



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 74
6010.58-M
OCTOBER 16, 2012**

**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: REIMBURSEMENT AND CODING UPDATES - JULY 2012

CONREQ: 16090

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: As indicated, otherwise upon direction of the Contracting Officer.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 80.

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DN: c=US, o=U.S. Government, ou=DoD,
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**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 25 PAGE(S)
DISTRIBUTION: 6010.58-M**

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

CHANGE 74
6010.58-M
OCTOBER 16, 2012

REMOVE PAGE(S)

CHAPTER 6

Section 8, pages 1 - 4

CHAPTER 7

Addendum D (FY 2010), pages 5 and 6

Addendum D (FY 2011), pages 5 and 6

Addendum D (FY 2012), pages 1 - 6

CHAPTER 13

Section 3, pages 15 - 24

INSERT PAGE(S)

Section 8, pages 1 - 4

Addendum D (FY 2010), pages 5 and 6

Addendum D (FY 2011), pages 5 and 6

Addendum D (FY 2012), pages 1 - 7

Section 3, pages 15 - 24

SUMMARY OF CHANGES

CHAPTER 6

1. Section 8. This change corrects the reporting instructions for obtaining the Capital and Direct Medical Education (CAP/DME) costs from the new CMS Cost Report Form.

CHAPTER 7

2. Addendum D (FY 2010), D (FY 2011), and D (FY 2012). This change removes an erroneous listing and adds new RTC facilities that were certified between October 1, 2011 and June 5, 2012.

CHAPTER 13

3. Section 3. This change updates the acronym for the Medical Benefits & Reimbursement Branch to MB&RB and corrects a typographical error to HCPCS Code C9355. A sentence in 3.1.5.8.3 was omitted in error, this change adds the sentence.

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

Issue Date: October 8, 1987
Authority: [32 CFR 199.14\(a\)\(1\)](#)

1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

2.0 ISSUE

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

3.0 POLICY

3.1 Adjustments to the DRG-Based Payment Amounts

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

3.2 Specific Adjustments

3.2.1 Capital Costs

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

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

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

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

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

3.2.1.5 To obtain the total allowable capital costs from the Medicare cost reports as of **May 1, 2010**, the contractor shall add the figures from Worksheet D, Part I, Column 3, lines 30-33, **lines 34 and 35 if the cost report reflects intensive care unit costs**, and **line 43**, to the figures from Worksheet D, Part II, Column 1, lines 50-76 and 88-93.

3.2.1.6 The instructions outlined in [paragraph 3.2.1.5](#), are effective for initial and amended requests received on or after **May 1, 2010**.

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

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

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

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

3.2.2 Direct Medical Education Costs

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

3.2.2.1 Direct medical education costs generally include:

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

3.2.2.1.2 Nursing schools.

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

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3.2.2.2 Direct medical education costs do not include:

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

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

3.2.2.3 To obtain the total allowable direct medical education costs from the Medicare cost reports on all initial and amended requests, the contractor shall add the figures from Worksheet B, Part I, Columns 21-24, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, line 33, and lines 37-63. These instructions are effective for all initial and amended requests received on or after October 1, 1998.

3.2.2.4 To obtain the total allowable direct medical education costs from the Medicare cost reports on all initial and amended requests as of **May 1, 2010**, the contractor shall add the figures from Worksheet B, Part I, Columns **20-23**, lines **30-33**, **lines 34 and 35 if the cost report reflects intensive care unit costs**, 43; and **50-76; and 88-93**. These instructions are effective for all initial and amended requests received on or after **May 1, 2010**.

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

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

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

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

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

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

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

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

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3.2.4 Payment Of CAP/DME Costs

3.2.4.1 General

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

3.2.4.1.1 Beginning October 1, 1998, initial requests for payment of CAP/DME shall be filed with the TRICARE contractor on or before the last day of the 12th month following the close of the hospitals' cost-reporting period. The request shall cover the one year period corresponding to the hospital's Medicare cost-reporting period. Thus, for cost-reporting periods ending on or after March 1, 1998, requests for payment of CAP/DME must be filed no later than (NLT) 12 months following the close of the cost-reporting period. For example, if a hospital's cost-reporting period ends on June 30, 1998, the request for payment shall be filed on or before June 30, 1999. Those hospitals that are not Medicare participating providers are to use an October 1 through September 30 fiscal year for reporting CAP/DME costs.

