



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 12  
6010.58-M  
SEPTEMBER 18, 2009**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE REIMBURSEMENT MANUAL (TRM)**

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to the 6010.58-M, issued February 2008.

**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 Feb 2008 TOM, Change No. 12 and Feb 2008 TSM, Change No. 12.

**Reta Michak  
Acting Chief, Medical Benefits and  
Reimbursement Branch**

**ATTACHMENT(S):** 80 PAGE(S)  
**DISTRIBUTION:** 6010.58-M

**REMOVE PAGE(S)**

**CHAPTER 1**

Table of Contents, pages 1 and 2  
Section 13, pages 1 and 2  
Section 14, pages 3 and 4  
Section 21, pages 1 and 2  
Section 22, pages 1 and 2  
Section 24, pages 1 and 2  
Section 27, pages 1 and 2

**CHAPTER 3**

Section 2, pages 1 through 3  
Section 3, pages 1 and 2

**CHAPTER 4**

Section 1, pages 3 and 4  
Section 3, pages 1, 2, 13, and 14

**CHAPTER 5**

Section 5, page 1

**CHAPTER 6**

Section 4, page 5

**CHAPTER 7**

Table of Contents, page 1  
Section 2, pages 1 through 3

**CHAPTER 8**

Section 1, page 1  
Section 2, pages 13 and 14

**INSERT PAGE(S)**

Table of Contents, pages 1 and 2  
Section 13, pages 1 and 2  
Section 14, pages 3 and 4  
Section 21, pages 1 and 2  
Section 22, pages 1 and 2  
Section 24, pages 1 and 2  
Section 27, pages 1 and 2

Section 2, pages 1 through 3  
Section 3, pages 1 and 2

Section 1, pages 3 and 4  
Section 3, pages 1, 2, and 13 through 16

Section 5, page 1

Section 4, page 5

Table of Contents, page 1  
Section 2, pages 1 through 3

Section 1, page 1  
Section 2, pages 13 and 14

**CHANGE 12**  
**6010.58-M**  
**SEPTEMBER 18, 2009**

**REMOVE PAGE(S)**

**CHAPTER 9**

Table of Contents, page 1  
Section 1, pages 1 through 8

**CHAPTER 15**

Section 1, pages 1 and 2

**APPENDIX A**

pages 3 through 28

**INDEX**

pages 3 and 4

**INSERT PAGE(S)**

Table of Contents, page 1  
Section 1, pages 1 through 7

Section 1, pages 1 through 7

pages 3 through 28

pages 3 through 5



# Chapter 1

## General

Section/Addendum	Subject/Addendum Title
1	Network Provider Reimbursement
2	Accommodation Of Discounts Under Provider Reimbursement Methods
3	Claims Auditing Software
4	Reimbursement In Teaching Setting
5	National Health Service Corps Physicians Of The Public Health Service
6	Reimbursement Of Physician Assistants (PAs), Nurse Practitioners (NPs), And Certified Psychiatric Nurse Specialists (CPNSs)
7	Reimbursement Of Covered Services Provided By Individual Health Care Professionals And Other Non-Institutional Health Care Providers
8	Economic Interest In Connection With Mental Health Admissions
9	Anesthesia
10	Postoperative Pain Management - Epidural Analgesia
11	Claims for Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)
12	Oxygen And Related Supplies
13	Laboratory Services
14	Ambulance Services
15	Legend Drugs And Insulin
16	Surgery
17	Assistant Surgeons
18	Professional Services: Obstetrical Care
19	Charges For Provider Administrative Expenses
20	State Agency Billing
21	Hospital Reimbursement - Billed Charges Set Rates
22	Hospital Reimbursement - Other Than Billed Charges
23	Hospital Reimbursement - Payment When Only Skilled Nursing Facility (SNF) Level Of Care Is Required
24	Hospital Reimbursement - Outpatient Services
25	Preferred Provider Organization (PPO) Reimbursement

