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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 85
6010.58-M
AUGUST 22, 2013**

**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: COMPLIANCE DATE CHANGE FOR CONVERSION FROM INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION (ICD-9) TO INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION (ICD-10) CODING

CONREQ: 16287

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): The Health Insurance Portability and Accountability Act (HIPAA) Final Rule published in the Federal Register on January 16, 2009, mandated nationwide conversion from ICD-9, Clinical Modification (ICD-9-CM) coding to ICD-10, Clinical Modification (ICD-10-CM) (diagnosis) and ICD-10, Procedure Coding System (ICD-10-PCS) (procedures). On September 5, 2012, the compliance date was changed to October 1, 2014, as part of a Final Rule published by Health and Human Services (HHS), for the ICD-10-CM and ICD-10-PCS Medical Data Code Sets. Language previously published in the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM) is revised to include the new compliance date.

EFFECTIVE DATE: October 1, 2014.

IMPLEMENTATION DATE: October 1, 2014.

This change is made in conjunction with Feb 2008 TOM, Change No. 103, Feb 2008 TPM, Change No. 95, and Feb 2008 TSM, Change No. 51.

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**ATTACHMENT(S): 30 PAGE(S)
DISTRIBUTION: 6010.58-M**

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

**CHANGE 85
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REMOVE PAGE(S)

CHAPTER 1

Section 20, pages 3 and 4
Section 34, pages 1 through 7
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CHAPTER 6

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CHAPTER 11

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Section 4, pages 19 and 20

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Addendum A, pages 1 and 2

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Section 4, pages 19 and 20

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Chapter 1, Section 20

State Agency Billing

CONDITION	PROCEDURE
Diagnosis Missing	Waive on office visits (unless services appear to be for a routine physical or related to other excluded services); consultations; drugs; lab; x-ray; assistant surgeon and anesthesiology. For services provided on or before September 30, 2014 , use International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code 799.9 in absence of a correct code. For services provided on or after October 1, 2014 , use International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code R69 or R99 in absence of a correct code.
Diagnosis Missing	Require on hospital, surgery, and mental health. For DME, if the record provides information other than a diagnosis which can reasonably support the payment, proceed. Return the incomplete claim, which requires a diagnosis, to the state for supporting information.
Timely filing limits.	The state shall file no later than (NLT) one year following the date of service: one year after the date the prescription was filled; one year after the date of discharge if the services were rendered during an inpatient admission; or one year after the state received the results of the annual data match from the Defense Manpower Data Center (DMDC), Defense Enrollment Eligibility Reporting System (DEERS) Division. For waivers, see the TOM, Chapter 8, Section 3, paragraph 2.0 .

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2.1.3 TRICARE Encounter Data (TED) Reporting of State Agency Claims

Claims received for state agencies will be processed with the Special Processing Code '1' on TEDs (see the TSM, [Chapter 2](#)). TED coding will follow the basic requirements for a participating claim with the state Medicaid agency designated as the payee. The amount paid by the government must be reported in the Amount Paid by Government Contractor field.

2.1.4 Development with State Agencies

States are obligated to provide the data needed to process the claims they submit, including eligibility and other beneficiary information. In some cases, the contractor will need to develop data through DEERS or other in-house information to accurately process the claim. For other required data, or in case of failure to locate essential information, the contractor shall deny the claim. If a state routinely fails to submit required data on its claims, the contractor shall contact the state agency and request cooperation. TRICARE Management Activity (TMA) shall be advised of any such problems and the results of any contacts.

2.1.5 Duplicate Checking

Contractors shall ensure that precautions are taken to prevent duplicate payments, as provided in the TOM, [Chapter 8, Section 9](#). In cases where the exact type of service data has not been provided, but a duplication of types of service is apparent; e.g., apparent duplication of lab and office services, the contractor shall attempt to resolve the case with the data available in-house. If the matter cannot be resolved, assume duplication and deny the claim. If the state agency has information to the contrary, it may resubmit with the necessary documentation to refute the assumption. If a beneficiary or provider has submitted claims for services directly to TRICARE and the same services have also been sent to the state for Medicaid payment, the possibility of fraud must be considered. Since the patient would have been TRICARE-eligible, any fraud would have been an offense against the state program. Return the claim to the state agency and advise them of the facts including that payment has been made by TRICARE. The contractor shall cooperate in any

state investigation to the extent possible under TRICARE guidelines. In any case of doubt about what information can be released in an investigation, contact TMA for instructions.

2.1.6 Non-Availability Statement (NAS)

The state must include the address of the beneficiary on the claim and the contractor shall verify whether a NAS is required, using normal processing rules, including a check of the related history files to determine if an NAS is on file. If an NAS is required, and none is available, the claim will be denied and the State Medicaid Agency notified on the Explanation of Benefits (EOB). No further action is required by the contractor.

2.1.7 Providers

Providers must be TRICARE-approved or TRICARE-eligible in accordance with the TOM, [Chapter 2](#). If the provider named on the claim is not on the contractor provider files, but is in a category which is normally acceptable under TRICARE; e.g., a physician, psychologist, hospital, etc., the contractor shall follow normal procedures to certify. If the provider is not in a certifiable category under the contract, return the claim to the state.

2.1.8 Third Party Liability (TPL)

When submitting claims to TRICARE for recovery of payments made, the state agency should attach information regarding possible TPL for those claims which carry a diagnosis requiring development (see the TOM, [Chapter 10](#)). However, if the TPL data submitted is not adequate to provide all the information required, return the claim to the state agency to obtain the necessary information. If the state agency does not provide the necessary information within 35 days, the claim shall be denied. It is expected that the state agency will have a fully developed file to establish or to rule out possible TPL. If TPL is involved, the state should have exercised its subrogation rights and the state's beneficiary claim file should reflect complete data, including the amount paid under TPL. Where TPL does exist, the TRICARE claim liability should be minimal. The contractor should **not** contact the beneficiary or the provider(s).

