



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 86
6010.58-M
SEPTEMBER 11, 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: CONSOLIDATED CHANGE 12-001

CONREQ: 16099

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: See the Summary of Changes.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TOM, Change No. 105 and Feb 2008 TPM, Change No. 97.

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ou=PKI, ou=TMA,
cn=FAZZINI.ANN.NOREEN.1199802271
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**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 9 PAGE(S)
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CHANGE 86
6010.58-M
SEPTEMBER 11, 2013

REMOVE PAGE(S)

CHAPTER 4

Section 4, pages 3 - 8

CHAPTER 15

Section 1, pages 5 - 7

INSERT PAGE(S)

Section 4, pages 3 - 8

Section 1, pages 5 - 7

SUMMARY OF CHANGES

CHAPTER 4

1. Section 4. Updates language related to claims processing procedures for TRICARE beneficiaries under the age of 65 who become entitled to Medicare due to a retroactive disability. EFFECTIVE October 28, 2009.

CHAPTER 15

2. Section 1. Removes obsolete language for expired demonstration.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 4, Section 4

Specific Double Coverage Actions

1.3.1.3.7 Home infusion claims (see [Chapter 3, Section 6, paragraph 2.2.4](#) and [Chapter 3, Section 7, paragraph 2.2.4](#)).

TRICARE will process the claim as a primary payer, for TRICARE benefits, with any applicable deductibles and cost-shares. With the exception of [paragraph 1.3.1.3.1](#), [1.3.1.3.6](#), and [1.3.1.3.7](#), since the contractor knows that Medicare cannot make a payment on such claims, the contractor can process the claim without evidence of processing by Medicare.

Note: In order to achieve status as a TRICARE authorized provider, DVA facilities must comply with the provisions of the TRICARE Policy Manual (TPM), [Chapter 11, Section 2.1](#).

1.3.1.4 When Medicare does not make a payment because services were rendered by a non-Medicare provider or effective for services on or after March 1, 2007, because the provider has a private contract with the beneficiary (also referred to as "opting out" of Medicare), and the services are a TRICARE benefit, TRICARE will process the claim as a second payer. In such cases, the TRICARE payment will be the amount that TRICARE would have paid had the Medicare program processed the claim (normally 20% of the allowable charge). If there is not an available Medicare allowed amount, the TRICARE allowed amount shall be calculated and 20% of that amount will be reimbursed. Evidence of processing by Medicare for non-Medicare providers is not required; rather a statement from the provider verifying their Medicare status is sufficient for processing. Opt out providers will be identified based on the Medicare Part B carriers web sites. In cases where the beneficiary's access to medical care is limited (i.e., under served areas), the TRICARE contractor may waive the second payer status for the services of a Medicare opt-out provider and pay the claim as the primary payer. In most cases, under served areas will be identified by zip codes for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs) on the Centers for Medicare and Medicaid Services (CMS) web site at <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/> and will automatically be paid as primary payer. In cases where the zip code for an underserved area is not identified on the CMS web site, or in areas where there are no or limited Medicare participating providers, a written waiver request with justification identifying the county where the service was received and a copy of the provider's private contract will be required by the contractor to pay the claim as the primary payer. TRICARE contractors will identify HPSA or PSA zip codes or the county for underserved areas on the above CMS web site and identify opt out providers based on the Medicare Part B carriers web sites.

Note: Under the TRICARE Provider Reimbursement Demonstration Project for the state of Alaska, TRICARE will pay as primary payer for the services of Medicare opt-out providers.

1.3.1.5 When Medicare does not make a payment based on their Competitive Bidding Program (CBP) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), the TRICARE contractor shall process the claim as second payer for otherwise TRICARE covered items of DMEPOS. In such cases, the TRICARE payment shall be the amount TRICARE would have paid had Medicare processed and paid the claim. Public use files containing the competitive bid single payment amounts per Healthcare Common Procedure Coding System (HCPCS) code are posted on the CMS' competitive bidding contractor's web site: <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home>. TRICARE contractors shall identify the competitive bid single payment amount using the above CMS web site to identify what Medicare would have allowed had the beneficiary followed Medicare's rules. Implementation of Medicare's DMEPOS CBP pricing is effective January 1, 2011.

