



TRICARE
MANAGEMENT ACTIVITY

MB&RB

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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CHANGE 87
6010.58-M
SEPTEMBER 13, 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: NEW INPATIENT REIMBURSEMENT METHODOLOGY FOR SOLE COMMUNITY HOSPITALS

CONREQ: 16069

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change implements the new inpatient reimbursement methodology for Sole Community Hospitals (SCHs).

EFFECTIVE DATE: January 1, 2014.

IMPLEMENTATION DATE: January 1, 2014.

This change is made in conjunction with Feb 2008 TSM, Change No. 52.

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ATTACHMENT(S): 52 PAGE(S)
DISTRIBUTION: 6010.58-M

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

CHANGE 87
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CHAPTER 3

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APPENDIX A

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Hospital Reimbursement - Billed Charges Set Rates

Issue Date: August 26, 1985
Authority: [32 CFR 199.14\(a\)](#)

1.0 APPLICABILITY

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

2.0 ISSUE

How are billed charges/set rates to be used in determining reimbursement for hospitals?

3.0 POLICY

3.1 Billed Charges

In those cases **where there is not an established reimbursement method for hospitals in [32 CFR 199.14](#)**, the most common method of reimbursement for covered services of hospitals is that of billed charges. The billed charge is allowable if it is reasonable and is not greater than:

3.1.1 The charge made to the general public; or

3.1.2 The allowed charge applicable to contractor policy-holders (subscribers), when extended to beneficiaries by consent or agreement; or

3.1.3 The charge set by local or state regulatory authority as applicable to citizens and extended by law or regulation, consent or agreement to TRICARE.

3.2 All-Inclusive Rates

3.2.1 Some providers do not routinely itemize their charges or vary their charges depending upon the various services rendered. Instead, such providers have a set schedule of "all-inclusive" rates which are charged to all patients (or all patients in a given category such as surgical, medical, obstetrical, etc.) regardless of the specific services rendered to each patient. Such rates are based on a per diem or per admission amount and may consist of a single amount for all services or a basic "room and board" charge and a separate set charge for ancillary services. Such all-inclusive rates may be reimbursed so long as they are uniformly charged to all patients and so long as the hospital is incapable of itemizing its bills.

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3.2.2 **Diagnosis Related Group (DRG)** amounts which hospitals have elected to use in lieu of normal billed charges also qualify as all-inclusive rates. These DRG amounts may be derived from some third-party payer such as Medicare or a Blue Cross plan. Payments based on DRG amounts are authorized only if they are the basis for the hospital's billing--not just the basis for payment by some source.

3.3 Room Charges

Reimbursement will be at the semi-private room rate unless there are medical indications for a private room.

3.3.1 Hospital Participation

3.3.2 Participation is required for all hospitals which participate in Medicare. This also applies to services of hospital-based professionals which are related to inpatient stays.

3.3.3 A hospital which is not Medicare-participating and which is exempt from the program's **reimbursement method for hospitals in 32 CFR 199.14**, may elect to participate on a claim-by-claim basis.

- END -

Hospital Reimbursement - Other Than Billed Charges

Issue Date: August 26, 1985
Authority: [32 CFR 199.14\(a\)](#)

1.0 APPLICABILITY

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

2.0 ISSUE

What methods other than the **established reimbursement methods for hospitals in 32 CFR 199.14** may be used to determine hospital reimbursement?

3.0 POLICY

3.1 Agreements

3.1.1 When discount agreements are available to the contractor, the contractor shall obtain such discounts for TRICARE reimbursement. Moreover, the contractor shall determine if any state in its jurisdiction has enacted legislation which implements a rate setting system which can be applied to TRICARE. If so, the contractor shall utilize the rates if this results in a lower cost to the government. The contractor shall maintain documentation of its actions with regard to each state which shows how any discounts or state-set rates are used or the reasons they cannot be used.

3.1.2 The contractors may negotiate individual or collective agreements with providers to establish reimbursement methods.

3.1.3 The **established reimbursement methods in 32 CFR 199.14**, are required for those hospitals which are subject to them ([Chapter 6, Section 4](#) and [Chapter 7, Section 1](#)). Therefore, none of the above agreements or procedures can be used for any hospital subject to the **established reimbursement methods in 32 CFR 199.14**. However, when the hospital participates with the contractor as a network provider, the **established reimbursement method in 32 CFR 199.14**, shall be further reduced by the negotiated (discount) rate.

