



DEFENSE  
HEALTH AGENCY

**MB&RS**

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS  
16401 EAST CENTRETECH PARKWAY  
AURORA, CO 80011-9066**

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**Ann N. Fazzini  
Team Chief, Medical Benefits &  
Reimbursement Section (MB&RS)  
Defense Health Agency (DHA)**

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**REMOVE PAGE(S)**

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Section 1, pages 11 - 14

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

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admitted with the expectation of a stay of several days, but died the same day) the cost-share is to be based on a one-day stay. (The number of hospital days must contain one day in this situation.) Where long-stay outlier days are subsequently determined to be not medically necessary by a Peer Review Organization (PRO), no cost-share will be required for those days, since payment for such days will be the beneficiary's responsibility entirely.

**1.3.3.4.2.2.1.2** Twenty-five percent (25%) of the billed charge. The billed charge to be used includes all inpatient institutional line items billed by the hospital minus any duplicate charges and any charges which can be billed separately (e.g., hospital-based professional services, outpatient services, etc.). The net billed charges for the cost-share computation include comfort and convenience items.

**1.3.3.4.2.2.2** Under no circumstances can the cost-share exceed the DRG-based amount.

**1.3.3.4.2.2.3** Where the dates of service span different fiscal years, the per diem cost-share amount for each year is to be applied to the appropriate days of the stay.

#### **1.3.3.4.3 TRICARE Extra**

**1.3.3.4.3.1** Cost-shares for ADFMs. The cost-sharing provisions for ADFMs are the same as those for TRICARE Standard.

**1.3.3.4.3.2** Cost-shares for beneficiaries other than ADFMs. The cost-sharing provisions for beneficiaries other than ADFMs is the same as those for TRICARE Standard, except the per diem copayment is \$250.

#### **1.3.3.4.4 TRICARE Prime**

There is no cost-share for ADFMs. For beneficiaries other than ADFMs, the cost-sharing provision is the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or a per diem rate of \$11, whichever is greater.

#### **1.3.3.4.5 Maternity Services**

See [paragraph 1.3.3.3](#), for the cost-sharing provisions for maternity services.

#### **1.3.3.5 Cost-Shares: Inpatient Mental Health Per Diem Payment System**

**1.3.3.5.1** General. These special cost-sharing procedures apply only to claims paid under the inpatient mental health per diem payment system. For inpatient claims exempt from this system, the procedures in [paragraph 1.3.3.2](#) or [1.3.3.4](#) are to be followed.

**1.3.3.5.2** Cost-shares for ADFMs. Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission. This \$20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any RTC, any Substance Use Disorder Rehabilitation Facility (SUDRF), and any PHP providing mental health or substance use disorder rehabilitation services. For Prime ADFMs care provided on or after April 1, 2001, cost-share is \$0 per day. See [Addendum A](#) for further information.

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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

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#### **1.3.3.5.3** Cost-shares for beneficiaries other than ADFMs.

**1.3.3.5.3.1** Higher volume hospitals and units. With respect to care paid for on the basis of a hospital specific per diem, the cost-share shall be 25% of the hospital specific per diem amount.

**1.3.3.5.3.2** Lower volume hospitals and units. For care paid for on the basis of a regional per diem, the cost-share shall be the lower of [paragraph 1.3.3.5.3.2.1](#) or [paragraph 1.3.3.5.3.2.2](#):

**1.3.3.5.3.2.1** A fixed daily amount multiplied by the number of covered days. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the inpatient mental health per diem payment system. This fixed daily amount shall be updated annually and published in the **Federal Register** along with the per diems published pursuant to [Chapter 7, Section 1](#). This fixed daily amount will also be furnished to contractors by DHA. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

- Fiscal Year 2000 - \$144 per day.
- Fiscal Year 2001 - \$149 per day.
- Fiscal Year 2002 - \$154 per day.
- Fiscal Year 2003 - \$159 per day.
- Fiscal Year 2004 - \$164 per day.
- Fiscal Year 2005 - \$169 per day.
- Fiscal Year 2006 - \$175 per day.
- Fiscal Year 2007 - \$181 per day.
- Fiscal Year 2008 - \$187 per day.
- Fiscal Year 2009 - \$193 per day.
- Fiscal Year 2010 - \$197 per day.
- Fiscal Year 2011 - \$202 per day.
- Fiscal Year 2012 - \$208 per day.
- Fiscal Year 2013 - \$213 per day.
- Fiscal Year 2014 - \$218 per day.
- Fiscal Year 2015 - \$224 per day.
- Fiscal Year 2016 - \$229 per day.
- **Fiscal Year 2017 - \$235 per day.**

