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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 13
6010.58-M
SEPTEMBER 28, 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: CODING AND REIMBURSEMENT UPDATES

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: As indicated.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 14.

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

**ATTACHMENT(S): 26 PAGE(S)
DISTRIBUTION: 6010.58-M**

CHANGE 13
6010.58-M
SEPTEMBER 28, 2009

REMOVE PAGE(S)

CHAPTER 6

Section 8, pages 1 - 4, 7, 8, and 13 - 16

CHAPTER 7

Section 1, pages 1 and 2

Section 3, pages 1 and 2

APPENDIX A

pages 17 through 28

INSERT PAGE(S)

Section 8, pages 1 - 4, 7, 8, and 13 - 16

Section 1, pages 1 and 2

Section 3, pages 1 and 2

pages 17 through 28

SUMMARY OF CHANGES

CHAPTER 6

1. Section 8 (Hospital Reimbursement - TRICARE/CHAMPUS Diagnosis-Related Group (DRG)-Based Payment System (Adjustments to Payment Amounts)). Clarified that inpatient acute-care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a Present on Admission (POA) indicator for both primary and secondary diagnoses on inpatient acute care hospital claims.

CHAPTER 7

2. Section 1 (Hospital Reimbursement - TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System). TRICARE/CHAMPUS DRG-Based Payment System. Clarified that 896 is a mental health DRG.
3. Section 3 (Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement). Clarified that payment is the lesser of the billed charge or the CHAMPUS Maximum Allowable Charge (CMAC). Clarification added for Outpatient Prospective Payment System (OPPS) applicability.

APPENDIX A

4. Added the Acronym "MUE".

Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment Amounts)

Issue Date: October 8, 1987

Authority: [32 CFR 199.14\(a\)\(1\)](#)

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 are the adjustments to the TRICARE DRG-based payment amounts?

3.0 POLICY

3.1 Adjustments to the DRG-Based Payment Amounts

There are several adjustments to the basic DRG-based amounts (the weight multiplied by the Adjusted Standardized Amount (ASA) which can be made.

3.2 Specific Adjustments

3.2.1 Capital Costs

TRICARE will reimburse hospitals for their capital costs as reported annually to the contractor (see below). Payment for capital costs will be made annually. See [Chapter 3, Section 2](#) for the procedures for paying capital costs.

3.2.1.1 For October 1, 2003, through present, TRICARE will reimburse 100% of capital-related costs.

3.2.1.2 Allowable capital costs are those specified in Medicare Regulation Section 413.130 of Title 42 CFR.

3.2.1.3 To obtain the total allowable capital costs from the Medicare cost reports as of October 1992, the contractor shall add the figures from Worksheet D, Part 1, Columns 3 and 6, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, and line 33, to the figures from Worksheet D, Part II, Columns 1 and 2, lines 37-63.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System
(Adjustments To Payment Amounts)

3.2.1.4 The instructions outlined in [paragraph 3.2.1.3](#) are effective for initial and amended requests received on or after October 1, 1998.

3.2.1.5 Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Section 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

3.2.1.5.1 The capital-related equipment is leased or rented by the provider;

3.2.1.5.2 The capital-related equipment is located on the provider's premises; and

3.2.1.5.3 The capital-related portion of the charge is separately specified in the charge to the provider.

3.2.2 Direct Medical Education Costs

TRICARE will reimburse hospitals their actual direct medical education costs as reported annually to the contractor (see below). Such direct medical education costs must be for a teaching program approved under Medicare Regulation Section 413.85. Payment for direct medical education costs will be made annually and will be calculated using the same steps required for calculating capital payments below. Allowable direct medical education costs are those specified in Medicare Regulation Section 413.85. See [Chapter 3, Section 2](#) for the procedures for paying direct medical education costs.