3.2 Outside the United States

The Director, TMA, or designee, is authorized by regulation to determine appropriate reimbursement methodologies for covered medical services or supplies provided by hospitals

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outside the United States (see [Section 34](#) for reimbursement methodology utilized for hospital services provided in the Philippines).

- END -

Hospital And Other Institutional Reimbursement

Issue Date:

Authority:

1.0 INTRODUCTION

TRICARE reimbursement of a non-network institutional health care provider shall be determined under the TRICARE Diagnosis Related Group (DRG)-based payment system as outlined in [Chapter 6](#) or other TRICARE-approved method. For network providers, the contractor is free to negotiate rates that would be less than the rates established under the TRICARE DRG-based payment system or other approved TRICARE method.

2.0 PAYMENT OF CAPITAL AND DIRECT MEDICAL EDUCATION (CAP/DME) COST

The contractor will make an annual payment to each hospital subject to the TRICARE DRG-based payment system (except children's hospitals) which requests reimbursement for CAP/DME. The payment will be computed based on [Chapter 6, Section 8](#). These procedures will apply to all types of CAP/DME payments (including active duty). All CAP/DME payments will be in accordance with payment instructions in Section G of the contract.

3.0 REASONABLE COST METHOD FOR CAHS

Effective for admissions on or after December 1, 2009, non-network inpatient care provided in CAHs shall be paid under the reasonable cost method. See [Chapter 15, Section 1](#) for additional instructions.

4.0 COST-TO-CHARGE RATIO (CCR)/DRG APPROACH FOR INPATIENT SERVICES FOR SOLE COMMUNITY HOSPITALS (SCHs)

Effective for admissions on or after January 1, 2014, non-network inpatient care provided in an SCH shall be paid under the primary and secondary methodology described in [Chapter 14, Section 1](#).

5.0 INPATIENT MENTAL HEALTH HOSPITAL, PARTIAL HOSPITALIZATION, AND RESIDENTIAL TREATMENT CENTER (RTC) FACILITY RATES

Each fiscal year, contractors shall submit inpatient mental health, partial hospitalization (half day-three to five hours and full day-six or more hours) and RTC rates by facility.

6.0 BILLED CHARGES/SET RATES

When a hospital or institution is not covered by a mandatory payment methodology (i.e., DRGs, inpatient mental health), the contractor shall reimburse for institutional care received from providers on the basis of billed charges, if reasonable for the area and type of institution, or on the basis of rates set by statute or some other arrangement. The basic guidance shall be that the beneficiary's share shall not be increased above that which would have been required by payment of a reasonable billed charge.

6.1 Verification Of Billed Services

Reimbursement of billed charges should be subjected to tests of reasonableness performed by the contractor. These tests should be used to protect against both inadvertent and intentional practices of overbilling and/or supplying of excessive services. The contractor should verify that no mathematical errors have been made in the bill.

6.2 Use Of Local Or State Regulatory Authority Allowed Charges

There are instances in which a local or state regulatory authority, in an attempt to control costs, has established allowable charges for the citizens of a community or state. If such allowable charges have been extended to TRICARE beneficiaries by consent, agreement, or law, and if they are generally (not on a case by case basis) less than TRICARE would otherwise reimburse, the contractor should use such rates in determining TRICARE reimbursement. However, if a state creates a reimbursement system which would result in payments greater than the hospital's normal billed charges, the contractor should not use the state-determined amounts.

6.3 Discounts Or Reductions

Contractors should attempt to take advantage of all available discounts or rate reductions when they do not conflict with other requirements of the Program. When such a discount or charge reduction is available but the contractor is uncertain whether it would conform to its TRICARE contract, TMA should be contacted for direction.

6.4 All-Inclusive Rate Providers

All-inclusive rates may be reimbursed if the contractor verifies that the provider cannot adequately itemize its bills to provide the normally required TRICARE Encounter Data (TED). Further, the contractor must ensure that appropriate revenue codes are included on the claim (as well as all other required Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 information), even though itemized charges are not required to be associated with the revenue codes. When a contractor reimburses a provider based on an all-inclusive rate, the contractor shall maintain documentation of its actions in approving the all-inclusive rate. The documentation must be available to TMA upon request. (Also, see [Chapter 1, Section 22.](#))

7.0 REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS (ASCs)

7.1 Payment for facility charges for ambulatory surgical services will be made using prospectively determined rates except for ambulatory surgery services performed in CAHs that are subject to the reasonable cost method on or after December 1, 2009, reference [Chapter 15, Section 1](#); or in a

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hospital outpatient clinic or in a hospital Emergency Room (ER) that are subject to the OPPS on or after May 1, 2009. The rates will be divided into 11 payment groups representing ranges of costs and will apply to all ambulatory surgical procedures identified by TMA and provided in a freestanding ASC.

