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TRICARE  
MANAGEMENT ACTIVITY

**MB&RS**

**CHANGE 2  
6010.58-M  
MAY 15, 2008**

**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.**

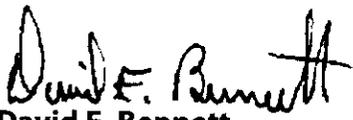
**CHANGE TITLE: CONSOLIDATED UPDATE**

**PAGE CHANGE(S): See page 2.**

**SUMMARY OF CHANGE(S): This change brings this Manual up-to-date with published changes in the Aug 2002 TRICARE Reimbursement Manual (TRM), 6010.55-M. The changes included are: Foreign Fee Schedules (Aug 2002 TRM, Change 73); Noble Eagle Demonstration (Aug 2002 TRM, Change 74); Consolidated Change (Aug 2002 TRM, Change 75); and TRM Miscellaneous Changes (Aug 2002 TRM, Change 76).**

**EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.**

**This change is made in conjunction with Feb 2008 TOM, Change No. 2, Feb 2008 TPM, Change No. 2, and Feb 2008 TSM, Change No. 2.**

  
**David E. Bennett  
Acting Chief, Office of Medical Benefits  
and Reimbursement Systems**

**ATTACHMENT(S): 46 PAGE(S)  
DISTRIBUTION: 6010.58-M**

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# Chapter 1

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## Reimbursement Of Physician Assistants (PAs), Nurse Practitioners (NPs), And Certified Psychiatric Nurse Specialists (CPNSs)

Issue Date: July 9, 1990

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

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### 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 Physician Assistant (PA), Nurse Practitioner (NP), and Certified Psychiatric Nurse Specialist (CPNS) services to be reimbursed?

### 3.0 POLICY

**3.1** The allowable charge for the services of the above listed providers may not exceed 85% of the allowable charge for a comparable service rendered by a physician. The employing physician of a PA must be an authorized TRICARE provider.

**3.1.1** When the employing physician of a PA is not participating in a TRICARE reimbursement plan at less than the allowable charge determined under the provisions of [Section 1](#), the allowable charge for the PA service may not exceed 85% of the allowable charge for the physician calculated in accordance with these provisions. When the PA and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit components), the allowable charge for the procedure (to include both the services of the physician and PA) may not exceed the allowable charge for the procedure rendered by a physician.

**3.1.2** When the employing physician is participating in a TRICARE reimbursement plan at less than the allowable charge as calculated in [paragraph 3.1.1](#), the allowable charge for the PA service may not exceed 85% of the reduced allowable charge for the physician unless the reimbursement plan has specifically included use of PAs in the negotiated rates.

**3.2** The allowable charge for PA services performed as an assistant-at-surgery may not exceed 65% of the allowable charge, **determined in accordance with paragraphs 3.1.1 and 3.1.2 as**

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**applicable**, for a physician serving as an assistant surgeon when authorized as TRICARE benefits in accordance with the provisions of [32 CFR 199.4\(c\)\(3\)\(iii\)](#).

**3.3** The allowable charge for NP services performed as an assistant-at-surgery may not exceed 85% of the allowable charge for a physician serving as an assistant surgeon when authorized as TRICARE benefits in accordance with the provisions of [32 CFR 199.4\(c\)\(3\)\(iii\)](#).

**3.4** The procedure or service performed by the PA is billed by the supervising or employing physician, billing it as a separately identified line item (e.g., PA Office Visit) and accompanied by the assigned PA provider number.

**3.5** The procedure or service performed by the NP or CPNS is billed by the NP or CPNS. Unlike a PA, a NP or CPNS can bill on their own behalf. Like the PA, the NP or CPNS shall bill using an assigned NP provider number.

#### **4.0 EFFECTIVE DATES**

**4.1** Reimbursement of PA services is effective for services rendered on or after July 1, 1990.

**4.2** Reimbursement of NP services as stated above is effective for services rendered on or after September 1, 2003.

**4.3** Reimbursement of CPNS services shall be 85% of the allowable amounts for physicians effective for services rendered on or after June 1, 2007.

- END -

## Chapter 1

## Section 11

# Claims for Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

Issue Date: December 29, 1982

Authority: [32 CFR 199.4\(d\)\(3\)\(ii\)](#), [\(d\)\(3\)\(iii\)](#), [\(d\)\(3\)\(vii\)](#), and [\(d\)\(3\)\(viii\)](#)

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### 1.0 APPLICABILITY

This policy is mandatory for reimbursement of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided by either network or non-network providers. Alternative network reimbursement methodologies are also permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### 2.0 ISSUE

How are claims for DMEPOS to be reimbursed?

### 3.0 POLICY

**3.1** Reimbursement for DMEPOS is established by fee schedules. The maximum allowable amount is limited to the lower of the billed charge, the negotiated rate (network providers) or the DMEPOS fee schedule amount.

**3.2** The DMEPOS fee schedule is categorized by state. The allowed amount shall be that which is in effect in the specific geographic location at the time covered services and supplies are provided to a beneficiary. For DMEPOS delivered to the beneficiary's home, the home address is the controlling factor in pricing and the home address shall be used to determine the DMEPOS allowed amount.

**3.3** Payment for an item of Durable Medical Equipment (DME) may also take into consideration:

**3.3.1** The lower of the total rental cost for the period of medical necessity or the reasonable purchase cost; and

**3.3.2** Delivery charge, pick-up charge, shipping and handling charges, and taxes.

**3.4** The fee schedule classifies most DMEPOS into one of six categories.

**3.4.1** Inexpensive or other routinely purchased DME.

**3.4.2** Items requiring frequent and substantial servicing.

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- 3.4.3** Customized items.
- 3.4.4** Other prosthetic and orthotic devices.
- 3.4.5** Capped rental items.
- 3.4.6** Oxygen and oxygen equipment.
- 3.5** Inexpensive or routinely purchased DME.
- 3.5.1** Payment for this type of equipment is for rental or lump sum purchase. The total payment may not exceed the actual charge of the fee for a purchase.
- 3.5.2** Inexpensive DME. This category is defined as equipment whose purchase price does not exceed \$150.
- 3.5.3** Other routinely purchased DME. This category consists of equipment that is purchased at least 75% of the time.
- 3.5.4** Modifiers used in this category are as follows (not an all-inclusive list):
- RR Rental
  - NU Purchase of new equipment. Only used if new equipment was delivered.
  - UE Purchase of used equipment. Used equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator).
- 3.6** Items requiring frequent and substantial servicing.
- 3.6.1** Equipment in this category is paid on a rental basis only. Payment is based on the monthly fee schedule amounts until the medical necessity ends. No payment is made for the purchase of equipment, maintenance and servicing, or for replacement of items in this category.
- 3.6.2** Supplies and accessories are not allowed separately.
- 3.6.3** For oxygen and oxygen supplies see [Section 12](#) and the TRICARE Policy Manual (TPM), [Chapter 8, Section 10.1](#).
- 3.7** Certain customized items.
- 3.7.1** The beneficiary's physician must prescribe the customized equipment and provide information regarding the patient's physical and medical status to warrant the need for the equipment.
- 3.7.2** See the TPM, [Chapter 9, Section 15.1](#) for further information regarding customization of DME.

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**3.8** Capped rental items. Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 15 months or on a purchase option basis not to exceed a period of continuous use of 13 months.

**3.9** Rental fee schedule.

**3.9.1** For the first three rental months, the rental fee schedule is calculated so as to limit the monthly rental of 10% of the average of allowed purchase prices on claims for new equipment during a base period, updated to account for inflation. For each of the remaining months, the monthly rental is limited to 7.5% of the average allowed purchase price. After paying the rental fee schedule amount for 15 months, no further payment may be made except for payment for maintenance and servicing.