3.2.2.1 Direct medical education costs generally include:

3.2.2.1.1 Formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution.

3.2.2.1.2 Nursing schools.

3.2.2.1.3 Medical education of paraprofessionals (e.g., radiological technicians).

3.2.2.2 Direct medical education costs do not include:

3.2.2.2.1 On-the-job training or other activities which do not involve the actual operation or support, except through tuition or similar payments, of an approved education program.

3.2.2.2.2 Patient education or general health awareness programs offered as a service to the community at large.

3.2.2.3 To obtain the total allowable direct medical education costs from the Medicare cost reports on all initial and amended requests, the contractor shall add the figures from Worksheet B,

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment Amounts)

Part I, Columns 21-24, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, line 33, and lines 37-63. These instructions are effective for all initial and amended requests received on or after October 1, 1998.

3.2.3 Determining Amount Of Capital And Direct Medical Education (CAP/DME) Payment

In order to account for payments by Other Health Insurance (OHI), TRICARE' payment amounts for CAP/DME will be determined according to the following steps. Throughout these calculations claims on which TRICARE made no payment because OHI paid the full TRICARE-allowable amount are not to be counted.

Step 1: Determine the ratio of TRICARE inpatient days to total inpatient days using the data described below. In determining total TRICARE inpatient days the following are not to be included:

- Any days determined to be not medically necessary, and
- Days included on claims for which TRICARE made no payment because OHI paid the full TRICARE-allowable amount.

Step 2: Multiply the ratio from Step 1 by total allowable capital costs.

Step 3: Reduce the amount from Step 2 by the appropriate capital reduction percentage(s). This is the total allowable TRICARE capital payment for DRG discharges.

Step 4: Multiply the ratio from Step 1 by total allowable direct medical education costs. This is the total allowable TRICARE direct medical education payment for DRG discharges.

Step 5: Combine the amounts from Steps 3 and 4. This is the amount of TRICARE payment due the hospital for CAP/DME.

3.2.4 Payment Of CAP/DME Costs

3.2.4.1 General

All hospitals subject to the TRICARE DRG-based payment system, except for children's hospitals (see below), may be reimbursed for allowed CAP/DME costs by submitting a request and the applicable pages from the Medicare cost-report to the TRICARE contractor.

3.2.4.1.1 Beginning October 1, 1998, initial requests for payment of CAP/DME shall be filed with the TRICARE contractor on or before the last day of the 12th month following the close of the hospitals' cost-reporting period. The request shall cover the one year period corresponding to the hospital's Medicare cost-reporting period. Thus, for cost-reporting periods ending on or after March 1, 1998, requests for payment of CAP/DME must be filed no later than (NLT) 12 months following the close of the cost-reporting period. For example, if a hospital's cost-reporting period ends on June 30, 1998, the request for payment shall be filed on or before June 30, 1999. Those hospitals

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System
(Adjustments To Payment Amounts)

that are not Medicare participating providers are to use an October 1 through September 30 fiscal year for reporting CAP/DME costs.

3.2.4.1.1.1 An extension of the due date for filing the initial request may only be granted if an extension has been granted by the Centers for Medicare and Medicaid Services (CMS) due to a provider's operations being significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire, as described in Section 413.24 of Title 42 CFR.

3.2.4.1.1.2 All costs reported to the TRICARE contractor must correspond to the costs reported on the hospital's Medicare cost report. If the costs change as a result of a subsequent Medicare desk review, audit or appeal, the revised costs along with the applicable pages from the amended Medicare cost report shall be provided to the TRICARE contractor within 30 days of the date the hospital is notified of the change. The request must be signed by the hospital official responsible for verifying the amounts. The Medicare Notice of Program Reimbursement (NPR) letter should be submitted with the amended cost report.

3.2.4.1.1.3 The 30 day period is a means of encouraging hospitals to report changes in its CAP/DME costs in a timely manner. If the contractor receives an amended request beyond the 30 days, it shall process the adjustment and inform the provider of the importance of submitting timely amendments.