1.3.1.6 When Medicare does not make a payment because Medicare rules were not followed or because the beneficiary failed to meet some other requirement of coverage (e.g., denied for no referral, no or untimely authorization, invalid place of service, etc.). TRICARE will process the claim as second payer as long as the services meet TRICARE coverage rules. The TRICARE payment will be the amount that TRICARE would have paid had the Medicare program processed the claim (normally 20% of the allowed charge). If there is not an available Medicare allowed amount, the TRICARE allowed amount shall be calculated and 20% of that amount will be reimbursed. This exception does not include Medicare medical necessity denials.

1.3.1.7 Effective October 28, 2009, TRICARE beneficiaries **who are entitled to premium-free Medicare Part A because of disability, where Social Security Disability Insurance (SSDI) is awarded on appeal remain eligible for coverage under the TRICARE program** (see the TOM, [Chapter 20, Section 1, paragraph 2.6](#)). **Eligible beneficiaries are required to keep Medicare Part B in order to maintain their TRICARE coverage for future months, but are considered to have coverage under the TRICARE program** for the retroactive months of their entitlement to Medicare Part A. For previously processed claims the contractor that processed the claim **shall not initiate recoupment due to eligibility or jurisdiction and existing actions should be terminated**. Medicare becomes primary payer effective as of the original Medicare Part B effective date.

1.3.2 Services That Are A Benefit Under Medicare But Not Under TRICARE

TRICARE will make no payment for services and supplies that are not a benefit under TRICARE, regardless of any action Medicare may take on the claim.

1.3.3 Services That Are A Benefit Under TRICARE But Not Under Medicare

If the service or supply is a benefit under TRICARE but never covered under Medicare, TRICARE will process the claim as the primary payer assessing any applicable deductibles and cost-shares. If the contractor has the documentation (e.g., Medicare transmittal or regulation) to support that Medicare would never cover the service or supply on the claim, the contractor can process the claim without evidence of processing by Medicare for that service or supply. These claims shall be handled in accordance with [32 CFR 199.10\(a\)\(1\)\(ii\)](#). This includes services billed with the **GY** modifier (Medicare statutory exclusion or does not meet the definition of any Medicare benefit) and services provided to a beneficiary participating in Cancer Clinical Trials that are not a Medicare benefit.

1.3.4 Services That Are Provided In A DVA Facility

If services or supplies are provided in a TRICARE authorized DVA hospital pursuant to the TPM, [Chapter 11, Section 2.1](#), Medicare will make no payment. In such cases TRICARE will process the claim as a second payer. The TRICARE payment will be the amount that TRICARE would have paid had the Medicare program processed the claim (normally 20% of the allowable charge).

Note: In order to achieve status as a TRICARE authorized provider, DVA facilities must comply with the provisions of the TPM, [Chapter 11, Section 2.1](#).

1.3.5 Services Provided By A Medicare At-Risk Plan

If the beneficiary is a member of a Medicare at-risk plan (for example, Medicare Plus

Choice), TRICARE will pay 100% of the beneficiaries copay for covered services. A claim containing the required information must be submitted to obtain reimbursement.

1.3.6 Beneficiary Cost-Shares

Beneficiary costs shares shall be based on the network status of the provider. Where TRICARE is primary payer, cost-shares for services received from network providers shall be TRICARE Extra cost-shares. Services received from non-network providers shall be TRICARE Standard cost-shares. Network discounts shall only be applied when the discount arrangement specifically contemplated the TFL population.

1.3.7 Application Of Catastrophic Cap

Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

1.4 End Stage Renal Disease (ESRD) in TRICARE beneficiaries less than 65 years of age. Medicare is the primary payer and TRICARE is the secondary payer for beneficiaries entitled to Medicare Part A and who have Medicare Part B coverage.