2.2 Reimbursement Procedures and Requirements

The contractor shall reimburse the State Medicaid Agency directly for all claims submitted by the agency providing an EOB for each claim, unless arrangements and agreement between the contractor and the state agency provide for a summary payment voucher. **No EOB or other notice will be sent to either the beneficiary or the provider.** The allowance determination shall be based on the amount billed to the Medicaid Agency by the provider of care. The contractor shall calculate the net amount which would have been payable by TRICARE including, when appropriate, the COB reduction, deductible and cost-share amounts in the determination. The state shall be paid the lesser of the amount it actually paid or the amount that TRICARE would have paid. The Medicaid billing by a provider is frequently less than the provider's customary charge. These charges shall not be included in the determination of the prevailing charges for an area. If a provider of care subsequently bills, requesting payment for the difference between the Medicaid payment and the amount customarily billed, the claim shall be denied as a duplicate. No additional payment shall be made. If a service which would be allowable by TRICARE has been denied by Medicaid and is subsequently submitted by a provider of care, the charge shall be considered as

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 \(o\)](#)

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 rates for those specified locations outside the 50 United States and the District of Columbia, shall be the lesser of (a) billed charges or; (b) the amount based on prospectively determined per diems which are 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 The prospectively determined per diem rates for specified locations outside the 50 United States and the District of Columbia, are developed into reimbursement groupings by

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utilizing diagnosis codes. For services provided **on or before September 30, 2014**, use diagnosis codes as contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). For services provided on or after **October 1, 2014**, use diagnosis codes as contained in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-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 This payment system will be applied by the foreign claims processor. It applies to hospital inpatient services furnished to retirees or their eligible family members or Standard Active Duty Family Members (ADFM) falling under the claims processing jurisdiction of the foreign claims processor.

4.2.3 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, 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; housekeeping items and services; and capital costs.

4.2.4 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 (e.g., 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 for services provided **on or before September 30, 2014**. A valid primary ICD-10-CM code or narrative description of services must be submitted by the hospital or institutional provider for services provided on or after **October 1, 2014**. The medical description provided shall be able to support development of the claim by the overseas claims processor prior to reimbursement.

4.3 Country Specific Index

The country specific index is a factor obtained from the World Bank's International Comparison Program. The index factor, known as Purchasing Power Parity (PPP) conversion 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 currency. The World Bank defines PPP conversion factor as: "Number of units of a country's currency required to buy the same amount of goods and services in the domestic market that a U.S. dollar would buy in the U.S." 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 the World Bank's International Comparison Program country specific index as provided in [Figure 1.34-1](#).

4.4 Institutional Payment Rates

4.4.1 For services provided **on or before September 30, 2014:**

National per diems are included in [Figure 1.34-2](#) and [Figure 1.34-3](#). The figures contain the ICD-9-CM code, code 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 adjusted per diems will be available at: <http://www.tricare.mil/tma/foreignfee/>.

4.4.2 For services provided on or after **October 1, 2014:**

National per diems are included in [Figure 1.34-2](#). The figures contain the ICD-10-CM code, code range, or groups of related diagnosis codes. The first alpha character and two digits of the principal ICD-10-CM diagnosis code determines placement into a diagnosis group as well as a reimbursement group. The adjusted per diems will be available at: <http://www.tricare.mil/tma/foreignfee/>.

4.4.3 The rate setting methodology was developed as follows:

4.4.3.1 For services provided **on or before September 30, 2014:**

- A rate setting methodology utilizing the first three digits of a primary diagnosis code.
- Eighteen diagnosis groupings were defined and designed based on 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 18 groups.
- 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, plus an add-on to reimburse for capital costs.

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4.4.3.2 For services provided on or after **October 1, 2014**:

- A rate setting methodology utilizing the first alpha character and two digits of a primary diagnosis code.
- Eighteen diagnosis groupings were defined and designed based on the groupings and definitions contained in the ICD-10-CM publication. For example, Group 1 is defined as ICD-10-CM codes A00 to B99, or Infectious and Parasitic Diseases. The first alpha character and two digits of a primary diagnosis code are utilized for placement into one of the 18 groups.
- The payment rate for each of the 18 diagnostic groups was the average allowed amount per day over all the ICD-10-CM codes in a diagnosis group, based upon the claim's primary diagnosis, plus an add-on to reimburse for capital costs.

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

4.4.3.4 Once the 18 groupings were defined, certain unique admissions were identified for reimbursement separately from the 18 groupings. These are listed in [Figure 1.34-3](#).

4.5 Payments

4.5.1 General. For services provided **on or before September 30, 2014**, the per diem group payment rate will be based on the first three digits of the primary diagnosis code. For services provided on or after **October 1, 2014**, the per diem group payment rate will be based on the first alpha character and two 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
- 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.

4.5.2 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. For services provided **on or before September 30, 2014**, 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. For services provided on or after **October 1, 2014**, each institutional claim for service reimbursement must contain a valid ICD-10-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.

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4.6 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.

4.7 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.

4.8 Updating Payment Rates

4.8.1 For services provided **on or before September 30, 2014**, 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](#).

4.8.2 For services provided on or after **October 1, 2014**, additions, changes, revisions, or deletions to the ICD-10-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 TOM, [Chapter 1, Section 4, paragraph 2.4](#).

4.9 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.

4.10 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.