7.2 TMA will provide the facility payment rates to the contractors on magnetic media and will provide updates each year. The magnetic media will include the locality-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. In addition, the contractors will be provided a zip code to MSA crosswalk.

7.3 Contractors are required to maintain only two sets of rates on their on-line systems at any time.

7.4 Professional services related to ambulatory surgical procedures will be reimbursed under the instructions for individual health care professionals and other non-institutional health care providers in [Section 1](#).

7.5 See [Chapter 9, Section 1](#) for additional instructions.

8.0 CLAIM ADJUSTMENTS

Facilities may not submit a late charge bill (frequency 5 in the third position of the bill type). They must submit an adjustment bill for any services required to be billed with HCPCS codes, units, and line item dates of service by reporting frequency 7 (replacement of a prior claim) or frequency 8 (void/cancel of a prior claim). Claims submitted with a frequency code of 7 or 8 should report the original claim number in Form Locator (FL) 64 on the CMS 1450 UB-04 claim form. Facilities should not submit claims on bill type 135 as this bill type is not allowed under TRICARE and will be denied.

9.0 PROPER REPORTING OF CONDITION CODES

Hospitals should report valid Condition Codes on the CMS 1450 UB-04 claim form as necessary.

9.1 Condition codes are reported in FLs 18-28 when applicable.

9.2 The following are two examples of condition code reporting:

9.2.1 Condition Code G0 identifies when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the ER twice on the same day - in the morning for a broken arm and later for chest pain.

- Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code **G0** on the second claim.
- Claims with condition code **G0** should not be automatically rejected as a duplicate claim.

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9.2.2 Condition Code 41 identifies a claim being submitted for Partial Hospitalization Program (PHP) services.

- END -

Discounts

Issue Date:

Authority:

1.0 PROVIDER DISCOUNTS

The contractor may negotiate agreements or contracts with providers which include reductions or discounts in the TRICARE reimbursement, however, the provider must agree to participate on all TRICARE claims. This section provides direction concerning processing of claims subject to such reductions in reimbursement.

2.0 AGREEMENTS

Agreements must meet the following conditions:

2.1 The provider must be TRICARE-authorized. If the provider is not currently certified, the contractor shall certify the provider through the normal provider certification process. If the provider is non-certifiable, the contractor shall notify both the provider and the Military Treatment Facility (MTF) if the MTF is involved. Contractors must ensure that clinics, Preferred Provider Organizations (PPOs), and other multi-member groups provide a list of the providers within the organization, along with their Employer Identification Numbers (EINs)/Social Security Numbers (SSNs). Contractors shall review these lists, making sure that each individual provider in the groups is authorized under TRICARE.

2.2 For all contractor negotiated agreements, the effective dates will be the first day of the month following the month the agreement was signed.

2.3 The agreement must contain date parameters (effective and termination dates). For multi-member groups, the effective date of each member will be the same unless otherwise indicated. Groups must identify the rendering physician on the claim.

2.4 The agreement must list specific procedure codes and the method and amount of discount, for example, a general description such as gynecological procedures is not acceptable.

2.5 Providers must agree to participate on all charges, whether the services provided are subject to the negotiated discount or not.

2.6 Providers cannot balance bill the beneficiary.

2.7 Provider must agree to bill the patient's other health insurance (OHI) prior to billing TRICARE.

2.8 Providers must be able to fluently speak, read, and write the English language.

3.0 METHODS

At a minimum, the following negotiated reimbursement reduction methods are authorized:

3.1 Agreements using a percent reduction method. Under the percent reduction method, provider reimbursement is reduced by a percentage rate (e.g., 20%) applied to the allowable amount for **established reimbursement methods in 32 CFR 199.14**. If the billed charge minus the discount amount exceeds the CHAMPUS Maximum Allowable Charge (CMAC), payment is limited to the CMAC unless an exception is allowed under demonstration authority. The discount will be taken from the applicable reimbursement methodology used for the provider, i.e., **Diagnosis Related Group (DRG)**, mental health per diem, **Residential Treatment Center (RTC)** per diem, **Sole Community Hospital (SCH) payment method for inpatient service**, etc. The cost-share is always applied after calculation of the discounted amount.

3.2 Agreements may include a discount for the initial 1,000 claims processed (does not include adjustments) during a stated period of time (e.g., 10%) and a higher discount for claims exceeding 1,000, (e.g., 15%). In this case the contractor must have counters to tally the number of claims processed by individual, provider or group.