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

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

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

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

3.2.4.1.2 Prior to October 1, 1998, TRICARE had no time limit for filing initial requests for reimbursement of CAP/DME, other than the six year statute of limitations. The time limitation for filing claims does not apply to CAP/DME payment requests. To allow TRICARE contractors to close out prior year data, all initial payment requests for CAP/DME for cost-reporting periods ending

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 TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2010

FACILITY	TRICARE RATE
TENNESSEE	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	451.00
Dickson Recovery Center 222 Church Street Dickson, TN 37055 EIN: 20-4990101	413.00
TEXAS	
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	696.00
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	758.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	632.00
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	711.00
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	653.00
UTAH	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	449.00

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FACILITY	TRICARE RATE
VIRGINIA	
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	445.00
Poplar Springs West HHC Poplar Springs, Inc 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	730.00
The Pines Residential Treatment Center - Kempsville, The 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	632.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	495.00
WASHINGTON	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	628.00

- END -

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Chapter 7, Addendum D (FY 2011)

TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2011

FACILITY	TRICARE RATE
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	745.00
TENNESSEE	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	462.00
TEXAS	
Cedar Crest Hospital and RTC HMTN Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	714.00
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	777.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	648.00
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	729.00
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	669.00
UTAH	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	460.00
UHS of Provo Canyon, Inc / Provo Canyon School 1350 East 750 North Orem, UT 84097 EIN: 23-3044423	460.00

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FACILITY	TRICARE RATE
UHS of Timpanogos Center of Change 1790 N. State Street Orem, UT 84057 EIN: 20-3687800	577.00
VIRGINIA	
Cumberland Hospital for Children and Adolescents dba Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 EIN: 02-0567575	762.00
Hallmark Youthcare - Richmond 12800 West Creek Parkway Richmond, VA 23238 EIN: 58-2156548	772.00
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	456.00
The Pines Residential Treatment Center - Kempsville, The 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	648.00
Poplar Springs West HHC Poplar Springs, Inc 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	748.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	507.00
WASHINGTON	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	644.00

- END -

Chapter 7

Addendum D (FY 2012)

**TRICARE-Authorized Residential Treatment Centers (RTCs) -
FY 2012**

The rates in this Addendum will be used for payment of claims for services rendered on or after October 1, 2011. The rates were adjusted by the lesser of the FY 2012 Medicare update factor (3.0%) or the amount that brought the rate up to the new cap amount of \$801.

This listing is for RTC per diem rates only. It does not reflect a facility's current status as a TRICARE-authorized RTC. Information regarding a facility's current status as an authorized provider can be obtained from the appropriate contractor.

FACILITY	TRICARE RATE
ALASKA	
DeBarr Residential Treatment Center Frontline Hospital, LLC 1500 DeBarr Circle Anchorage, AK 99508 EIN: 72-1539254	801.00
ARIZONA	
Southwest Children's Health Services dba Parc Place 2190 North Grace Blvd Chandler, AZ 85225 EIN: 86-0768611	429.00
ARKANSAS	
BHC Pinnacle Pointe Hospital 11501 Financial Center Parkway Little Rock, AR 72211 EIN: 62-1658502	796.00
COLORADO	
CBR Youth Connect 28071 Hwy 109 La Junta, CO 81050 EIN: 84-0500375	737.00
PSI Cedar Springs Hospital, Inc. Cedar Springs Behavioral Health Systems, Inc 2135 Southgate Road Colorado Springs, CO 80906 EIN: 74-3081810	801.00

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 TRICARE-Authorized Residential Treatment Centers (RTCs) - FY 2012

FACILITY	TRICARE RATE
FLORIDA	
LaAmistad Behavioral Health Services 1650 Park Avenue North Maitland, FL 32751 EIN: 58-1791069	760.00
Manatee Palms Youth Service 4480 51st Street West Bradenton, FL 34210 EIN: 65-0816927	713.00
The National Deaf Academy, LLC RTC 19650 Hwy 441 Mt. Dora, FL 32757 EIN 59-3653865	801.00
River Point Behavioral Health TBJ Behavioral, LLC 6300 Beach Blvd Jacksonville, FL 32216 EIN: 20-4865566	617.00
University Behavioral, LLC dba University Behavioral Center 2500 Discovery Drive Orlando, FL 32826 EIN: 20-5202458	684.00
GEORGIA	
Costal Harbor Treatment Center UHS of Savannah, LLC 1150 Cornell Avenue Savannah, GA 31406 EIN: 20-0931196	442.00
UHS of Laurel Heights, LP Laurel Heights Hospital 934 Briarcliff Road NE Atlanta, GA 30306 EIN: 23-3045288	764.00
Youth Villages, Inc 4685 Dorsett Shoals Road Douglasville, GA 30135 EIN: 58-1716970	801.00
HAWAII	
Kahi Mohala Behavioral Health Sutter Health Pacific 91-2301 Fort Weaver Road Ewa Beach, HI 96706 EIN: 99-0298651	801.00

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FACILITY	TRICARE RATE
Queen's Medical Center/Family Treatment Ctr The Queen's Healthcare System 1301 Punchbowl Honolulu, HI 96813 EIN: 99-0073524	773.00
IDAHO	
Eastern Idaho Regional Medical Center - Behavioral Health Center 2280 E 25th Street Idaho Falls, ID 83404 EIN: 82-0436622	363.00
Kootenai Medical Center 2003 Lincoln Way Coeur d'Alene, ID 83814 EIN: 82-0231746	461.00
INDIANA	
Michiana Behavioral Health Center HHC Indiana, Inc 1800 North Oak Road Plymouth, IN 46563 EIN: 20-0768028	452.00
Valle Vista Hospital, LLC Valle Vista Health System 898 East Main Street Greenwood, IN 46143 EIN: 62-1740366	478.00
KENTUCKY	
Ten Broeck Hospital -- Dupont TBD Acquisition, LLC Louisville, KY 40207 EIN: 20-5048087	677.00
Ten Broeck Hospital -- Louisville KMI Acquisition, LLC 8521 LaGrange Road Louisville, KY 40242 EIN: 20-5048153	720.00
MARYLAND	
Adventist Healthcare Inc dba Adventist Behavior Health 14901 Broschart Road Rockville, MD 20850 EIN: 52-1532556	416.00