**1.3.3.5.3.2.2** Twenty-five percent (25%) of the hospital's billed charges (less any duplicates).

**1.3.3.5.4** Claim which spans a period in which two separate per diems exist. A claim subject to the inpatient mental health per diem payment system which spans a period in which two separate per diems exist shall have the cost-share computed on the actual per diem in effect for each day of care.

**1.3.3.5.5** Cost-share whenever leave days are involved. There is no patient cost-share for leave days when such days are included in a hospital stay.

**1.3.3.5.6** Claims for services that are provided during an inpatient admission which are not included in the per diem rate are to be cost-shared as an inpatient claim if the contractor cannot determine where the service was rendered and the status of the patient when the service was provided. The contractor would need to examine the claim for place of service and type of service

to determine if the care was rendered in the hospital while the beneficiary was an inpatient of the hospital. This would include non-mental health claims and mental health claims submitted by individual professional providers rendering medically necessary services during the inpatient admission.

### **1.3.3.6 Cost-Shares: Partial Hospitalization**

Cost-sharing for partial hospitalization is on an inpatient basis. The inpatient cost-share also applies to the associated psychotherapy billed separately by the individual professional provider. These providers will have to identify on the claim form that the psychotherapy is related to a partial hospitalization stay so the proper inpatient cost-sharing can be applied. Effective for care on or after October 1, 1995, the cost-share for ADFMs for inpatient mental health services is \$20 per day for each day of the inpatient admission. For care provided on or after April 1, 2001, the cost-share for ADFMs enrolled in Prime for inpatient mental health services is \$0. For retirees and their family members, 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 ADFMs is to be taken from the PHP claim.

### **1.3.3.7 Cost-Shares: Ambulatory Surgery**

**1.3.3.7.1** Non-Prime ADFMs or Authorized NATO Beneficiary. For all services reimbursed as ambulatory surgery, the cost-share will be \$25 and will be assessed on the facility claim. No cost-share is to be deducted from a claim for professional services related to ambulatory surgery. This applies whether the services are provided in a freestanding ASC, a hospital outpatient department or a hospital emergency room. So long as at least one procedure on the claim is reimbursed as ambulatory surgery, the claim is to be cost-shared as ambulatory surgery as required by this section.

**1.3.3.7.2** Other Beneficiaries. Since the cost-share for other beneficiaries is based on a percentage rather than a set amount, it is to be taken from all ambulatory surgery claims. For professional services, the cost-share is 25% of the allowed amount. For the facility claim, the cost-share is the lesser of:

**1.3.3.7.2.1** Twenty-five percent (25%) of the applicable group payment rate (see [Chapter 9, Section 1](#)); or

**1.3.3.7.2.2** Twenty-five percent (25%) of the billed charges; or

**1.3.3.7.2.3** Twenty-five percent (25%) of the allowed amount as determined by the contractor.

**1.3.3.7.2.4** The special cost-sharing provisions for beneficiaries other than ADFMs will ensure that these beneficiaries are not disadvantaged by these procedures. In most cases, 25% of the group payment rate will be less, but because there is some variation within each group, 25% of billed charges could be less in some cases. This will ensure that the beneficiaries get the benefit of the group payment rates when they are more advantageous, but they will never be disadvantaged by them. If there is no group payment rate for a procedure, the cost-share will simply be 25% of the allowed amount.

### **1.3.3.8 Cost-Shares and Deductible: Former Spouses**

**1.3.3.8.1** Deductible. In accordance with the FY 1991 Appropriations and Authorization Acts, Sections 8064 and 712 respectively, beginning April 1, 1991, an eligible former spouse is responsible for payment of the first one hundred and fifty dollars (\$150.00) of the reasonable costs/charges for otherwise covered outpatient services and/or supplies provided in any one fiscal year. Although the law defines former spouses as family members of the member or former member, there is no legal familial relationship between the former spouse and the member or former member. Moreover, any TRICARE-eligible children of the former spouse will be included in the member's or former member's family deductible. Therefore, the former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of that of any TRICARE-eligible children. In other words, a former spouse must independently meet the \$150.00 deductible in any fiscal year.