3.2.4.1.1.4 The hospital official is certifying in the initial submission of the cost report that any changes resulting from a subsequent Medicare audit will be promptly reported. Failure to promptly report the changes resulting from a Medicare audit is considered a misrepresentation of the cost report information. Such a practice can be considered fraudulent, which may result in criminal civil penalties or administrative sanctions of suspension or exclusion as an authorized provider.

3.2.4.1.2 Prior to October 1, 1998, TRICARE had no time limit for filing initial requests for reimbursement of CAP/DME, other than the six year statute of limitations. The time limitation for filing claims does not apply to CAP/DME payment requests. To allow TRICARE contractors to close out prior year data, all initial payment requests for CAP/DME for cost-reporting periods ending before March 1, 1998, shall be filed with the TRICARE contractor NLT five months after October 1, 1998. Requests for reimbursement for these periods must be post-marked on or before March 1, 1999. During this 5 month period, the following criteria apply:

3.2.4.1.3 If a hospital has documentation indicating it was underpaid based on the number of inpatient days reported on the initial request, the hospital may request separate reimbursement for these costs, however, it is the hospital's responsibility to provide documentation substantiating the number of TRICARE inpatient days.

3.2.4.1.4 The contractor shall follow the instructions for processing initial requests as outlined in [paragraph 3.2.4.3.1](#).

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment Amounts)

to the hospital must be made within 10 working days of identification of the discrepancy and include the inpatient day verification report.

3.2.4.3.2.4 The contractor shall wait until the end of the following month to hear from the hospital. If the hospital does not respond, the contractor shall make payment based on its totals.

3.2.4.3.2.5 The contractor shall verify the accuracy of the financial amounts listed for CAP/DME with the applicable pages of the amended Medicare cost report. If the financial amounts do not match, the contractor shall reimburse the hospital based on the figures in the cost-report and notify the hospital of the same.

3.2.4.3.2.6 The contractor must make the CAP/DME payment to the hospital within 30 days of the amended request unless notification has been sent to the hospital regarding a discrepancy in the number of days as outlined in [paragraph 3.2.4.3.2.2](#).

3.2.4.4 Negotiated Rates. If a contract between the **Managed Care Support (MCS)** prime contractor and a subcontractor or institutional network provider does not specifically state the negotiated rate includes all costs that would otherwise be eligible for additional payment, such as CAP/DME, the MCS prime contractor is responsible for reimbursing these costs to the subcontractors and institutional network providers if a request for reimbursement is made.

3.2.4.5 CAP/DME costs for children's hospitals. Amounts for CAP/DME are included in both the hospital-specific and the national children's hospital differentials (see below). The amounts are based on national average costs. No separate or additional payment is allowed.

3.2.4.6 CAP/DME costs under TRICARE for Life (TFL). TRICARE will make no payments for CAP/DME costs for any claims on which Medicare makes payment. These costs are included in the Medicare payment. TRICARE CAP/DME cost payments will be made only on claims on which TRICARE is the primary payer (e.g., claims for stays beyond 150 days), and in those cases payment will be made following the procedures described above.

3.2.5 Children's Hospital Differential

3.2.5.1 General

All DRG-based payments to children's hospitals for admissions occurring on or after April 1, 1989, are to be increased by adding the applicable children's hospital differential to the appropriate ASA prior to multiplying by the DRG weight.

3.2.5.2 Qualifying for the Children's Hospital Differential

In order to qualify for a children's hospital differential adjustment, the hospital must be exempt from the Medicare **Prospective Payment System (PPS)** as a children's hospital. If the hospital is not Medicare-participating, it must meet the criteria in [32 CFR 199.6\(b\)\(4\)\(i\)](#). In addition, more than half of its inpatients must be individuals under the age of 18.

