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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 27
6010.58-M
MARCH 18, 2010**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: PARTIAL HOSPITALIZATION PROGRAMS (PHPs)/PSYCHIATRIC
HOSPITAL RATE CORRECTIONS

CONREQ: 14995

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides rate corrections for PHPs, freestanding psychiatric PHP reimbursement, and psychiatric hospitals and units with low TRICARE volume. These rates are corrected to be consistent with Federal Register mental health notice.

EFFECTIVE DATE: October 1, 2009.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.


**John D'Alessandro
Chief, Medical Benefits and
Reimbursement Branch**

ATTACHMENT(S): 5 PAGE(S)
DISTRIBUTION: 6010.58-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

CHANGE 27
6010.58-M
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REMOVE PAGE(S)

CHAPTER 6

Section 4, pages 3 and 4

CHAPTER 7

Addendum A, pages 1 and 2

Addendum B, page 1

INSERT PAGE(S)

Section 4, pages 3 and 4

Addendum A, pages 1 and 2

Addendum B, page 1

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Chapter 6, Section 4

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

3.3.7 All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) bone marrow transplants which would otherwise be paid under DRG 009.

3.3.8 All services related to discharges involving children (beneficiary less than 18 years old upon admission) who have been determined to be HIV (Human Immunodeficiency Virus) seropositive.

3.3.9 All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) cystic fibrosis.

3.3.10 For admissions occurring on or after October 1, 1997, an additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a TRICARE patient who is a hemophiliac. Payment will be made for blood clotting factor when one of the following hemophilia ICD-9-CM diagnosis codes is listed on the claim:

286.0	Congenital Factor VIII Disorder;
286.1	Congenital Factor IX Disorder;
286.2	Congenital Factor XI Deficiency;
286.3	Congenital Deficiency of Other Clotting Factors;
286.4	Von Willebrand's Disease;
286.5	Hemorrhagic Disorder Due to Circulating Anticoagulants; and
286.7	Acquired Coagulation Factor Deficiency.

3.3.10.1 Each unit billed on the hospital claim represents 100 payment units except Q0187, Factor VIIa. For example, if the hospital indicates that 25 units of Factor VIII were provided, this would represent 2,500 actual units of factor, and the payment would be \$1,600 (paid at \$0.64/unit - Factor VIII). For HCPCS Q0187, one billing unit represents 1.2mg.

Note: Since the costs of blood clotting factor are reimbursed separately, for these claims all charges associated with the factor are to be subtracted from the total charges in determining applicability of a cost outlier. However, the charges for the blood clotting factor are to be included when calculating the cost-share based on billed charges.

3.3.10.2 Contractors shall make payment for blood clotting factor using Average Sale Price (ASP) plus 6%, using the Medicare Part B Drug Pricing file. The price allows for payment of a furnishing fee and is included in the ASP per unit.

3.4 Hospitals Subject To The TRICARE DRG-Based Payment System

All hospitals within the 50 United States, the District of Columbia, and Puerto Rico which are authorized to provide services to TRICARE beneficiaries are subject to the DRG-based payment system except for those hospitals and hospital units below.

3.5 Substance Use Disorder Rehabilitation Facilities (SUDRFs)

With admissions on or after July 1, 1995, SUDRFs are subject to the DRG-based system.

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Chapter 6, Section 4

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

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

3.6.1 Hospitals within hospitals.

3.6.2 Psychiatric hospitals.

3.6.3 Rehabilitation hospitals.

3.6.4 Psychiatric and rehabilitation units (distinct parts).

3.6.5 Long-term hospitals.

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

3.6.7 Christian Science sanitariums.

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

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

3.6.10 Satellite facilities.

3.7 Hospitals Which Do Not Participate In Medicare

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

Chapter 7

Addendum A

Table Of Regional Specific Rates For Psychiatric Hospitals
And Units With Low TRICARE Volume - FY 2008 - FY 2010

UNITED STATES CENSUS REGIONS	FY 2008 REGIONAL RATES 10/01/07 - 09/30/08	FY 2009 REGIONAL RATES 10/01/08 - 09/30/09	FY 2010 REGIONAL RATES 10/01/09 - 09/30/10
NORTHEAST:			
New England (ME, NH, VT, MA, RI, CT)	\$707	\$730	\$745
Mid-Atlantic (NY, NJ, PA)	\$681	\$703	\$718
MIDWEST:			
East North Central (OH, IN, IL, MI, WI)	\$588	\$607	\$620
West North Central (MN, IA, MO, ND, SD, NE, KS)	\$555	\$573	\$585
SOUTH:			
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	\$701	\$723	\$738
East South Central (KY, TN, AL, MS)	\$750	\$774	\$790
West South Central (AR, LA, TX, OK)	\$639	\$659	\$673
WEST:			
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	\$638	\$658	\$672
Pacific (WA, OR, CA, AK, HI)	\$754	\$778	\$794
Puerto Rico	\$481	\$496	\$506

Note: This table reflects maximum rates.

For FY 2009: For wage index values greater than 1.0, the wage portion or labor related share subject to the area wage adjustment is 69.7%. The non-labor related share is 30.3. 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 Diagnosis Related Group (DRG) wage index file for area wage adjustment calculations.

For FY 2009/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 \$193 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2008.

For FY 2010: For wage index values greater than 1.0, the wage portion or labor related share subject to the area wage adjustment is 68.8%. The non-labor related share is 31.2%. For wage index

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Table Of Regional Specific Rates For Psychiatric Hospitals And Units With Low
TRICARE Volume - FY 2008 - FY 2010

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 2010/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 \$197 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2009.

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Chapter 7

Addendum B

Table Of Maximum Rates For PHPs Before May 1, 2009
(Implementation Of OPPS), And Thereafter, Freestanding
Psychiatric PHP Reimbursement - FY 2008 - FY 2010

UNITED STATES CENSUS REGIONS	FULL-DAY RATE (6 HOURS OR MORE)			HALF-DAY RATE (3-5 HOURS)		
	10/01/07- 09/30/08	10/01/08- 09/30/09	10/01/09- 09/30/10	10/01/07- 09/30/08	10/01/08- 09/30/09	10/01/09- 09/30/10
NORTHEAST:						
New England (ME, NH, VT, MA, RI, CT)	\$284	\$293	\$299	\$214	\$221	\$222
Mid-Atlantic (NY, NJ, PA)	\$308	\$318	\$325	\$232	\$239	\$244
MIDWEST:						
East North Central (OH, IN, IL, MI, WI)	\$271	\$280	\$286	\$203	\$209	\$213
West North Central (MN, IA, MO, ND, SD, NE, KS)	\$271	\$280	\$286	\$203	\$209	\$213
SOUTH:						
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	\$292	\$301	\$307	\$219	\$226	\$231
East South Central (KY, TN, AL, MS)	\$315	\$325	\$332	\$237	\$245	\$250
West South Central (AR, LA, TX, OK)	\$315	\$325	\$332	\$237	\$245	\$250
WEST:						
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	\$318	\$328	\$334	\$240	\$248	\$253
Pacific (WA, OR, CA, AK, HI)	\$312	\$322	\$328	\$234	\$241	\$246
Puerto Rico	\$203	\$209	\$213	\$153	\$158	\$161
Days of 3 hours or less: no payment authorized.						

Note: This table reflects maximum rates.

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