3.3 Agreements using negotiated per diems are authorized for hospitalization and RTC care, but the established method of payment cannot be altered, i.e., a DRG hospital cannot revert to using a per diem, unless an exception is allowed under demonstration authority. The cost-share is applied after calculation of the new allowed amount.

3.4 Agreements on which each procedure code listed in the agreement could have a different percentage discount or fee schedule.

3.5 Agreements which have different discounts for inpatient and outpatient services. This can be for both professional and institutional providers.

3.6 Agreements with provider groups when only some of the members of the group will honor the participation/discount agreement. Groups must identify the rendering physician on the claim.

4.0 CONTRACTOR RESPONSIBILITIES

4.1 The contractor shall load the name of the provider and EIN, the applicable negotiated reimbursement, and the effective date parameters within 45 days of receipt of the agreement/contract.

4.2 The contractor shall ensure, by implementing an automated payment mechanism, that claims from affiliated providers with agreements or contracts which include negotiated reimbursements are processed using an authorized and correct reimbursement method.

4.3 The contractor shall report the discounted amount as the allowed amount.

1.4.2.2 Not included are:

- Certain federal government programs which are designed to provide benefits to a distinct beneficiary population and for which entitlement does not derive from either premium payment or monetary contribution (e.g., Medicaid and Worker's Compensation).
- Health care delivery systems not considered within the definition of either an insurance plan, medical service or health plan including the Department of Veterans Affairs (DVA), the Maternal and Child Health Program, the Indian Health Services (IHS), and entitlement to receive care from the designated provider. These programs are designed to provide benefits to a distinct beneficiary population, and they require no premium payment or monetary contribution prior to obtaining care.

1.5 No Waiver of Benefit From Other Insurer

Beneficiaries may not waive benefits due from any plan which meets the above definitions. If a double coverage plan provides, or may provide, benefits for the services, a claim must be filed with the double coverage plan. Refusal by the beneficiary to claim benefits from the other coverages must result in a denial of TRICARE benefits. Benefits are considered to be the services available. For example, if the other plan includes psychotherapy as a benefit, but only by a psychiatrist, the beneficiary cannot elect to waive this benefit in order to receive services from a psychologist. For TRICARE for Life (TFL) claims, an exception exists for mental health counselors and pastoral counselors as well as for services received under a private contract (see [Section 4, paragraph 1.3.1.4](#)).

1.6 Beneficiary Liability

In all double coverage situations, a beneficiary's liability is limited by all TRICARE provisions. As a result, a provider cannot collect from a TRICARE beneficiary any amount that would result in total payment to the provider that exceeds TRICARE limitations. For example, a beneficiary is not liable for any cost-sharing or deductible amounts required by the primary payer, if the sum of the primary payer's and TRICARE's payments are at least equal to 115% of the TRICARE allowable amount for a nonparticipating provider. This is true whether TRICARE actually makes any payment or not. This also applies to claims from participating non-network providers and from network providers. Because of the payment calculations, the provider usually will receive payments from the primary payer and from TRICARE that equal the billed charges. In those rare cases where this does not occur, the provider cannot collect any amount from the beneficiary that would result in payment that exceeds the TRICARE allowable amount.

Note: It is important to note that this paragraph addresses beneficiary liability and does not change in any way the amounts TRICARE will pay based on provisions elsewhere in this chapter.

1.7 Claims Processed Under the TRICARE **Diagnosis Related Group (DRG)-Based Payment System or the Inpatient Mental Health Per Diem Payment System**

When double coverage exists on a claim processed under the TRICARE DRG-based payment system or the inpatient mental health per diem payment system, the TRICARE payment cannot exceed an amount that, when combined with the primary payment, equals the lesser of the

TRICARE DRG-based amount, the inpatient mental health per diem based amount, or the hospital's charges for the services (including any discount arrangements). Thus, when the DRG-based amount or the inpatient mental health per diem based amount is greater than the hospital's actual billed charge, and the primary payer has paid the full billed charge, TRICARE will make no additional payment. Similarly, when the DRG-based amount or the inpatient mental health per diem based amount is less than the hospital's actual billed charge, and the primary payer has paid the full DRG-based amount or inpatient mental health per diem based amount, no additional payment can be made. Nor can the hospital bill the beneficiary for **any** additional amounts in these cases.