3.2.5.3 Calculation of the Children's Hospital Differentials

They will be calculated so that they are "revenue neutral" for children's hospitals; that is, for **Fiscal Year (FY) 1988** overall TRICARE payments to children's hospitals under the DRG-based payment system would have been equal to those under the old payment system. To accomplish this, TMA (the Office of Program Development) calculated separate ASAs for children's hospitals. Normally in calculating ASAs, TMA reduces the adjusted charges according to the Medicare Cost-to-Charge Ratio (CCR) (0.66 during FY 1988). However, in recognition of the higher costs of children's hospitals, we do not use this step in calculating the children's hospital differentials. We subtract the appropriate ASA from the children's hospital ASAs, and these amounts are the children's hospital differentials. The differentials will not be subject to annual inflation updates nor will they be recalculated except as provided below.

3.2.5.4 Differential Amounts

3.2.5.4.1 Admissions prior to April 1, 1992. High volume children's hospitals (those children's hospitals with 50 or more TRICARE discharges during FY 1988) have a hospital-specific differential for a three year transition period ending April 1, 1992. All other children's hospitals use national differentials. There are two national differentials--one for large urban areas and one for other urban areas.

3.2.5.4.1.1 Calculation of the national children's hospital differentials. These differentials are calculated using the procedures described in [paragraph 3.2.5.3](#), but based on a database of only low-volume children's hospitals. They were calculated initially using a database of claims processed from July 1, 1987, through June 30, 1988 and updated to FY 1988 using the hospital market basket. They were subsequently finalized based on claims processed from April 1, 1989, through March 31, 1990.

3.2.5.4.1.2 Calculation of the hospital-specific differentials for high-volume children's hospitals. The hospital-specific differentials were calculated using the same procedures used for calculating the national differentials, except that the database used was limited to claims from the specific high-volume children's hospital.

3.2.5.4.1.3 Administrative corrections. Any children's hospital that believed TMA erroneously failed to classify the hospital as a high-volume hospital or correctly calculate (in the case of a high-volume hospital) the hospital's differential could obtain administrative corrections by submitting appropriate documentation to TMA. The corrected differential was effective retroactively to April 1, 1989, so this process included adjustments, by the contractor, to any previously processed claims which were processed using an incorrect differential.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System
(Adjustments To Payment Amounts)

3.2.6.6 Children's Hospital Outliers

The following special provisions apply to cost outliers.

3.2.6.6.1 The threshold shall be the same as that applied to other hospitals.

3.2.6.6.2 Effective October 1, 2006, the standardized costs are calculated using a CCR of 0.4282. Effective October 1, 2007, the CCR was 0.4198. (This is equivalent to the Medicare CCR increased to account for CAP/DME costs.) **Effective October 1, 2008, the CCR was 0.4099.**

3.2.6.6.3 The marginal cost factor shall be 80%.

3.2.6.6.4 For admissions occurring during FY 2007, the marginal cost factor shall be adjusted by 1.27. For admissions occurring during FY 2008, the marginal cost factor shall be adjusted by 1.26. **For admissions occurring during FY 2009, the marginal cost factor shall be adjusted by 1.14.**

3.2.6.6.5 The NOSCASTC for calculating the cost-outlier threshold for FY 2007 the NOSCASTC is 0.925, for FY 2008, the NOSCASTC is 0.925, **and for FY 2009, the NOSCASTC is 0.925.**

The following calculation shall be used in determining cost outlier payments for children's hospitals and neonates:

Step 1: Computation of Standardized Costs:

Billed Charges x CCR

(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the CCR.)

Step 2: Determination of Cost-Outlier Threshold:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + [DRG Based Payment (wage-adjusted) x (1 + IDME)]}

Step 3: Determination of Cost Outlier Payment

{[(Standardized costs - Cost-Outlier Threshold) x Marginal Cost Factor] x Adjustment Factor}

Step 4: Total Payments = Outlier Payments + [DRG Base Rate x (1 + IDME)]

3.2.6.7 Neonatal Outliers

Neonatal outliers in hospitals subject to the TRICARE DRG-based payment system (other than children's hospitals) shall be determined under the same rules applicable to children's hospitals, except that the standardized costs for cost outliers shall be calculated using the CCR of 0.64. Effective for admissions occurring on or after October 1, 2005, and subsequent years, the CCR used to calculate cost outliers for neonates in acute care hospitals shall be reduced to the same CCR used for all other acute care hospitals.