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**  
Chapter 1, General

Section/Addendum	Subject/Addendum Title
26	Supplemental Insurance
27	Legal Obligation To Pay
28	Reduction Of Payment For Noncompliance With Utilization Review Requirements
29	Reimbursement Of Emergency Inpatient Admissions To Unauthorized Facilities
30	Reimbursement Of Certain Prime Travel Expenses
31	Newborn Charges
32	Hospital-Based Birthing Room
33	Bonus Payments In Health Professional Shortage Areas (HPSAs) And In Physician Scarcity Areas (PSAs)
34	Hospital Inpatient Reimbursement In Locations Outside The 50 United States And The District Of Columbia
	Figure 1.34-1 Country Specific Index Factors - 2008
	Figure 1.34-2 Institutional Inpatient Diagnostic Groupings For Specified Locations Outside The 50 United States And The District Of Columbia - National Inpatient Per Diem Amounts - 2008
	Figure 1.34-3 Unique Admissions - National Inpatient Per Diem Amounts - 2008
35	Professional Provider Reimbursement In Specified Locations Outside The 50 United States And The District Of Columbia
	Figure 1.35-1 Country Specific Index Factors - 2008
A	Sample State Agency Billing Agreement
B	Figures
	Figure 1.B-1 Suggested Wording To The Beneficiary Concerning Rental vs. Purchase Of DME

## Laboratory Services

Issue Date: August 26, 1985  
Authority: [32 CFR 199.4\(c\)\(2\)\(x\)](#)

---

### 1.0 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.

### 2.0 ISSUE

How are laboratory services to be reimbursed?

### 3.0 POLICY

**3.1** 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.

#### 3.2 Determining Prevailing Charges for Single Laboratory Tests.

**3.2.1** 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.

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

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

#### **4.0 EXCEPTION**

Effective October 1, 2008, CPT<sup>1</sup> 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 -

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 1, Section 14

#### Ambulance Services

---

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 CPT<sup>1</sup> procedures codes 93012 and 93270 as guidelines for determining the allowable amount.

**3.2.4** 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:

**3.2.4.1** 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.

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

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

**3.2.4.3** Be furnished by a paramedic ALS intercept supplier that meets the following conditions:

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

**3.3** 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\(a\)\(4\)](#)).

**3.3.1** Ambulance transfers from a beneficiary's place of residence, accident scene, or other location to a civilian hospital, Military Treatment Facility (MTF), Veterans Affairs (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-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 4.3.13.5](#)).

**3.3.2** 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.

**3.3.3** 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 allowable charge.

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 1, Section 14

#### Ambulance Services

---

**3.3.4** 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.

**3.3.5** 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. 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.

**3.3.6** Cost-share amounts for ambulance services are included in [Chapter 2, Section 1](#).

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

## 4.0 POLICY CONSIDERATIONS

**4.1** Ambulance Membership Programs.

**4.1.1** 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.

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

**4.2** 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 Healthcare Common Procedure Coding System (HCPCS) codes A0426 through A0429 subject to applicable beneficiary cost-sharing.

**4.3** The TRICARE 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.

**4.4** 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\(a\)](#)

---

### 1.0 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.

### 2.0 ISSUE

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

### 3.0 POLICY

#### 3.1 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:

**3.1.1** The charge made to the general public; or

**3.1.2** The allowed charge applicable to contractor policy-holders (subscribers), when extended to beneficiaries by consent or agreement; or

**3.1.3** The charge set by local or state regulatory authority as applicable to citizens and extended by law or regulation, consent or agreement to TRICARE.

#### 3.2 All-Inclusive Rates

**3.2.1** 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 single amount for all services or a basic "room and board" charge and a separate set charge for ancillary services. Such all-inclusive

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 1, Section 21

#### Hospital Reimbursement - Billed Charges Set Rates

---

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.

**3.2.2** 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.

### **3.3 Room Charges**

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

#### **3.3.1 Hospital Participation**

**3.3.2** 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.

**3.3.3** 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\(a\)](#)

---

### 1.0 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.

### 2.0 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?

### 3.0 POLICY

#### 3.1 Agreements

**3.1.1** 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 if this results in a lower cost to the government. 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.

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

**3.1.3** The DRG-based payment system, the inpatient mental health per diem payment system, **the reasonable cost method for CAHs**, are required for those hospitals which are subject to them ([Chapter 6, Section 4](#) and [Chapter 7, Section 1](#)). 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 or the mental health per diem amount, **or the reasonable cost method for CAHs**, shall be further reduced by the negotiated (discount) rate.

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 1, Section 22

Hospital Reimbursement - Other Than Billed Charges

---

**3.2 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 199.4\(a\)\(3\)](#) and [\(a\)\(5\)](#)

---

### 1.0 APPLICABILITY

**1.1** 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.

**1.2** 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.

### 2.0 POLICY

**2.1** When professional services or diagnostic tests (e.g., laboratory, radiology, electrocardiogram (EKG), electroencephalogram (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.

