agreement. Percentage reductions shall be applied to TRICARE allowable charges for professional services.

B. Negotiated professional service reimbursement reductions shall be applied to either the current or prior year's prevailing charge profile based on dates of service.

C. Examples

1. Percentage reduction applied to the DRG allowable amount (e.g., a 10% reduction). The following example illustrates calculation of a reduced DRG payment:

10% negotiated reduction, \$265 per diem cost-share for a retiree (assuming the per diem is less than 10% of the billed charge), four-day stay.	
DRG allowance	\$5,000.00
Less negotiated reduction	<u>- 500.00</u>
Negotiated allowed amount	\$4,500.00
Less cost-share (\$265 x 4 x .90)	<u>- 954.00</u>
Payment to hospital	\$3,546.00

2. The following example illustrates application of a percentage reduction in the standard per diem for a high volume mental health provider or an RTC:

10% negotiated reduction, 25% cost-share for retiree, \$375 per diem, 30-day stay.	
Standard allowed amount (\$375 x 30)	\$11,250.00
Less negotiated reduction	<u>-1,125.00</u>
Negotiated allowed amount	\$10,125.00
Less cost-share (.25 x \$10,125)	<u>-2,531.25</u>
Payment to facility	\$7,593.75

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3. The following example illustrates application of a percentage reduction in the standard per diem for a low volume mental health provider:

10% negotiated reduction, 25% cost-share for a retiree, \$410 regional per diem (net of adjustments), 30-day stay billed at \$500 per day.	
Standard allowed amount (\$410 x 30)	\$12,300.00
Less negotiated reduction	<u>-1,230.00</u>
Negotiated allowed amount	\$11,070.00
Less cost-share (.25 x \$11,070)	<u>-2,767.50</u>
(NOTE: 25% of the negotiated allowed amount is less than the daily cost-share of \$126.)	
Payment to facility	\$8,302.50

4. The following example illustrates payment calculation for a negotiated per diem (applicable to high volume mental health providers, and RTCs):

\$400 standard per diem, \$350 negotiated per diem, 25% cost-share for a retiree, 30-day stay.	
Standard allowed amount (\$400 x 30)	\$12,000.00
Negotiated allowed amount (\$350 x 30)	<u>\$10,500.00</u>
Less cost-share (.25 x \$10,500)	<u>- 2,625.00</u>
Payment to facility	\$ 7,875.00

5. Percentage reduction may be applied to the billed charge (e.g., 20% reduction in the billed charge) for inpatient or outpatient services delivered by institutional providers not reimbursed under the TRICARE DRG-based payment system or the TRICARE inpatient mental health per diem system. The following example illustrates calculation of a payment for inpatient services using the negotiated percent reduction method:

10% negotiated reduction in billed charges, 25% cost-share for a retiree, four-day stay billed at \$400 per day.	
Billed charge (\$400 x 4)	\$1,600.00
Less negotiated reduction	<u>-160.00</u>
Negotiated allowed amount	\$1,440.00
Less cost-share (.25 x \$1,440)	<u>-360.00</u>
Payment to hospital	\$1,080.00

(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 **Diagnosis Related Group (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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DOUBLE COVERAGE

H. **Claims Processed Under The Reasonable Cost Method For Critical Access Hospitals (CAHs).** When double coverage exists on a claim processed under the reasonable cost method for CAHs, the TRICARE payment cannot exceed an amount that when combined with the primary payment equals the lesser of the established cap amount multiplied by the billed charges or 101% of reasonable cost. The reasonable cost method for CAHs is the lesser of the established/determined Cost-to-Charge Ratio (CCR) cap (reference [Chapter 15, Section 1](#) for FY inpatient and outpatient CCR cap) multiplied by billed charges or 101% of reasonable costs [1.01 x (hospital-specific CCR x billed charges)].

I. **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 -

COORDINATION OF BENEFITS

ISSUE DATE:

AUTHORITY: [32 CFR 199.8](#)

I. DISPUTES OVER PRIMARY PAYOR STATUS

The contractor shall attempt to resolve any disputes over primary payor status with the double coverage plan. The contractor should call the double coverage plan and explain that under Federal Law, Title 10, U.S.C., Chapter 55, Section 1079, TRICARE is always second pay, except to Medicaid. In no case should the contractor compromise that position without direction from the TRICARE Management Activity (TMA).

II. COMPUTATION OF TRICARE PAYMENT

In double coverage situations, the TRICARE contractor will pay the lower of:

- A. The amount TRICARE would have paid as primary payor; or
- B. The amount remaining after the double coverage plan has paid its benefits.

NOTE: Generally, the provider's billed charge will be used in determining the amount remaining after the double coverage plan has paid (Step 2 of the Three Step Computation or Steps 3 and 4 of the **Diagnosis Related Group (DRG)**/Inpatient Mental Health Per Diem claims computation). There are two exceptions. By law, when a professional provider does not participate, the provider can be paid, from all sources, no more than 115% of the TRICARE allowable charge. Therefore, for nonparticipating professional providers, the lower of the billed charge or 115% of the TRICARE allowable charge is to be used. Similarly, the law forbids TRICARE payment when the beneficiary or sponsor has no legal obligation to pay (see [Chapter 4, Section 1, paragraph I.I.](#)) Therefore, when the beneficiary's liability is limited under the **Other Health Insurance (OHI)** (e.g., due to an OHI negotiated rate) and the OHI allowed amount plus charges for any services denied by the OHI for which the beneficiary is responsible is lower than the billed charge or 115% of the TRICARE allowable charge (not to exceed the billed charge), the OHI allowed amount plus charges for any services denied by the OHI for which the beneficiary is responsible shall be used. This limitation of legal liability must be clearly evident on the EOB from the OHI. If it is not clearly evident, the claim is to be processed as if no such agreement exists. The provider's billed charge, the amount allowed by OHI, and the OHI payment together with other necessary data shall be entered on the payment record as required by the TRICARE Systems Manual ([TSM](#)), [Chapter 2](#).

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CHAPTER 4, SECTION 3 COORDINATION OF BENEFITS

III. THREE STEP COMPUTATION

For all claims except those subject to the TRICARE DRG-based payment system or the TRICARE Inpatient Mental Health Per Diem Payment System, the last-pay share of charges is computed as follows:

- STEP 1: Determine the amount that TRICARE would have paid in the absence of double coverage. In determining this amount, take into account non-covered services, and services provided outside the period(s) of eligibility, discounts, reasonable charge reductions, payment reduction (due to the provider's noncompliance with the utilization review requirements), deductible and cost-share.
- STEP 2: From the billed charge (or, if applicable, 115% of the allowable charge but not to exceed the billed charge or the OHI allowed amount if the beneficiary's liability is limited under the OHI deduct:
- Any charges that duplicate previous or current charges and all other disallowed charges.
 - Charges for services/supplies for which evidence of processing by the double coverage plan is not provided.
 - The actual amount(s) paid by all double coverage plans. For inpatient mental health claims only, this should be limited to the amount(s) paid for only those days covered by TRICARE.

NOTE: The contractor is not required to analyze the OHI's specific coverage provisions for the claimed services. Nevertheless, where it is possible, based on information available from the face of the claim, the contractor should ensure that the OHI payment applies only to those services included on the TRICARE claim (whether covered by TRICARE or not). For example, some services may be included in the OHI payment but do not pertain to the current TRICARE claim. These services must be deducted from the total OHI paid amount before subtracting the OHI payment from the currently billed charges as required in this step. Conversely some of the services on the TRICARE claim may not have been processed by the OHI. In this case, the contractor is to deduct the charges for those services from the amount billed TRICARE before subtracting the OHI payment from the billed amount as required in this step.