1.5 Pharmacy Claims. TRICARE cost-sharing of medications through a Medicare part D prescription drug plan is subject to the double coverage provisions found in [32 CFR 199.8](#).

2.0 TRICARE AND MEDICAID

Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting Public Law 97-377, it was the intent of Congress that no class of TRICARE beneficiary should have to resort to welfare programs, and therefore, Medicaid was exempted from these double coverage provisions. Whenever a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a TRICARE beneficiary, TRICARE shall reimburse the appropriate Medicaid agency for the amount TRICARE would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less. See [Chapter 1, Section 20](#).

3.0 MATERNAL AND CHILD HEALTH PROGRAM/INDIAN HEALTH SERVICE (IHS)

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage (see [Section 1](#)).

4.0 TRICARE AND THE DVA

Eligibility for health care through the DVA for a service-connected disability is not considered double coverage. If an individual is eligible for health care through the DVA and is also eligible for TRICARE, he/she may use either TRICARE or veterans benefits. In addition, at any time a beneficiary may get medically necessary care through TRICARE, even if the beneficiary has received some treatment for the same Episode Of Care (EOC) through the DVA. However, TRICARE will not duplicate payments made by or authorized to be made by the DVA for treatment of a service-

connected disability.

5.0 TRICARE AND WORKER'S COMPENSATION

TRICARE benefits are not payable for work-related illness or injury which is covered under a Worker's Compensation program. The TRICARE beneficiary may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. If a claim indicates that an illness or injury might be work related, the contractor will process the claim following the provisions as provided in TOM, [Chapter 10, Section 5, paragraphs 5.0 and 6.0](#) and refer the claim to the Uniformed Service Claims Office for recovery, if appropriate.

6.0 TRICARE AND SUPPLEMENTAL INSURANCE PLANS

6.1 Not Considered Double Coverage

Supplemental plans (see [Chapter 1, Section 26](#)) or complementary insurance coverage is a health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services and items that are not reimbursed under TRICARE due to program limitations, or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental plans, general indemnity plans and those offered through a direct service Health Maintenance Organization (HMO). Supplemental insurance plans are not considered double coverage. TRICARE benefits will be paid without regard to the beneficiary's entitlement to supplemental coverage.

6.2 Income Maintenance Plans

Income maintenance plans pay the beneficiary a flat amount per day, week or month while the beneficiary is hospitalized or disabled. They usually do not specify a type of illness, Length-Of-Stay (LOS), or type of medical service required to qualify for benefits, and benefits are not paid on the basis of incurred expenses. Income maintenance plans are not considered double coverage. TRICARE will pay benefits without regard to the beneficiary's entitlement to an income maintenance plan.

6.3 Other Secondary Coverage

Some insurance plans state that their benefits are payable only after payment by all government, Blue Cross/Blue Shield (BC/BS) and private plans to which the beneficiary is entitled. In some coverages, however, it provides that if the beneficiary has no other coverage, it will pay as a primary carrier. Such plans are double coverage under TRICARE law, regulation, and policy and are subject to the usual double coverage requirements.

7.0 SCHOOL COVERAGE - SCHOOL INFIRMARY

TRICARE benefits shall be paid for covered services provided to students by a school infirmary provided that the school imposes charges for the services on all students or on all students who are covered by health insurance.

8.0 TRICARE AND PREFERRED PROVIDER ORGANIZATIONS (PPOs)

See [Chapter 1, Section 25](#).

9.0 DOUBLE COVERAGE AND EXTENDED CARE HEALTH OPTION (ECHO)

All double coverage rules and procedures which apply to claims under the basic program are also to be applied to ECHO claims. All local resources must be considered and utilized before TRICARE benefits under the ECHO may be extended. If an ECHO beneficiary is eligible for other federal, state, or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only for amounts left unpaid by the other program, up to the TRICARE maximums established in TPM, [Chapter 9](#). The beneficiary may not waive available federal, state, or local assistance in favor of using TRICARE.