**3.9.2** Modifiers used in this category are as follows:

RR	Rental
KH	First month rental
KI	Second and third month rental
KJ	Fourth to fifteenth months
BR	Beneficiary elected to rent
BP	Beneficiary elected to purchase
BU	Beneficiary has not informed supplier of decision after 30 days
MS	Maintenance and Servicing
NU	New equipment
UE	Used equipment

**3.9.3** Claims Adjudication Determinations.

**3.9.3.1** Adjudication of DME claims involves a two-step sequential process involving the following determinations by the contractor:

**Step 1:** Whether the equipment meets the definition of DME, is medically necessary, and is otherwise covered; and

**Step 2:** Whether the equipment should be rented or obtained through purchase (including lease/purchase). To arrive at a determination, the following information is required:

- A physician's statement of the patient's prognosis and the estimated length of medical necessity for the equipment.
- The reasonable monthly rental charge.
- The reasonable purchase cost of the equipment.
- The contractor must determine whether, given the estimated period of medical necessity, it would be more economical and appropriate for the equipment to be

rented or purchased.

**3.9.3.2** If the beneficiary opts to rent/purchase, the contractor must establish a mechanism for making regular monthly payments without requiring the claimant to submit a claim each month. (It is not required or expected that the contractor will automate the automatic payment; the volume of this type claim will be quite low.) In cases of "indefinite needs," medical necessity must be evaluated after the first three months and every six months thereafter. Special care should be taken to avoid payment after termination of TRICARE eligibility or in excess of the total allowable benefit. In making monthly payments, the contractor will report on the TRICARE Encounter Data (TED) only that portion of the billed charge which is applicable to that monthly payment. (See the TRICARE Systems Manual (TSM), [Chapter 2](#).) For example, a wheelchair is being purchased for which the total charge is \$770. The contractor determines that payments will be made over a 10 month period. The allowed charge is \$600. The contractor will show the monthly billed charge as \$77 and \$60 as the allowed. For **Extended Care Health Option (ECHO)**, the maximum number of contiguous months during which a prorated amount may be authorized for cost-share shall be the lesser of:

**3.9.3.2.1** The number of months calculated by dividing the initial allowable cost for the item of equipment by \$2,500 and doubling the resulting quotient, or

**3.9.3.2.2** The number of months of useful equipment life for the requesting beneficiary, as determined by the contractor.

**3.9.4** Notice To Beneficiary. When the contractor makes a determination to rent or purchase, the beneficiary shall be notified of that determination. The beneficiary is not required to follow the contractor's determination. He or she may purchase the equipment even though the contractor has determined that rental is more cost effective. However, payment for the equipment will be based on the contractor's determination. Because of this, the notice should be carefully worded to avoid giving any impression that compliance is mandatory, but should caution the beneficiary concerning the expenses in excess of the allowed amount. Suggested wording is included in [Addendum B](#).

**3.10** Oxygen and oxygen equipment. Oxygen and oxygen equipment is to be reimbursed in accordance with [Section 12](#).

**3.11** Parenteral/enteral nutrition therapy. Parenteral/enteral pumps can be either rented or purchased.

**3.12** The DMEPOS pricing information is available at <http://www.cms.hhs.gov/suppliers/dmepos> and the claims processors are required to replace the existing pricing with the updated pricing information within 10 calendar days of publication on the internet. See the TRICARE Operations Manual (TOM), [Chapter 1, Section 4](#) regarding updating and maintaining TRICARE reimbursement systems.

**3.13** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any TRICARE coverage.

**3.14** Extensive maintenance which, based on manufacturer recommendations, must be performed by authorized technicians is covered as medically necessary. This may include breaking down sealed components and performing tests that require specialized testing equipment not

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available to the beneficiary. Maintenance may be covered for patient owned-DME when such maintenance must be performed by an authorized technician.

**4.0 EXCLUSIONS AND LIMITATIONS**

**4.1** A cost that is non-advantageous to the government shall not be allowed even when the equipment cannot be rented or purchased within a "reasonable distance" of the beneficiary's current address. The charge for delivery and pick up is an allowable part of the cost of an item; consequently, distance does not limit access to equipment.

**4.2** Line-item interest and carrying charges for equipment purchase shall not be allowed. A lump-sum payment for purchase of an item of equipment is the limit of the government cost-share liability. Interest and carrying charges result from an arrangement between the beneficiary and the equipment vendor for prorated payments of the beneficiary's cost-share liability over time.

**4.3** Routine periodic servicing such as testing, cleaning, regulating, and checking that is generally expected to be done by the owner. Normally, the purchasers are given operating manuals that describe the type of service an owner may perform. Payment is not made for repair, maintenance, and replacement of equipment that requires frequent substantial servicing, oxygen equipment, and capped rental items that the patient has not elected to purchase.

**5.0 EFFECTIVE DATE**

September 1, 2005.

- END -



## Bonus Payments In Health Professional Shortage Areas (HPSAs) And In Physician Scarcity Areas (PSAs)

Issue Date: April 18, 2003  
Authority: [32 CFR 199.14](#)

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### 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 bonus payments in medically underserved areas made?

### 3.0 POLICY

**3.1** On April 15, 2002, the **Final Rule** was published in the **Federal Register**. This rule provided for a bonus payment, in addition to the amount normally paid under the allowable charge methodology, to providers in medically underserved areas. Medically underserved areas are the same as those determined by the Secretary of Health and Human Services (HHS) for the Medicare program, designated as Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs) found in all 50 states and Puerto Rico. HPSAs include both primary care and mental health identified HPSAs and PSAs include both primary care and specialty identified PSAs. Only one HPSA bonus can be paid, even if the primary care and mental health HPSAs overlap. This is also true when there is an overlapping of primary care and specialty PSAs.

**3.2** The bonus payments shall be equal to the bonus payments authorized by Medicare, except as necessary to recognize any unique or distinct characteristics or requirements of the TRICARE program, and as described in instructions issued by the Deputy Director, TMA. The bonus payment, for HPSA, both medical and mental health areas, is 10% of the amount actually paid, not 10% of the amount allowed, e.g., CHAMPUS Maximum Allowable Charge (CMAC). The HPSA bonus payment only applies to physician's, podiatrist's, oral surgeon's, and optometrist's services rendered in these medically underserved areas. The PSA bonus payment is 5% of the amount actually paid to primary care physicians (general practitioners, family physicians, internists, and OB/GYN) and to other specialties. **The PSA bonus payment goes through June 30, 2008.** Oral surgeons (dentists), podiatrists, and optometrists are not eligible for the PSA bonus payment. For services with both a professional and technical component, only the professional component would be included in the calculation of the bonus payment. The bonus payment is based on where the service is performed which must be in the medically underserved area, not the billing office, etc. The bonus payment

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applies to both assigned and non-assigned claims. It also applies to network and non-network physicians. In addition, claims filed under Prime, Extra, and Standard for services provided in medically underserved areas can receive the bonus payment. For TRICARE For Life (TFL) claims, only those claims where TRICARE is primary would qualify for the bonus payment. For Other Health Insurance (OHI) claims, the bonus payment would apply, but only on the amount paid by the government.

**3.3** Depending on the areas, the bonus shall be calculated based on 10% or 5% of the amount actually paid a physician during a calendar quarter for services rendered in a medically underserved area. In order to receive the HPSA bonus payment, the physician must put a "QU" modifier on the claim for services rendered in an urban HPSA and a "QB" modifier on a claim for services rendered in a rural HPSA. In order to receive the PSA bonus payment, the physician must put an "AR" modifier on the claim for services rendered in a PSA. "QB", "QU" and "AR" are modifiers to the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes. The contractor shall sum all claim payments that qualify for the quarter and pay an additional 10% for the "QB" and "QU" modifier claims and an additional 5% for the "AR" modifier claims. An overlapping of HPSAs and PSAs can occur. When this happens, only one HPSA bonus and one PSA bonus can be paid. This means that a maximum of 15% bonus could be paid. There are no retroactive payments, adjustments or appeals, for obtaining a bonus payment. The contractor is not responsible for prescreening or post auditing of claims.