**2.2** 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 [Section 15, paragraph 3.3.1](#).

**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.

**2.3** 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

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 1, Section 24

#### Hospital Reimbursement - Outpatient Services

---

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.

**2.4** 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 OPPS 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.

**2.5** 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.

**2.6** Surgical outpatient procedures which are not otherwise reimbursed under the hospital OPPS will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under OPPS for services rendered on or after implementation of OPPS. Refer to [Section 16, paragraph 3.1.1.1 through 3.1.1.3](#) and [Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3](#) for further detail.

**2.7** 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.

**2.8** 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 [\(g\)\(13\)](#)

---

### 1.0 APPLICABILITY

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

### 2.0 ISSUE

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

### 3.0 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.

### 4.0 EXCEPTIONS

**4.1** 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.

#### 4.2 Hospitals Which Do Not Charge

**4.2.1** 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:

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

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

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 1, Section 27

Legal Obligation To Pay

---

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

**4.2.2** 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.

**4.2.3** 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 Employer 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:

---

### 1.0 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. For network providers, the contractor is free to negotiate rates that would be less than the rates established under the TRICARE DRG-based payment system or other approved TRICARE method.

### 2.0 PAYMENT OF CAPITAL AND DIRECT MEDICAL EDUCATION (CAP/DME) COST

The contractor will make an annual payment to each hospital subject to the TRICARE DRG-based payment system (except children's hospitals) which requests reimbursement for 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 in accordance with payment instructions in Section G of the contract.

### 3.0 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.

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

Each fiscal year, contractors shall submit inpatient mental health, partial hospitalization (half day-three to five hours and full day-six or more hours) and RTC rates by facility.

### 5.0 BILLED CHARGES/SET RATES

When a hospital or institution is not covered by a mandatory payment methodology (i.e., DRGs, inpatient mental health), the contractor shall reimburse for institutional care received from 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.

### **5.1 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.

### **5.2 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.

### **5.3 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.

### **5.4 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 Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 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](#).)

## **6.0 REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS (ASCs)**

**6.1** 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.

**6.2** 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

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Chapter 3, Section 2

### Hospital And Other Institutional Reimbursement

---

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.

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

**6.4** 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 [Section 1](#).

**6.5** See [Chapter 9, Section 1](#) for additional instructions.

### **7.0 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.

### **8.0 PROPER REPORTING OF CONDITION CODES**

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

**8.1** Condition codes are reported in FLs 18-28 when applicable.

**8.2** The following are two examples of condition code reporting:

**8.2.1 Condition Code G0** 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.

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

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

- END -



## Discounts

Issue Date:

Authority:

---

### 1.0 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.

### 2.0 AGREEMENTS

Agreements must meet the following conditions:

**2.1** 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.

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

**2.3** 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.

**2.4** 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.

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

**2.6** Providers cannot balance bill the beneficiary.

**2.7** Provider must agree to bill the patient's other health insurance (OHI) prior to billing TRICARE.

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

### **3.0 METHODS**

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

**3.1** 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.

**3.2** 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.

**3.3** 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.

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

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

**3.6** 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.

### **4.0 CONTRACTOR RESPONSIBILITIES**

**4.1** 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.

**4.2** 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.

**4.3** The contractor shall report the discounted amount as the allowed amount.

**1.4.2.2** Not included are:

- Certain federal government programs which are designed to provide benefits to a distinct beneficiary population and for which entitlement does not derive from either premium payment or monetary contribution (e.g., Medicaid and Worker's Compensation).
- Health care delivery systems not considered within the definition of either an insurance plan, medical service or health plan including the Department of Veterans Affairs (DVA), the Maternal and Child Health Program, the Indian Health Services (IHS), 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.

**1.5 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 (TFL) claims, an exception exists for mental health counselors and pastoral counselors as well as for services received under a private contract (see [Section 4, paragraph 1.3.1.5](#)).

**1.6 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 TRICARE beneficiary any amount that would result in total payment to the provider that exceeds TRICARE 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.

**1.7 Claims Processed Under the TRICARE **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 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 DRG-based amount, the inpatient mental health per diem based amount, or the hospital's charges for the services (including any discount arrangements). 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.

**1.8 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 Fiscal Year (FY) inpatient and outpatient CCR cap) multiplied by billed charges or 101% of reasonable costs [1.01 x (hospital-specific CCR x billed charges)].