Note: The requirements of [paragraph 9.0](#) notwithstanding, TRICARE is primary payer for medical services and items that are provided under Part C of the Individuals with Disabilities Education Act in accordance with the Individualized Family Service Plan (IFSP) and that are otherwise allowable under the TRICARE Basic Program or the ECHO.

10.0 PRIVATELY-PURCHASED, NON-GROUP COVERAGE

Privately-purchased, non-group health insurance coverage is considered double coverage.

11.0 LIABILITY INSURANCE

If a TRICARE beneficiary is injured as a result of an action or the negligence of a third person, the contractor must develop the claim(s) for potential Third Party Liability (TPL) (see the TOM, [Chapter 10, Section 5](#)). The contractor shall pursue the Government's subrogation rights under the Federal Medical Care Recovery Act (FMCRA), if the other health insurance does not cover all expenses.

12.0 TRICARE AND PRE-PAID PRESCRIPTION PLANS

If the beneficiary has a "pre-paid prescription plan," where the beneficiary pays only a "flat fee" no matter what the actual cost of the drug, the contractor shall cost-share the fee and not develop for the actual cost of the drug, since the beneficiary is liable only for the "fee."

13.0 TRICARE AND STATE VICTIMS OF CRIME COMPENSATION PROGRAMS

Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

14.0 SURROGATE ARRANGEMENTS

Contractual arrangements between a surrogate mother and adoptive parents are considered other coverage. For pregnancies in which the surrogate mother is a TRICARE beneficiary, services and supplies associated with antepartum care, postpartum care, and complications of pregnancy

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 4, Section 4

Specific Double Coverage Actions

may be cost-shared only as a secondary payer, and only after the contractually agreed upon amount has been exhausted. This applies where contractual arrangements for payment include a requirement for the adoptive parents to pay all or part of the medical expenses of the surrogate mother as well as where contractual arrangements for payment do not specifically address reimbursement for the mother's medical care. If brought to the contractor's attention, the requirements of TOM, [Chapter 10, Section 5, paragraph 2.10](#) would apply.

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TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 15, Section 1

Critical Access Hospitals (CAHs)

that are unnecessary in the efficient delivery of services covered by the program.

4.3.1 TMA shall calculate an overall inpatient CCR and overall outpatient CCR, obtained from data on the hospital's most recently filed Medicare cost report as of July 1 of each year.

4.3.2 The inpatient and outpatient CCRs are calculated using Medicare charges, e.g., Medicare costs for outpatient services are derived by multiplying an overall hospital outpatient CCR (by department or cost center) by Medicare charges in the same category.

4.3.3 The following methods are used by TMA to calculate the CCRs for CAHs. The worksheet and column references are to the CMS Form 2552-96 (Cost Report for Electronic Filing of Hospitals).

INPATIENT CCRs	
Numerator	Medicare costs were defined as Worksheet D-1, Part II, line 49 MINUS (worksheet D, Part III, Column 8, sum of lines 25-30 PLUS Worksheet D, Part IV, line 101).
Denominator	Medicare charges were defined as Worksheet D-4, Column 2, sum of lines 25-30 and 103.
OUTPATIENT CCRs	
Numerator	Outpatient costs were taken from Worksheet D, Part V, line 104, the sum of Columns 6, 7, 8, and 9.
Denominator	Total outpatient charges were taken from the same Worksheet D, Part V, line 104, sum of Columns 2, 3, 4, and 5 for the same breakdowns.

4.3.4 To reimburse the vast majority of CAHs for all their costs in an administratively feasible manner, TRICARE will identify CCRs that are outliers using the method used by Medicare to identify outliers in its Outpatient Prospective Payment System (OPPS) reimbursement methods. Specifically, Medicare classifies CCR outliers as values that fall outside of three standard deviations from the geometric mean. Applying this method to the CAH data, those limits will be considered the threshold limits on the CCR for reimbursement purposes. **The CAH Fiscal Year (FY) is effective on December 1 of each year.** For FY 2011, the inpatient CCR cap is 2.57 and the outpatient CCR cap is 1.31. For FY 2012, the inpatient CCR cap is 2.46 and the outpatient CCR cap is 1.32. **For FY 2013, the inpatient CCR cap is 2.48 and the outpatient CCR cap is 1.36.** Thus, for FY 2013, TRICARE will pay the lesser of 2.48 multiplied by the billed charges or 101% of costs (using the hospital's CCR and billed charges) for inpatient services and the lesser of 1.36 multiplied by the billed charges or 101% of costs for outpatient services. Following is the two step comparison of costs.