**1.3.3.8.2** Cost-Share. An eligible former spouse is responsible for payment of cost-sharing amounts identical to those required for beneficiaries other than ADFMs.

### **1.3.3.9 Cost-Share Amount: Under Discounted Rate Agreements**

Under managed care, where there is a negotiated (discounted) rate agreed to by the network provider, the cost-share shall be based on the following:

**1.3.3.9.1** For non-institutional providers providing outpatient care, and for institution-based professional providers rendering both inpatient and outpatient care; the cost-share (20% for outpatient care to ADFMs, 25% for care to all others) shall be applied to (after duplicates and noncovered charges are eliminated), the lowest of the billed charge, the prevailing charge, the maximum allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge.

**1.3.3.9.2** For institutional providers subject to the DRG-based reimbursement methodology, the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

- The single, specific per diem supplied by DHA after the application of the agreed upon discount rate; OR,
- Twenty-five percent (25%) of the billed charge.

**1.3.3.9.3** For institutional providers subject to the Mental Health Per Diem Payment System (high volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be 25% of the hospital per diem amount after it has been adjusted by the discount.

**1.3.3.9.4** For institutional providers subject to the Mental Health per diem payment system (low volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

- The fixed daily amount supplied by DHA after the application of the agreed upon discount rate; OR,
- Twenty-five percent (25%) of the billed charge.

## Chapter 7

### Mental Health

Section/Addendum	Subject/Addendum Title
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- |   |   |
|---|---|
| 1 | Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System  |
| 2 | Psychiatric Partial Hospitalization Program (PHP) 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 2015 - FY 2017            |
| B | Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates<br>Figure 7.B-1 TMA Form 771 |



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### Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
1,096	October 1, 2015 through September 30, 2016
1,126	October 1, 2016 through September 30, 2017

**3.3.3** Request for Recalculation of Per Diem Amount. Any psychiatric hospital or unit which has determined DHA 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 appealable. Unless the provider can prove that the contractor calculation is incorrect, the contractor's calculation is final. The burden of proof shall be on the hospital or unit.

### 3.4 Regional Per Diems for Lower Volume Psychiatric Hospitals and Units

**3.4.1** Regional Per Diem. Hospitals and units with a lower volume of TRICARE patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and IDME. Base period regional per diems shall be calculated based upon all TRICARE/lower volume hospitals' and units' claims paid (processed) during the base period. Each regional per diem amount shall be the quotient of all covered charges (without consideration of other health insurance payments) divided by all covered days of care, reported on all TRICARE claims from lower volume hospitals and units in the region paid (processed) during the base period, after having been standardized for IDME costs, and area wage indexes. Direct medical education costs shall be subtracted from the calculation. The regions shall be the same as the federal census regions. See [Addendum A](#), for the regional per diems used for hospitals and units with a lower volume of TRICARE patients.

**3.4.2** Adjustments to Regional Per Diem Rates. Two adjustments shall be made to the regional per diem rates when applicable.

**3.4.2.1** Wage Portion or Labor-Related Share. The wage portion or labor-related share is adjusted by the DRG-based area wage adjustment. See [Addendum A](#), for area wage adjustment rates. The calculated adjusted regional per diem is not to be rounded up to the next whole dollar.

**3.4.2.2** IDME Adjustment. The IDME adjustment factors shall be calculated for teaching hospitals in the same manner as in the DRG-based payment system and applied to the applicable regional per diem rate for each day of the admission. For an exempt psychiatric unit in a teaching hospital, there should be a separate IDME adjustment factor for the unit (separate from the rest of the hospital) when medical education applies to the unit.

**3.4.3** Reimbursement of Direct Medical Education Costs. In addition to payments made to lower volume hospitals and units, the government shall annually reimburse hospitals for actual direct medical education costs associated with TRICARE beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the DRG-based payment system.

**Note:** No additional payment is to be made for capital costs. Such costs have been covered in the regional per diem rates which are based on charges.