**Note:** Effective January 1, 2006, for services rendered on or after this date, the "QU" and "QB" modifiers shall be replaced with modifier "AQ".

**4.0 EFFECTIVE DATE**

June 1, 2003.

- END -

## Hospital Inpatient Reimbursement In Locations Outside The 50 United States And The District Of Columbia

Issue Date: September 9, 2004

Authority: 32 CFR 199.1(b) and 32 CFR 199.14(m), (n), and (o)

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### 1.0 APPLICABILITY

This policy is mandatory for reimbursement of all hospital inpatient services provided in the locations identified in paragraph 4.2. This policy revises, replaces, and supersedes the previously issued policy, effective October 1, 2004, for hospital reimbursement in the Philippines. Puerto Rico follows Continental United States (CONUS) based reimbursement methodologies used for the 50 United States and the District of Columbia.

### 2.0 ISSUE

How are specified inpatient hospital services reimbursed in the locations specified in paragraph 4.2?

### 3.0 POLICY

The institutional per diem for those specified locations outside the 50 United States and the District of Columbia is the maximum amount TRICARE will authorize to be paid for inpatient services on a per diem basis. The allowable Institutional per diem rates for those specified locations outside the 50 United States and the District of Columbia, shall be the lesser of (a) daily billed charges or; (b) the prospectively determined per diems adjusted by a country specific index factor.

### 4.0 BACKGROUND

Reimbursement Systems:

#### 4.1 General

**4.1.1** Payment for inpatient hospital stays in specified locations outside the 50 United States and the District of Columbia, are made utilizing the lesser of:

- Billed charges; or
- The prospectively determined per diems adjusted by a country specific index.

**4.1.2** Payment for OCONUS hospital inpatient services shall be made using prospectively determined per diem rates. The per diem rates for specified locations outside the 50 United States and the District of Columbia, were developed into reimbursement groupings by utilizing diagnosis

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codes as contained in the International Classification of Diseases, 9th Revision, and Clinical Modification (ICD-9-CM). The per diem rates are the maximum allowable amounts that TRICARE shall reimburse and the amount on which patient cost-shares are calculated. The National U.S. per diem rate is multiplied by a unique country specific index factor which adjusts the National U.S. per diems for the applicable country. The country specific hospital per diem, for those specified locations outside the 50 United States and the District of Columbia is the product of the National U.S. per diem and the country specific index.

#### 4.2 Applicability

4.2.1 This payment system applies to all hospitals providing services in:

- The Philippines.
- Panama.
- Other as designated by the Government.

4.2.2 Institutional providers accepting, admitting and treating TRICARE beneficiaries will receive the per diem reimbursement on applicable hospital services included on inpatient claims. This payment system is to be used regardless of the type of hospital inpatient services provided. The prospectively determined per diem rates established under this system are all-inclusive and are intended to include, but not be limited to, a standard amount for nursing and technician services; room, board and meals; drugs including any take home drugs; biologicals; surgical dressings, splints, casts; durable medical equipment (DME) for use in the hospital and is related to the provision of a surgical service, procedure or procedures, and equipment related to the provision and performance of surgical procedures; laboratory services and testing; X-ray or other diagnostic procedures directly related to the inpatient episode of care (EOC); special unit operating costs, such as intensive care units; malpractice costs, if applicable, or other administrative costs related to the services furnished to the patients, recordkeeping and the provision of records; and housekeeping items and services.

4.2.3 The per diem rates do not include such items as physicians' fees, irrespective of a physician's employment status with the hospital. The per diem rates do not include other professional providers (i.e., nurse anesthetist) recognized by TRICARE who render directly related inpatient services and bill independently from the hospital for them. A valid primary ICD-9-CM code or narrative description of services must be submitted by the hospital or institutional provider. The medical description provided shall be able to support development of the claim by the overseas claims processor prior to reimbursement.

#### 4.3 Exceptions

None.

#### 4.4 Country Specific Index

The country specific index is a factor obtained from the World Bank's International Comparison Program. The index factor is based on a large array of goods and services or market basket within the specific country which is then standardized and weighted to a U.S. standard and

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currency. The use of the country specific index enables a conversion and therefore creates parity between the U.S. and the specific country in the purchasing of the same amount and type of medical services. TRICARE is utilizing a two year phase in approach for the implementation of the World Bank's International Comparison Program country specific index.

	COUNTRY SPECIFIC INDEX FACTOR*	COUNTRY SPECIFIC INDEX FACTOR EFFECTIVE MARCH 1, 2009
Philippines	0.52	0.229
Panama	0.70	0.60

\*Effective data as directed by Contracting Officer (CO) through February 28, 2009.

#### 4.5 Institutional Payment Rates

**4.5.1** TRICARE Management Activity (TMA) shall annually calculate the U.S. National group payment rates and provide them electronically to the overseas claims processor. The provided data will contain the ICD-9-CM range or groups of related diagnosis codes. The first three digits of the principal ICD-9-CM diagnosis code determines placement into a diagnosis group as well as a reimbursement group. The data will also contain a description of the diagnosis ICD-9-CM groups. The rate for each group is the average U.S. allowed amounts per day in short-stay hospitals for all ICD-9-CM diagnoses in the particular group. The file will also designate the effective date of the per diem rates. Additions, deletions, corrections, and updates shall be communicated to the overseas claims processor at least annually, or as specifics may dictate. TMA shall also communicate the country specific factor to the overseas claims processor every three years or as dictated by the World Bank's International Comparison Program or as determined by TRICARE.

**4.5.2** The rate setting methodology was developed as follows:

**4.5.2.1** A rate setting methodology utilizing the first three digits of a primary diagnosis code.

**4.5.2.2** Eighteen diagnosis groupings were defined and designed to coincide with the groupings and definitions contained in the ICD-9-CM publication. For example, Group 1 is defined as ICD-9-CM codes 001 to 139, or Infectious and Parasitic Diseases. The first three digits of a primary diagnosis code are utilized for placement into one of the eighteen groups.

**4.5.2.3** The payment rate for each of the 18 diagnostic groups was the average allowed amount per day over all the ICD-9-CM codes in a diagnosis group, based upon the claim's primary diagnosis.

**4.5.2.4** Group payments were calculated by dividing total allowed charges by total inpatient days for the group.

#### 4.6 Payments

**4.6.1** General. The per diem group payment rate will be based on the first three digits of the primary diagnosis code. The TRICARE allowable charge and amount reimbursed for hospital inpatient care shall be the lesser of:

- Actual billed charges for hospital inpatient care; or

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### Hospital Inpatient Reimbursement In Locations Outside The 50 United States And The District Of Columbia

- The TRICARE U.S. National per diem rate multiplied by the country specific index factor is the country specific hospital per diem. This per diem is multiplied by the number of covered days of hospital inpatient care and equals the maximum amount allowed by TRICARE to be paid for the episode on inpatient care.

**4.6.2** Only the primary diagnosis code, on the date of admission, will be taken into consideration when determining the group for a payment rate. Only one payment group can be assigned to each independent episode of inpatient care. Each institutional claim for service reimbursement must contain a valid ICD-9-CM code or narrative description of services, and must be used to represent the primary diagnosis for inpatient admission. If a valid diagnosis code or narrative description is not supplied by the institutional provider it must be developed and supported by the overseas claims processor. Development of an institutional claim should contain the necessary elements to satisfy TRICARE Encounter Data (TED) requirements.