1.8 Claims Processed Under The Reasonable Cost Method For Critical Access Hospitals (CAHs)

When double coverage exists on a claim processed under the reasonable cost method for CAHs, the TRICARE payment cannot exceed an amount that when combined with the primary payment equals the lesser of the established cap amount multiplied by the billed charges or 101% of reasonable cost. The reasonable cost method for CAHs is the lesser of the established/ determined Cost-to-Charge Ratio (CCR) cap (reference [Chapter 15, Section 1](#) for Fiscal Year (FY) inpatient and outpatient CCR cap) multiplied by billed charges or 101% of reasonable costs [1.01 x (hospital-specific CCR x billed charges)].

1.9 No Legal Obligation to Pay

Payment should not be extended for services and supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary was not an eligible TRICARE beneficiary. Whenever possible, all double coverage claims should be accompanied by an Explanation Of Benefits (EOB) from the primary insurer. If the existence of a participating agreement limiting liability of a beneficiary is evident on the EOB, payment is to be limited to that liability; however, if it is not clearly evident, the claim is to be processed as if no such agreement exists.

1.10 Claims Processed Under The CCR Methodology for Sole Community Hospitals (SCHs)

When double coverage exists on a claim processed under the CCR methodology for SCHs, the TRICARE payment cannot exceed an amount that when combined with the primary payment equals the lesser of billed charges, negotiated rate, or the CCR methodology as described in [Chapter 14, Section 1](#).

- 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). Admission prior to January 1, 2014, (the effective date of the SCH reimbursement methodology described in Chapter 14, Section 1), 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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(Adjustments To Payment Amounts)

- 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
- 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.

Hospital Reimbursement - TRICARE DRG-Based Payment System (Information Provided By TMA)

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

1.0 ISSUE

What information will be provided by the TRICARE Management Activity (TMA) concerning the TRICARE DRG-based payment system?

2.0 POLICY

2.1 Information provided by TMA. The following specific data, which is necessary to determine the payment amount under the TRICARE DRG-based payment system, will be provided to the contractors by TMA. Updates to these data will be provided during September of each year.

2.1.1 DRG weighting factors.

2.1.2 Adjusted Standardized Amounts (ASAs) (urban and rural), including the labor-related and nonlabor-related portions.

2.1.3 Area wage indexes.

2.1.4 Outlier cutoffs for each DRG.

2.1.5 Children's hospital outlier cutoffs. As of October 1, 1998, payment for long-stay outliers has been eliminated for all neonates and children's hospitals and children's hospital outlier cutoffs are no longer provided.

2.1.6 Geometric mean Length-Of-Stay (LOS) for each DRG.

2.1.7 Per diem cost-share for beneficiaries other than dependents of active duty members.

2.1.8 Children's hospital differentials (national and hospital-specific).

2.1.9 The ratio of interns and residents to beds for those hospitals subject to the Medicare Prospective Payment System (PPS), as listed in Centers for Medicare and Medicaid Services' (CMSs') most recently available Provider Specific File.

2.1.10 The Indirect Medical Education (IDME) factors for all hospitals subject to the TRICARE DRG-based payment system.

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Chapter 6, Section 9

Hospital Reimbursement - TRICARE DRG-Based Payment System (Information Provided By TMA)

2.2 TMA will provide the contractors with corrected wage indexes when applicable.

- END -

3.9 Exemptions from the TRICARE Inpatient Mental Health Per Diem Payment System

3.9.1 Providers Subject to the DRG-Based Payment System. Providers of inpatient care which are neither psychiatric hospitals nor psychiatric units as described earlier, or which otherwise qualify under that discussion, are exempt from the inpatient mental health per diem payment system.

3.9.2 Services Which Group into Mental Health DRG. Admissions to psychiatric hospitals and units for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424 prior to October 1, 2008, or services which group into DRG 876 on or after October 1, 2008) are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

3.9.3 Non-Mental Health Procedures. Admissions for non-mental health procedures that group into non-mental health DRG, in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

3.9.4 Sole Community Hospital (SCH). Admission prior to January 1, 2014, (the effective date of the SCH reimbursement methodology described in Chapter 14, Section 1), any hospital which has qualified for special treatment under the Medicare Prospective Payment System (PPS) as a SCH and has not given up that classification is exempt. For additional information on SCHs, refer to Chapter 14, Section 1.

3.9.5 Hospital Outside the 50 States, the District of Columbia, or Puerto Rico. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia, or Puerto Rico.

3.9.6 Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the DRG-based payment system or the inpatient mental health per diem payment system shall be determined on the basis of billed charges or set rates.