- STEP 3: Compare the amounts in Steps 1 and 2 and pay the lower.

IV. SECONDARY PAYMENT CALCULATION FOR CLAIMS SUBJECT TO THE TRICARE DRG-BASED PAYMENT SYSTEM OR THE TRICARE INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM

When this computation is used for claims subject to the TRICARE Inpatient Mental Health Per Diem Payment System, the per diem amount is to be used in lieu of the DRG-based amount.

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insurance which has paid \$1,645.00 on the claim. The wage adjusted TRICARE APC rate for the procedure performed is \$1,235.00.

- STEP 1: \$ 1,235.00 - APC allowed amount
 - 0.00 - Deductible and cost-sharing not applied since beneficiary is a Prime active duty family member
 \$ 1,235.00 - Amount payable by TRICARE in the absence of other coverage
- STEP 2: \$ 2,450.00 - Billed charge
 - 1,645.00 - OHI payment
 \$ 805.00 - Unpaid balance
- STEP 3: TRICARE pays \$805.00 balance, since it is less than what TRICARE would have paid in the absence of double coverage.

NOTE: The above COB methodology for hospital outpatient services will not go into effect until implementation of the hospital outpatient prospective payment system. This new reimbursement system is scheduled to become effective May 1, 2009 (implementation of the Outpatient Prospective Payment System (OPPS)).

VII. EXAMPLES OF COMPUTATION OF THE TRICARE SHARE WHEN THE BENEFICIARY'S LIABILITY IS LIMITED UNDER THE OHI

EXAMPLE 1: The bill for outpatient care for an active duty dependent is \$200.00, which is considered allowable by TRICARE. The TRICARE deductible has been met. The provider submitted the claim on a participating basis, along with an EOB from the OHI. The OHI discounted rate is \$100.00 and it paid \$90.00. The beneficiary's liability is limited to \$100.00 under the OHI, and this is evident on the EOB from the OHI. The provider submitted a claim for \$200.00.

- STEP 1: \$ 200.00 - Allowable charges
 x 80% - TRICARE portion for active duty dependents
 \$ 160.00 - Amount payable by TRICARE in the absence of other coverage
- STEP 2: \$ 100.00 - OHI amount allowed
 - 90.00 - Paid by OHI
 \$ 10.00 - Unpaid balance
- STEP 3: TRICARE pays \$10.00 to the provider since this is the lower of the two computations. The beneficiary owes nothing, since the full legal liability has been paid.

EXAMPLE 2: A provider's normal charge for an outpatient service is \$160.00. The provider is a network provider and has a negotiated discount rate of 10% off the CMAC amount which is \$145.00. The provider also has a discounted rate of \$110.00 with the OHI and receives no OHI payment due to application of OHI deductible. The beneficiary is a retiree who is enrolled in Prime. The

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beneficiary's liability is limited to \$110.00 under the OHI, and this is evident on the EOB from the OHI.

- STEP 1: \$ 160.00 - Billed amount
 \$ 145.00 - CMAC amount
 \$ 130.50 - Negotiated rate (10% off the CMAC amount)
 - 12.00 - TRICARE Prime copay for retirees
 \$ 118.50 - Amount payable by TRICARE in the absence of other coverage
- STEP 2: \$ 110.00 - OHI amount allowed
 - 0.00 - Paid by OHI
 \$ 110.00 - Unpaid balance
- STEP 3: TRICARE pays \$110.00 since this is the lower of the two computations, and the beneficiary owes nothing.

EXAMPLE 3: The billed charge for seven days of inpatient care in March 2002 for a retiree is \$5,000.00. The claim is subject to the TRICARE DRG-based payment system, and the DRG-based amount is \$6,000.00. The hospital has agreed to a 10% discount off the DRG amount. The retiree cost-share under the DRG-based payment system is \$1,250.00, which is 25% of the billed charges. (This is lower than the per diem of \$414.00 reduced by the 10% discount and multiplied by 7 days.) The OHI discounted rate is \$4,200.00 and it paid \$4,000.00. The beneficiary's liability is limited to \$4,200.00 under the OHI, and this is evident on the EOB from the OHI. The hospital submits a claim for \$1,000.00 along with an EOB from the OHI.

- STEP 1: \$ 6,000.00 - DRG-based amount
 - 600.00 - 10% discount
 \$ 5,400.00 - DRG amount reduced by the discount
 - 1,250.00 - Cost-share
 \$ 3,150.00
- STEP 2: \$ 5,400.00 - DRG amount reduced by the discount
 - 4,000.00 - OHI payment
 \$ 1,400.00
- STEP 3: \$ 4,200.00 - OHI amount allowed
 - 4,000.00 - OHI payment
 \$ 200.00
- STEP 4: \$ 4,200.00 - OHI amount allowed
 - 1,250.00 - Cost-share
 \$ 2,950.00
- STEP 5: TRICARE pays \$200.00, since it is the lowest amount of Steps 1 - 4. The beneficiary owes nothing, since the full legal liability has been paid.

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COORDINATION OF BENEFITS

VIII. EXAMPLES OF COMPUTATION OF THE TRICARE SHARE FOR SERVICES PROVIDED IN A CRITICAL ACCESS HOSPITAL (CAH)

When double coverage exists on a claim processed under the reasonable cost method for CAHs, the TRICARE allowable amount is the lesser of the established cap amount multiplied by billed charges or 101% of reasonable cost. The Two Step comparison of costs to determine the TRICARE allowable amount is as follows:

- Inpatient, pay the lesser of (FY CCR Cap (FY 2010 cap is 2.31) x billed charges) or (1.01 x (hospital-specific CCR x billed charges))
- Outpatient, pay the lesser of (FY CCR Cap (FY 2010 cap is 1.26 x billed charges) or (1.01 x (hospital-specific CCR x billed charges)).

EXAMPLE 1: The bill for outpatient care for an active duty dependent enrolled in TRICARE Prime is \$1,000.00. The TRICARE deductible has been met. The provider submitted the claim on a participating basis, along with an EOB from the OHI. The OHI paid \$635.00.

- Outpatient, pay the lesser of (1.26 x billed charges) or (1.01 x (hospital-specific CCR x billed charges))
- Reasonable Cost Method Two Step Calculation for Outpatient using hospital-specific CCR of 0.44.

STEP 1: FY 2010 CCR 1.26 x 1000 = \$1,260

STEP 2: 1.01 (0.44 x 1000) = \$440.00

OHI Calculation

STEP 1: \$ 440.00 - Allowable charge and amount payable by TRICARE in the absence of other coverage
 - 0.00 - Prime Active Duty Dependent Cost-Share
 \$ 440.00

STEP 2: \$ 1,000.00 - Billed charge
 - 635.00 - Paid by OHI
 \$ 365.00 - Unpaid balance

STEP 3: TRICARE pays the \$365.00 balance, since it is less than the \$440.00 which TRICARE would have paid in the absence of double coverage.

EXAMPLE 2: The bill for inpatient care for an active duty dependent enrolled in TRICARE Prime is \$10,000.00. The provider submitted the claim on a participating basis, along with an EOB from the OHI. The OHI paid \$6,500.00.

- Inpatient, pay the lesser of (2.31 x billed charges) or (1.01 x (hospital-specific CCR x billed charges))
- Reasonable Cost Method Two Step Calculation for Inpatient using hospital-specific CCR of 2.56.