#### 4.7 Beneficiary - Change in Eligibility Status

Since payment is on a per diem basis, the hospital claim for services shall be paid for the days the beneficiary is TRICARE eligible and denied for the days the beneficiary is not TRICARE eligible.

#### 4.8 Beneficiary Cost-Shares

Inpatient cost-shares as contained in Chapter 2, Section 1, for non-Diagnosis Related Group (DRG) facilities shall be applicable to TRICARE's hospital allowable charge.

#### 4.9 Updating Payment Rates

Additions, changes, revisions or deletions to the ICD-9-CM codes or country specific index shall be communicated to the overseas claims processor and be considered as routine updates to this payment system and processed under TRICARE Operations Manual (TOM), Chapter 1, Section 4, paragraph 2.4.

**4.10** The overseas claims processor shall maintain the current year and two immediate past years' iterations of the TRICARE U.S. National per diems and the country specific index factors.

**4.11** There is no TRICARE waiver process applicable to hospitals in specified locations outside the 50 United States and the District of Columbia for institutional inpatient rates.

**FIGURE 1.34-1 INSTITUTIONAL INPATIENT DIAGNOSTIC GROUPINGS FOR SPECIFIED LOCATIONS OUTSIDE THE 50 UNITED STATES AND THE DISTRICT OF COLUMBIA - NATIONAL INPATIENT PER DIEM AMOUNTS**

GROUP	DESCRIPTION	ICD-9-CM CODE RANGE	NATIONAL INPATIENT PER DIEM
01	Infectious Disease	1 - 139	\$1,847
02	Cancer	140 - 239	\$2,136
03	Endocrine	240 - 289	\$2,119
04	Mental Health	290 - 319	\$909
05	Nervous System	320 - 389	\$1,906

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 Hospital Inpatient Reimbursement In Locations Outside The 50 United States  
 And The District Of Columbia

**FIGURE 1.34-1 INSTITUTIONAL INPATIENT DIAGNOSTIC GROUPINGS FOR SPECIFIED LOCATIONS OUTSIDE THE 50 UNITED STATES AND THE DISTRICT OF COLUMBIA - NATIONAL INPATIENT PER DIEM AMOUNTS (CONTINUED)**

<b>GROUP</b>	<b>DESCRIPTION</b>	<b>ICD-9-CM CODE RANGE</b>	<b>NATIONAL INPATIENT PER DIEM</b>
06	Circulatory	390 - 459	\$3,044
07	Respiratory	460 - 519	\$1,828
08	Digestive	520 - 579	\$1,888
09	Genitourinary	580-629	\$1,980
10	Pregnancy, birth (mother)	630 - 679, V22 - V24, V27	\$1,076
11	Musculoskeletal and skin	680 - 739	\$3,079
12	Congenital abnormalities	740 - 759	\$2,916
13	Perinatal Fetus and infant	760 - 779, V21, V29 - V39	\$731
14	Signs, Symptoms, etc.	780 - 799	\$1,950
15	Injuries	800 - 959	\$2,246
16	Poisoning	960 - 995	\$1,801
17	Complications	996 - 999	\$2,333
18	All other "V" based codes		\$1,640

- END -



## Professional Provider Reimbursement In Specified Locations Outside The 50 United States And The District Of Columbia

Issue Date: April 7, 2008

Authority: [32 CFR 199.14\(m\)](#), [\(n\)](#), and [\(o\)](#)

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### 1.0 APPLICABILITY

This policy is mandatory for reimbursement of providers of professional services in specified locations outside the 50 United States and the District of Columbia. This policy revises, replaces, and supersedes the current reimbursement policies for professional reimbursement, effective March 2004, in the Philippines. Puerto Rico follows the reimbursement methodologies used for the 50 United States and the District of Columbia.

### 2.0 ISSUE

How are providers of professional services in locations specified in [paragraph 4.1](#) reimbursed?

### 3.0 POLICY

**3.1** The term "allowable charge" is the maximum amount TRICARE will reimburse for covered health care services:

**3.2** The allowable charge is the lowest of: (a) the actual billed charge or (b) the maximum allowable charge. The maximum allowable charge is developed prospectively and utilizes the U.S. National CHAMPUS Maximum Allowable Charge (CMAC) which incorporates Relative Value Units (RVUs). For any covered service, the National CMAC rate is multiplied by a country specific index factor. This standardizes the National CMAC for that country and thus represents the maximum allowable TRICARE will reimburse in that country for that service.

### 4.0 BACKGROUND

#### 4.1 Reimbursement Systems

**4.1.1** Locations Affected. This payment system applies to covered professional services delivered in all designated locations outside the 50 United States and the District of Columbia. The designated locations are:

- The Philippines
- Panama
- Other as designated by the Government.

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

## Chapter 1, Section 35

### Professional Provider Reimbursement In Specified Locations Outside The 50 United States And The District Of Columbia

#### 4.2 General Methodology

Payment for professional services, in specified locations outside the 50 United States and the District of Columbia, are made utilizing the lesser of (a) billed charges or (b) prospectively determined rates that multiplies the U.S. National CMAC rates by a country specific index factor. The National CMAC rates are comprised of approximately 7,000 Current Procedural Terminology (CPT) codes. Each CPT code associates with an established CMAC rate. There are a limited number of CPT codes that do not have a National CMAC established. If these CPT codes are billed to the TRICARE program, they shall be reimbursed at billed charges. The U.S. National CMAC rates utilized in specified locations outside the 50 United States and the District of Columbia are paid at "the site of service" location of physicians' office without regard of the actual location where the service is delivered. This site of service location (physicians' office) represents the highest reimbursement allowed for all physicians. For example, should a physician, in a specified location outside the 50 United States and the District of Columbia, deliver a service in the emergency room, his payment will be based on the CPT code submitted, and paid at the site of service level of physician office (the highest). Each CPT code rate is multiplied by a specific country index factor and represents the maximum allowed to be paid to professional providers in designated locations outside the 50 United States and the District of Columbia.

#### 4.3 Country Specific Index

**4.3.1** The country specific index factor is obtained from the World Bank's International Comparison Program. It is based upon a large array of goods and services or market basket within a specific country which is then standardized and weighted to a U.S. standard and currency. The use of a country specific index enables a conversion and therefore parity between the U.S. and the specific country in the purchasing of the same amount and type of medical services. TRICARE is utilizing a two year phase in approach for the implementation of the World Bank's International Comparison Program country specific index.

COUNTRY SPECIFIC INDEX FACTOR*		COUNTRY SPECIFIC INDEX FACTOR EFFECTIVE MARCH 1, 2009
Philippines	0.52	0.229
Panama	0.70	0.60

\* Effective data as directed by Contracting Officer (CO) through February 28, 2009.

**4.3.2** The payment rates are all inclusive. An eligible and a representative procedure code or narrative description must be submitted by the provider or developed by the overseas claims processor.

#### 4.4 Updating Professional Payment Rates

Annually, TRICARE shall calculate the National CMAC rates and supply them electronically to the overseas claims processor. The data will contain each CPT code, a short description, a U.S. National payment rate, as well as the effective date. On an annual basis, the National CMAC may increase or decrease as determined by TRICARE. TRICARE shall separately supply the country specific index every three years or as dictated by the World Bank's International Comparison program or as determined by TRICARE, and documented in the TRICARE Reimbursement Manual

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Chapter 1, Section 35

Professional Provider Reimbursement In Specified Locations Outside The 50 United States And The District Of Columbia

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(TRM). For those codes that contain a technical as well as professional component, each component shall have a separate supplied payment rate. Additions, changes, revisions or deletions to the CPT codes or country specific index will be communicated to the overseas claims processor and be considered as routine updates to this payment system and processed under TRICARE Operations Manual (TOM), [Chapter 1, Section 4, paragraph 2.4](#).