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FACILITY	TRICARE RATE
MISSOURI	
Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 EIN: 44-0545808	345.00
Heartland Behavioral Health Services, Inc Great Plains Hospital, Inc 1500 W. Asland Nevada, MO 64772 EIN: 43-1328523	422.00
Lakeland Regional Hospital Lakeland Hospital Acquisition Corporation 440 South Market Avenue Springfield, MO 65806 EIN: 58-2291915	431.00
MONTANA	
Acadia Montana 55 Basin Creek Road Butte, MT 59701 EIN: 62-1681724	463.00
Shodair Children's Hospital Montana Children's Home & Hospital 2755 Colonial Drive Helena, MT 59601 EIN: 81-0231789	461.00
NEVADA	
Willow Springs Center Willow Springs, LLC 690 Edison Way Reno, NV 89502 EIN: 62-1814471	801.00
NEW MEXICO	
BHC Lovelace Sandia Health System BHC Mesilla Valley Hospital, LLC 3751 Del Ray Blvd Las Cruces, NM 88012 EIN: 20-2612295	338.00
NORTH CAROLINA	
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 EIN: 56-1317433	491.00

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FACILITY	TRICARE RATE
OHIO	
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 EIN: 62-1658523	423.00
PENNSYLVANIA	
KidsPeace National Centers 5300 KidsPeace Drive Orefield, PA 18069 EIN: 23-2654908	561.00
SOUTH CAROLINA	
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 EIN: 57-1101380	460.00
Three Rivers Residential Treatment - Midlands Campus 200 Ermine Road West Columbia, SC 29170 EIN: 57-0884924	768.00
TENNESSEE	
Compass Intervention Center Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125 EIN: 62-1837606	476.00
TEXAS	
Cedar Crest Hospital and RTC HMTH Cedar Crest, LLC 3500 South IOH - 35 Belton, TX 76513 EIN: 20-1915868	736.00
Laurel Ridge Treatment Center Texas Laurel Ridge Hospital 17720 Corporate Woods Drive San Antonio, TX 78259 EIN: 43-2002326	801.00
Meridell Achievement Center 12550 W Hwy 29 Liberty Hill, TX 78642 EIN 74-1655289	668.00

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FACILITY	TRICARE RATE
San Marcos Treatment Center Texas San Marcos Treatment, LP 120 Bert Brown Road San Marcos, TX 78666 EIN: 43-2002231	751.00
Southwest Mental Health Center 8535 Tom Slick Drive San Antonio, TX 78229-3363 EIN: 74-1153067	690.00
UTAH	
UHS of Provo Canyon, Inc / Provo Canyon School 4501 North University Avenue Provo, UT 84604 EIN: 23-3044423	474.00
UHS of Provo Canyon, Inc / Provo Canyon School 1350 East 750 North Orem, UT 84097 EIN: 23-3044423	474.00
UHS of Timpanogos Center of Change 1790 N. State Street Orem, UT 84057 EIN: 20-3687800	595.00
VIRGINIA	
Cumberland Hospital for Children and Adolescents dba Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 EIN 02-0567575	785.00
Hallmark Youthcare - Richmond 12800 West Creek Parkway Richmond, VA 23238 EIN: 58-2156548	796.00
Harbor Point Behavioral Health Center 301 Fort Lane Portsmouth, VA 23704 EIN: 54-1465094	668.00
Newport News Behavioral Health Center 17579 Warwick Blvd Newport News, VA 23603 EIN: 32-0066225	470.00

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FACILITY	TRICARE RATE
North Spring Behavioral Healthcare 42009 Victory Lane Leesburg, VA 20176 EIN: 20-1215130	504.00
The Pines Residential Treatment Center - Kempsville, The 860 Kempsville Road Norfolk, VA 23502 EIN: 54-1465094	668.00
Poplar Springs West HHC Poplar Springs, Inc 350 Poplar Drive Petersburg, VA 23805 EIN: 20-0959684	771.00
Riverside Health Behavioral Center 2244 Executive Drive Hampton, VA 23666 EIN: 54-1979321	523.00
WASHINGTON	
Tamarack Center 2901 West Fort George Wright Drive Spokane, WA 99224 EIN: 91-1216841	664.00

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Chapter 13, Section 3

Prospective Payment Methodology

3.1.5.6 Rural SCH payments will be increased by 7.1%. This adjustment will apply to all services and procedures paid under the OPSS (SIs of **P, S, T, V, and X**), excluding drugs, biologicals and services paid under the pass-through payment policy (SIs of **G and H**).

3.1.5.6.1 The adjustment amount will not be reestablished on an annual basis, but may be reviewed in the future, and if appropriate, may be revised.