- END -

Sole Community Hospitals (SCHs)

Issue Date: November 6, 2007

Authority: [32 CFR 199.14\(a\)\(1\)\(ii\)\(D\)\(6\)](#)

1.0 APPLICABILITY

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

2.0 DESCRIPTION

A Sole Community Hospital is a hospital that is designated by the Centers for Medicare and Medicaid Services (CMS) as an SCH and meets the applicable requirements established by [32 CFR 199.6\(b\)\(4\)\(xvii\)](#).

3.0 ISSUE

How are SCHs to be reimbursed?

4.0 POLICY

4.1 Background

Under Title 10, United States Code (USC), Section 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare."

4.2 Payment Method For Inpatient Services

4.2.1 For admissions prior to January 1, 2014, institutional inpatient services (other than professional) provided by SCHs shall be reimbursed based on billed charges or negotiated rates.

4.2.2 Primary and Secondary Reimbursement Methodologies

4.2.2.1 For admissions on or after January 1, 2014, inpatient services that are provided by SCHs shall be reimbursed using a primary methodology referred to as a Cost-To-Charge Ratio (CCR) methodology. That is, claims shall be reimbursed by multiplying the SCH's specific Medicare overall inpatient CCR obtained from the CMS Inpatient Provider Specific File (PSF) by the hospital's billed

charges. However, during the transition period discussed in [paragraph 4.2.4](#), a modified CCR is used.

4.2.2.2 Claims shall also be priced using the secondary methodology, i.e., the Diagnosis Related Group (DRG)-based payment methodology, for accumulation and subsequent comparison to the primary methodology amount at year-end.

4.2.3 Year-End Comparison

4.2.3.1 At year-end, the contractor shall compare the aggregate allowed amount under the primary methodology, i.e., the CCR methodology (described in [paragraph 4.2.2.1](#) or [4.2.4](#) during the transition period) to the aggregate allowed amount for the same care under the secondary methodology, i.e., the DRG-based payment methodology.

4.2.3.2 In the event that the DRG allowed amount is the greater of the two calculations, the contractor shall reimburse the hospital the difference between the aggregate allowed amount under the primary cost-based methodology and what would have been allowed under the secondary DRG-based methodology.

4.2.3.3 The comparison shall be applied at the end of the TRICARE SCH year, based on a 12 month period after the effective date of implementation which is January 1, 2014. The first SCH year is January 1, 2014 to December 31, 2014.

4.2.3.4 TMA shall provide the contractor a hospital-specific capital adjustment factor in the file with the hospital specific CCR. The contractor shall adjust the DRG amount to include capital by multiplying the DRG amount by the DRG capital adjustment factor. The DRG capital adjustment factor will be equal to one plus a value equal to the capital CCR for a specific hospital divided by its operating CCR.

4.2.4 Transition Period

4.2.4.1 In the Final Rule published in the **Federal Register** on August 8, 2013, TRICARE created a multi-year transition period to buffer the impact from any potential decrease in revenue that hospitals may experience during the implementation of a revised SCH inpatient payment system. This transition period provides SCHs with sufficient time to adjust and budget for potential revenue reductions. The transition is as follows:

TMA will measure the ratio of allowed charges to billed charges during Fiscal Year 2012 (FY12) (the base year) for inpatient hospitalizations where TRICARE is the primary payer and a ratio of allowed to billed charges will be established for each SCH during FY12. This ratio will be used in calculating the modified CCR during the transition period. In the first year of the transition, the allowed amount for each claim under the modified CCR methodology shall be equal to the billed charge multiplied by the modified CCR. The modified CCR is determined separately for each SCH. For network hospitals, the modified CCR is equal to the base year ratio of the allowed to billed minus 0.10. Each year thereafter the modified CCR will decline by 0.10 until it reaches the SCH's Medicare CCR. The SCH's specific Medicare CCR is equal to the sum of the SCH's operating and capital CCR taken from the most recently available CMS Inpatient PSF. For non-network SCHs, the base year rate will decline by 0.15 each year until the SCH reaches its specific Medicare CCR as taken from the most recently available CMS Inpatient PSF.

Example: In the case of a non-network hospital with Medicare CCR of 0.40 and a base year allowed-to-billed ratio of 1.0, payment in the first year for an inpatient hospitalization claim would be equal to the billed charges on that claim multiplied by a factor of 0.85. The factor in the second year would be 0.70, in the third year it would be 0.55, in the fourth year it would be 0.40, in the fifth year it would be 0.25, and in the sixth year it would be 0.10. In no case can the ratio in a year be less than the hospital's CCR in that year. In the case of a network hospital with a Medicare CCR of 0.40 and an allowed-to-billed base year ratio of 0.90, payment in the first year for an inpatient hospitalization claim would be equal to the billed charges on that claim multiplied by 0.80. The factors in subsequent years would be 0.70, 0.60, 0.50, 0.40, etc. until the CCR is reached.