3.2.7 IDME adjustment

3.2.7.1 General

The DRG-based payments for any hospital which has a teaching program approved under Medicare Regulation Section 413.85, Title 42 CFR shall be adjusted to account for IDME costs. The adjustment factor used shall be the one in effect on the date of discharge (see below). The adjustment will be made by multiplying the total DRG-based amount by 1.0 plus a hospital-specific factor equal to:

$$1.04 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

- For admissions occurring during FY 2007, the same formula shall be used except the first number shall be 1.00.
- For admissions occurring during FY 2008 and subsequent years, the same formula shall be used except the first number shall be 1.02.
- For admissions occurring during FY 2009 and subsequent years, the same formula shall be used except the first number shall be 1.02.

3.2.7.2 Number of Interns and Residents

TRICARE will use the number of interns and residents from CMS most recently available Provider Specific File.

3.2.7.3 Number of Beds

TRICARE will use the number of beds from CMS' most recently available Provider Specific File.

3.2.7.4 Updates of IDME Factors

3.2.7.4.1 TRICARE will use the ration of interns and residents to beds from CMS' most recently available Provider Specific File to update the IDME adjustment factors. The ratio will be provided to the contractors to update each hospital's IDME adjustment factor at the same time as the annual

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System
(Adjustments To Payment Amounts)

DRG update. The updated factors provided with the annual DR update shall be applied to claims with a date of discharge on or after October 1 of each year.

3.2.7.4.2 Other updates of IDME factors. It is the contractor's responsibility to update the IDME factor if a hospital provides information (for the same base periods) which indicates that the IDME factor provided by TRICARE with the DRG update is incorrect or needs to be updated. An IDME factor is updated based on the hospital submitting CMS Worksheet showing the number of interns, residents, and beds. The effective date of these other updates shall be the date payment is made to the hospital (check issued) for its CAP/DME costs, but in no case can it be later than 30 days after the hospital submits the appropriate worksheet or information. The contractor shall notify TMA of such IDME updates.

3.2.7.4.3 This alternative updating method shall only apply to those hospitals subject to the Medicare PPS as they are the only ones included in the Provider Specific File.

3.2.7.5 Adjustment for Children's Hospitals

An IDME adjustment factor will be applied to each payment to qualifying children's hospitals. The factors for children's hospitals will be calculated using the same formula as for other hospitals. The initial factor will be based on the number of interns and residents and hospital bed size as reported by the hospital to the contractor. If the hospital provides the data to the contractor after payments have been made, the contractor will not make any retroactive adjustments to previously paid claims, but the amounts will be reconciled during the "hold harmless" process. At the end of its fiscal year, a children's hospital may request that its adjustment factor be updated by providing the contractor with the necessary information regarding its number of interns and residents and beds. The number of interns, residents, and beds must conform to the requirements above. The contractor is required to update the factor within 30 days of receipt of the request from the hospital, and the effective date shall conform to the policy contained above.

3.2.7.5.1 Beginning in August 1998, and each subsequent year, the contractor shall send a notice to each children's hospital in its Region, who have not provided the contractor with updated information on its number of interns, residents and beds since the previous October 1 and advise them to provide the updated information by October 1 of that same year.

3.2.7.5.2 The contractors shall send the number of interns, residents, and beds and the updated ratios for children's hospitals to TMA, **Medical Benefits and Reimbursement Branch (MB&RB)**, or designee, by April 1 of each year to be used in TMA's annual DRG update calculations. These updated amounts will be included in the files for the October DRG update.