**4.5 Beneficiary Eligibility - Change in Eligibility Status**

Since the payment is on a date of service basis, the professional, and other charges shall be paid for all dates of service that the beneficiary is TRICARE eligible and denied for all dates of services the beneficiary is not TRICARE eligible.

**4.6 Beneficiary Cost-Shares**

Beneficiary cost-shares are contained in [Chapter 2, Section 1](#), and shall be applicable to TRICARE's applicable professional allowable charges.

**4.7** The overseas claims processor and the overseas contractor shall maintain the current year and two immediate past years' iterations of the TRICARE National CMAC CPT rates and the country specific index factors.

- END -



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

### Chapter 2, Section 1

#### Cost-Shares And Deductibles

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allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CHAMPUS Maximum Allowable Charge (CMAC)). In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

**1.1.6.3.3** The exception to the deductible and cost-share requirements under Operation Noble Eagle/Operation Enduring Freedom for TRICARE Standard and Extra is effective for services rendered from September 14, 2001, through October 31, 2008.

#### **1.1.6.4 For Certain Reservists**

The Director, TRICARE Management Activity (TMA), may waive the individual or family deductible for family members of a Reserve Component (RC) member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a RC member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 United States Code (USC) 101(a)(13). Also, for this purpose a family member is a lawful husband or wife of the member or an eligible child.

### **1.2 TRICARE Prime**

**1.2.1** Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See [Addendum A](#) for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act, PL 106-398, for services provided on or after April 1, 2001, a \$0 copayment shall be charged to TRICARE Prime ADFMs of active duty service members (ADSMs) who are enrolled in TRICARE Prime. Pharmacy copayments and POS charges are not waived by the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2001.

**1.2.2** In instances where the CMAC or allowable charge is less than the copayment shown on [Addendum A](#), network providers may only collect the lower of the allowable charge or the applicable copayment.

**1.2.3** The TRICARE Prime copayment requirement for emergency room services is on a PER VISIT basis; this means that only one copayment is applicable to the entire emergency room episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers.

**1.2.4** Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply):

**1.2.4.1** Diagnostic radiology and ultrasound services included in the CPT<sup>1</sup> procedure code range from 70000 - 76999, **or any other code for associated contrast media;**

**1.2.4.2** Diagnostic nuclear medicine services included in the CPT<sup>1</sup> procedure code range from 78000 - 78999;

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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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**1.2.4.3** Pathology and laboratory services included in the CPT<sup>2</sup> procedure code range from 80000 - 89399; and

**1.2.4.4** Cardiovascular studies included in the CPT<sup>2</sup> procedure code range from 93000 - 93350.

**1.2.4.5** Venipuncture included in the CPT<sup>2</sup> procedure code range from 36400 - 36416.

**1.2.4.6** Fetal monitoring for CPT<sup>2</sup> procedure codes 59020, 59025, and 59050.

**1.2.5** POS option. See [Section 3](#).

### **1.3 Basic Program: TRICARE Standard**

#### **1.3.1 Deductible Amount: Outpatient Care**

**1.3.1.1** For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

**1.3.1.1.1** Deductible, Individual: Each beneficiary is liable for the first fifty dollars (\$50.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

**1.3.1.1.2** Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

**1.3.1.2** For care rendered on or after April 1, 1991, for all TRICARE beneficiaries except family members of active duty sponsors of pay grade E-4 or below.

**1.3.1.2.1** Deductible, Individual: Each beneficiary is liable for the first \$150.00 of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

**1.3.1.2.2** Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed \$300.00.

**1.3.1.3** TRICARE-Approved Ambulatory Surgery Centers (ASCs), Birthing Centers, or Partial Hospitalization Programs (PHPs). No deductible shall be applied to allowable amounts for services or items rendered to ADFMs or authorized NATO family members.

**1.3.1.4** Allowable Amount Does Not Exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (or \$300.00 if [paragraph 1.3.1.2](#), applies), and no one beneficiary's allowable amounts exceed \$50.00 (or \$150.00 if [paragraph 1.3.1.2](#) applies), neither the family nor the individual deductible will have been met and no TRICARE benefits are payable.

**1.3.1.5** In the case of family members of an active duty member of pay grade E-5 or above, with Persian Gulf conflict service who is, or was, entitled to special pay for hostile fire/imminent danger authorized by 37 USC 310, for services in the Persian Gulf area in connection with Operation Desert

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

### Chapter 3, Section 1

#### Reimbursement Of Individual Health Care Professionals And Other Non-Institutional Health Care Providers

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approved codes for retail and Mail Order Pharmacy (MOP). (Reference the TSM, [Chapter 2, Addendum E.](#))

**2.6** Professional surgical procedures will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under the Outpatient Prospective Payment System (OPPS) for services rendered on or after implementation of OPPS. Refer to [Chapter 1, Section 16, paragraphs 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** Professional procedures which are terminated or are bilateral will be subject to discounting based on modifier guideline requirements as prescribed under the OPPS for services rendered on or after implementation of OPPS. Refer to [Chapter 1, Section 16, paragraphs 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.

### **2.8 Prevention Of Gross Dollar Errors**

Parameters Consistent With Private Business. The contractor shall establish procedures for the review and authorization of payment for all claims exceeding a predetermined dollar amount. These authorization schedules shall be consistent with the contractor's private business standards.

## **3.0 CHAMPUS MAXIMUM ALLOWABLE CHARGE (CMAC) SYSTEM**

### **3.1 General**

The CMAC system is effective for all services. The zip code where the service was rendered determines the locality code to be used in determining the allowable charge under CMAC. In most instances the zip code used to determine locality code will be the zip code of the provider's office. For processing an adjustment, the zip code which was used to process the initial claim must be used to determine the locality for the allowable charge calculation for the adjustment. Adjustments shall be processed using the appropriate rate based on the date of service. Post office box zip codes are acceptable only for Puerto Rico and for providers whose major specialty is anesthesiology, radiology or pathology (see [Chapter 5, Section 3](#)).

### **3.2 Locality Code**

For TED reporting, the locality code used in the reimbursement of the procedure code is to be reported for each payment record line item, i.e., on each line item where payment is based on a CMAC, the locality shall be reported. Any adjustment to a claim originally paid under CMAC without a locality code, shall include the locality code that it was priced on at the time of the initial payment. The locality code reported on the initial claim shall be used to process any future adjustments of that claim unless one of the conditions listed below occurs:

- The adjustment is changing the type of pricing from CMAC to a different payment method, in which case the locality code should be blank filled, or;
- The initial claim was priced incorrectly because of using a wrong locality code, in which case the correct locality code should be used.

#### 4.0 BONUS PAYMENTS IN MEDICALLY UNDERSERVED AREAS

**4.1** An additional payment shall be made quarterly to physicians who qualify and provide services in medically underserved areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)]. To initiate action for the additional payment, providers shall use modifiers that will signify the provider is requesting the additional payment. The modifiers are "QU" (urban HPSA), "QB" [rural HPSA], and "AR" [PSA bonus payment]. "QU", "QB" and "AR" are modifiers to the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes. The provider shall be paid an additional 10% HPSA bonus of the total amount paid, excluding interest payments, for claims that were processed during the calendar quarter for services rendered on or after June 1, 2003. The provider shall be paid an additional five percent (5%) PSA bonus of the total amount paid, excluding interest payment, for claims that were processed during the calendar quarter for services rendered on or after January 1, 2005. The contractor shall have 30 calendar days from the end of the calendar quarter to make the payments to the providers who qualify. The bonus payments could be paid to network, non-network, participating, or non-participating physicians. Special programs such as TRICARE Prime Remote (TPR), Supplemental Health Care Program (SHCP), and TRICARE Senior Prime (TSP) shall be included in the bonus payment process. Contractors shall send bonus payments directly to the non-participating physician. Contractors shall report these claims on TEDs as required by the TSM, [Chapter 2, Section 2.7](#) (Procedure Code Modifiers). See [Chapter 1, Section 33](#) for additional information.