4.2.4.2 In no year shall the modified CCR fall below the hospital's overall Medicare CCR, as measured by the most recently available inpatient Medicare CCR from the CMS inpatient PSF.

4.2.4.3 Once the hospital reaches its Medicare CCR, the transition is complete for that hospital.

4.2.5 Nursery and Labor/Delivery Adjustment (NLDA)

At the end of a SCH's transition period, i.e., when the SCH reaches its Medicare CCR, a special allowable cost shall be applied to charges for inpatient nursery and labor/delivery DRGs (610-613, 631-636, 646-651, 676-681, 765-768, 774, 775, 787-792, and 795). Instead of applying the Medicare CCR for these DRGs, TRICARE shall apply 130% of the Medicare CCR.

4.2.6 New SCHs and SCHs Without Inpatient Claims

TRICARE shall pay a new SCH using the average Medicare CCR for all SCHs calculated in the most recent year until its Medicare CCR is available in the CMS inpatient PSF. This applies to any SCH without a Medicare CCR in the inpatient PSF. TRICARE shall pay hospitals that have a CCR in the inpatient PSF and that change their status to an SCH using that Medicare CCR. For SCHs that had no inpatient claims from TRICARE immediately prior to implementation of the SCH payment reform but do have a claim after implementation of SCH payment reform, TRICARE shall pay them based directly on their Medicare CCR.

4.2.7 TMA Data

4.2.7.1 During the transition period, on an annual basis, TMA shall provide the contractors with modified CCRs. The overall Medicare CCR is the sum of Medicare's operating and capital inpatient CCRs for each SCH. The operating and capital CCR shall be from the most recently available CMS inpatient PSF.

4.2.7.2 The updated CCRs shall be effective for admissions on and after January 1 of each respective year.

4.2.7.3 TMA shall also provide the contractors the average Medicare CCR to use for SCHs, without a CCR in the inpatient PSF.

4.2.8 Process for SCHs Year One (Effective January 1, 2014 through December 31, 2014) and Subsequent Years

4.2.8.1 Approximately three months after the end of the TRICARE SCH year, the contractors shall run query reports of claims history and compare the aggregate allowed amount per SCH under the cost-based methodology during the previous TRICARE SCH year to the aggregate allowed amount per SCH for the same care under the DRG-based payment system methodology, for each SCH.

4.2.8.2 In the event that the DRG allowed amount is the greater of the two calculations, the contractor shall process adjustment payments per the instructions in Section G of their contract under invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No payments will be sent out without approval from TMA-Aurora (TMA-A), Contract Resource Management (CRM), Budget.

4.2.8.3 The year-end adjustments will be paid approximately six months following the end of the TRICARE SCH year.

4.2.9 General Temporary Military Contingency Payment Adjustments (TMCPAs)

The TMA Director, or designee, may approve a General TMCPA based on the following criteria:

- The hospital serves a disproportionate share of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs);
- The hospital is a TRICARE network hospital;
- The hospital's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and
- Without the General TMCPA, Department of Defense's (DoD's) ability to meet military contingency mission requirements will be significantly compromised.

4.2.10 Essential Access Community Hospitals (EACHs)

The SCH reimbursement method applies to hospitals classified by CMS as EACHs.

4.2.11 Direct Medical Education

TRICARE will reimburse SCHs who timely file a request for their direct medical education costs as outlined in [Chapter 6, Section 8](#).

4.3 Payment Method For Outpatient Services

Outpatient services provided by a SCH are subject to TRICARE's Outpatient Prospective Payment System (OPPS). Reference [Chapter 13](#).

4.4 SCH Listing

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

4.4.2 After June 1, 2006, and prior to January 1, 2014, if an SCH 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.

4.4.3 If the contractor receives documentation from an SCH indicating their status is different than what is on the SCH listing on TMA's web site, the contractor shall send the information to TMA, Medical Benefits & Reimbursement Branch (MB&RB) to review and to update the listings on the web, if appropriate.

4.5 Billing And Coding Requirements

4.5.1 The contractors shall use type of institution 91 for SCHs.

4.5.2 The contractors shall use pricing rate code CR for inpatient SCH claims priced using the methodology described in paragraphs 4.2.2.1 and 4.2.4.