3.2.7.6 TRICARE for Life (TFL)

No adjustment for IDME costs is to be made on any TFL claim on which Medicare has made any payment. If TRICARE is the primary payer (e.g., claims for stays beyond 150 days) payments are to be adjusted for IDME in accordance with the provisions of this section.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 6, Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment Amounts)

3.2.8 Present On Admission (POA) Indicators and Hospital Acquired Conditions (HACs)

3.2.8.1 Effective for admissions on or after October 1, 2009, those inpatient acute care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a POA indicator for **both primary and secondary diagnoses** on inpatient acute care hospital claims. Providers shall report POA indicators to TRICARE in the same manner they report to the CMS, and in accordance with the UB-04 Data Specifications Manual, and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-9-CM Official Guidelines for Coding and Reporting.

3.2.8.2 There are five POA indicator reporting options, as defined by the ICD-9-CM Official Coding Guidelines for Coding and Reporting:

- Y = Indicates that the condition was present on admission.
- W = Affirms that the provider has determined based on data and clinical judgement that it is not possible to document when the onset of the condition occurred.
- N = Indicates that the condition was not present on admission.
- U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
- 1 = Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.

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

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

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

3.2.8.6 Exempt providers.

3.2.8.6.1 The following hospitals are exempt from POA reports for TRICARE:

- Critical Access Hospitals (CAHs)
- Long-Term Care (LTC) Hospitals
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children's Inpatient Hospitals

Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

Issue Date: November 28, 1988

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 is the TRICARE inpatient mental health per diem payment system to be used in determining reimbursement for psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the **Diagnosis** Related Groups (DRG)-based payment system?

3.0 POLICY

3.1 Inpatient Mental Health Per Diem Payment System

The inpatient mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the DRG-based payment system. The system uses two sets of per diems. One set of per diems applies to psychiatric hospitals and psychiatric units of general acute hospitals that have a relatively high number (25 or more per federal fiscal year) of TRICARE mental health discharges. For higher volume hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to psychiatric hospitals and units with a relatively low number (less than 25 per federal fiscal year) of TRICARE mental health discharges. For higher volume providers, the contractors are to maintain files which will identify when a provider becomes a high volume provider; the federal fiscal year when the provider had 25 or more TRICARE mental health discharges; the calculation of each provider's high volume rate; and the current high volume rate for the provider. For lower volume hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and Indirect Medical Education (IDME) costs and additional pass-through payments for direct medical education costs.

3.2 Applicability of the Inpatient Mental Health Per Diem Payment System

3.2.1 Facilities. The inpatient mental health per diem payment system applies to services covered that are provided in a Medicare DRG-exempt psychiatric hospitals and a Medicare DRG-

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Section 1

Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

exempt unit of a hospital. In addition, any psychiatric hospital that does not participate in Medicare, or any hospital that has a psychiatric unit that has not been so designated for exemption from Medicare DRG because the hospital does not participate in Medicare, must be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the inpatient mental health per diem payment system upon demonstrating that it meets the same Medicare criteria. The contractor is responsible for requesting from a hospital that does not participate in Medicare sufficient information from that hospital which will allow it to make a determination as to whether the hospital meets the Medicare criteria in order to designate it as a DRG-exempt hospital or unit. The inpatient mental health per diem payment system does not apply to mental health services provided in non-psychiatric hospitals or non-psychiatric units. Substance use disorder rehabilitation facilities are not reimbursed under the inpatient mental health per diem payment system (see [Section 3](#)).

3.2.2 DRGs. All psychiatric hospitals' and psychiatric units' covered inpatient claims which are classified into a mental health DRG of 425 - 432 or a substance use disorder DRG of 433, DRGs 521 - 523, and DRGs 900 and 901 shall be subject to the TRICARE inpatient mental health per diem payment system. Effective October 1, 2008, all psychiatric hospitals and psychiatric units covered claims which are classified into a mental health DRG of 880 - 887 or a substance use disorder DRG of 894 - 896, 898, and 899 shall be subject to the TRICARE inpatient mental health per diem system.

3.2.3 State Waivers. The DRG-based payment system provides for state waivers for states utilizing state developed rates applicable to all payers, i.e., Maryland. Psychiatric hospitals and units in these states, may also qualify for the waiver; however, the per diem may not exceed the cap amount applicable to other higher volume hospitals.