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COORDINATION OF BENEFITS

STEP 1: FY 2010 CCR 2.31 x \$10,000 = \$23,100

STEP 2: 1.01 (2.56 x 10,000) = \$25,856

OHI Calculation

STEP 1: \$ 23,100.00 - Allowable charge and amount payable by TRICARE in the absence
of other coverage
 - 0.00 - Prime Active Duty Dependent Cost-Share
\$23,100.00

STEP 2: \$ 10,000.00 - Billed charge
 - 6,500.00 - Paid by OHI
\$ 3,500.00

STEP 3: TRICARE pays the \$3,500.00 to the provider. The beneficiary owes nothing, since
the full legal liability has been paid.

EXAMPLE 3: The bill for inpatient care for an active duty dependent enrolled in TRICARE
Prime is \$10,000.00. The provider submitted the claim on a participating basis,
along with an EOB from the OHI. The OHI paid \$6,500.00.

- Inpatient, pay the lesser of (2.31 x billed charges) or (1.01 x (hospital-specific
CCR x billed charges))
- Reasonable Cost Method Two Step Calculation for Inpatient using hospital-
specific CCR of 0.58.

STEP 1: FY 2010 CCR 2.31 x \$10,000 = \$23,100

STEP 2: 1.01 (0.58 x 10,000) = \$5,858

OHI Calculation

STEP 1: \$ 5,858.00 - Allowable charge and amount payable by TRICARE in the absence
of other coverage
 - 0.00 - Prime Active Duty Dependent Cost-Share
\$5,858.00

STEP 2: \$ 10,000.00 - Billed charge
 - 6,500.00 - Paid by OHI
\$ 3,500.00

STEP 3: TRICARE pays the \$3,500.00 to the provider since it is less than what TRICARE
would have paid in the absence of double coverage.

- END -

PAYMENT FOR PROFESSIONAL/TECHNICAL COMPONENTS OF DIAGNOSTIC SERVICES

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)\(ix\)](#) and [\(c\)\(2\)\(x\)](#)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by **the TRICARE Management Activity (TMA)** and specifically included in the network provider agreement.

II. ISSUE

How are professional and technical components of diagnostic services to be reimbursed?

III. POLICY

A. Frequently, charges for diagnostic services are split between the professional (physician) and the technical (equipment) components. Wherever possible, separate allowable charges are developed for each component. When a bill is received for the total service, the total allowable charge is to be used in the processing of the claim.

B. Under the national allowable charge system, the Maximum Allowable Charge file provides the contractor with a complete allowable charge or with separate allowable charges for professional and technical components.

C. For diagnostic procedures that are still priced using area prevailing allowable charges, the contractor is to establish professional and technical components from the billed charges for the service as identified on the claims.

D. Clinical diagnostic lab tests furnished by Critical Access Hospitals (CAHs), are reimbursed under the reasonable cost method, reference [Chapter 15, Section 1](#).

- END -

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(APPLICABILITY OF THE DRG SYSTEM)

e. For admissions occurring on or after October 1, 2002, through September 30, 2003, the following HCPCS codes and payment rates shall be used for blood clotting factors:

J7190 Factor VIII (antihemophilic factor - human), per IU	\$0.86 per unit
J7191 Factor VIII (antihemophilic factor - porcine), per IU	2.04 per unit
J7192 Factor VIII (antihemophilic factor - recombinant), per IU	1.24 per unit
J7193 Factor IX (antihemophilic factor, purified - non-recombinant), per IU	1.05 per unit
J7194 Factor IX (complex), per IU	0.33 per unit
J7195 Factor IX (antihemophilic factor - recombinant), per IU	1.12 per unit
J7198 Anti-Inhibitor, per IU	1.43 per unit
J7199 Hemophilia Clotting Factor, not otherwise classified (the provider must report the name of the drug and how the drug is dispensed in the remarks section of the claim)	
Q0187 Factor VIIa (coagulation factor - recombinant) one billing unit per 1.2mg	1,596 per unit
Q2022 Von Willebrand Factor (complex - human) per IU	0.95 per unit

f. For admissions occurring on or after October 1, 2003, contractors shall use the "J" code pricing file to price blood clotting factor. For pricing of blood clotting factor that is not listed in the "J" code pricing file, the contractor shall use 95 percent of the median AWP.

g. For admissions occurring on or after October 1, 2005, contractors shall make payment for blood clotting factor using Average Sale Price (ASP) plus 6 percent, using the Medicare Part B Drug Pricing file. The price allows for payment of a furnishing fee and is included in the ASP per unit.

D. Hospitals subject to the TRICARE/CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are authorized to provide services to TRICARE/CHAMPUS beneficiaries are subject to the DRG-based payment system except for those hospitals and hospital units below.

E. Substance Use Disorder Rehabilitation Facilities. With admissions on or after July 1, 1995, substance use disorder rehabilitation facilities, are subject to the DRG-based system.

F. The following types of hospitals or units which are exempt from the Medicare PPS, are exempt from the TRICARE CHAMPUS DRG-based payment system. In order for hospitals and units which do not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system, they must meet the same criteria (as determined by the TRICARE Management Activity, or designee) as required for exemption from the Medicare PPS as contained in Section 412 of Title 42 CFR.

1. Hospitals within hospitals.
2. Psychiatric hospitals.

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3. Rehabilitation hospitals.
4. Psychiatric and rehabilitation units (distinct parts).
5. Long-term hospitals.

6. Sole Community Hospitals (SCHs). Any hospital which has qualified for special treatment under the Medicare PPS as a sole community hospital and has not given up that classification is exempt from the TRICARE/CHAMPUS DRG-based payment system. For additional information on SCHs, refer to [Chapter 14, Section 1](#).

7. Christian Science sanitariums.

8. Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare PPS is exempt from the TRICARE/CHAMPUS DRG-based payment system.

9. Hospitals outside the 50 United States, the District of Columbia, and Puerto Rico.

10. Satellite facilities.

G. Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized TRICARE/CHAMPUS provider. However, any hospital which is subject to the TRICARE/CHAMPUS DRG-based payment system and which otherwise meets TRICARE/CHAMPUS requirements but which is not a Medicare-participating provider (having completed a CMS 1561, Health Insurance Benefit Agreement, and a CMS 1514, Hospital Request for Certification in the Medicare/Medicaid Program) must complete a participation agreement ([Chapter 6, Addendum A](#)) with TMA. By completing the participation agreement, the hospital agrees to participate on all inpatient claims and to accept the TRICARE/CHAMPUS-determined allowable amount as payment in full for its services. Any hospital which does not participate in Medicare and does not complete a participation agreement with TMA will not be authorized to provide services to program beneficiaries.

H. Critical Access Hospitals (CAHs). **Prior to December 1, 2009**, CAHs are subject to the DRG-based payment system. For additional information on CAHs, refer to [Chapter 15, Section 1](#).