5.0 EXCLUSIONS

5.1 Psychiatric and rehabilitation distinct part units are exempt from the inpatient SCH CCR methodology.

5.2 State Waivers. The DRG-based payment system provides for state waivers for states utilizing state developed rates applicable to all payers; i.e., Maryland. Psychiatric hospitals and units in these states, may also qualify for the waiver; however, the per diem may not exceed the cap amount applicable to other higher volume hospitals.

5.3 The SCH reimbursement method does not apply to any costs of physician services or other professional services provided to SCH inpatients.

5.4 The SCH reimbursement method does not apply to hospitals in states that are paid by Medicare and TRICARE under a cost containment waiver; i.e., Maryland.

6.0 EFFECTIVE DATE

Implementation of the SCH CCR reimbursement method for inpatient services is effective for admissions on or after January 1, 2014.

- END -

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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

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 General Temporary Military Contingency Payment Adjustments (TMCPAs)

The TMA Director, or designee, may approve a General TMCPA based on the following criteria:

- The hospital serves a disproportionate share of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs);
- The hospital is a TRICARE network hospital;
- The hospital's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and
- Without the General TMCPA, Department of Defense's (DoD's) ability to meet military contingency mission requirements will be significantly compromised.

4.5 CAH Listing

4.5.1 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.

4.5.2 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.

4.5.3 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.

4.5.4 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.

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Critical Access Hospitals (CAHs)

4.5.5 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.

4.6 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.

4.7 Billing and Coding Requirements

4.7.1 The contractors shall use type of institution 91 for services provided prior to January 1, 2014. For services provided on or after January 1, 2014, the contractors shall use type of institution 93 for CAHs.

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

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

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

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

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

4.8 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 -

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Appendix A

Acronyms And Abbreviations

DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DLI	Donor Lymphocyte Infusion
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMR	Direct Member Reimbursement
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty (Band)
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action

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Appendix A

Acronyms And Abbreviations

DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DS Logon	DoD Self-Service Logon
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSMT	Diabetes Self-Management Training
DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Versatile Disc (formerly Digital Video Disc)
DVD-R	Digital Versatile Disc-Recordable
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EACH	Essential Access Community Hospital

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Appendix A

Acronyms And Abbreviations

EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
eFRC	Electronic Federal Records Center
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Early Identification Enrollment Information for Dental
EIDS	Executive Information and Decision Support
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing

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Appendix A

Acronyms And Abbreviations

EMG	Electromyograma
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
EOP	Explanation of Payment
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis

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Appendix A

Acronyms And Abbreviations

FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FOUO	For Official Use Only
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSH	Follicle Stimulating Hormone
FSO	Facility Security Officer
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHP	Group Health Plan
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder

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HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly HCFA Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDGC	Hereditary Diffuse Gastric Cancer
HDL	Hardware Description Language
HDR	High Dose Radiation
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department

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HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HSWL	Health, Safety and Work-Life
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act

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IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFC	Interim Final Rule with comment
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management

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IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVD	Ischemic Vascular Disease
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
LLLT	Low Level Laser Therapy

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LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
LVSD	Left Ventricular Systolic Dysfunction
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill

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MH	Mental Health
MHCC	Maryland Health Care Commission
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMPCMHP	Maryland Multi-Payer Patient-Centered Medical Home Program
MMPP	Maryland Multi-Payer Patient
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time

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MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACHA	National Automated Clearing House Association
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps

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NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLDA	Nursery and Labor/Delivery Adjustment
NLT	No Later Than
NMA	Non-Medical Attendant
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act

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OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights Optical Character Recognition
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OTCD	Ornithine Transcarbamylase Deficiency
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier

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PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMH	Patient-Centered Medical Home
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PPPWD	Program for Persons with Disabilities

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Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PII	Personally Identifiable Information
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPC-PCMH	Physician Practice Connections Patient-Centered Medical Home
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity

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PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSF	Provider Specific File
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program

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QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RARC	Remittance Advice Remark Code
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RIA	Radioimmunoassay
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROMF	Record Object Metadata File
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority

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RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry

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SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
T-3	TRICARE Third Generation
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management

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TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment

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TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application

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Appendix A

Acronyms And Abbreviations

TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouses
URL	Universal Resource Locator
US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense

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Appendix A

Acronyms And Abbreviations

USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report

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Appendix A

Acronyms And Abbreviations

WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

2D	Two Dimensional
3D	Three Dimensional

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