**Note:** Effective January 1, 2006, for services rendered on or after this date, the "QU" and "QB" modifiers shall be replaced with modifier "AQ".

**4.1.1** The contractor is to inform providers of the PSA and HPSA bonus payments through stuffers and their quarterly news bulletin. The stuffers and bulletin should provide direction on what is required in order to obtain the bonus payment.

**4.1.2** Basis of bonus payments to TRICARE-authorized providers is solely when a "AQ", "QU", "QB", or "AR" modifier is found on the claim.

**4.2** Bonus payments are passthrough payments, non-financially underwritten payments. The contractor shall follow the process below and the financial provisions in the contract.

**4.2.1** Bonus Payment Procedures. The contractor shall use the following procedures in making bonus payments to physicians:

**4.2.1.1** Accumulate and tally claims paid with n "QU", "QB", or "AR" modifiers.

**4.2.1.2** Compute the amount due each physician for submitted claims during the calendar quarter for HPSA services rendered on or after June 1, 2003 and PSA services rendered on or after January 1, 2005. The PSA bonus only goes through **June 30, 2008**. Stop processing prior to check writing. Compute the total amount due all physicians. For services with both a professional and technical component, only the professional component would be included in the calculation of the bonus payment. The amount due is computed from claims with the "QU", "QB", and "AR" modifiers, then based on the amount paid (see [paragraph 4.2.2](#)).

## **2.4 Medicare Claims**

Claims processed on which Medicare is primary payer require review for possible double coverage. Contractors are required to build other health insurance files on these beneficiaries that identify coverages (primarily Medicare supplements) that may be primary to TRICARE. Contractors may use any reasonably reliable indicator to identify other coverages including crossover claims received from Medicare carriers and fiscal intermediaries, crossover files received from Medicare carriers and fiscal intermediaries, paper claims, information resulting from refunds, information from providers, etc. Also, contractors must ensure that providers are aware that if they receive any TRICARE payments that duplicate payments made by another coverage, they must return the TRICARE payment. Since TRICARE remains secondary payer to all other coverages, contractors must recover all payments that they subsequently identify as duplicating a payment made by any coverage, including Medicare supplements, that is primary to TRICARE.

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

Payment under the SNF PPS is dependent upon the PPS-specific information submitted by the provider with the TRICARE Claim (see [Chapter 8, Section 2](#)). However, if the beneficiary has other health insurance (OHI) which has processed the claim as primary payer, it is likely that the information necessary to determine the TRICARE PPS payment amount will not be available. Therefore, special procedures have been established for processing SNF claims involving OHI. These claims will not be processed as PPS claims. Such claims will be allowed as billed unless there is a provider discount agreement. TRICARE payment will be the difference between the billed charge and the OHI payment. The only exception to this is cases when there is evidence on the face of the claim that the beneficiary's liability is limited to less than the billed charge (e.g., the OHI has a discount agreement with the provider under which the provider agrees to accept a percentage of the billed charge as payment in full). In such cases, the TRICARE payment is to be the difference between the limited amount established by the OHI and the OHI payment.

## **2.6 Statutory Limitation On Inpatient Mental Health Services**

The application of TRICARE's double coverage rules cannot result in circumvention of the statutory limit on inpatient mental health services. (See the TRICARE Policy Manual (TPM), [Chapter 7, Section 3.1](#).) Thus, calculation of TRICARE payment in a double coverage situation cannot result in payment, in any amount, for more than the allowed number days of inpatient mental health services unless a waiver has been granted.

- END -



## Locality-Based Reimbursement Rate Waiver

Issue Date: September 27, 2001

Authority: [32 CFR 199.14](#)

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### 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 is the process of the locality-based reimbursement rate waivers?

### 3.0 POLICY

**3.1** Under the locality-based reimbursement rate waiver, two access locations may be considered for provider reimbursement rates above the CHAMPUS Maximum Allowable Charge (CMAC). These are:

**3.1.1** Network Waivers: If it is determined that **the availability of an adequate number and mix of qualified health care providers in a network in a specific locality is not found**, higher rates may be necessary. The amount of reimbursement would be limited to the lesser of:

- An amount equal to the local fee for service charge; or
- Up to 115% of the CMAC. Our first attempt should be to get the provider to join the network at the prevailing CMAC rate.

**3.1.2** Locality Waivers: If it is determined that access to specific health care services is severely impaired, higher payment rates could be applied to all similar services performed in a locality, or a new locality could be defined for application of the higher payment rates. Payment rates could be established through addition of a percentage factor to an otherwise applicable payment amount, or by calculating a prevailing charge, or by using another government payment rate. Higher payments will be paid on a claim by claim basis.

**3.2** Coordination of the request for a locality-based reimbursement rate waiver shall be submitted to the TMA **Chief, Medical Benefits and Reimbursement Systems (MB&RS)** by the Director, TRICARE Regional Office (DTRO). The Director shall work with the Managed Care Support Contractor (MCSC) to ensure that both are in agreement with the waiver request.

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

## Chapter 5, Section 2

### Locality-Based Reimbursement Rate Waiver

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**3.3** The procedures that are to be followed when submitting a waiver are as follows:

**3.3.1** Identify the waiver that is being requested.

- Network waivers. Needed to ensure availability of an adequate number and mix of qualified network providers.
- Locality waivers. Needed to ensure access to services in a locality defined by a current TRICARE locality or a new one established by zip code.

**3.3.2** Who can apply:

- DTRO
- Providers through the DTRO
- Beneficiaries through the DTRO
- MCSC through the DTRO
- Military Treatment Facility (MTF) through the DTRO

**3.3.3** How to apply:

**3.3.3.1** Applicant must submit a written waiver request to the TRO. The request must justify that access to health care services is severely impaired due to low reimbursement levels (CMAC payment rates).

**3.3.3.2** Justification for the waiver must include at the minimum:

- Number of providers in a locality.
- Mix of primary/specialty providers needed to meet patient access standards.
- Number of providers who are TRICARE participating.
- Number of eligible beneficiaries in the locality.
- Availability of MTF providers.
- Geographic characteristics.
- Efforts that have attempted to create an adequate network, including any additional non-health care payments above the CMAC rates made by the MCSC.
- Letters of intent.
- Cost effectiveness.

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

Chapter 5, Section 2

Locality-Based Reimbursement Rate Waiver

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- Other relevant factors that warrant the higher payment to resolve the access to care issue.

**3.4** The TRO shall conduct a thorough analysis and forward recommendations with a cost estimate for approval to the TMA Director **or designee** through the TMA **Contracting Officer (CO)** for coordination. Disapprovals by the DTRO will not be forwarded to the TMA Director **or designee**. The TMA Director **or designee** is the final approval authority. A decision by the TMA Director **or designee** to authorize, not authorize, terminate, or modify the authorization of higher payment amounts is not subject to appeal.

- Network waivers: If the TMA Director **or designee** approves an increase of up to 15% above the CMAC, the contractor will have the authority to offer specified providers up to 15% above CMAC for joining the network.
- Locality waivers: If the TMA Director **or designee** approves a higher payment rate for certain services in a locality, reimbursement rates for those procedure codes in that locality would be adjusted by the managed care support contractor in order to improve the access to services.

- END -



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

### Chapter 5, Section 3

#### CHAMPUS Maximum Allowable Charges (CMAC)

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**3.4** The CMAC applies to all 50 states, Puerto Rico, and the Philippines. Further information regarding the reimbursement of professional services in the Philippines, see the TRICARE Operations Manual (TOM), [Chapter 24, Section 9](#). Guam and the U.S. Virgin Islands are to still be paid as billed for professional services.