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### Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

#### 3.5 Base Period and Update Factors

**3.5.1** Hospital-Specific Per Diem Calculated Using Date of Payment. The base period for calculating the hospital-specific and regional per diems, as described above is federal FY 1988. The base period calculations shall be based on actual claims paid (processed) during the period July 1, 1987 through May 31, 1988, trended forward to September 30, 1988, using a factor of 1.1%.

**3.5.2** Hospital-Specific Per Diem Calculated Using Date of Discharge. Upon application by a higher volume hospital or unit to the appropriate contractor, the hospital or unit may have its hospital-specific base period calculations based on TRICARE claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988, if it has generally experienced unusual delays in TRICARE claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least \$5.00 with the revised per diem not exceeding the cap amount. For this purpose, the unusual delays mean that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations (204 days) longer than the national average (94 days). The burden of proof shall be on the hospital.

**3.5.3** Updating Hospital-Specific and Regional Per Diems. Per diems shall be updated by the Medicare update factor. Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each federal fiscal year by the contractors. New hospitals shall be notified by the contractor at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the **Federal Register** prior to the start of that fiscal year. Initiating FY 2007, Medicare has determined a market basket and subsequent update factor specific to psychiatric facilities.

FISCAL YEAR	UPDATE FACTOR
2006	3.8%
2007	3.4%
2008	3.4%
2009	3.2%
2010	2.1%
2011	2.6%
2012	3.0%
2013	2.6%
2014	2.5%
2015	2.9%
2016	2.4%
2017	2.7%

#### 3.6 Higher Volume Hospitals and Units

##### 3.6.1 Higher Volume of TRICARE Mental Health Discharges and Hospital-Specific Per Diem Calculation

**3.6.1.1** In any federal fiscal year in which a hospital or unit not previously classified as a higher volume hospital or unit has 25 or more TRICARE mental health discharges, that hospital or unit shall

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#### Hospital Reimbursement - TRICARE Inpatient Mental Health Per Diem Payment System

be considered to be a higher volume hospital or unit during the next federal fiscal year and all subsequent fiscal years. All other hospitals and units covered by the TRICARE inpatient mental health per diem payment system shall be considered lower volume hospitals and units.

**3.6.1.2** The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE mental health discharges and the base period. The base period amount, however, cannot exceed the cap described in this section. Once a statistically valid rate is established based on a year in which the hospital or unit had at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem.

**3.6.1.2.1** The TRICARE contractor shall be requested at least annually to submit to the DHA Office of Medical Benefits and Reimbursement Branch (MB&RB) a listing of high volume providers.

**3.6.1.2.2** Percent of change and Deflator Factor (DF).

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 2013	243.52%	3.4352
September 30, 2014	258.27%	3.5827
September 30, 2015	279.73%	3.7973

### 3.6.2 New Hospitals and Units

**3.6.2.1** The inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under Tax Equity and Fiscal Responsibility Act (TEFRA) rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are DRG-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE mental health discharges. This provision also applies to the preceding fiscal year (if it had any TRICARE patients during the preceding fiscal year). A retrospective payment shall be required if payments were originally made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the claims processing standards.

**3.6.2.2** By definition, a new hospital is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the Medicare and or TRICARE programs under the present and previous ownership for less than three full years. A change in ownership in itself does not constitute a new hospital.

**3.6.2.3** Such new hospitals must agree not to bill beneficiaries for any additional cost-share beyond that determined initially based on the regional rate.

### **3.6.3 Request for a Review of Higher or Lower Volume Classification**

Any hospital or unit which DHA improperly fails to classify as a higher or lower volume hospital or unit may apply to the appropriate contractor for such a classification. The hospital or unit shall have the burden of proof.

## **3.7 Payment for Hospital Based Professional Services**

**3.7.1** Lower Volume Hospitals and Units. Lower volume hospitals and units may not bill separately for hospital based professional services; payment for those services is included in the per diems.

**3.7.2** Higher Volume Hospitals and Units. Higher volume hospitals and units, whether they billed separately for hospital based professional services or included those services in the hospital's or unit's charges, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to the appropriate contractor notice of its request to change its billing procedures for hospital-based professional services.

## **3.8 Leave Days**

**3.8.1** No Payment. The government shall not pay (including holding charges) for days where the patient is absent on leave (including therapeutic absences) from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement.