3.1.5.6.2 The adjustment is budget neutral and will be applied before calculating outliers and copayments/cost-sharing.

3.1.5.7 Temporary Transitional Payment Adjustments (TTPAs)

3.1.5.7.1 On May 1, 2009 (implementation of TRICARE's OPSS), the TTPAs shall apply to all network and non-network hospitals. For network hospitals, the TTPAs will cover a four year period. The four year transition will set higher payment percentages for the 10 APC codes 604-609 and 613-616 during the first year, with reductions in each of the transition years. For non-network hospitals, the adjustment will cover a three year period, with reductions in each of the transition years for the same 10 APC codes. Figure 13.3-4 provides the TTPA percentage adjustments for the 10 visit APC codes for network and non-network hospitals. An applicable Explanation of Benefits (EOB) message will be applied.

3.1.5.7.2 TTPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

FIGURE 13.3-4 TTPA ADJUSTMENT PERCENTAGES FOR 10 VISIT APC CODES

YEARS	NETWORK		NON-NETWORK	
	EMERGENCY ROOM	HOSPITAL CLINIC	EMERGENCY ROOM	HOSPITAL CLINIC
Year 1	200%	175%	140%	140%
Year 2	175%	150%	125%	125%
Year 3	150%	130%	110%	110%
Year 4	130%	115%	100%	100%
Year 5	100%	100%	100%	100%

3.1.5.8 Temporary Military Contingency Payment Adjustments (TMCPAs)

Under the authority of the last paragraph of 32 CFR 199.14(a)(6)(ii), the following OPSS adjustments are authorized.

3.1.5.8.1 Transitional TMCPAs

In view of the ongoing military operations in Afghanistan and Iraq, the TMA Director has determined that it is impracticable to support military readiness and contingency operations without adjusting OPSS payments for network hospitals that provide a significant portion of the health care of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs). Therefore effective May 1, 2009, network hospitals that have received OPSS payments of \$1.5 million or more for care provided to ADSMs and ADDs during an OPSS year (May 1 through April 30), shall be granted a Transitional TMCPA in addition to the TTPAs for the first four years of the

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OPPS implementation. At the end of the first year of OPPS implementation, i.e., April 30, 2010, the total TRICARE OPPS payments for each one of these qualifying hospitals will be increased by 20%. Second and subsequent year adjustments (assuming a hospital continues to meet the \$1.5 million threshold) will be reduced by 5% per year until the OPPS payment levels are reached; (i.e., 15% year two, 10% year three, and 5% year four). The adjustment will be applied to the total year OPPS payment amount received by the hospital for all active duty members and all TRICARE beneficiaries (including ADDs, retirees and their family members, but excluding TRICARE For Life (TFL) beneficiaries) for whom TRICARE is primary payer. These year-end adjustments will be paid approximately four months following the end of the OPPS year. In year five, the OPPS payments will be at established APC levels.

3.1.5.8.1.1 TMA will run a query of claims history to determine which network hospitals qualify for Transitional TMCPAs at year end; i.e., those network hospitals receiving OPPS payments of \$1.5 million or more for care of ADSMs and ADDs during the previous OPPS year (May 1 through April 30).

3.1.5.8.1.2 These queries will be run in subsequent Transitional TMCPA years to determine those network hospitals qualifying for Transitional TMCPAs.

3.1.5.8.1.3 The year end adjustment will be paid approximately four months following the end of the OPPS year. Each year, subsequent adjustments will be issued to the qualifying hospitals for the prior OPPS year to ensure claims that were not Processed To Completion (PTC) the previous year are adjusted. This adjustment payment is separate from the applicable TMCPA percentage in effect during the current transitional year.

Example: At the end of the second OPPS year, a qualifying hospital's total TRICARE OPPS payments will be increased by 15%. The hospital will also receive an additional adjustment for the first OPPS year for those claims that were not PTC and included in the prior year's payment. This subsequent adjustment would be paid at the first year's TMCPA percentage of 20%.

3.1.5.8.1.4 The TMA Medical Benefits and Reimbursement **Branch** (MB&RB) shall verify the accuracy of the Transitional TMCPA amounts and provide the contractor's with a copy of the report noting which hospitals in their region qualify for the Transitional TMCPAs and the amounts to pay. MB&RB shall also provide a copy of the report to Contract Resource Management (CRM).

3.1.5.8.1.5 The contractors shall submit the Transitional TMCPAs amounts on a voucher in accordance with the requirements of the TRICARE Operations Manual (TOM), [Chapter 3, Section 4](#). The voucher shall be sent electronically to RM.Invoices@tma.osd.mil at the TMA CRM Office and to OPPS.MBRB@tma.osd.mil at the MB&RB before releasing payments. The vouchers should contain the following information: hospital name, address, Medicare number or provider number, Tax Identification Number (TIN), and the amount to be paid. Listings shall separate payments for prior OPPS years and the current OPPS year.

3.1.5.8.1.6 CRM shall send an approval to the contractors to issue Transitional TMCPA payments out of the non-financially underwritten bank account based on fund availability.