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FIGURE 1.34-1 COUNTRY SPECIFIC INDEX FACTORS

	COUNTRY SPECIFIC INDEX FACTOR	EFFECTIVE
2008		
Philippines	0.52	November 1, 2008
Panama	0.70	February 1, 2009
2012		
Philippines	0.57	December 1, 2012
Panama	0.70	December 1, 2012

FIGURE 1.34-2 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 (FOR SERVICES ON OR BEFORE SEPTEMBER 30, 2014)	ICD-10-CM CODE RANGE (FOR SERVICES ON OR AFTER OCTOBER 1, 2014)	NATIONAL INPATIENT PER DIEM
2008				
01	Infectious Disease	1 - 139	A00 - B99	\$2,463
02	Cancer	140 - 239	C00 - D49	\$2,576
03	Endocrine	240 - 289	D50 - D89, E00 - E89	\$2,457
04	Mental Health	290 - 319	F01 - F99	\$851
05	Nervous System	320 - 389	G00 - G99, H00 - H95	\$2,212
06	Circulatory	390 - 459	I00 - I99	\$3,810
07	Respiratory	460 - 519	J00 - J99	\$1,972
08	Digestive	520 - 579	K00 - K95	\$2,172
09	Genitourinary	580-629	N00 - N99	\$2,482
10	Pregnancy, birth (mother)	630 - 679, V22 - V24, V27	O00 - O9A, Z34, Z37, Z39	\$1,196
11	Musculoskeletal and skin	680 - 739	L00 - L99, M00 - M99	\$4,304
12	Congenital abnormalities	740 - 759	Q00 - Q99	\$3,570
13	Perinatal Fetus and infant	760 - 779, V21, V29 - V39	P00 - P96, Z00, Z37	\$717
14	Signs, Symptoms, etc.	780 - 799	R00 - R99	\$2,326
15	Injuries	800 - 959	S00 - T34	\$2,689
16	Poisoning	960 - 995	T36 - T50	\$2,302
17	Complications	996 - 999	T81 - T88	\$3,022
18	All other "V" or "Z" based codes			\$2,080

Note: Care delivered must be a benefit of TRICARE under 32 CFR 199.4 and 199.5.

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FIGURE 1.34-2 INSTITUTIONAL INPATIENT DIAGNOSTIC GROUPINGS FOR SPECIFIED LOCATIONS OUTSIDE THE 50 UNITED STATES AND THE DISTRICT OF COLUMBIA - NATIONAL INPATIENT PER DIEM AMOUNTS (CONTINUED)

GROUP	DESCRIPTION	ICD-9-CM CODE RANGE (FOR SERVICES ON OR BEFORE SEPTEMBER 30, 2014)	ICD-10-CM CODE RANGE (FOR SERVICES ON OR AFTER OCTOBER 1, 2014)	NATIONAL INPATIENT PER DIEM
DECEMBER 1, 2012				
01	Infectious Disease	1 - 139	A00 - B99	\$2,475
02	Cancer	140 - 239	C00 - D49	\$3,220
03	Endocrine	240 - 289	D50 - D89, E00 - E89	\$2,389
04	Mental Health	290 - 319	F01 - F99	\$978
05	Nervous System	320 - 389	G00 - G99, H00 - H95	\$2,181
06	Circulatory	390 - 459	I00 - I99	\$3,407
07	Respiratory	460 - 519	J00 - J99	\$1,977
08	Digestive	520 - 579	K00 - K95	\$2,309
09	Genitourinary	580-629	N00 - N99	\$2,510
10	Pregnancy, birth (mother)	630 - 679, V22 - V24, V27	O00 - O9A, Z34, Z37, Z39	\$1,525
11	Musculoskeletal and skin	680 - 739	L00 - L99, M00 - M99	\$4,691
12	Congenital abnormalities	740 - 759	Q00 - Q99	\$4,282
13	Perinatal Fetus and infant	760 - 779, V21, V29 - V39	P00 - P96, Z00, Z37	\$1,094
14	Signs, Symptoms, etc.	780 - 799	R00 - R99	\$2,143
15	Injuries	800 - 959	S00 - T34	\$3,573
16	Poisoning	960 - 995	T36 - T50	\$2,287
17	Complications	996 - 999	T81 - T88	\$2,951
18	All other "V" or "Z" based codes			\$2,352

Note: Care delivered must be a benefit of TRICARE under 32 CFR 199.4 and 199.5.

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FIGURE 1.34-3 UNIQUE ADMISSIONS - NATIONAL INPATIENT PER DIEM AMOUNTS

DESCRIPTION	ICD-9-CM CODE (FOR SERVICES ON OR BEFORE SEPTEMBER 30, 2014)	ICD-10-CM CODE (FOR SERVICES ON OR AFTER OCTOBER 1, 2014)	NATIONAL INPATIENT PER DIEM
2008			
Heart Transplant	V42.1	Z94.1	\$9,819
Kidney Transplant	V42.0	Z94.0	\$8,017
Combined Small Intestine/Liver (SI/ L) Transplant	V42.7	Z94.4	\$5,055
Lung Transplant	V42.6	Z94.2	\$9,915
Simultaneous Pancreas-Kidney (SPK) Transplant	V42.89	Z94.89	\$6,590
Pancreas Transplant	V42.83	Z94.83	\$3,807
Note: Care delivered must be a benefit of TRICARE under 32 CFR 199.4 and 199.5.			
Coronary Artery Bypass Grafts (CABG)	V43.4	Z95.828	\$5,351
Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty (PTCA)	V45.82	Z98.61	\$5,475
DECEMBER 1, 2012			
Heart Transplant	V42.1	Z94.1	\$9,817
Kidney Transplant	V42.0	Z94.0	\$4,993
Combined Small Intestine/Liver (SI/ L) Transplant	V42.7	Z94.4	\$5,765
Lung Transplant	V42.6	Z94.2	\$7,221
Simultaneous Pancreas-Kidney (SPK) Transplant	V42.89	Z94.89	\$4,525
Pancreas Transplant	V42.83	Z94.83	\$5,167
Coronary Artery Bypass Grafts (CABG)	V43.4	Z95.828	\$4,823
Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty (PTCA)	V45.82	Z98.61	\$6,076

- END -

Medical Errors

Issue Date: April 1, 2011

Authority: [32 CFR 199.4](#) and 10 USC Section 1079(a)(13)

1.0 APPLICABILITY

10 United States Code (USC) Section 1079(a)(13) provides that TRICARE may only pay for medically necessary care. This statute has been implemented by the Code of Federal Regulations ([32 CFR 199.4](#)), which states that TRICARE will pay for "medically necessary services and supplies required in the diagnosis and treatment of illness or injury." Therefore, TRICARE can cost share only medically necessary supplies and services. Services that are not medically necessary are specifically excluded from TRICARE coverage.