Step 1: Inpatient, pay the lesser of:

FY cap x billed charges (minus non-covered charges) OR
1.01 x (hospital-specific CCR x billed charges (minus non-covered charges))

Step 2: Outpatient, pay the lesser of:

FY cap x billed charges OR
1.01 x (hospital-specific CCR x billed charges)

4.3.5 TMA shall provide a list of CAHs to the Managed Care Support Contractors (MCSCs) with their corresponding inpatient and outpatient CCRs by November 1 each year. The CCRs shall be updated on an annual basis using the second quarter CMS Hospital Cost Report Information

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 15, Section 1

Critical Access Hospitals (CAHs)

System (HCRIS) data. The updated CCRs shall be effective as of December 1 of each respective year, with the first update occurring December 1, 2009.

4.3.6 TMA shall also provide the MCSCs the State median inpatient and outpatient CAH CCRs to use when a hospital specific CCR is not available.

4.4 CAH Listing

4.4.1 TMA will maintain the CAH listing on the TMA's web site at <http://www.tricare.mil/hospitalclassification/>, and will update the list on a quarterly basis and will notify the contractors by e-mail when the list is updated.

4.4.2 For payment purposes for those facilities that were listed on both the CAH and Sole Community Hospital (SCH) lists prior to June 1, 2006, the contractors shall use the implementation date of June 1, 2006, as the effective date for reimbursing CAHs under the DRG-based payment system. The June 1, 2006, effective date is for admissions on or after June 1, 2006. For admissions prior to June 1, 2006, if a facility was listed on both the CAH and SCH lists, the SCH list took precedence over the CAH list. The contractors shall not initiate recoupment action for any claims paid billed charges where the CAH was also on the SCH list, prior to the June 1, 2006, effective date. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

4.4.3 The effective date on the CAH list is the date supplied by the Centers for Medicare and Medicaid Services (CMS) upon which the facility began receiving reimbursement from Medicare as a CAH, however, if a facility was listed on both the CAH and SCH lists prior to June 1, 2006, the effective date for TRICARE DRG reimbursement is June 1, 2006. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

4.4.4 After June 1, 2006, if a CAH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

4.4.5 If the contractor receives documentation from a CAH indicating their status is different than what is on the CAH listing on TMA's web site, the contractor shall send the information to TMA, Medical Benefits & Reimbursement Branch (MB&RB) to update the listings on the web.

4.5 Prior to December 1, 2009, the contractor's shall update their institutional provider files to include CAH's and their Indirect Medical Education (IDME) factors, if applicable, as the CMS Inpatient Provider Specific File used to update the annual DRG Provider File does not contain CAH information.

4.6 Billing and Coding Requirements

4.6.1 The contractors shall use type of institution 91 for CAHs.

4.6.2 CAHs shall utilize bill type 11X for inpatient services.

4.6.3 CAHs shall utilize bill type 85X for all outpatient services including services approved as Ambulatory Surgery Center (ASC) services.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 15, Section 1

Critical Access Hospitals (CAHs)

4.6.4 CAHs shall utilize bill type 12X for ancillary/ambulance services.

4.6.5 CAHs shall utilize bill type 14X for non-patient diagnostic services.

4.6.6 CAHs shall use bill type 18X for swing bed services.

4.7 Beneficiary Liability

Applicable TRICARE deductible and cost-sharing provisions apply to CAH inpatient and outpatient services.

5.0 EFFECTIVE DATE

Implementation of the CAH reasonable cost methodology is effective for admissions and outpatient services occurring on or after December 1, 2009.

- END -