3.3 Hospital-Specific Per Diems for Higher Volume Psychiatric Hospitals and Units

3.3.1 Hospital-Specific Per Diem. A hospital-specific per diem amount shall be calculated for each hospital or unit with a higher volume of TRICARE mental health discharges. The base period per diem amount shall be equal to the hospital's average daily charge for charges allowed by the government in the base period (July 1, 1987 through May 31, 1988). The average daily charge in the base period shall be calculated by reference to all TRICARE claims paid (processed) during the base period. The base period amount, however, may not exceed the cap.

3.3.2 Cap Amount. The cap amount is established at the 70th percentile.

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
832	October 1, 2005 through September 30, 2006
860	October 1, 2006 through September 30, 2007
889	October 1, 2007 through September 30, 2008
917	October 1, 2008 through September 30, 2009

3.3.3 Request for Recalculation of Per Diem Amount. Any psychiatric hospital or unit which has determined TMA calculated a hospital-specific per diem which differs by more than five (\$5) dollars from that calculated by the hospital or unit, may apply to the appropriate contractor for a recalculation unless the calculated rate has exceeded the cap amount described in the previous paragraph. The recalculation does not constitute an appeal, as the per diem rates are not

Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement

Issue Date: June 26, 1995

Authority: [32 CFR 199.14\(a\)\(1\)\(ii\)\(E\)](#) and [\(a\)\(2\)\(ix\)](#)

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 The following reimbursement methodology will be used for payment of all Substance Use Disorder Rehabilitation Facilities (SUDRFs) prior to implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of Outpatient Prospective Payment System (OPPS). Thereafter, this methodology will only be used in the reimbursement of freestanding SUDRFs.

2.0 ISSUE

Reimbursement of SUDRFs. This includes reimbursement for both inpatient and partial hospitalization for the treatment of substance use disorder rehabilitation care.

3.0 POLICY

3.1 Inpatient SUDRFs. Admissions to authorized SUDRFs are subject to the **Diagnosis** Related Group (DRG)-based payment system.

3.2 Partial hospitalization for the treatment of substance use disorders. Substance use disorder rehabilitation partial hospitalization services 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 institutional services provided, including board, routine nursing services, ancillary services (includes art, music, dance, occupational and other such therapies), psychological testing and assessments, overhead and any other services for the customary practice among similar providers is included as part of the institutional charges.

3.3 Outpatient **professional** services will be reimbursed using the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Payment is the **lesser of the billed charge or the CHAMPUS Maximum Allowable Charge (CMAC)**.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 7, Section 3

Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement

3.4 Family therapy provided on an inpatient or outpatient basis will be reimbursed under the CMAC for the procedure code(s) billed.

3.5 Cost-sharing. The cost-share for **Active Duty Dependents (ADDs)** for inpatient substance use disorder services is \$20.00 per day for each day of the inpatient admission. The \$20.00 cost-share amount also applies to substance use disorder rehabilitation care provided in a partial hospitalization setting. The inpatient cost-share applies to the associated services billed separately by the individual professional providers. For retirees and their dependents, the cost-share is 25% of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for **ADDs** is to be taken from the partial hospitalization facility claim.

- END -

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
MUE	Medically Unlikely Edits
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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

NIS	Naval Investigative Service
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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

OMB	Office of Management and Budget
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 ₂	Partial Pressure of Carbon Dioxide
PAO ₂	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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

PDA	Patent Ductus Arteriosus Personal Digital Assistant
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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

POA	Power of Attorney Present On Admission
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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions
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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

RUG	Resource Utilization Group
RV	Residual Volume
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
SIF	Source Input Format
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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
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
TCSRC	Transitional Care for Service-Related Conditions
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

TDP	TRICARE Dental Plan
TDY	Temporary Duty
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
TMH	Telemental Health
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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses
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 Thoroscopic 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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

WATS	Wide Area Telephone Service
WC	Worker's Compensation
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 -