**3.5** Updates to the CMACs shall occur annually and quarterly when needed. The annual update usually takes place February 1. However, circumstances may cause the updates to be delayed. MCSCs shall be notified when the annual update is delayed.

**3.6** Provisions which affect the TRICARE allowable charge payment methodology.

**3.6.1** Reductions in maximum allowable payments to Medicare levels.

#### **3.6.2 Site of Service**

CMAC payments based on site of service becomes effective for services rendered on or after April 1, 2005. Payment based on site of service is a concept used by Medicare to distinguish between services rendered in a facility setting as opposed to a non-facility setting. Prior to April 1, 2005, CMACs were established at the higher rate of the facility or non-facility payment level. For some services such as radiology and laboratory tests, the facility and non-facility payment levels are the same. In addition, prior to April 1, 2005, CMAC pricing was established by class of provider (1, 2, 3, and 4). These four classes of providers will be superseded by four categories.

##### **3.6.2.1 Categories**

- Category 1: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 0510), Residential Treatment Centers (RTCs), ambulances, hospices, MTFs, psychiatric facilities, Community Mental Health Centers (CMHCs), Skilled Nursing Facilities (SNFs), Ambulatory Surgical Centers (ASCs), etc.
- Category 2: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a non-facility including provider offices, home settings, and all other non-facility settings.
- Category 3: Services, of all other providers not found in Category 1, provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 0510), RTCs, ambulances, hospices, MTFs, psychiatric facilities, CMHCs, SNFs, ASCs, etc.
- Category 4: Services, of all other providers not found in Category 2, provided in a non-facility including provider offices, home settings, and all other non-facility settings.

**3.6.2.2 Linking The Site Of Service With The Payment Category**

The contractor is responsible for linking the site of service with the proper payment category. The rates of payment are found on the CMAC file that are supplied to the contractor by TMA through its contractor that calculates the CMAC rates.

**3.6.2.3 Payment Of 0510 And 0760 Series Revenue Codes**

Effective for services upon implementation of Outpatient Prospective Payment System (OPPS), payment of 0510 and 0760 series revenue codes will be based on the HCPCS codes submitted on the claim and reimbursed under the OPPS for providers reimbursed under the OPPS methodology.

**3.6.2.4 Reimbursement Hierarchy For Procedures Paid Outside The OPPS**

**3.6.2.4.1 CMAC Facility Pricing Hierarchy (No Technical Component (TC) Modifier).**

The following table includes the list of rate columns on the CMAC file. The columns are number 1 through 6 by description. The pricing hierarchy for facility CMAC is 8, 6, 4, then 2.

COLUMN	DESCRIPTION
1	Non-facility CMAC for physician/LLP class
2	Facility CMAC for physician/LLP class
3	Non-facility CMAC for non-physician class
4	Facility CMAC for non-physician class
5	Physician class Professional Component (PC) rate
6	Physician class Technical Component (TC) rate
7	Non-physician class PC rate
8	Non-physician class TC rate

**Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the physician class TC rate. Otherwise, if the facility CMAC for non-physician class > 0, then pay the facility CMAC for non-physician class. Otherwise, pay facility CMAC for physician/LLP class.**

If there is no CMAC available, the contractor shall reimburse the procedure under Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

**3.6.2.4.2 DMEPOS.** If there is no DMEPOS available, the contractor shall reimburse the procedure using state prevailings.

**3.6.2.4.3 State Prevailing Rate.** If there is no state prevailing rate available, the contractor shall reimburse the procedure based on billed charges.

**3.6.2.5 Services and procedure codes not affected by site of service.** Anesthesia services, laboratory services, component pricing services such as radiology, and "J" codes are some of the more common services and codes that will not be affected by site of service.

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

Chapter 5, Section 3

CHAMPUS Maximum Allowable Charges (CMAC)

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**3.6.3** Multiple Surgery Discounting. Professional surgical procedures which are reimbursed under the CMAC payment methodology will be subject to the same multiple surgery guidelines and modifier requirement as prescribed under the OPPS for services rendered on or after implementation of OPPS. Refer to [Chapter 1, Section 16, paragraphs 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.

- END -



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

### Chapter 8, Section 2

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

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index is not built into the FY 2006 SNF Pricer, contractors will use the values provided in [Addendum E \(FY 2006\)](#). TMA will provide to contractors a separate zip to wage index crosswalk file containing the FY 2006 SNF PPS transition wage index.

**4.3.15** If the SNF does an off-schedule assessment, a late patient assessment or, in some cases, no patient assessment at all, the SNF will submit the claim using the default HIPPS rate code of AAA and the two digit default assessment indicator modifier code of 00 which will result in payment of the default rate.

**4.3.16** With regard to payment for the lower 18 RUGs (i.e., IB2, IB1, IA2, IA1, BB2, BB1, BA2, BA1, PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1), TRICARE will follow the SNF level of care criteria as provided in the Medicare Benefit Policy Manual, Chapter 8 (Publication # 100-02), which can be accessed at <http://www.hhs.gov/manuals>. Beneficiaries in the lower 18 RUGs do not automatically qualify for SNF coverage. Instead, these beneficiaries will be individually reviewed to determine whether they meet criteria for skilled services and the need for skilled services as defined in 42 CFR 409.32, Subpart D, which can be accessed at <http://www.gpoaccess.gov/>. In determining "medical necessity", the contractor will use generally acceptable criteria such as InterQual. If SNF services are determined not to be medically necessary under Medicare, they will not be covered under TRICARE.

**Note:** Prior to January 1, 2006, the upper 26 RUGs (i.e., the first 26 RUGs listed in [Addendum A, Figure 8.A-1](#)) represent the required SNF level of care during the immediate post-hospital period. With the addition of 9 new RUGs, effective January 1, 2006, the upper 35 RUGs (i.e., the first 35 RUGs listed in [Addendum A, Figure 8.A-2](#)) represent the required SNF level of care during the immediate post-hospital period. A beneficiary who is correctly assigned to one of the upper RUGs under the initial 5 day assessment is automatically classified as meeting the SNF level of care definition and does not require a medical review unless there is a reason to do so (e.g., data analysis suggests an unusual pattern of claims submission). When a beneficiary is correctly assigned to one of the upper RUG-III groups under the initial 5 day assessment, the SNF level of care requirement is met for the period from SNF admission up to and including the assessment reference date for that assessment. This presumption of coverage only applies if the beneficiary is admitted to the SNF immediately following a three day qualifying hospital stay, and lasts through the assessment reference date of the five day assessment, which must occur NLT the eighth day of the stay due to the three day grace period for SNF assessments.

**4.3.17** If a pediatric SNF is certified by Medicaid, it will be considered to meet the Medicare certification requirement in order to be an authorized provider under TRICARE. The cover letter to SNFs and the Participation Agreement are provided at [Addendum G](#) which the contractor will send to SNFs. SNFs must provide evidence that they are certified by Medicare (or Medicaid). The contractor will be responsible for verification that the SNF is Medicare-certified (or Medicaid-certified), and has entered into a Participation Agreement with TRICARE. TRICARE will not permit a waiver to allow non-Medicare (or non-Medicaid) certified SNFs to be authorized SNFs under TRICARE. Non-participating SNFs will not be eligible for reimbursement under TRICARE. If a PPS claim is received from a SNF that has not signed a TRICARE Participation Agreement, the contractor will deny the claim and send a Participation Agreement to the SNF for signature. Once the SNF has signed the Participation Agreement, the claim will be processed provided the SNF was Medicare (or Medicaid) certified and met all other TRICARE SNF criteria at the time when the services were furnished to the TRICARE beneficiary.