- END -

MENTAL HEALTH

SECTION	SUBJECT
1	Hospital Reimbursement - TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System
2	Psychiatric Partial Hospitalization Program (PHP) Reimbursement
3	Substance Use Disorder Rehabilitation Facilities Reimbursement
4	Residential Treatment Center (RTC) Reimbursement
ADDENDUM A	Table Of Regional Specific Rates For Psychiatric Hospitals And Units With Low TRICARE Volume (FY 2007 - FY 2009)
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 2007 - FY 2009)
ADDENDUM C	Participation Agreement For Substance Use Disorder Rehabilitation Facility (SUDRF) Services For TRICARE/CHAMPUS Beneficiaries
ADDENDUM D	TRICARE/CHAMPUS Standards For Inpatient Rehabilitation And Partial Hospitalization For The Treatment Of Substance Use Disorders (SUDRFs)
ADDENDUM E	Participation Agreement For Residential Treatment Center (RTC)
ADDENDUM F	Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates
ADDENDUM G	(FY 2007) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2006
ADDENDUM G	(FY 2008) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2007
ADDENDUM G	(FY 2009) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2008
ADDENDUM H	TRICARE/CHAMPUS Standards For Residential Treatment Centers (RTCs) Serving Children And Adolescents
ADDENDUM I	Participation Agreement For Hospital-Based Psychiatric Partial Hospitalization Program Services

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SECTION	SUBJECT
ADDENDUM J	Participation Agreement For Freestanding Psychiatric Partial Hospitalization Program Services

PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM (PHP) REIMBURSEMENT

ISSUE DATE: July 14, 1993

AUTHORITY: [32 CFR 199.14\(a\)\(2\)\(ix\)](#)

I. APPLICABILITY

A. This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

B. Reimbursement of PHPs **prior to implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of Outpatient Prospective Payment System (OPPS)**, and thereafter, freestanding psychiatric PHPs.

II. POLICY

A. Per diem payment for psychiatric partial hospitalization services. Psychiatric partial hospitalization services authorized and provided under [32 CFR 199.4\(b\)\(10\)](#) and provided by psychiatric PHPs authorized under [32 CFR 199.4\(b\)\(3\)\(xii\)](#) are reimbursed on the basis of prospectively determined, all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all PHP services provided. The following services and supplies are included in the per diem rate approved for an authorized PHP and are not covered even if separately billed by an individual professional provider. Effective on May 1, 2009 (implementation of OPPS), hospital-based PHP services are reimbursed under the hospital OPPS as described in [Chapter 13, Section 2, paragraph G](#).

1. Board. Includes use of the partial hospital facilities such as food service, supervised therapeutically constructed recreational and social activities, etc.

2. Patient assessment. Includes the assessment of each individual accepted by the facility, and must, at a minimum, consist of a physical examination; psychiatric examination; psychological assessment; assessment of physiological, biological and cognitive processes; developmental assessment; family history and assessment; social history and assessment; educational or vocational history and assessment; environmental assessment; and recreational/activities assessment. Assessments conducted within 30 days prior to admission to a partial program may be used if approved and deemed adequate to permit treatment planning by the **PHP**.

3. Psychological testing and assessment.

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4. Treatment services. All services including routine nursing services, group therapy, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the psychotherapy as indicated in [paragraph II.B.1.](#)). All mental health services must be provided by a authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

5. Ancillary therapies. Includes art, music, dance, occupational, and other such therapies.

6. Overhead and any other services for which the customary practice among similar providers is included as part of the institutional charges.

B. Services which may be billed separately. The following services are not considered as included within the per diem payment amount and may be separately billed when provided by an authorized individual professional provider:

1. Psychotherapy sessions. Professional services provided by an authorized individual professional provider (who is not employed by or under contract with the PHP) for purposes of providing clinical patient care to a patient in the PHP may be cost-shared when billed by the individual professional provider. Any obligation of a professional provider to provide services through employment or contract in a facility or distinct program of a facility would preclude that professional provider from receiving separate TRICARE/CHAMPUS reimbursement on a fee-for-service basis to the extent that those services are covered by the employment or contract arrangement. Psychotherapy services provided outside of the employment/contract arrangement can be reimbursed separately from the PHPs per diem. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family, etc.) per authorized treatment day not to exceed five sessions in any calendar week in any combination of individual and family therapy. Five sessions per week is an absolute limit, and additional sessions are not covered.

NOTE: Group therapy is strictly included in the per diem and cannot be paid separately even if billed by an individual professional provider.

2. Primary/Attending Provider. When a patient is approved for admission to a PHP, the primary or attending provider (if not contracted or employed by the partial program) may provide psychotherapy only when the care is part of the treatment environment which is the therapeutic partial program. That is why the patient is there--because that level of care and that program have been determined as medically necessary. The therapy must be adapted toward the events and interactions outlined in the treatment plan and be part of the overall partial treatment plan. Involvement as the primary or attending is allowed and covered only if he is part of the coherent and specific plan of treatment arranged in the partial setting. The treatment program must be under the general direction of the psychiatrist employed by the program to ensure medication and physical needs of the patients are met and the therapist must be part of the treatment team and treatment plan. An attending

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provider must come to the treatment plan meetings and his/her care must be coordinated with the treatment team and as part of the treatment plan. Care given independent of this is not covered.

3. Non-mental health related medical services. Those services not normally included in the evaluation and assessment of a partial hospitalization patient and not related to care in the PHP. These medical services are those services medically necessary to treat a broken leg, appendicitis, heart attack, etc., which may necessitate emergency transport to a nearby hospital for medical attention. Ambulance services may be cost-shared when billed for by an authorized provider if determined medically necessary for emergency transport.

C. Per diem rate. For any full-day PHP (minimum of six hours), the maximum per diem payment amount is 40% of the average inpatient per diem amount per case paid to both high and low volume psychiatric hospitals and units established under the mental health per diem reimbursement system. The rates shall be updated to the current year using the same factors as used under the TRICARE mental health per diem reimbursement system. A PHP of less than six hours (with a minimum of three hours) will be paid a per diem rate of 75% of the rate for full-day PHP. TRICARE will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half or full-day program. See [Chapter 7, Addendum B](#), for the current maximum rate limits which are to be used as is for the full-day and half-day program.

D. Other requirements. No payment is due for leave days, for days in which treatment is not provided, for days in which the patient does not keep an appointment, or for days in which the duration of the program services was less than three hours.

E. CAHs. Effective December 1, 2009, PHPs in CAHs shall be reimbursed under the reasonable cost method, reference [Chapter 15, Section 1](#).

- END -

SKILLED NURSING FACILITY (SNF) REIMBURSEMENT

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.14\(b\)](#)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by **the TRICARE Management Activity (TMA)** and specifically included in the network provider agreement.

II. ISSUE

How are SNFs to be reimbursed?

III. POLICY

A. For admissions before August 1, 2003:

SNF reimbursement may follow any of the payment methodologies listed for hospitals which are not subject to the TRICARE **Diagnosis Related Group (DRG)**-based payment system or the mental health per diem payment system. The most common method of reimbursement for covered services of hospitals in which the DRG based payment system or the inpatient mental health per diem payment system is not used, is that of billed charges or negotiated rates for network providers. This payment methodology will apply for all admissions before August 1, 2003, for the duration of the covered SNF stay regardless of the date of discharge. In addition, this payment methodology will apply to a covered SNF admission that is not subject to SNF **Prospective Payment System (PPS)** regardless of the date of admission, such as children under the age of 10 and Critical Access Hospitals (CAHs) swing beds.

B. For admissions on or after August 1, 2003:

SNF reimbursement shall be based on SNF PPS. The CAH swing beds and children under age 10 on the date of admission to a SNF will not be subject to SNF PPS. **Children under age 10** will be reimbursed based on the methodology described in [paragraph III.A](#). **For admissions on or after December 1, 2009, CAH swing beds will be reimbursed under the reasonable cost method. Refer to Chapter 15, Section 1 for information on CAH reimbursement.** For SNF PPS policy, see [Chapter 8, Section 2](#). Unless required by their Memorandum of Understanding (**MOU**) or Provider Agreement, **Veterans Affairs (VA)**

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facilities may not be subject to SNF PPS. SNFs in Puerto Rico and the U.S. Territories (Guam, the U.S. Virgin Islands, and American Samoa) are required to be Medicare certified and will be subject to SNF PPS.