2.0 POLICY

2.1 TRICARE will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the provider performs:

- A wrong surgical or other invasive procedure on a patient;
- A surgical or other invasive procedure on the wrong body part; or
- A surgical or other invasive procedure on the wrong patient.

2.2 TRICARE will not cover hospitalizations and other services related to these medical errors. Services related to the medical error include:

- All services provided in the operating room when an error occurs are considered related and therefore not covered.
- All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment.
- All related services provided during the same hospitalization in which the error occurred are not covered.

Note: Related services do not include performance of the correct procedure.

2.3 Following hospital discharge, any reasonable and necessary services are covered regardless of whether they are or are not related to the surgical error.

2.4 Beneficiary Liability

A TRICARE authorized provider cannot shift financial liability for the non-covered services to the beneficiary.

2.5 Inpatient Claims - Hospital Billing Procedures When a Medical Error Occurs

2.5.1 Hospitals are required to submit a no-pay claim (Type of Bill (TOB) 110) when an erroneous surgery/medical error as stated in this policy occurs.

2.5.2 If there are covered services/procedures provided during the same stay as the erroneous surgery/medical error, hospitals are then required to bill two claims - one claim with covered services or procedures unrelated to the erroneous surgery/medical error, and the other claim with the non-covered services/procedures as a no-pay claim. Hospitals are required to bill two claims when a surgical error is reported and a covered service is also being reported:

2.5.2.1 One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(ies) on a TOB 11X (with the exception of 110); and

2.5.2.2 The other claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(ies) on a TOB 110 (no-pay claim).

Note: Both the covered and non-covered claim shall have a matching Statement Covers Period.

2.5.2.3 Additionally, the non-covered, no-pay claim TOB 110 must have one of the following diagnoses on the claim.

- Performance of wrong operation (procedure) on correct patient (existing code).
- Performance of operation (procedure) on patient not scheduled for surgery.
- Performance of correct operation (procedure) on wrong side/body part.

Note: The above diagnoses shall not be reported, as External Causes of Morbidity (V - Z codes).

2.5.2.4 In the event the hospital submits a TOB 11X claim with a diagnosis listed above, the claim is to be denied.

2.5.3 The onus is on the provider/hospital to bill correctly. The contractor is to ensure providers and hospitals understand the billing procedures outlined in this policy.

2.6 Outpatient, Ambulatory Surgery Centers (ASCs), and Individual Professional Provider Claims

2.6.1 Providers are required to append one of the following applicable Healthcare Common Procedure Coding System (HCPCS) modifiers to all lines related to the erroneous surgery(ies):

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

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Medical Errors

2.6.2 Claim lines submitted with one of the above HCPCS modifiers will be denied as services that are not medically necessary. Claim lines for medically necessary services (i.e., without one of the above modifiers shall be allowed).

2.7 Within five business days of receiving a claim for a surgical error, contractors will begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error).

2.7.1 In addition, contractors will establish a mechanism to identify incoming claims that have the potential to be related.

2.7.2 When the contractor identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

2.8 Appeals And Hearings

Medical error denials are appealable. The contractor is required to follow the requirements outlined in [32 CFR 199.10](#) and the TRICARE Operations Manual (TOM), [Chapter 13](#) related to the appeals and hearing process.

- END -

Sample State Agency Billing Agreement

STATE AGENCY BILLING AGREEMENT

BETWEEN

THE STATE OF _____
(State Name)

DEPARTMENT OF _____
(Name Of Executive Level Department)

(Name of State Medicaid Agency, if different)

AND

THE TRICARE MANAGEMENT ACTIVITY (TMA)

The purpose of this agreement is to provide a billing procedure to enable the State to claim reimbursement from the TRICARE Management Activity (TMA), for payments for TRICARE covered medical services made by a State Medicaid Agency, on behalf of recipients who were also eligible for TRICARE at the time the services were rendered. Medical services are defined by Title XIX of the Social Security Act, and the State Plan for Medical Assistance on file at the appropriate Regional Office of the Centers for Medicare and Medicaid Services. When a beneficiary is eligible for both TRICARE and Medicaid, [32 CFR 199.8](#) establishes TRICARE as the primary payor.

I

TMA agrees, through its designated Managed Care Support (MCS) contracts, to:

- A. Reimburse the State Agency for claims under the following conditions:
 1. The claim is filed no later than one year following the date of service or the date of discharge for inpatient services. Waivers to the claims filing deadline shall be granted by the MCS contractor for the State requesting the waiver. The contractor shall review the request for waiver against limited waiver circumstances.
 2. The claim contains the necessary information as defined in paragraph IID.
 3. The claim is signed either by the recipient/beneficiary (patient) or by a designated State official on behalf of the patient; and if the latter, the State official may sign each claim individually or attach a signed statement to each batch of claims submitted for reimbursement at the same time. A "batch" of claims is defined as those claims submitted under a single covering document and shall not include more than two hundred fifty (250) claims. A separate certification document shall be submitted for each two hundred fifty (250) or fewer claims.

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B. Provide the State with complete remittance advice in the form of an Explanation of Benefits (EOB). Consistent with the capabilities of each MCS contractor, the EOB shall include a claim identification number supplied by the State.

II

The State Agency agrees to:

A. Submit claims to the MCS contractor on an approved claim form or in an acceptable electronic media. The State Agency may submit documentation of the services rendered as an attachment to the claim form. The attached documentation must contain the required information as listed in Section D. below, unless the required information is also entered on the face of the claim. In no case shall any document or attachment be sent which does not clearly identify the patient. The attached documentation of services shall follow the basic format specified in item 24 of the CMS 1500 (08/2005) or CMS 1450 UB-04 claim forms. If the services of more than one provider are included on an attachment, the name and address of the provider of each service or group of services shall be clearly indicated.