3.1.5.8.1.7 Hospitals that previously qualified for Transitional TMCPAs but subsequently fell below \$1.5 million revenue threshold would no longer be eligible for the adjustment. However, if a

subsequent adjustment for the prior OPSS year results in a hospital exceeding the \$1.5 million revenue threshold, the hospital shall receive the Transitional TMCPA for the prior year.

3.1.5.8.1.8 New hospitals that meet the \$1.5 million revenue threshold would be eligible for the Transitional TMCPA percentage adjustment in effect during the transitional year in which the revenue threshold was met.

Example: A hospital that meets the \$1.5 million revenue threshold in year three of the transition but failed to meet it in year one and two, would receive a percentage adjustment of 10%.

3.1.5.8.2 General TMCPAs

The TMA Director, or designee at any time after OPSS implementation, has the authority to adopt, modify and/or extend temporary adjustments for TRICARE network hospitals located within MTF Prime Service Areas (PSAs) and deemed essential for military readiness and support during contingency operations. The TMA Director may approve a General TMCPA for hospitals that serve a disproportionate share of ADSMs and ADDs. In order for a hospital to be considered for a General TMCPA, the hospital's outpatient revenue received for services provided to TRICARE ADSMs and ADDs must have been at least 10% of the hospital's total outpatient revenue received during the previous OPSS year (May 1 through April 30) or the number of OPSS visits by ADSMs and ADDs during that same 12-month period must have been at least 50,000. Billed charges will not be used as the basis for determining a hospital's eligibility for a General TMCPA.

3.1.5.8.2.1 General TMCPA Process for the First OPSS Year (May 1, 2009 through April 30, 2010); Second OPSS Year (May 1, 2010 through April 30, 2011); and Third OPSS Year (May 1, 2011 through April 30, 2012)

3.1.5.8.2.1.1 The Director, TRICARE Regional Office (DTRO), shall conduct a thorough analysis and recommend the appropriate year end adjustment to total OPSS payments for a network hospital qualifying for a General TMCPA.

3.1.5.8.2.1.2 In analyzing and recommending the appropriate year end percentage adjustment, the DTRO will ensure the General TMCPA adjustment does not exceed 95% of the amount that would have been paid prior to implementation of OPSS. Although, the maximum amount that a hospital can receive is 95% of the pre-OPSS amount, this does not infer the hospital is entitled to receive the full 95%. It is the DTRO's discretion on what percentage adjustment is appropriate to ensure access to care (ATC) in a facility requesting a General TMCPA. This applies to TRICARE beneficiaries when TRICARE is the primary payer. The contractors shall provide the history of pre-OPSS payments for the analysis to the DTRO.

3.1.5.8.2.1.3 Total TRICARE OPSS payments (including the TTPAs) and Transitional TMCPAs, if applicable, of the qualifying hospital will be increased by the Director TMA, or designee, approved adjustment percentage by way of an additional payment after the end of the OPSS year (May 1 through April 30). **At the end of the second and third OPSS years**, subsequent adjustments will be issued to the qualifying hospitals for the **first and second OPSS years** to ensure claims that were not PTC the previous year are adjusted. This adjustment payment is separate from the applicable General TMCPA percentage approved for the current OPSS year.

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Example: Assume a hospital was approved for a General TMCPA of 5% for the first year of OPPS and a General TMCPA of 8% for the second year of OPPS. At the end of the second year, the hospital will receive an adjustment of 5% for the first OPPS year for those claims that were not PTC and included in the prior year's payment. The General TMCPA is applied to the total OPPS payment amount at year end.

3.1.5.8.2.1.4 General TMCPAs will be reviewed and approved on an annual basis; i.e., General TMCPAs will have to be evaluated on a yearly basis by the DTRO in order to determine if the hospital continues to serve a disproportionate share of ADSMs and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities. This will include a recommendation for the appropriate OPPS year end adjustment to total OPPS payments.

3.1.5.8.2.1.5 The hospital's request for a General TMCPA for the first OPPS year (May 1, 2009 through April 30, 2010); second OPPS year (May 1, 2010 through April 30, 2011); and third OPPS year (May 1, 2011 through April 30, 2012) shall include the data requirements in [paragraph 3.1.5.8.2.2](#), and a full 12 months of claims payment data from the OPPS year the General TMCPA is requested.

3.1.5.8.2.1.6 The TMA MB&RB shall verify the accuracy of the General TMCPA amounts and provide the contractor's with a copy of the report noting which hospitals in their region qualify for the General TMCPAs and the amounts to pay. MB&RB shall also provide a copy of the report to CRM.

3.1.5.8.2.1.7 The contractor shall submit the General TMCPA amounts on a voucher in accordance with the requirements of the TOM, [Chapter 3, Section 4](#). The voucher shall be sent electronically to RM.Invoices@tma.osd.mil at the TMA CRM Office and to OPPS.MBRB@tma.osd.mil at the MB&RB before releasing payments. The vouchers should contain the following information: hospital name, address, Medicare number or provider number, TIN, and the amount to be paid. Listings shall separate payments for prior OPPS years and the current OPPS year. Additional vouchers shall be submitted, as needed, for voided/staledated checks and/or for reissued or adjusted payments.