**3.8.2** Does Not Constitute a Discharge. The government shall not count a patient's departure for a leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital.

## **3.9 Exemptions from the TRICARE Inpatient Mental Health Per Diem Payment System**

**3.9.1** Providers Subject to the DRG-Based Payment System. Providers of inpatient care which are neither psychiatric hospitals nor psychiatric units as described earlier, or which otherwise qualify under that discussion, are exempt from the inpatient mental health per diem payment system.

**3.9.2** Services Which Group into Mental Health DRG. Admissions to psychiatric hospitals and units for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424 prior to October 1, 2008, or services which group into DRG 876 on or after October 1, 2008) are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

**3.9.3** Non-Mental Health Procedures. Admissions for non-mental health procedures that group into non-mental health DRG, in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

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**3.9.4** Sole Community Hospital (SCH). Admission prior to January 1, 2014, (the effective date of the SCH reimbursement methodology described in [Chapter 14, Section 1](#)), any hospital which has qualified for special treatment under the Medicare Prospective Payment System (PPS) as a SCH and has not given up that classification is exempt. For additional information on SCHs, refer to [Chapter 14, Section 1](#).

**3.9.5** Hospital Outside the 50 States, the District of Columbia, or Puerto Rico. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia, or Puerto Rico.

**3.9.6** Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the DRG-based payment system or the inpatient mental health per diem payment system shall be determined on the basis of billed charges or set rates.

- END -



Chapter 7

Addendum A

Table Of Regional Specific Rates For Psychiatric Hospitals  
And Units With Low TRICARE Volume - FY 2015 - FY 2017

UNITED STATES CENSUS REGIONS	FY 2015 REGIONAL RATES 10/01/14 - 09/30/15	FY 2016 REGIONAL RATES 10/01/15 - 09/30/16	FY 2017 REGIONAL RATES 10/01/16 - 09/30/17
<b>NORTHEAST:</b>			
New England (ME, NH, VT, MA, RI, CT)	\$851	\$871	\$895
Mid-Atlantic (NY, NJ, PA)	\$820	\$840	\$863
<b>MIDWEST:</b>			
East North Central (OH, IN, IL, MI, WI)	\$709	\$726	\$746
West North Central (MN, IA, MO, ND, SD, NE, KS)	\$669	\$685	\$703
<b>SOUTH:</b>			
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	\$844	\$864	\$887
East South Central (KY, TN, AL, MS)	\$902	\$924	\$949
West South Central (AR, LA, TX, OK)	\$769	\$787	\$808
<b>WEST:</b>			
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	\$768	\$786	\$807
Pacific (WA, OR, CA, AK, HI)	\$908	\$930	\$955
Puerto Rico	\$579	\$593	\$609

**Note:** This table reflects maximum rates.

**For FYs 2015 through 2017:** For wage index values greater than 1.0, the wage portion or labor related share subject to the area wage adjustment is 69.6%. The non-labor related share is 30.4%. For wage index values less than or equal to 1.0, the wage portion or labor related share subject to the area wage adjustment is 62%. The non-labor related share is 38%. Utilize the appropriate year DRG wage index file for area wage adjustment calculations.

**For FY 2015/Beneficiary Cost-Share:** Beneficiary cost-share (other than active duty members) for care paid on a basis of a regional per diem rate is the lower of \$224 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2014.

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Chapter 7, Addendum A

Table Of Regional Specific Rates For Psychiatric Hospitals And Units

With Low TRICARE Volume - FY 2014 - FY 2016

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**For FY 2016/Beneficiary Cost-Share:** Beneficiary cost-share (other than active duty members) for care paid on a basis of a regional per diem rate is the lower of \$229 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2015.

**For FY 2017/Beneficiary Cost-Share:** Beneficiary cost-share (other than active duty members) for care paid on a basis of a regional per diem rate is the lower of \$235 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2016.

- END -

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Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

**RTC CAPPED AMOUNTS (CONTINUED)**

DATES OF SERVICE		CAPPED AMOUNTS
October 1, 1994	- April 5, 1995	530
April 6, 1995	- September 30, 1997	515
October 1, 1997	- September 30, 1998	515
October 1, 1998	- September 30, 1999	528
October 1, 2015	- September 30, 2016	889
October 1, 2016	- September 30, 2017	914

**4.2.2** The 70th percentile of the day-weighted current (Fiscal Year (FY) 1995) per diems was used in establishing a new cap amount for services rendered on or after April 6, 1995. The following methodology was used in establishing the RTC cap and floor amounts:

**4.2.2.1** RTC institutional claims data from the period October 1, 1993 to March 31, 1994 were used (the first half of FY 1994).