B. If the State has a standard format which it uses for coordinating benefits which does not substantially follow the format of the claim forms, then the State may negotiate with the MCS contractor on a nonconforming format. However, the agreement must be approved by TMA and any extra processing expense must be borne by the State and will be paid directly to the MCS contractor.

C. Reimburse TRICARE for all claims, where the patient is subsequently found to have been ineligible for TRICARE coverage on the date of service or which was found to have been incorrectly paid or submitted as a result of audit. The State will cooperate with TMA and other Federal Government investigative or audit agencies by making any required records available for review upon request.

D. Provide the MCS contractor with adequate information for accurate processing of each claim submitted, in accordance with the requirement of each claim form. If the CMS 1450 UB-04 is used, it will be submitted using the National Standard Codes. At a minimum, the following data elements must be included or attached:

1. Patient's name, address (at the time of service), and date of birth.
2. Sponsor's name, Social Security Number, and relationship to patient.
3. Date(s) medical service(s) was (were) received.
4. Amount billed by the provider for each service.
5. Amount paid by Medicaid for each service.
6. Procedure Code billed (in CPT-4 format) and/or narrative description and number of times the service was provided.
7. Diagnosis or diagnosis code (in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) format) or a written description of the symptoms, condition or circumstances requiring care for services provided **on or before September 30, 2014**. Diagnosis or diagnosis code (in International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) format) or a written description of the symptoms, condition or circumstances requiring care for services provided **on or after October 1, 2014**.

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provided on or before September 30, 2014, the birth weight is to be indicated through use of a fifth digit on the neonatal International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code. For services provided on or after October 1, 2014, the birth weight is to be indicated through use of a sixth digit on the neonatal International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis code.

3.2.2.2.1 In situations where the narrative diagnosis on the DRG claim does not correspond to the numerical diagnosis code, the contractor shall give precedence to the narrative and revise the numerical code accordingly. Contractors are not required to make this comparison on every claim. Precedence should be given to the narrative code in those cases where a difference is identified as the result of editing, prepayment review, or other action that would identify a discrepancy. If an adjustment is subsequently necessary because the numerical code was, in fact, correct, the adjustment should be submitted under a Record Processing Mode (RPM) a reason for adjustment code indicating that there was no contractor error.

3.2.2.2.2 It is the hospital's responsibility to submit the information necessary for the contractor to assign a discharge to a DRG.

3.2.2.2.3 When the discharge data is inadequate (i.e., the contractor is unable to assign a DRG based on the submitted data), the contractor is to develop the claim for the additional information.

3.2.2.2.4 In some cases the "admitting diagnosis" may be different from the principal diagnosis. Although the admitting diagnosis is not required to assign a DRG to a claim, it may be needed to determine if a Non-Availability Statement (NAS) is required for mental health admissions (see the TRICARE Policy Manual (TPM), [Chapter 1, Section 6.1](#)).

3.2.2.2.5 For neonatal claims only (other than normal newborns), the following rules apply.

- If a neonate (patient age 0 - 28 days at admission) is premature, the appropriate prematurity diagnosis code must be used as a principal or secondary diagnosis.
- Where a prematurity diagnosis code is used, a fifth digit value of 0 through 9 must be used in the principal or secondary diagnosis to specify the birth weight. If no fifth digit is used, the Grouper will ignore that diagnosis code and the claim will be denied.
- If a neonate is not premature, a prematurity diagnosis code must not be used. The Grouper will automatically assign a birth weight of "> 2,499 grams" and assign the appropriate PM-DRG. If the birth weight is less than 2,500 grams, the birth weight must be provided in the "remarks" section of the CMS 1450 UB-04.
- If there is more than one birth weight on the claim, the Grouper will assign the claim to the "ungroupable" DRG, and the claim will be denied.
- All claims for beneficiaries less than 29 days old upon admission (other than normal newborns) will be assigned to a PM-DRG, except those classified to DRGs 103, 480, 495, 512, and 513. Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgates/>.

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3.2.2.3 Each discharge will be assigned to only one DRG (related, except as provided in [paragraphs 3.2.2.4](#) and [3.2.2.5](#), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

3.2.2.4 When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the contractor is to develop the claim to assure that the data are not the result of miscoding by either the contractor or the hospital. Where the procedure and medical condition are supported by the services and the procedure is unrelated to the principal diagnosis, the claim will be assigned to the DRG, Unrelated OR Procedure.

3.2.2.5 When the discharge data submitted by a hospital result in assignment of a DRG which may need to be reviewed for coverage (e.g., abortion without dilation and curettage, which does not meet the TRICARE requirements for coverage), the contractor is to review the claim to determine if other diagnoses or procedures which were rendered concurrently are covered. If other covered services were rendered, the contractor shall change the principal diagnosis to the most logical alternative covered diagnosis, delete the abortion diagnosis and procedure from the claim so that it does not result in a more complex DRG, and regroup the claim.

Example: If a claim is grouped into the DRG for an abortion and the abortion is not covered, but a tubal ligation was performed concurrently, the contractor should change the principal diagnosis to that for the tubal and delete the abortion from the procedures performed. If no covered services were rendered, the claim must be denied, and all related ancillary and professional services which are submitted separately must also be denied.

3.2.2.5.1 Contractors are not normally required to review all diagnoses and procedures to determine their coverage. Contractors are required to develop for medical necessity only if the principal diagnosis is generally not covered but potentially could be. Deletion of a diagnosis and/or procedure is required only when the principal diagnosis or procedure is not covered.

3.2.2.5.2 The only exception to the above paragraph is for abortions. Since abortions are statutorily excluded from coverage in most cases, the contractor is to ensure that payment is not affected by a noncovered abortion diagnosis or procedure whether it is principal or secondary. In all cases where payment would be affected, the abortion data is to be deleted from the claim.

3.3 Beneficiary Eligibility

3.3.1 Change Of Eligibility Status

3.3.1.1 Payment when eligibility changes. If a beneficiary is eligible for TRICARE coverage during any part of his/her inpatient confinement, except for the following cases, the claim shall be processed as if the beneficiary was eligible for the entire stay.