**1.9 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 (COB)

Issue Date:

Authority: [32 CFR 199.8](#)

---

### 1.0 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, United States Code (USC), 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).

### 2.0 COMPUTATION OF TRICARE PAYMENT

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

- 2.1 The amount TRICARE would have paid as primary payor; or
- 2.2 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 [Section 1, paragraph 1.9](#)). 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 [Explanation of Benefits \(EOB\)](#) 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](#).

### 3.0 THREE STEP COMPUTATION

For all claims except those subject to the TRICARE DRG-based payment system or the

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 4, Section 3

#### Coordination Of Benefits (COB)

---

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.

**Step 3:** Compare the amounts in Steps 1 and 2 and pay the lower.

**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.

#### **4.0 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.

**Step 1:** Determine the DRG-based amount TRICARE would allow minus any TRICARE discounts, payment reduction (due to the provider's non-compliance with the utilization review requirements), and the beneficiary cost-sharing amounts.

**Step 2:** Determine the DRG-based amount TRICARE would allow minus any TRICARE discounts and the actual amount paid by the OHI.

reimbursement system is tentatively scheduled to become effective **May 1, 2009** (implementation of OPPS).

**7.0 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 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.

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 4, Section 3

#### Coordination Of Benefits (COB)

**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
<u>\$ 5,400.00</u>	- DRG amount reduced by the discount
- 1,250.00	- Cost-share
<u>\$ 3,150.00</u>	

**Step 2:**

\$ 5,400.00	- DRG amount reduced by the discount
- 4,000.00	- OHI payment
<u>\$ 1,400.00</u>	

**Step 3:**

\$ 4,200.00	- OHI amount allowed
- 4,000.00	- OHI payment
<u>\$ 200.00</u>	

**Step 4:**

\$ 4,200.00	- OHI amount allowed
- 1,250.00	- Cost-share
<u>\$ 2,950.00</u>	

**Step 5:** TRICARE pays \$200.00, since it is the lowest amount of Steps 1 through 4. The beneficiary owes nothing, since the full legal liability has been paid.

## 8.0 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 Fiscal Year (FY) Cost-to-Charge (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)

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 4, Section 3

Coordination Of Benefits (COB)

**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 - DRG amount reduced by the discount

**Step 2:**       \$ 1,000.00 - Billed charge  
                  - 635.00 - OHI payment  
                  \$ 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.

**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 -

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 4, Section 3

Coordination Of Benefits (COB)

**Step 2:** \$ 10,000.00 - Billed charge  
          - 6,500.00 - OHI payment  
          \$ 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 - OHI payment  
          \$ 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.

- END -

## Payment For Professional/Technical Components Of Diagnostic Services

Issue Date: August 26, 1985

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

---

### 1.0 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.

### 2.0 ISSUE

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

### 3.0 POLICY

**3.1** 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.

**3.2** 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.

**3.3** 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.

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

- END -



**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 6, Section 4

Hospital Reimbursement - TRICARE DRG-Based Payment System (Applicability Of The DRG System)

---

**3.8 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 -



## Chapter 7

### Mental Health

Section/Addendum	Subject/Addendum Title
1	Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System
2	Psychiatric <b>Partial Hospitalization Program (PHP)</b> Reimbursement
3	Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement
4	Residential Treatment Center (RTC) Reimbursement
A	Table Of Regional Specific Rates For Psychiatric Hospitals And Units With Low TRICARE Volume - FY 2007 - FY 2009
B	Table Of Maximum Rates For PHPs Before May 1, 2009 (Implementation Of OPPS), And Thereafter, Freestanding Psychiatric PHP Reimbursement - FY 2007 - FY 2009
C	Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates Figure 7.C-1 TMA Form 771
D (FY 2007)	TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2007
D (FY 2008)	TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2008
D (FY 2009)	TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2009



## Psychiatric Partial Hospitalization Program (PHP) Reimbursement

Issue Date: July 14, 1993

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

---

### 1.0 APPLICABILITY

**1.1** 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.

**1.2** 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 PHPs.

### 2.0 POLICY

#### 2.1 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 3.7](#).

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

**2.1.2** 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.

**2.1.3** Psychological testing and assessment.

**2.1.4** 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 2.2.1](#)). 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.]

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

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

## **2.2 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:

**2.2.1** 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 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.

**2.2.2** 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 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.

**2.2.3** 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.

### **2.3 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 [Addendum B](#), for the current maximum rate limits which are to be used as is for the full-day and half-day program.