- END -

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approved by the MTF. Otherwise the care will be approved by the Service Point of Contact/Military Medical Support Office (SPOC/MMSO). TRICARE will pay the claim and the ADSM will not have any out-of-pocket expense.

D. SNF PPS will apply to TAMP beneficiaries.

E. SNF PPS will apply to CHCBP beneficiaries.

F. SNF PPS claims are required to be filed sequentially at least every 30 days. Current timeliness standards will continue to apply which require claims to be filed within one year after the date the services were provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility. If a claim is not filed sequentially, the contractor may return that to the submitting SNF.

G. TRICARE will allow those hospital-based SNFs with medical education costs to request reimbursement for those expenses. Only medical education costs that are allowed under the Medicare SNF PPS will be considered for reimbursement. These education costs will be separately invoiced by hospital-based SNFs on an annual basis as part of the reimbursement process for hospitals (see [Chapter 6, Section 8](#)). Hospitals with SNF medical education costs will include appropriate lines from the cost report and the ratio of TRICARE days/total facility days. The product will equal the portion that TRICARE will pay. TRICARE days do not include any days determined to be not medically necessary, and days included on claims for which TRICARE made no payment because other health insurance or Medicare paid the full TRICARE allowable amount. The hospital's reimbursement requests will be sent on a voucher to the TMA Finance Office for reimbursement as a pass through cost.

H. Swing Bed Providers.

1. TRICARE will follow CMS policy regarding swing bed providers. To be reimbursed under SNF PPS, a hospital must be certified as a swing bed provider by CMS.

2. TRICARE will exempt Critical Access Hospital (CAH) swing beds from the SNF PPS. Section 203 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 [Pub. L. 106-554], exempted CAH swing-beds from the SNF PPS. Accordingly, it will not be necessary to complete an MDS assessment for CAH swing-bed SNF resident. The CAH will directly bill the claims processor for the services received. Under the TRICARE benefit, CAHs will be reimbursed for their swing-bed SNF services **based on the reasonable cost method**, reference [Chapter 15, Section 1](#). Currently, the list of current CAHs can be accessed at <http://www.flexmonitoring.org>.

3. The CAH swing bed claims can be identified by the Medicare provider number (CMS 1450 UB-04). There are two provider numbers issued to each CAH with swing beds. One number is all numeric and the second number is an alpha "z" in the third digit. For example, the acute beds would use 131300 and the swing beds 13z300. Other than the "z" the numbers are identical. The first two digits identifies the State code, and the 1300-1399 series identifies the CAH category.

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I. Children under age 10 at the time of admission to a SNF will not be assessed using the MDS. TRICARE contractors will determine whether SNF services for these pediatric residents are covered based on the criteria of skilled services defined in 42 CFR 409.32, **Subpart D and the Medicare Benefit Policy Manual, Chapter 8**. The criteria used to determine SNF coverage for a child under the age of 10 will be the same whether that child is or is not Medicare-eligible. SNF benefit requirements will apply to these pediatric patients. SNF care for children under age 10 will be paid as provided in **Chapter 8, Section 1, paragraph III.A**. The TRICARE contractor will have the ability to negotiate these reimbursement rates.

J. **The Waiver of Liability provisions in the TRICARE Policy Manual (TPM), Chapter 1, Section 4.1 apply to SNF cases.**

- END -

AMBULATORY SURGERY CENTERS (ASCs)

SECTION	SUBJECT
1	Ambulatory Surgical Center (ASC) Reimbursement

AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.14\(d\)](#)

I. APPLICABILITY

A. The policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

B. Reimbursement of surgical procedures performed in an ASC **prior to the implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of TRICARE's Outpatient Prospective Payment System (OPPS), and thereafter, freestanding ASCs, and other providers who are exempt from the TRICARE OPPS and provide scheduled ambulatory surgery.** For purposes of this section, these facilities are known as non-OPPS facilities. Non-OPPS facilities include any facility not subject to the OPPS as outlined in [Chapter 13, Section 1, paragraph III.D.1.b.](#)

II. BACKGROUND

A. Reimbursement System **Prior to Implementation of Reasonable Cost Method for CAHs and Implementation of TRICARE's OPPS.**

1. General. Ambulatory surgery procedures performed in ASCs will be reimbursed using prospectively determined rates. The rates will be: established on a cost-basis, divided into eleven payment groups representing ranges of costs, and adjusted for area labor costs based on Metropolitan Statistical Areas (MSAs).

2. Applicability.

a. The ambulatory surgery payment system is to be used regardless of where the ambulatory surgery procedures are provided, that is, in a freestanding ASC, in a **Hospital Outpatient Department (HOPD)**, or in a hospital Emergency Room (ER). No additional benefits are payable outside the ASC payment rate; e.g., revenue codes 0260, 0450, 0510, 0636, etc.

b. The payment rates established under this system apply only to the facility charges for ambulatory surgery. The facility rate is a standard overhead amount that includes nursing and technician services; use of the facility; drugs including take-home drugs for less

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than \$40; biologicals; surgical dressings, splints, casts and equipment directly related to provision of the surgical procedure; materials for anesthesia; intraocular lenses (IOLs); and administrative, recordkeeping and housekeeping items and services. The rate does not include items such as physicians' fees (or fees of other professional providers authorized to render the services identified and to bill independently for them); laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure); prosthetic devices (except IOLs); ambulance services; leg, arm, and back braces; artificial limbs; and durable medical equipment for use in the patient's home.

NOTE: A radiology and diagnostic procedure is considered directly related to the performance of the surgical procedure only if it is an inherent part of the surgical procedure, e.g., the **Current Procedural Terminology (CPT)** code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description (i.e., CPT¹ procedure code 47560).

3. State Waiver. Ambulatory surgery services provided by freestanding ASCs in Maryland are not exempt from this system and are to be reimbursed using the procedures set forth in this section. (See [Chapter 1, Section 24, paragraph II.E.](#) for payment of professional services related to ambulatory surgery.)

4. Ambulatory Surgery Payment Rates.

a. TMA, or its data contractor, will calculate the payment rates and will provide them electronically to the claims processing contractors. The magnetic media will include the locally-adjusted payment rate for each payment group for each MSA and will identify, by procedure code, the procedures in each group and the effective date for each procedure. Additions or deletions to the list of procedures will be given to the contractors as they occur, but the electronic data will be provided only on an annual basis. The MSAs and corresponding wage indexes will be those used by Medicare.

b. In addition to the payment rates, the contractors will be provided a zip code to MSA crosswalk, so that they can determine which payment rate to use for each ambulatory surgery provider. For this purpose the zip code of the facility's physical address (as opposed to its billing address) is to be used. This crosswalk may be updated periodically throughout the year and sent to the contractors.

c. In order to calculate payment rates, only those procedures with at least 25 claims nationwide during the database period will be used.

d. The rates were initially calculated using the following steps.

(1) For each ambulatory surgery procedure, a median standardized cost was calculated on the basis of all ambulatory surgery charges nationally under TRICARE during the one year database period. The steps in this calculation included:

(a) Standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare;

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(b) Applying the cost-to-charge ratio (CCR) using the Medicare CCR for freestanding ASCs for TRICARE ASCs.

(c) Calculating a median cost for each procedure; and

(d) Updating to the year for which the payment rates were in effect by the Consumer Price Index-Urban (CPI-U).

(2) Procedures were placed into one of ten groups by their median per procedure cost, starting with \$0 to \$299 for Group 1 and ending with \$1,000 to \$1,299 for Group 9 and \$1,300 and above for Group 10. Groups 2 through 8 were set on the basis of \$100 fixed intervals.