3.1.5.8.2.1.8 CRM shall send an approval to the contractors to issue General TMCPA payments out of the non-financially underwritten bank account based on fund availability.

3.1.5.8.2.2 Annual Data Requirements for General TMCPAs for the First OPPS Year (May 1, 2009 through April 30, 2010); Second OPPS Year (May 1, 2010 through April 30, 2011); and Third OPPS Year (May 1, 2011 through April 30, 2012)

Hospital required data submissions to the contractor for review and consideration:

3.1.5.8.2.2.1 The hospital's percent of outpatient revenue derived from ADSM plus ADD OPPS visits; i.e., the outpatient revenue from TRICARE ADSM plus ADD visits divided by total outpatient revenue (TRICARE and non-TRICARE) derived from all other third party payers and private pay during the previous OPPS year; i.e., May 1 through April 30. Reference [paragraph 3.1.5.8.2](#).

3.1.5.8.2.2.2 The number of OPPS visits by ADSMs and ADDs during the previous OPPS year; i.e., May 1 through April 30.

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3.1.5.8.2.2.3 Hospital-specific Medicare outpatient CCR based on the hospital's most recent cost reporting period.

3.1.5.8.2.2.4 Hospital's Medicare outpatient payment to charge ratio based on the corresponding Medicare cost reporting period.

3.1.5.8.2.2.5 The hospital's recommended percentage adjustment as supported by the above data requirement submissions.

3.1.5.8.2.3 Annual Contractor Data Review Requirements for the First OPSS Year (May 1, 2009 through April 30, 2010); Second OPSS Year (May 1, 2010 through April 30, 2011); and Third OPSS Year (May 1, 2011 through April 30, 2012)

3.1.5.8.2.3.1 Data requirements for evaluation of network adequacy necessary to support military contingency operations:

- Number of available primary care and specialist providers in the network locality;
- Availability (including reassignment) of military providers in the locations or nearby;
- Appropriate mix of primary care and specialists needed to satisfy demand and meet appropriate patient access standards (appointment/waiting time, travel distance, etc.);
- Efforts that have been made to create an adequate network, and
- Other cost effective alternatives and other relevant factors.

3.1.5.8.2.3.2 If upon initial evaluation, the contractor determines the hospital meets the disproportionate share criteria in [paragraph 3.1.5.8.2](#), and is essential for continued network adequacy, the request from the hospital along with the above supporting documentation shall be submitted to the TRICARE Regional Office (TRO) for review and determination.

3.1.5.8.2.4 For the first OPSS year (May 1, 2009 through April 30, 2010); second OPSS year (May 1, 2010 through April 30, 2011); and third OPSS year (May 1, 2011 through April 30, 2012); the DTRO shall conduct a thorough analysis and recommend the appropriate percentage adjustments to be applied for that year; i.e., the General TMCPAs will be reviewed and approved on an annual basis. The recommendation with a cost estimate shall be submitted to the MB&R to be forwarded to the Director, TMA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&R for TMA Director review and approval.

3.1.5.8.2.5 General TMCPA Process for OPSS Year Four and Subsequent Years (May 1, 2012 and After)

3.1.5.8.2.5.1 The hospital's request for a General TMCPA shall include the data requirements in [paragraphs 3.1.5.8.2.2.1](#) through [3.1.5.8.2.2.4](#).

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3.1.5.8.2.5.2 The MCSC shall conduct an initial evaluation and determine if the requesting hospital meets the disproportionate share criteria in [paragraph 3.1.5.8.2](#), and is essential for continued network adequacy. The request from the hospital for a General TMCPA along with the supporting documentation in [paragraphs 3.1.5.8.2.2.1](#) through [3.1.5.8.2.2.4](#) and [3.1.5.8.2.3](#), shall be submitted to the DTRO for review and determination.

3.1.5.8.2.5.3 The DTRO shall request TMA MB&RB run a query of claims history to determine if the network hospital qualifies for a General TMCPA, i.e., the hospital's payment-to-cost ratio is less than 1.3 for care provided to ADSMs and ADDs during the previous OPPS year (May 1 through April 30).

3.1.5.8.2.5.4 The DTRO shall review the supporting documentation and the report from TMA MB&RB, determine if the network hospital qualifies for a General TMCPA. The recommendation for approval of a General TMCPA shall be submitted to the MB&RB to be forwarded to the Director, TMA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RB for TMA Director review and approval.

3.1.5.8.2.5.5 If a hospital meets the disproportionate share criteria in [paragraph 3.1.5.8.2](#), and is deemed essential for network adequacy to support military contingency operations, the approved hospital's General TMCPA payment will be set so the hospital's payment-to-cost ratio for TRICARE HOPD services does not exceed a ratio of 1.30. A hospital cannot be approved for a General TMCPA payment if it results in the hospital earning more than 30% above its costs for TRICARE beneficiaries.