**Note:** VA facilities are required to be Medicare approved or they are required to be Joint Commission accredited in order to have deemed status under Medicare or TRICARE. The VA facilities that enter into an MOU with Department of Defense (DoD) are not required to enter into the Participation Agreement provided at [Addendum G](#).

**4.3.18** At their own discretion, the contractors may conduct any data analysis to identify aberrant PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG.

**4.3.19** Refer to the TRICARE Systems Manual (TSM), [Chapters 2](#) and [4](#) for the SNF PPS related revenue and edit codes.

#### **4.4 For Admissions on or after August 1, 2003, when TRICARE is Secondary Payer to Medicare**

**4.4.1** TRICARE is the secondary payer to Medicare for SNF care for beneficiaries under age 65 who are eligible for Medicare, with no OHI and for beneficiaries age 65 and over who are eligible for Medicare with less than a 100-day covered Medicare SNF stay with no OHI.

**4.4.2** The beneficiary has no liability under Medicare for days 1 through 20; therefore, there will not be any unpaid amount for TRICARE to reimburse until day 21. For days 21 to 100, the beneficiary does have a cost-share for which TRICARE will pay the remaining liability as secondary payer.

**4.4.3** The Medicare-eligible patient will be assessed by the SNF using the MDS.

**4.4.4** The MDS data will be run through the MDS RUG-III grouper to generate a three digit RUG-III code. The RUG-III grouper software assigns a RUG-III code for billing and payment purposes. Each Medicare-certified SNF must process the MDS assessment data by using the RUG-III grouper. A two digit modifier will be added to this to get the five digit HIPPS code which the SNF will put on the claim and send that to the Medicare claims processor for payment.

**4.4.5** For TFL beneficiaries, the Medicare claims processor will pay the SNF claim as the primary payer and then electronically submit the claim to the TRICARE contractor for secondary payer purposes.

**4.4.6** For a beneficiary who is both Medicare and TRICARE eligible, TRICARE can pay secondary for a SNF that participates in Medicare **and has entered into** a Participation Agreement with TRICARE. **Upon exhaustion of Medicare benefits**, TRICARE **may** pay primary **to such SNFs**.

**4.4.7** As secondary payer, TRICARE will use Medicare's determination of coverage rather than performing an additional review. If Medicare denies the services as not medically necessary, TRICARE will also deny the care and the beneficiary will have appeal rights through Medicare.

#### **5.0 MISCELLANEOUS POLICY**

**5.1** TMA will follow CMS policy regarding use of the default payment rate whenever the SNF does an off-schedule assessment, a late patient assessment, or in some cases, no patient assessment at

## Acronyms And Abbreviations

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3D	Three Dimensional
AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
AAFES	Army/Air Force Exchange Service
AAMFT	American Association for Marriage and Family Therapy
AAP	American Academy of Pediatrics
AAPC	American Association of Pastoral Counselors
AARF	Account Authorization Request Form
AATD	Access and Authentication Technology Division
ABA	American Banking Association Applied Behavioral Analysis
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
ACD	Augmentative Communication Devices
ACI	Autologous Chondrocyte Implantation
ACIP	Advisory Committee on Immunization Practices
ACO	Administrative Contracting Officer
ACOG	American College of Obstetricians and Gynecologists
ACOR	Administrative Contracting Officer's Representative
ACS	American Cancer Society
ACTUR	Automated Central Tumor Registry
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act
ADAMHA	Alcohol, Drug Abuse, And Mental Health Administration
ADAMHRA	Alcohol, Drug Abuse, And Mental Health Reorganization Act
ADCP	Active Duty Claims Program
ADD	Active Duty Dependent
ADFM	Active Duty Family Member
ADL	Activities of Daily Living
ADP	Automated Data Processing

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

## Appendix A

### Acronyms And Abbreviations

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ADSM	Active Duty Service Member
AFOSI	Air Force Office of Special Investigations
<b>AGR</b>	<b>Active Guard/Reserve</b>
AHA	American Hospital Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIIM	Association for Information and Image Management
AIS	Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous Leukemia
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance

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

## Appendix A

### Acronyms And Abbreviations

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PCS	Permanent Change of Station
PD	Passport Division
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
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
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PL	Public Law
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

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POA	Power of Attorney
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
PPS	Prospective Payment System Ports, Protocols and Services
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
<b>PRPP</b>	<b>Pharmacy Redesign Pilot Project</b>
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
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
QA	Quality Assurance
QC	Quality Control

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## Appendix A

### Acronyms And Abbreviations

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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
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
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder

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

## Appendix A

### Acronyms And Abbreviations

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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) Status Indicator
SIDS	Sudden Infant Death Syndrome
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
SOR	Statement of Reasons
SP	Special Processing Code
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)

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

### Appendix A

#### Acronyms And Abbreviations

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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
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
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
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
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

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

### Appendix A

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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
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
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

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### Appendix A

#### Acronyms And Abbreviations

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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
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
URL	Universal Resource Locator
US	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

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## Appendix A

### Acronyms And Abbreviations

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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	Veteran Affairs (hospital) Veteran 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
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
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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Reimbursement			FY 2006	8	D (FY2006)
Administration	3	5	FY 2007	8	D (FY2007)
Ambulatory Surgical Center (ASC)	9	1	FY 2008	8	D (FY2008)
Birthing Center (Freestanding and Hospital-Based)	10	1	Example Of Computation of Adjusted PPS Rates And SNF Payment		
Covered Services Provided By Individual Health Care Professionals And Other Non-Institutional Health Care Providers	1	7	FY 2007	8	B (FY2007)
Emergency Inpatient Admissions To Unauthorized Facilities	1	29	FY 2008	8	B (FY2008)
Freestanding Ambulatory Surgical Center (ASC)	9	1	Fact Sheet Regarding Consolidated Billing and Ambulance Services	8	C
Freestanding Psychiatric Partial Hospitalization Program (PHP)	7	2	Illustration Of Per Diem Rate Calculations for FY 2006	8	B (FY2006)
Hospital	3	2	Letter To SNF Regarding Participation Agreement	8	G
In Teaching Setting	1	4	Prospective Payment System (PPS) Reimbursement	8	2
Individual Health Care Professionals	3	1	Resource Utilization Group-III (RUG-III)	8	A
Institutional Health Care Provider	3	2	Wage Indexes		
Network Provider	1	1	Rural Areas (Based On CBSA Labor Market Areas)		
Non-Institutional Health Care Providers	3	1	FY 2007	8	F (FY2007)
Non-OPPS Facilities	9	1	FY 2008	8	F (FY2008)
Physician Assistants, Nurse Practitioners, And Certified Psychiatric Nurse Specialists	1	6	Transition		
Preferred Provider Organization (PPO)	1	25	FY 2006	8	E (FY2006)
Prime Travel Expenses	1	30	Urban Areas (Based On CBSA Labor Market Areas)		
Psychiatric Partial Hospitalization Program (PHP)	7	2	FY 2007	8	E (FY2007)
Residential Treatment Center (RTC)	7	4	FY 2008	8	E (FY2008)
Skilled Nursing Facility (SNF)	8	1	Sole Community Hospitals (SCHs)	14	1
Substance Use Disorder Rehabilitation Facilities (SUDRFs)	7	3	Specific Double Coverage Actions	4	4
Residential Treatment Centers (RTCs)			State Agency Billing	1	20
Guidelines For The Calculation Of Individual RTC Per Diem Rates	7	C	Sample Agreement	1	A
Reimbursement	7	4	Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement	7	3
TRICARE-Authorized Facilities			Supplemental Insurance	1	26
FY 2007	7	D (FY2007)	Surgery	1	16
FY 2008	7	D (FY2008)			

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