(3) The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

(4) Procedures for which there was no or insufficient (less than 25 claims) data were assigned to groups by:

(a) Calculating a volume-weighted ratio of TRICARE payment rates to Medicare payment rates for those procedures with sufficient data;

(b) Applying the ratio to the Medicare payment rate for each procedure; and

(c) Assigning the procedure to the appropriate payment group.

e. The amount paid for any ambulatory surgery service under these procedures cannot exceed the amount that would be allowed if the services were provided on an inpatient basis. The allowable inpatient amount equals the applicable DRG relative weight multiplied by the national large urban adjusted standardized amount. This amount will be adjusted by the applicable hospital wage index.

f. As of November 1, 1998, an eleventh payment group is added to this payment system. This group will include extracorporeal shock wave lithotripsy.

5. Payments.

a. General. The payment for a procedure will be the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the same labor/non-labor-related cost ratio and hospital wage index as used for ASCs by Medicare. This calculation will be done by TMA, or its data contractor. For participating claims, the ambulatory surgery payment rate will be reimbursed regardless of the actual charges made by the facility--that is, regardless of whether the actual charges are greater or smaller than the payment rate. For nonparticipating claims, reimbursement (TRICARE payment plus beneficiary cost-share plus any double coverage payments, if applicable) cannot exceed the lower of the billed charge or the group payment rate.

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b. Procedures Which Do Not Have An Ambulatory Surgery Rate and Are Provided by an ASC. Only those procedures that have an ambulatory surgery rate listed on TMA's ambulatory surgery web site (<http://www.tricare.mil/ambulatory>) are to be reimbursed under this reimbursement process. If a claim is received from an ASC for a procedure which is not listed on TMA's ambulatory web site, the facility charges are to be reimbursed using the process in [paragraph II.B.](#)

c. Multiple and Terminated Procedures. The following rules are to be followed whenever there is a terminated surgical procedure or more than one procedure is included on an ambulatory surgery claim. The claim for professional services, regardless of what type of ambulatory surgery facility provided the services and regardless of what procedures were provided, is to be reimbursed according to the multiple surgery guidelines in [Chapter 1, Section 16, paragraph III.A.1.a.](#) through [c.](#)

(1) Discounting for Multiple Surgical Procedures.

(a) If all the procedures on the claim are listed on TMA's ambulatory surgery web site, the claim is to be reimbursed at 100% of the group payment rate for the major procedure (the procedure which allows the greatest payment) and 50% of the group payment rate for each of the other procedures. This applies regardless of the groups to which the procedures are assigned.

(b) If the claim includes procedures listed on TMA's ambulatory surgery web site as well as procedures not listed on TMA's ambulatory surgery web site, the following rule is to be followed. Each service is to be reimbursed according to the method appropriate to it. That is, the allowable amount for procedures listed on TMA's ambulatory surgery web site is to be based on the appropriate group payment amount while the allowable amount for procedures not listed on TMA's ambulatory surgery web site is to be based on the process in [paragraph II.B.](#) Regardless of the method used for determining the reimbursement for each procedure, only one procedure (the procedure which allows the greatest payment) is to be reimbursed at 100%. All other procedures are to be reimbursed at 50%. If the contractor is unable to determine the charges for each procedure (i.e., a single billed charge is made for all procedures), the contractor is to develop the claim for the charges using the steps contained in the TRICARE Operations Manual (TOM). If development does not result in usable charge data, the contractor is to reimburse the major procedure (the procedure for which the greatest amount is allowed) if that can be determined (e.g., the major procedure is on TMA's ambulatory surgery web site or is identified on the claim) and deny the other procedures using EOB message "Requested information not received". If the major procedure cannot be determined, the entire claim is to be denied.

(2) Discounting for Bilateral Procedures.

(a) Following are the different categories/classifications of bilateral procedures:

1 Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

2 Inherent bilateral (i.e., procedure in and of itself is bilateral).

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3 Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures).

(b) Terminated bilateral procedures or terminated procedures with units greater than one should not occur. Line items with terminated bilateral procedures or terminated procedures with units greater than one are denied.

(c) Inherent bilateral procedures will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code.

(3) Modifiers for Discounting Terminated Surgical Procedures.

(a) Industry standard modifiers may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers are essential for ensuring accurate processing and payment of these claim types.

(b) Industry standard modifiers are used to identify surgical procedures which have been terminated prior to and after the delivery of anesthesia.

1 Modifiers 52 and 73 are used to identify a surgical procedure that is terminated prior to the delivery of anesthesia and is reimbursed at 50% of the allowable; i.e., the ASC tier rate, the Ambulatory Payment Classification (APC) allowable amount for OPSS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.

2 Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100% of the appropriated allowable amounts referenced above.

(4) Unbundling of Procedures. Contractors should ensure that reimbursement for claims involving multiple procedures conforms to the unbundling guidelines as outlined in [Chapter 1, Section 3](#).

(5) Incidental Procedures. The rules for reimbursing incidental procedures as contained in [Chapter 1, Section 3](#), are to be applied to ambulatory surgery procedures reimbursed under the rules set forth in this section. That is, no reimbursement is to be made for incidental procedures performed in conjunction with other procedures which are not classified as incidental. This limitation applies to payments for facility claims as well as to professional services.

6. Updating Payment Rates.

a. The rates will be updated annually by TMA by the same update factor as is used in the Medicare annual updates for ASC payments. Periodically the rates will be recalculated using the steps in [paragraph II.A.4.d](#).

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b. The rates were updated by 3.0% effective November 1, 2002. This update included the wage indexes as updated by Medicare.

c. The group payment rates that are effective November 1, 2003, have been recalculated using the steps in [paragraph II.A.4.d](#). However, we used 100 claims rather than 25 claims to calculate a rate for individual procedures, because it produced more statistically valid results while still resulting in calculated rates for about 83% of TRICARE ambulatory surgery services. In addition, the rates were updated by the Medicare update factor of 2.0% and included the wage indexes as updated by Medicare.

d. The rates were reduced by 2.0% effective April 1, 2004.

B. Reimbursement for procedures not listed on TMA's ambulatory surgery web site. Prior to January 28, 2000, these procedures were to be denied if performed in an ASC and reimbursed in accordance with [Chapter 1, Section 24](#). Effective January 28, 2000, ambulatory surgery procedures that are not listed on TMA's ambulatory surgery web site, and are performed in either a freestanding ASC or hospital may be cost-shared. These procedures are reimbursed at the lesser of billed charges or network discount. On May 1, 2009 (implementation of OPSS), these non-ASC procedures are subject to [Chapter 13](#) discounting of surgical, bilateral and terminated procedures.

C. Reimbursement System On Or After May 1, 2009 (Implementation of OPSS).

1. For ambulatory surgery procedures performed in an OPSS qualified facility, the provisions in [Chapter 13](#) shall apply.

2. For ambulatory surgery procedures performed in freestanding ASCs and non-OPSS facilities, the provisions in [paragraph II.A](#) shall apply, except as follows:

a. Contractors will no longer be allowed to group other procedures not listed on TMA's ambulatory surgery web site. On May 1, 2009 (implementation of OPSS), these groupers will be end dated. Only ambulatory surgery procedures listed on TMA's ambulatory surgery web site are to be grouped.

b. Multiple and Terminated Procedures. For services rendered on or after May 1, 2009 (implementation of OPSS), the professional services shall be reimbursed according to the multiple surgery guidelines in [Chapter 13, Section 3, paragraph III.A.5.b](#) and [c](#).

c. Discounting for Multiple Surgical Procedures. For services rendered on or after May 1, 2009 (implementation of OPSS), discounting for multiple surgical procedures are subject to the provisions in [Chapter 13, Section 1](#).

d. Discounting for Bilateral Procedures. For services rendered on or after May 1, 2009 (implementation of OPSS), bilateral procedures will be discounted based on the application of discounting formulas appearing in [Chapter 13, Section 3, paragraph III.A.5.c\(6\)](#) and [\(7\)](#).