3.3.1.1.1 Claims which qualify for the long-stay or short-stay outlier payment. The long-stay outlier was eliminated for all cases, except neonates and children's hospitals, for admissions occurring on or after October 1, 1997. The long-stay outlier was eliminated for neonates and children's hospitals for admissions occurring on or after October 1, 1998. See [paragraph 3.3.1.3](#).

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3.3.1.1.2 Claims which qualify for the cost outlier payment after August 1, 2003. See [paragraph 3.3.1.3](#).

3.3.1.1.3 Claims where a beneficiary gains eligibility after admission. The DRG-based payment is calculated beginning on the first day of TRICARE eligibility.

3.3.1.1.4 Claims where the loss of TRICARE eligibility results from gaining Medicare eligibility. The claim may still be processed by TRICARE, but it must be submitted to Medicare first and TRICARE payment will be determined under the normal double coverage procedures.

3.3.1.2 Transfer payments when eligibility status changes. Since payments to a transferring hospital are always based on a per diem amount, if the beneficiary's eligibility status changes while an inpatient in a transferring hospital, payment shall be made only for those days for which the beneficiary was eligible. The procedures below shall be followed in paying outlier amounts in cases involving transfers.

3.3.1.3 Outlier payments when eligibility status changes. For admissions prior to August 1, 2003, when requested, cost outlier payments are to be made in cases where the beneficiary gains or loses eligibility during an inpatient stay, and the contractor will not be required to determine which costs occurred outside the beneficiary's TRICARE eligibility. Since both long-stay and short-stay outlier payments are made on a per diem basis, no payment is to be made for any days of care which occurred after loss of eligibility and which result from either the long-stay or short-stay outlier. The hospital may bill the beneficiary for any services which would result in long-stay or short-stay outlier payments were it not for the beneficiary's loss of eligibility. For admissions on or after August 1, 2003, when computing the standardized costs for the cost outlier payment, any charges that occur after a beneficiary loses TRICARE eligibility, shall be subtracted from the billed charges prior to multiplying the billed charges by the Cost-to-Charge Ratio (CCR) when calculating the cost outlier payment. The contractor shall request an itemized bill from the hospital to identify these charges.

Example 1: The beneficiary loses eligibility on day two where the short-stay outlier cutoff is three days. The beneficiary was discharged on the seventh day. TRICARE reimbursement will be made for two days on a short-stay outlier basis. The beneficiary's cost-share will be based on the two paid days. The hospital may bill the beneficiary for all days of care beyond the second day.

Example 2: The beneficiary is discharged on day 10 and lost eligibility on day six. The short-stay outlier cutoff is day 2. TRICARE reimbursement will be based on the normal DRG payment which will apply to the entire Length-Of-Stay (LOS) (nine days). The beneficiary cost-share for a retiree would be based on the total covered days (nine days times the per diem), assuming this is not greater than 25% of the billed charge. An active duty dependent's cost-share would be nine times the current active duty per diem amount. The hospital cannot bill the beneficiary for any costs other than the cost-share.

Example 3: The beneficiary gains eligibility after admission. The DRG calculation begins on the first day of TRICARE eligibility. For example, a beneficiary is admitted March 6, 1992 and discharged May 16, 1992, but was only TRICARE eligible starting May 10, 1992. The claim should be treated as if the beneficiary was admitted on May 10, 1992, and the base DRG rate calculated.

3.3.2 Change Of Sponsor Status From Active Duty To Retired During An Active Duty Family Member's (ADFM's) Inpatient Stay

An inpatient claim is to be cost-shared as active duty whenever there is evidence that the sponsor was on active duty during any period of the ADFM's inpatient stay.

3.3.3 Change Of Sponsor Status From Active Duty To Retired During An Active Duty Member's Inpatient Stay

An inpatient claim is to be cost-shared as retired if an Active Duty Service Member's (ADSM's) status changes to retired during an inpatient stay.

3.3.4 Professional Claims

Since payment for related professional services are itemized and billed on a daily basis, the claim shall be paid for the days the beneficiary is TRICARE eligible and denied for the days the patient was not TRICARE eligible.

3.3.5 Infant Of An Unmarried Family Member

A child of an unmarried family member is not eligible, therefore, charges for an infant of an unmarried family member are not eligible for reimbursement.

- END -

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Note: Payment for trauma services (e.g., revenue code 068X), is included in the TRICARE DRG-based payment 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 the DRGs for such transplants.

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:

3.3.10.1 For services provided **on or before September 30, 2014**, 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 International Classification of Diseases, 9th Revision, Clinical Modification (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
286.7	Acquired Coagulation Factor Deficiency

3.3.10.2 For services provided on or after **October 1, 2014**, 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 International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes is listed on the claim:

D66	Hereditary Factor VIII Deficiency
D67	Hereditary Factor IX Deficiency
D68.0	Von Willebrand's Disease
D68.1	Hereditary Factor XI Deficiency
D68.2	Hereditary Deficiency of Other Clotting Factors
D68.31	Hemorrhagic Disorder Due to Intrinsic Circulating Anticoagulants
D68.4	Acquired Coagulation Factor Deficiency

3.3.10.3 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

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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.

3.3.10.4 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.

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.

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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.

3.8 Critical Access Hospitals (CAHs)

Prior to December 1, 2009, CAHs are subject to the DRG-based payment system. For additional information on CAHs, refer to [Chapter 15, Section 1](#).

- END -

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factor equal to:

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

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

3.2.7.2 Number of Interns and Residents

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

3.2.7.3 Number of Beds

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

3.2.7.4 Updates of IDME Factors

3.2.7.4.1 TRICARE will use the ration of interns and residents to beds from CMS' most recently available Provider Specific File to update the IDME adjustment factors. The ratio will be provided to the contractors to update each hospital's IDME adjustment factor at the same time as the annual DRG update. The updated factors provided with the annual DR update shall be applied to claims with a date of discharge on or after October 1 of each year.