### **2.4 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.

### **2.5 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\(b\)](#)

---

### 1.0 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.

### 2.0 ISSUE

How are Skilled Nursing Facilities (SNFs) to be reimbursed?

### 3.0 POLICY

**3.1** 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.

**3.2** For admissions on or after August 1, 2003: SNF reimbursement shall be based on SNF PPS. Children under age 10 will be reimbursed based on the methodology described in [paragraph 3.1](#). **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 [Section 2](#). Unless required by their Memorandum of Understanding (MOU) or Provider Agreement, **Department of Veteran Affairs (DVA)** 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 -



## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 8, Section 2

#### Skilled Nursing Facility (SNF) Prospective Payment System (PPS)

---

all (but can prove patient eligibility). The default payment will always be equal to the lowest RUG-III group rate (currently, this is the payment rate for PA1).

**5.2** Preauthorization is not a requirement for SNF care. TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard, Extra, and TFL patients when TRICARE is the primary payer. The review required for the lower 18 RUGs is a requirement for all TRICARE patients when TRICARE is primary (see [paragraph 4.3.16](#)). There will be no review for Standard, Extra, or TFL patients where TRICARE is the secondary payer. The existing referral and authorization procedures for PRIME beneficiaries will remain unaffected.

**5.3** Supplemental care benefits for ADSM will be paid according to the TRICARE SNF PPS. If the ADSM is enrolled to a Military Treatment Facility (MTF), this care must be 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.

**5.4** SNF PPS will apply to Transitional Assistance Management Program (TAMP) beneficiaries.

**5.5** SNF PPS will apply to Continued Health Care Benefit Program (CHCBP) beneficiaries.

**5.6** 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.

**5.7** 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.

**5.8** Swing Bed Providers.

**5.8.1** 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.

**5.8.2** TRICARE will exempt CAH swing beds from the SNF PPS. Section 203 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 [Public Law 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

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 8, Section 2

Skilled Nursing Facility (SNF) Prospective Payment System (PPS)

---

services based on the reasonable cost method, reference as provided in Section 1, paragraph 3.1. Currently, the list of current CAHs can be accessed at <http://www.flexmonitoring.org>.

**5.8.3** 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.

**5.9** 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, 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 Section 1, paragraph 3.1. The TRICARE contractor will have the ability to negotiate these reimbursement rates.

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

- END -

## Chapter 9

# Ambulatory Surgery Centers (ASCs)

Section/Addendum	Subject/Addendum Title
------------------	------------------------

---

1	Ambulatory Surgical Center (ASC) Reimbursement
---	--



## Ambulatory Surgical Center (ASC) Reimbursement

Issue Date: August 26, 1985  
Authority: [32 CFR 199.14\(d\)](#)

---

### 1.0 APPLICABILITY

**1.1** 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.

**1.2** 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 3.4.1.2](#).

### 2.0 BACKGROUND

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

##### 2.1.1 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).

##### 2.1.2 Applicability

**2.1.2.1** 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 260, 450, 510, 636, etc.

**2.1.2.2** 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 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 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 (DME) 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 Common Procedure Terminology (CPT) code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description (i.e., CPT<sup>1</sup> procedure code 47560).

### 2.1.3 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 2.5](#) for payment of professional services related to ambulatory surgery.)

### 2.1.4 Ambulatory Surgery Payment Rates

**2.1.4.1** TMA, or its data contractor, will calculate the payment rates and will provide them electronically to the claims processing contractors. The electronic 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.

**2.1.4.2** 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.

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

**2.1.4.4** The rates were initially calculated using the following steps.

**2.1.4.4.1** 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:

- 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;

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 9, Section 1

#### Ambulatory Surgical Center (ASC) Reimbursement

---

- Applying the Cost-to-Charge Ratio (CCR) using the Medicare CCR for freestanding ASCs for TRICARE ASCs.
- Calculating a median cost for each procedure; and
- Updating to the year for which the payment rates were in effect by the Consumer Price Index-Urban (CPI-U).

**2.1.4.4.2** Procedures were placed into one of 10 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.

**2.1.4.4.3** The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

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

- Calculating a volume-weighted ratio of TRICARE payment rates to Medicare payment rates for those procedures with sufficient data;
- Applying the ratio to the Medicare payment rate for each procedure; and
- Assigning the procedure to the appropriate payment group.