D. CAHs. Effective December 1, 2009, ambulatory surgery services performed in CAHs shall be reimbursed under the reasonable cost method, reference [Chapter 15, Section 1](#).

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E. Claims for Ambulatory Surgery.

1. 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.

2. Claim Data.

a. Billing Data. The claim must identify all procedures which were performed (by CPT-4 or HCPCS code). The facility claim shall be submitted on the CMS 1450 UB-04, the procedure code will be shown in Form Locator (FL) 44.

NOTE: Claims from ASCs must be submitted on the CMS 1450 UB-04 claim form. Claims not submitted on the appropriate claim form will be denied.

b. TRICARE Encounter Data (TED). All ambulatory surgery services are to be reported on the TED using the appropriate CPT-4 code. The only exception is services which are billed using a HCPCS code and for which no CPT-4 code exists.

F. Wage Index Changes. If, during the year, Medicare revises any of the wage indexes used for ambulatory surgery reimbursement, such changes will not be incorporated into the TRICARE payment rates until the next routine update. These changes will not be incorporated regardless of the reason Medicare revised the wage index.

G. Subsequent Hospital Admissions. If a beneficiary is admitted to a hospital subject to the DRG-based payment system as a result of complications, etc. of ambulatory surgery, the ambulatory surgery procedures are to be billed and reimbursed separately from the hospital inpatient services. The same rules applicable to emergency room services are to be followed.

H. Cost-Shares for Ambulatory Surgery Procedures. All surgical procedures performed in an outpatient setting shall be cost-shared at the ASC cost-sharing levels. Refer to [Chapter 2, Section 1, paragraph I.C.3.g.](#)

- END -

CRITICAL ACCESS HOSPITALS (CAHS)

ISSUE DATE: November 6, 2007

AUTHORITY: [32 CFR 199.14\(a\)\(3\)](#), [\(a\)\(5\)\(iii\)](#), and [\(a\)\(5\)\(iv\)](#)

I. APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

II. DESCRIPTION

A CAH is a small facility that provides limited inpatient and outpatient hospital services primarily in rural areas and meets the applicable requirements established by [32 CFR 199.6\(b\)\(4\)\(xvi\)](#).

III. ISSUE

How are CAHS to be reimbursed?

IV. POLICY

A. Background.

1. Hospitals are authorized TRICARE institutional providers under 10 United States Code (USC) 1079(j)(2) and (4). Under 10 USC 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare]". Under [32 CFR 199.14\(a\)\(1\)\(ii\)\(D\)\(1\)](#) through (9) it specifically lists those hospitals that are exempt from the Diagnosis Related Groups (DRG)-based payment system. Prior to December 1, 2009, CAHS were not listed as excluded, thereby making them subject to the DRG-based payment system.

2. Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs, under which certain facilities participating in Medicare could become CAHS. CAHS represent a separate provider type with their own Medicare conditions of participation as well as a separate payment method. Since that time, a number of hospitals, acute care and general, as well as Sole

Community Hospitals (SCHs), have taken the necessary steps to be designated as CAHs. Since the statutory authority requires TRICARE to apply the same reimbursement rules as apply to payments to providers of services of the same type under Medicare to the extent practicable, effective December 1, 2009, TRICARE is exempting CAHs from the DRG-based payment system and adopting a reasonable cost method similar to Medicare principles for reimbursing CAHs. To be eligible as a CAH, a facility must be a currently participating Medicare hospital, a hospital that ceased operations on or after November 29, 1989, or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or health center. The facility must be located in a rural area of a State that has established a Medicare rural hospital flexibility program, or must be located in a Metropolitan Statistical Area (MSA) of such a State and be treated as being located in a rural area based on a law or regulation of the State, as described in 42 CFR 412.103. It also must be located more than a 35-mile drive from any other hospital or CAH unless it is designated by the State, prior to January 1, 2006, to be a "necessary provider". In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 25 beds for acute (hospital-level) inpatient care or in the case of a CAH with a swing bed agreement, swing beds used for SNF-level care. The CAH maintains a length-of-stay, as determined on an annual average basis, of no longer than 96 hours. The facility is also required to meet the conditions of participation for CAHs (42 CFR Part 485, Subpart F). Designation by the State is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by the Centers of Medicare and Medicaid Services (CMS).

B. Scope of Benefits.

1. Inpatient Services.

a. Prior to December 1, 2009, inpatient services provided by CAHs are subject to the DRG-based payment system.

b. For admissions on or after December 1, 2009, payment for inpatient services of a CAH other than services of a distinct part unit, shall be reimbursed under the reasonable cost method, reference [paragraph IV.C.](#)

c. Items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by an acute care hospital to its inpatients. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements:

- (1) The facility has been certified as a CAH by CMS;
- (2) The facility operates up to 25 beds for either acute (CAH) care or SNF swing bed care; and
- (3) The facility has been granted swing-bed approval by CMS.

d. Payment for post-hospital SNF care furnished by a CAH, shall be reimbursed under the reasonable cost method.

e. Payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients. Payment for professional medical services furnished in a CAH to CAH inpatients is made on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a Hospital Outpatient Department (HOPD). For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a Physician Assistant (PA) or a Nurse Practitioner (NP). These services are to be billed on the CMS 1500 (08/05) using the appropriate Healthcare Common Procedure Coding System (HCPCS) code or a UB-04 using the appropriate HCPCS code and professional revenue codes.

f. A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004. The CAH distinct part units must meet the following requirements:

- (1) The facility distinct part unit has been certified as a CAH by CMS;
- (2) The distinct part unit meets the conditions of participation requirements for hospitals;
- (3) The distinct part unit must also meet the requirements, other than conditions of participation requirements, that would apply if the unit were established in an acute care hospital;
- (4) Inpatient services provided in psychiatric distinct part units are subject to the CHAMPUS mental health per diem system and inpatient services provided in rehabilitation distinct part units shall be reimbursed based on billed charges or set rates.
- (5) Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;
- (6) The bed limitations for each distinct part unit is 10.

g. CAHs are not subject to the lesser of cost or charges principle.

2. Outpatient Services.

a. Prior to December 1, 2009, outpatient facility services provided by CAHs were reimbursed based on billed charges.

b. Effective December 1, 2009, outpatient services including ambulatory surgery, provided by a CAH shall be reimbursed under the reasonable cost method, reference [paragraph IV.C.](#)

c. Payment to a CAH for outpatient services does not include any costs of physician services or other professional services to CAH outpatients. Payment for professional medical services furnished in a CAH to CAH outpatients is made on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a HOPD. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a PA or a NP. These services are to be

billed on a CMS 1500 (08/05) using appropriate HCPCS code or a UB-04 using the appropriate HCPCS code and professional revenue code.

d. Payment for clinical diagnostic laboratory tests shall be reimbursed under the reasonable cost method only if the individuals are outpatients of the CAH and are physically present in the CAH at the time the specimens are collected (bill type 85X). A CAH cannot seek reasonable cost reimbursement for tests provided to individuals in locations such as rural health clinics, the individual's home or SNF. *Individuals in these locations are non-patients of a CAH and their lab test would be categorized as "referenced lab tests" for the non-patients bill type 14X), and are paid under the lab fee schedule.*

e. Multi-day supplies of take-home oral anti-cancer drugs, oral anti-emetic drugs, and immunosuppressive drugs, as well as the associated supplying fees and all inhalation drugs and the associated dispensing fees shall be paid under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule. The associated supplying and dispensing fees must be billed on the same claim as the drug. Hospitals shall submit a separate claim for these services.