3.1.5.8.2.5.6 Total TRICARE OPPS payments (including the TTPAs and the Transitional TMCPA) of the qualifying hospital will be increased by the Director TMA, or designee, by way of an additional payment after the end of the OPPS year (May 1 through April 30). Subsequent adjustments will be issued to the qualifying hospitals for the prior OPPS year to ensure claims that were not PTC the previous year are adjusted. The adjustment payment is separate from the applicable General TMCPA approved for the current OPPS year.

3.1.5.8.2.5.7 Upon approval of the General TMCPA request by the TMA Director, MB&RB shall notify the TRO of the approval. The TRO shall notify the Contracting Officer (CO) who shall send a letter to the MCSC notifying them of the approval.

3.1.5.8.2.5.8 The MCSCs shall submit the General TMCPA amounts on a voucher in accordance with requirements of the TOM, [Chapter 3, Section 4](#). The voucher shall be sent electronically to RM.Invoices@tma.osd.mil at the TMA CRM Office before releasing payments. The vouchers should contain the following information: hospital name, address, Medicare number or provider number, TIN, and the amount to be paid. Listings shall separate payments for prior OPPS years and the current OPPS year.

3.1.5.8.2.5.9 CRM shall send an approval to the contractors to issue General TMCPA payments out of the non-financially underwritten bank account based on fund availability.

3.1.5.8.2.5.10 General TMCPAs will be reviewed and approved on an annual basis; i.e., they will have to be evaluated on a yearly basis by the DTRO in order to determine if the hospital continues to serve a disproportionate share of ADSMs and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities.

3.1.5.8.2.6 TMA Director, or designee review.

- The Director, TMA or designee is the final approval authority.
- A decision by the Director TMA or designee to adopt, modify, or extend General TMCPAs is not subject to appeal.

3.1.5.8.3 Non-Network TMCPAs

TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that the procedures cannot be obtained timely enough from a network hospital. This determination will be based on the contractor's and TRO's evaluation of network adequacy data related to the specific procedures for which the TMCPA is being requested as outlined under [paragraph 3.1.5.8.2.3](#). Non-network TMCPAs will be adjusted on a claim-by-claim basis. **The associated costs would be underwritten or non-underwritten following the applicable financing rules of the contract.**

3.1.5.8.4 Application of Cost-Sharing

3.1.5.8.4.1 Transitional and General TMCPAs are not subject to cost-sharing.

3.1.5.8.4.2 Non-network TMCPAs shall be subject to cost-sharing since they are applied on a claim-by-claim basis.

3.1.5.8.5 Reimbursement of Transitional, General, and Non-Network TMCPA costs shall be paid as pass-through costs. The contractor does not financially underwrite these costs.

3.1.5.9 Hold Harmless TRICARE Transitional Outpatient Payments (TTOPs)

3.1.5.9.1 Effective January 1, 2010, TRICARE adopted Medicare's hold harmless provision for rural hospitals with 100 or fewer beds and all SCHs regardless of bed size. TRICARE will apply the hold harmless provision to these hospitals as long as the provision remains in effect under Medicare.

3.1.5.9.2 TTOPs will be made to qualifying hospitals that have OPPS costs that are greater than their TRICARE allowed amounts. The 7.1% increase for SCHs, the TTPAs for ER and clinic visits, Transitional and General TMCPAs, if applicable, will be included in the allowed amounts when determining if a hospital's OPPS costs are greater than their TRICARE allowed amounts.

3.1.5.9.3 TRICARE will use a method similar to Medicare to reimburse these hospitals their TTOPs. TRICARE will pay qualifying hospitals an amount equal to 85% of the difference between the estimated OPPS costs and the OPPS payment.

3.1.5.9.4 Process for TTOPs Year One (Effective January 1, 2010, through December 31, 2010) and Subsequent Years

3.1.5.9.4.1 TMA will run query reports of claims history to determine which hospitals qualify for TTOPs at year end; i.e., those hospitals whose costs exceeded their allowed amounts during the previous TTOPs year (January 1 through December 31).

3.1.5.9.4.2 These query reports will be run in subsequent TTOPs years to determine those hospitals qualifying for TTOPs.

3.1.5.9.4.3 The year end adjustment will be paid approximately six months following the end of the TTOPs year. Each year, subsequent adjustments will be issued to the qualifying hospitals for the prior TTOPs year to ensure claims that were not PTC the previous year are adjusted.

3.1.5.9.4.4 The TMA MB&RB shall provide the MCSC with a copy of the query report noting which hospitals in their region qualify for the TTOPs and the amounts to pay. A copy of the report shall also be provided to TMA's CRM.

3.1.5.9.4.5 The contractor shall process the adjustment payments per the instructions in Section G of their contracts under Invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No payments will be sent out without approval from TMA-Aurora (TMA-A), CRM, Budget.

3.2 Transitional Pass-Through for Innovative Medical Devices, Drugs, and Biologicals

3.2.1 Items Subject to Transitional Pass-Through Payments

3.2.1.1 Current Orphan Drugs

A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

Note: Orphan drugs will be paid separately at the Average Sales Price (ASP) + 6%, which represents a combined payment for acquisition and overhead costs associated with furnishing these products. Orphan drugs will no longer be paid based on the use of drugs because all orphan drugs, both single-indication and multi-indication, will be paid under the same methodology. The TRICARE contractors will not be required to calculate orphan drug payments.