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

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

3.2.7.5 Adjustment for Children's Hospitals

An IDME adjustment factor will be applied to each payment to qualifying children's hospitals. The factors for children's hospitals will be calculated using the same formula as for other hospitals. The initial factor will be based on the number of interns and residents and hospital bed size as reported by the hospital to the contractor. If the hospital provides the data to the contractor after payments have been made, the contractor will not make any retroactive adjustments to previously paid claims, but the amounts will be reconciled during the "hold harmless" process. At

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the end of its fiscal year, a children's hospital may request that its adjustment factor be updated by providing the contractor with the necessary information regarding its number of interns and residents and beds. The number of interns, residents, and beds must conform to the requirements above. The contractor is required to update the factor within 30 days of receipt of the request from the hospital, and the effective date shall conform to the policy contained above.

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

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

3.2.7.6 TRICARE for Life (TFL)

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

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

3.2.8.1 Effective for admissions on or after October 1, 2009:

3.2.8.1.1 For services provided **on or before September 30, 2014:**

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

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

Y = Indicates that the condition was present on admission.

W = Affirms that the provider has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.

N = Indicates that the condition was not present on admission.

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- U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
- 1 = (Definition prior to FY 2011.) Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.
- 1 = (Definition for FY 2011 and subsequent years.) Unreported/not used. Exempt from POA reporting.
(This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.)

3.2.8.1.2 For services provided on or after **October 1, 2014**:

3.2.8.1.2.1 Those inpatient acute care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a POA indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. Providers shall report POA indicators to TRICARE in the same manner they report to the CMS, and in accordance with the UB-04 Data Specifications Manual, and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-10-CM Official Guidelines for Coding and Reporting.

3.2.8.1.2.2 There are five POA indicator reporting options, as defined by the ICD-10-CM Official Coding Guidelines for Coding and Reporting:

- Y = Indicates that the condition was present on admission.
- W = Affirms that the provider has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.
- N = Indicates that the condition was not present on admission.
- U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
- 1 = (Definition prior to FY 2011.) Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-10-CM diagnosis codes is available in the ICD-10-CM Official Coding Guidelines.
- 1 = (Definition for FY 2011 and subsequent years.) Unreported/not used. Exempt from POA reporting. (This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.)

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3.2.8.2 HACs. TRICARE shall adopt those HACs adopted by CMS. The HACs, and their respective diagnosis codes, are posted at <http://www.tricare.mil/drgrates/>.

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

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

3.2.8.5 Exempt providers.

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

- Critical Access Hospitals (CAHs)
- Long-Term Care (LTC) Hospitals
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children's Inpatient Hospitals
- Inpatient Rehabilitation Hospitals
- Psychiatric Hospitals and Psychiatric Units
- Sole Community Hospitals (SCHs)
- Department of Veterans Affairs (DVA) Hospitals

3.2.8.5.2 Contractors shall identify claims from those hospitals that are exempt from POA reporting, and shall take the actions necessary to be sure that the TRICARE grouper software does not apply HAC logic to the claim.

3.2.8.6 The DRG payment is considered payment in full, and the hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complications or charges because the DRG was demoted to a lesser-severity level.

3.2.8.7 Effective October 1, 2009, claims will be denied if a non-exempt hospital does not report a valid POA indicator for each diagnosis on the claim.

3.2.8.8 Replacement Devices

3.2.8.8.1 TRICARE is not responsible for the full cost of a replaced device if a hospital receives a partial or full credit, either due to a recall or service during the warranty period. Reimbursement in cases in which an implanted device is replaced shall be made:

- At reduced or no cost to the hospital; or
- With partial or full credit for the removed device.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 11, Section 3

Hospice Reimbursement - Conditions For Coverage

Definition: Notify the contractor responsible for processing your claims of the beneficiary's election of hospice benefits by forwarding Form CMS 1450 UB-04.

- **Item 5. Federal Tax Number.** Enter Tax Identification Number (TIN) or Employer Identification Number (EIN) and the sub-identifier assigned by the contractor.
- **Item 8. Patient's Name Required.** Show the patient's name with the surname first, first name, and middle initial, if any.
- **Item 9. Patient's Address Required.** Show the patient's full mailing address including street name and number or RFD, city, state, and zip code.
- **Item 10. Patient's Birthdate Required.** Show the month, day, and year of birth numerically as MM-DD-YY. If the date of birth cannot be obtained after a reasonable effort, leave this field blank.
- **Item 11. Patient's Sex Required.** Show and "M" for male or an "F" for female.
- **Item 12. Admission Date Required.** Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than two calendar days.

Example: The hospice election (admission) is January 1, 2006. The physician's certification is dated January 10, 1994. The hospice admission date for coverage and billing is January 8, 2006. The first benefit period will end 90 days from January 8, 2006.

- **Item 38. Transferring Hospice ID Required.** Only when the admission is for a patient who has changed an election from one hospice to another.
- **Item 58A, B, C. Insured's Name Required.** If the primary payer(s) is other than TRICARE, enter the name of person(s) carrying other insurance in 58A or 58A and 58B as recorded on ID card. If TRICARE is primary, enter the sponsor's name as recorded on the ID card, in line 58A.
- **Item 60A, B, C. Certificate/Social Security Number (SSN)/Health Insurance Claim/Identification Number.** If primary payer(s) is other than TRICARE, enter the unique ID number assigned by the primary payer to the person(s) carrying other insurance in line 60A or 60A and 60B. Enter the sponsor's SSN in line 60B or 60C if TRICARE patient; or enter the NATO in line 60B or 60C if a NATO beneficiary.
- **Item 67. Principle Diagnosis Code Required.** For services provided **on or before September 30, 2014**, show the full International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code. For services provided on or after **October 1, 2014**, show the full International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis code. The principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the patient's admission.