**2.1.4.5** 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 Diagnosis Related Group (DRG) relative weight multiplied by the national large urban adjusted standardized amount. This amount will be adjusted by the applicable hospital wage index.

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

## **2.1.5 Payments**

### **2.1.5.1 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.

**2.1.5.2 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 2.2](#).

**2.1.5.3 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, paragraphs 3.1.1.1 through 3.1.1.3](#).

**2.1.5.3.1 Discounting for Multiple Surgical Procedures**

**2.1.5.3.1.1** 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.

**2.1.5.3.1.2** 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 2.2](#). 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 Explanation of Benefits (EOB) message "Requested information not received". If the major procedure cannot be determined, the entire claim is to be denied.

### **2.1.5.3.2 Discounting for Bilateral Procedures**

**2.1.5.3.2.1** Following are the different categories/classifications of bilateral procedures:

- Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).
- Inherent bilateral (i.e., procedure in and of itself is bilateral).
- 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).

**2.1.5.3.2.2** 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.

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

### **2.1.5.3.3 Modifiers for Discounting Terminated Surgical Procedures**

**2.1.5.3.3.1** 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.

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

- 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 OPPS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.
- 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.

### **2.1.5.3.4 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](#).

### **2.1.5.3.5 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.

### **2.1.6 Updating Payment Rates**

The rates will be updated annually by TMA by the same update factor as is used in the Medicare annual updates for ASC payments.

## **2.2 Reimbursement for Procedures Not Listed On TMA's Ambulatory Surgery Web Site**

Ambulatory surgery procedures that are not listed on TMA's ambulatory surgery web site, and are performed in either a freestanding ASC may be cost-shared, but only if doing so results in no additional costs to the program.

## **2.3 Reimbursement System On Or After May 1, 2009 (Implementation Of OPPS)**

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

**2.3.2** For ambulatory surgery procedures performed in freestanding ASCs and non-OPPS facilities, the provisions in [paragraph 2.1](#) shall apply, except as follows:

- 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 OPPS), these groupers will be end dated. Only ambulatory surgery procedures listed on TMA's ambulatory surgery web site are to be grouped.
- Multiple and Terminated Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), the professional services shall be reimbursed according to the multiple surgery guidelines in [Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3](#).
- Discounting for Multiple Surgical Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), discounting for multiple surgical procedures are subject to the provisions in [Chapter 13, Section 3](#).
- Discounting for Bilateral Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), bilateral procedures will be discounted based on the application of discounting formulas appearing in [Chapter 13, Section 3, paragraphs 3.1.5.3.6 and 3.1.5.3.7](#).

## **2.4 CAHs**

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

## **2.5 Claims for Ambulatory Surgery**

### **2.5.1 Claim Forms**

Claims for facility charges must be submitted on a Centers for 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 (08/2005) claim form. The preferred form is the CMS 1500 (08/2005). 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.

### **2.5.2 Claim Data**

**2.5.2.1 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.

**2.5.2.2 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. These services are to be reported on the TED using one of the codes in the TRICARE Systems Manual (TSM), [Chapter 2, Addendum N](#).

## **2.6 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.

## **2.7 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 ER services are to be followed.

## **2.8 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 1.3.3.7](#).

- END -



## Critical Access Hospitals (CAHs)

Issue Date: November 6, 2007

Authority: [32 CFR 199.14\(a\)\(3\)](#) and [\(a\)\(6\)\(ii\)](#)

---

### 1.0 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.

### 2.0 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\(b\)\(4\)\(xvi\)](#)

### 3.0 ISSUE

How are CAHs to be reimbursed?

### 4.0 POLICY

#### 4.1 Background

**4.1.1** 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 Group (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.

**4.1.2** Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs (MRHFPs), 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 MRHFP, 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 (LOS), 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).

## **4.2 Scope of Benefits**

### **4.2.1 Inpatient Services**

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

**4.2.1.2** 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 4.3](#).

**4.2.1.3** 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:

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

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

**4.2.1.5** 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.

**4.2.1.6** 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:

- The facility distinct part unit has been certified as a CAH by CMS;
- The distinct part unit meets the conditions of participation requirements for hospitals;
- 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;
- 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.
- Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;
- The bed limitations for each distinct part unit is 10.
- CAHs are not subject to the lesser of cost or charges principle.