3.2.1.2 Current Cancer Therapy Drugs, Biologicals, and Brachytherapy

These items are drugs or biologicals that are used in cancer therapy, including (but not limited to) chemotherapeutic agents, antiemetics, hematopoietic growth factors, colony stimulating factors, biological response modifiers, biphosphonates, and a device of brachytherapy if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

3.2.1.3 Current Radiopharmaceutical Drugs and Biological Products

A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service was being made on the first date that the OPPS was implemented.

3.2.1.4 New Medical Devices, Drugs, and Biologicals

New medical devices, drugs, and biologic agents, will be subject to transitional pass-

through payment in instances where the item was not being paid for as a hospital outpatient service as of December 31, 1996, and where the cost of the item is "not insignificant" in relation to the hospital OPPS payment amount.

3.2.2 Items eligible for transitional pass-through payments are generally coded under a Level II HCPCS code with an alpha prefix of "C".

- Pass-through device categories are identified by SI of **H**
- Pass-through drugs and biological agents are identified by SI of **G**

3.2.3 Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2009

3.2.3.1 Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug Competitive Acquisition Program (CAP) at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Social Security Act (SSA) rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug or biological.

3.2.3.2 Provide payment for drugs and biologicals with pass-through status that are not part of the Part B drug CAP at a rate of ASP + 6%, the amount authorized under section 1843(o) of the Act, rather than ASP + 4% that would be the otherwise applicable fee schedule portion associated with drug and biological.

3.2.3.3 The difference between ASP + 4% and ASP + 6%, therefore would be the CY 2009 pass-through payment amount for these drugs and biologicals.

3.2.3.4 Considering diagnostic radiopharmaceuticals to be drugs for pass-through purposes which will be reimbursed based on the ASP methodology; i.e., ASP + 6%.

3.2.3.5 Therapeutic radiopharmaceuticals with pass-through status in CY 2009 will be paid at hospital charges adjusted to cost, the same payment methodology as other therapeutic radiopharmaceuticals in CY 2009.

3.2.3.6 If a drug or biological that has been granted pass-through status for CY 2009 becomes covered under the Part B drug CAP (if the program is reinstated) the Centers for Medicare and Medicaid Services (CMS) will provide payment for Part B Drugs that are granted pass-through status and are covered under the Part B drug CAP at the Part B drug CAP rate.

3.2.3.7 Beneficiary copayments/cost-sharing will be based on the entire ASP of the transition pass-through drug or biological.

3.2.3.8 Drugs and biologicals that are continuing pass-through status or have been granted pass-through status as of January 2009 for CY 2009 are displayed in [Figure 13.3-5](#).

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FIGURE 13.3-5 DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2009

CY 2008	CY 2009			
HCPCS	HCPCS	SHORT DESCRIPTOR	SI	APC
C9238	J1953	Levetiracetam injection	G	9238
C9239	J9330	Temsirolimus injection	G	1168
C9240*	J9207	Exabepilone injection	G	9240
C9241	J1267	Doripenem injection	G	9241
C9242	J1453	Fosaprepitant injection	G	9242
C9243	J9033	Bendamustine injection	G	9243
C9244	J2785	Injection, regadenoson	G	9244
C9354	C9354	Veritas collagen matrix, cm2	G	9354
C9355	C9355	Neuromatrix nerve cuff, cm	G	9355
C9356	C9356	TendoGlide Tendon prot, cm2	G	9356
C9357	Q4114	Integra flowable wound matri	G	1251
C9358	C9358	SurgiMend, 0.5cm2	G	9358
C9359	C9359	Implant, bone void filler	G	9359
J1300	J1300	Eculizumab injection	G	9236
J1571	J1571	Hepagam b im injection	G	0946
J1573	J1573	Hepagam b intravenous, inj	G	1138
J3488*	J3488	Reclast injection	G	0951
J9225*	J9225	Vantas implant	G	1711
J9226	J9226	Supprelin LA implant	G	1142
J9261	J9261	Nelarabine injection	G	0825
Q4097	J1459	Inj IVIG privigen 500 mg	G	1214
	C9245	Injection, romiplostim	G	9245
	C9246	Inj, gadoxetate	G	9246
	C9248	Inj, clevidipine butyrate	G	9248

* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology (prior to January 1, 2009) while identified as pass-through under the OPPS.

3.2.4 Reduction of Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals to Offset Costs Packaged Into APC Groups

3.2.4.1 Prior to CY 2008, certain diagnostic radiopharmaceuticals were paid separately under the OPPS if their mean per day cost were greater than the applicable year's drug packaging threshold.

3.2.4.2 In CY 2008, CMS payment for all non-pass-through diagnostic radiopharmaceuticals were packaged as ancillary and supportive items and service.

3.2.4.3 In CY 2009, continued to package payment for all non-pass-through diagnostic radiopharmaceuticals.

3.2.4.4 For OPPS pass-through purposes, radiopharmaceuticals are considered to be "drugs" where the transitional pass-through for the drugs and biologicals is the difference between the