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Chapter 11, Section 3

Hospice Reimbursement - Conditions For Coverage

- **Item 76. Attending Physician ID Required.** Enter the name, number and address of the licensed physician normally expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment. Use Item 94 "Remarks" for additional space for recording this information.
- **Item 78. Other Physician ID Required.** Enter the word "employee" or "non-employee" here to describe the relationship that the patient's attending physician has with the hospice program.
- **Items 85 and 86. Provider Representative Signature and Date Required.** Deleted from UB-04, see FL 45, line 23. A hospice representative makes sure that the required physician's certification and a signed hospice election statement are in the records.

3.2.3.2 Contractor's Reply to Notice of Admission

The reply to the notice of admission is furnished according to the contractor's arrangements with the particular hospice program. Whether the reply is given by telephone, mail, or wire, it is based upon the contractor's query of DEERS. The purpose of the reply is to inform the hospice that the admission has been received and that the beneficiary is eligible for coverage under TRICARE.

3.2.3.3 Change of Election

The second (receiving) hospice will use Item 38 of the admission notice to indicate a change of election from one hospice program to another.

3.2.3.3.1 When a receiving hospice submits an admission notice involving a patient who changed from one hospice to another, this item reflects the transferring hospice's complete name, address, and provider number (refer to Item 38).

3.2.3.3.2 This information is to alert the contractor that the hospice admission continues a hospice benefit period rather than beginning a new one.

3.2.3.4 Revocation of Election

The contractor will be notified of the beneficiary's revocation of his or her hospice election through Item 31 of the CMS 1450 UB-04.

CODE	TITLE	DEFINITION
42	Termination of Hospice Care	The date the patient's hospice care ends. Care may be terminated by a change in the hospice election to another hospice, a revocation of the hospice election, or death. Show Termination Code 42 in Item 32.

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Chapter 11, Section 4

Hospice Reimbursement - Guidelines For Payment Of Designated Levels Of Care

3.1.11.14.2 Use these revenue codes to bill TRICARE.

CODE	DESCRIPTION	STANDARD ABBREVIATION
651	Routine Home Care	RTN Home
652	Continuous Home Care	CTNS Home (a minimum of eight hours, not necessarily consecutive, in a 24-hour period is required. Less than eight hours is routine home care for reimbursement purposes. A portion of an hour is one hour).
655	Inpatient Respite Care	IP Respite
656	General Inpatient Care	GNL IP
657	Physician Services	PHY Ser (must be accompanied by a physician CPT procedure code)

As of October 1, 1997, hospices will be required to submit claims for payment for hospice care furnished in an individual's home (i.e., revenue codes 651 and 652) based on the geographic location at which the service is furnished as opposed to the location of the hospice. Providers will be required to indicate the **Core Based Statistical Area (CBSA)** code number with value code 61 on the bill. For dates of service beginning on or after October 1, 1997, hospice claim bill types 81X and 82X with revenue codes 651 and 652 that do not contain value code 61 and a **CBSA** code will be rejected.

3.1.11.15 Item 46 - Units of Service Required

Enter the number of units for each type of service on the line adjacent to the revenue code and description. Units are measured in days for codes 651, 655, and 656, in hours for code 652, and in procedures for code 657.

3.1.11.16 Item 47 - Total Charges Required

Enter the total charges for the billing period by revenue code (column 42) on the adjacent line in column 47. The last revenue code entered in column 42 represents the grand total of all charges billed. The total is in column 47 on the adjacent line. Each line allows up to eight numeric digits (000000.00).

3.1.11.17 Item 50A, B, C - Payer Identification Required

If TRICARE is the **only insurer** other than Medicaid and TRICARE Supplemental Plans, TRICARE is the primary payer. Enter the correct contractor in line 50A. If there are other insurers besides Medicaid and TRICARE supplemental plans, TRICARE is not the primary payer. Enter the name of the group(s) or plan(s) in line 50A or 50A and 50B. Enter the correct contractor in line 50B or 50C.

3.1.11.18 Item 58A, B, C - Insured's Name Required

If the primary payer(s) is other than TRICARE, enter the name of person(s) carrying **other** insurance in 58A or 58A and 58B. Enter the sponsor's name in line 58B or 58C if TRICARE patient as recorded on ID card. If TRICARE is primary, enter the sponsor's name as recorded on the ID card, in line 58A.

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Chapter 11, Section 4

Hospice Reimbursement - Guidelines For Payment Of Designated Levels Of Care

3.1.11.19 Item 60A, B, C - Certificate/Social Security Number (SSN)/Health Insurance Claim/Identification Number

If primary payer(s) is other than TRICARE, enter the unique ID number assigned by the primary payer to the person(s) carrying other insurance in line 60A or 60A & 60B. Enter the sponsor's SSN in line 60B or 60C if TRICARE patient; or enter the NATO in line 60B or 60C if a NATO beneficiary.

3.1.11.20 Item 67 - Principal Diagnosis Code Required

For services provided **on or before September 30, 2014**, show the full International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code. For services provided on or after **October 1, 2014**, show the full International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis code. The principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the patient's admission.

3.1.11.21 Item 82 - Attending Physician ID Required

Enter the name, number and address of the licensed physician normally expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment. Use Item 84 "Remarks" for additional space for recording this information.

3.1.11.22 Item 78 - Other Physician ID Required

Enter the word "employee" or "nonemployee" to describe the relationship that the patient's attending physician has with the hospice program.

3.1.11.23 Item 80 - Remarks

Enter any remarks needed to provide information not shown elsewhere on the bill but which are necessary for proper payment.

3.1.11.24 Items 85 and 86 - Provider Representative Signature and Date

Deleted from UB-04, see FL 45, line 23. A hospice representative makes sure that the required physician's certification and a signed election statement are in the records before submitting the CMS 1450 UB-04.

3.1.12 Special Processing and Reporting Requirements

3.1.12.1 The various levels of hospice care will be considered institutional care for payment and reporting purposes. The special rate code "P" (TRICARE Systems Manual (TSM), [Chapter 2, Section 2.8](#)) will be designated for the four levels of hospice care.

3.1.12.2 The conventional coding for hospice care on the CMS 1450 UB-04, Item 4, is a four digit numerical code designating the TOB required.