## **4.2.2 Outpatient Services**

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

**4.2.2.2** Effective December 1, 2009, outpatient services including ambulatory surgery, provided by a CAH shall be reimbursed under the reasonable cost method, reference [paragraph 4.3](#).

**4.2.2.3** 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.

**4.2.2.4** 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.

**4.2.2.5** 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.

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

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

### **4.2.3 Ambulance Services**

**4.2.3.1** 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).

**4.2.3.2** 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.

## **4.3 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.

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 15, Section 1

Critical Access Hospitals (CAHs)

**4.3.1** 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.

**4.3.2** 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.

**4.3.3** 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**

<b>Numerator</b>	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).
------------------	---

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

**OUTPATIENT CCRs**

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

<b>Denominator</b>	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.
--------------------	---

**4.3.4** 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.

**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)

**4.3.5** 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.

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 15, Section 1

#### Critical Access Hospitals (CAHs)

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

#### **4.4 CAH Listing**

**4.4.1** 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.

**4.4.2** For payment purposes for those facilities that were listed on both the CAH and Sole Community Hospital (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.**

**4.4.3** The effective date on the CAH list is the date supplied by the Centers for Medicare and Medicaid Services (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.**

**4.4.4** 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.

**4.4.5** 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

**4.5** 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 18, Section 8](#).

**4.6** **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.

#### **4.7 Billing and Coding Requirements**

**4.7.1** The contractors shall use type of institution 91 for CAHs.

**4.7.2** CAHs shall utilize bill type 11X for inpatient services.

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 15, Section 1

Critical Access Hospitals (CAHs)

---

**4.7.3** CAHs shall utilize bill type 85X for all outpatient services including services approved as Ambulatory Surgery Center (ASC) services.

**4.7.4** CAHs shall utilize bill type 12X for ancillary/ambulance services.

**4.7.5** CAHs shall utilize bill type 14X for non-patient diagnostic services.

**4.7.6** CAHs shall use bill type 18X for swing bed services.

**4.8 Beneficiary Liability**

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

**5.0 EFFECTIVE DATE**

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

- END -



# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
<b>ATA</b>	<b>American Telemedicine Association</b>
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross Blue Shield
BC	Birth Center
BCC	Biostatistics Center
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BRest CAncer
BS	Bachelor of Science
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

C&A	Certification and Accreditation
C&CS	Communications and Customer Service
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAP	Competitive Acquisition Program
CAH	Critical Access Hospital
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBHCO	Community-Based Health Care Organizations
CBSA	Core Based Statistical Area
CC	Common Criteria Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEA	Carotid Endarterectomy
CEIS	Corporate Executive Information System

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFS	Chronic Fatigue Syndrome
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CIF	Central Issuing Facility
	<b>Common Intermediate Format</b>
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTA	Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CVAC	CHAMPVA Center
CVS	Contractor Verification System

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service
DCN	Document Control Number
DCP	Data Collection Period
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

DLE	Dialyzable Leukocyte Extract
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DSM	Diagnostic and Statistical Manual of Mental Disorders

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSO	DMDC Support Office
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
ECAS	European Cardiac Arrhythmia Society
EHRA	European Heart Rhythm Association
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFF	Environmental Failure Protection

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EIA	Educational Interventions for Autism Spectrum Disorders
EIDS	Executive Information and Decision Support
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOE	Evoked Otoacoustic Emission
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAR	Federal Acquisition Regulations

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV <sub>1</sub>	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Nonpolposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

IE	Interface Engine Internet Explorer
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPN	Intraperitoneal Nutrition
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LLLT	Low Level Laser Therapy
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
<b>MRHFP</b>	<b>Medicare Rural Hospital Flexibility Program</b>
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
RUG	Resource Utilization Group
RV	Residual Volume

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

---

RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAO	Security Assistant Organizations
SAP	Special Access Program
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
<b>SIF</b>	<b>Source Input Format</b>
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
<b>TCSRC</b>	<b>Transitional Care for Service-Related Conditions</b>
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
<b>TMH</b>	<b>Telemental Health</b>
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

---

URL	Universal Resource Locator
US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

---

WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

- END -





**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Index

---

<b>S (CONTINUED)</b>	<b>Chap</b>	<b>Sec/Add</b>
Sole Community Hospitals (SCHs)	14	1
Specific Double Coverage Actions	4	4
State Agency Billing	1	20
Sample Agreement	1	A
Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement	7	3
Supplemental Insurance	1	26
Surgery	1	16

- END -