**4.2.2.2** The FY 1994 per diems were merged onto the claims (from the RTC per diem list in the TRICARE Policy Manual (TPM)) and updated by 1.046 (the CPI-U) to represent FY 1995 per diems.

**4.2.2.3** The 30th and 70th percentiles of the day-weighted FY 1995 per diems were calculated as \$429 and \$515. Any RTC per diem above \$515 was cut to \$515 as of April 6, 1995.

**5.0 ADJUSTMENT OF BASE YEAR RATE**

**5.1** The base year rate is adjusted by the following annual inflation factors (CPI-U) for medical care] to bring it forward to the current fiscal year:

**UPDATE FACTORS FOR RTC PER DIEM RATES**

TIME PERIOD		CPI-U INFLATION FACTORS
July 1, 1988	- November 30, 1988	2.6%
December 1, 1988	- July 30, 1989	4.9
October 1, 1989	- September 30, 1990	9.2
October 1, 1990	- September 30, 1991	8.6
October 1, 1991	- September 30, 1992	7.4
October 1, 1992	- September 30, 1993	6.0
October 1, 1993	- September 30, 1994	4.6
October 1, 1994	- September 30, 1995	4.4
October 1, 1995	- September 30, 1996	3.6

**Note:** The FY 1997 CPI-U for medical care is 2.6%. This inflation will be used in adjusting FY 1995 RTC rates falling below the 30th percentile of all established FY 1995 rates (\$429.00).

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Chapter 7, Addendum B

Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates

**UPDATE FACTORS FOR RTC PER DIEM RATES (CONTINUED)**

TIME PERIOD		MEDICARE UPDATE FACTOR
October 1, 1997	- September 30, 1998	2.4
October 1, 1998	- September 30, 1999	2.4
October 1, 1999	- September 30, 2000	2.9
October 1, 2000	- September 30, 2001	3.4
October 1, 2001	- September 30, 2002	3.3
October 1, 2002	- September 30, 2003	3.5
October 1, 2003	- September 30, 2004	3.4
October 1, 2004	- September 30, 2005	3.3
October 1, 2005	- September 30, 2006	3.8

**Note:** The FY 1997 CPI-U for medical care is 2.6%. This inflation will be used in adjusting FY 1995 RTC rates falling below the 30th percentile of all established FY 1995 rates (\$429.00).

**5.2** If the RTC's base year falls within the previous year's reporting period, the inflation factor is prorated for the remaining time in that period. The updating process can best be demonstrated through the following example:

**Example:** RTC E is submitting reimbursement information as a final step in its certification process. The data was collected over the facility's first 12 months of operation (April 1, 1991 - March 31, 1992). Since the RTC's base period extended six months (or 180 days, based on 30-day months and a 360-day year) into the inflation reporting period, the inflation factor for the subsequent update year (October 1 - September 30) was prorated for the remaining time period of May 1, 1992 - September 30, 1992 (six months or 180 days). The following are the calculations used in updating the RTC's all-inclusive base year per diem to FY 1996 (current year per diem amount):

ADJUSTMENT OF BASE YEAR PER DIEM RATE	
Derived rate at 33.33% of total patient days during base period of April 1, 1991 through March 31, 1992.	\$320.00
Plus:	
Consumer Price Indices - Urban Wage Earner for medical care [CPI-U (medical)]:	
For 6-month period ending September 30, 1992 (7.4% x 6/12 = 3.7%)	11.84
Adjusted Rate	\$331.84
For 12-month period ending September 30, 1993 (6.0%)	19.91
Adjusted Rate	\$351.75
For 12-month period ending September 30, 1994 (4.6%)	16.81
Adjusted Rate	\$367.93
For 12-month period ending September 30, 1995 (4.4%)	16.19
Adjusted Rate	\$384.12
TRICARE all-inclusive per diem rate for services on or after October 1, 1995	\$385.00

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