NOTE: When an outpatient service includes an oral anti-cancer drug, oral anti-emetic drug or immunosuppressive drug, so long as no more than one day's drug supply (i.e., only today's) is given to the beneficiary, and the beneficiary receives additional services, the claim shall be processed and paid under the reasonable cost method. Inhalation drugs that are an integral part of a hospital procedure (inpatient or outpatient) shall also be processed and paid under the reasonable cost method, when billed in conjunction with other services on the same day.

f. Authorized Partial Hospitalization Programs (PHPs) shall be reimbursed under the reasonable cost method.

g. CAHs are not subject to the lesser of cost or charges principle.

3. Ambulance Services.

a. Effective for services provided on or after December 1, 2009, ambulance services furnished by CAHs exempt from the allowable charge methodology, are paid under the reasonable cost method. To be exempt, the provider must "self-attest" on each claim by using the B2 condition code. This self-attestation indicates compliance with the eligibility criteria included in 42 CFR 413.70(b)(5) and requires the provider to be the only provider or supplier of ambulance services located within a 35-mile drive of the facility in question. Under TRICARE, these ambulance services shall be reimbursed using the hospital's outpatient Cost-to-Charge Ratio (CCR).

b. Reasonable cost will determined without regard to any per-trip limits or fee schedule that would otherwise apply. The distance between the CAH or entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the nearest provider or supplier of ambulance services are garaged. An improved road is any road that is maintained by a local, state, or federal government entity

and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the CAH and the front entrance of the garage.

NOTE: CAHs that are not exempt from the allowable charge methodology may not report condition code B2.

C. Reasonable Cost Methodology. Reasonable cost is based on the actual cost of providing services and excluding any costs, that are unnecessary in the efficient delivery of services covered by the program.

1. TMA shall calculate an overall inpatient CCR and overall outpatient CCR, obtained from data on the hospital's most recently filed Medicare cost report as of July 1 of each year.

2. The inpatient and outpatient CCRs are calculated using Medicare charges, e.g., Medicare costs for outpatient services are derived by multiplying an overall hospital outpatient CCR (by department or cost center) by Medicare charges in the same category.

3. The following methods are used by TMA to calculate the CCRs for CAHs. The worksheet and column references are to the CMS Form 2552-96 (Cost Report for Electronic Filing of Hospitals).

Inpatient CCRs

Numerator Medicare costs were defined as Worksheet D-1, Part II, line 49 MINUS (worksheet D, Part III, Column 8, sum of lines 25-30 PLUS Worksheet D, Part IV, line 101).

Denominator Medicare charges were defined as Worksheet D-4, Column 2, sum of lines 25-30 and 103.

Outpatient CCRs

Numerator Outpatient costs were taken from Worksheet D, Part V, line 104, the sum of Columns 6, 7, 8, and 9.

Denominator Total outpatient charges were taken from the same Worksheet D, Part V, line 104, sum of Columns 2, 3, 4, and 5 for the same breakdowns.

4. To reimburse the vast majority of CAHs for all their costs in an administratively feasible manner, TRICARE will identify CCRs that are outliers using the method used by Medicare to identify outliers in its Outpatient Prospective Payment System (OPPS) reimbursement methods. Specifically, Medicare classifies CCR outliers as values that fall outside of three standard deviations from the geometric mean. Applying this method to the CAH data, those limits will be considered the threshold limits on the CCR for reimbursement purposes. For Fiscal Year (FY) 2010, this calculation resulted in an inpatient CCR cap of 2.31 and outpatient CCR cap of 1.26; these will be re-calculated each year with the CCR update. Thus, for FY 2010, TRICARE will pay the lesser of 2.31 multiplied by the billed charges or 101% of costs (using the hospital's CCR and billed charges) for inpatient services and the lesser of 1.26 multiplied by the billed charges or 101% of costs for outpatient services. Following is the two step comparison of costs.

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STEP 1: Inpatient, pay the lesser of:

FY cap x billed charges OR
1.01 x (hospital-specific CCR x billed charges)

STEP 2: Outpatient, pay the lesser of:

FY cap x billed charges OR
1.01 x (hospital-specific CCR x billed charges)

5. TMA shall provide a list of CAHs to the Managed Care Support Contractors (MCSCs) with their corresponding inpatient and outpatient CCRs by November 1 each year. The CCRs shall be updated on an annual basis using the second quarter CMS Hospital Cost Report Information System (HCRIS) data. The updated CCRs shall be effective as of December 1 of each respective year, with the first update occurring December 1, 2009.

6. TMA shall also provide the MCSCs the State median inpatient and outpatient CAH CCRs to use when a hospital specific CCR is not available.

D. CAH Listing.

1. TMA will maintain the CAH listing on the TMA's web site at <http://www.tricare.mil/hospitalclassification/>, and will update the list on a quarterly basis and will notify the contractors by e-mail when the list is updated.

2. For payment purposes for those facilities that were listed on both the CAH and SCH lists prior to June 1, 2006, the contractors shall use the implementation date of June 1, 2006, as the effective date for reimbursing CAHs under the DRG-based payment system. The June 1, 2006, effective date is for admissions on or after June 1, 2006. For admissions prior to June 1, 2006, if a facility was listed on both the CAH and SCH lists, the SCH list took precedence over the CAH list. The contractors shall not initiate recoupment action for any claims paid billed charges where the CAH was also on the SCH list, prior to the June 1, 2006, effective date. **For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.**

3. The effective date on the CAH list is the date supplied by CMS upon which the facility began receiving reimbursement from Medicare as a CAH, however, if a facility was listed on both the CAH and SCH lists prior to June 1, 2006, the effective date for TRICARE DRG reimbursement is June 1, 2006. **For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.**

4. After June 1, 2006, if a CAH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

5. If the contractor receives documentation from a CAH indicating their status is different than what is on the CAH listing on TMA's web site, the contractor shall send the information to TMA, Medical Benefits & Reimbursement Branch (MB&RB) to update the listings on the web.

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E. CAHs participating in the demonstration in the state of Alaska, from July 1, 2007 through November 30, 2009, are exempt from the DRG-based payment system and are subject to the payment rates under the TRICARE Demonstration Project. For information on the demonstration, refer to the TRICARE Operations Manual (TOM), Chapter 20, Section 9.

F. Prior to December 1, 2009, the contractor's shall update their institutional provider files to include CAH's and their Indirect Medical Education (IDME) factors, if applicable, as the CMS Inpatient Provider Specific File used to update the annual DRG Provider File does not contain CAH information.

G. Billing and Coding Requirements.

1. The contractors shall use type of institution 91 for CAHs.
2. CAHs shall utilize bill type 11X for inpatient services.
3. CAHs shall utilize bill type 85X for all outpatient services including services approved as Ambulatory Surgery Center (ASC) services.
4. CAHs shall utilize bill type 12X for ancillary/ambulance services.
5. CAHs shall utilize bill type 14X for non-patient diagnostic services.
6. CAHs shall use bill type 18X for swing bed services.

H. Beneficiary Liability. Applicable TRICARE deductible and cost-sharing provisions apply to CAH inpatient and outpatient services.

V. EFFECTIVE DATE

Implementation of the CAH reasonable cost methodology is effective for admissions and outpatient services occurring on or after December 1, 2009.

- END -

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