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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 99
6010.55-M
SEPTEMBER 25, 2009

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/ revision(s) to the 6010.55-M, issued August 2002.

CHANGE TITLE: CODING AND REIMBURSEMENT UPDATES

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: As indicated.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 106

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Acting Chief, Medical Benefits and
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ATTACHMENT(S): 12 PAGE(S)
DISTRIBUTION: 6010.55-M

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

CHANGE 99
6010.55-M
SEPTEMBER 25, 2009

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 6	
Section 8, pages 17 through 20	Section 8, pages 17 through 20
CHAPTER 7	
Table of Contents, pages i and ii	Table of Contents, pages i and ii
Section 1, pages 1 and 2	Section 1, pages 1 and 2
Section 3, pages 1 and 2	Section 3, pages 1 and 2
INDEX	
pages 15 and 16	pages 15 and 16

SUMMARY OF CHANGES

CHAPTER 6

1. Section 8 (Hospital Reimbursement - TRICARE/CHAMPUS Diagnosis-Related Group (DRG)-Based Payment System (Adjustments to Payment Amounts)). Clarified that inpatient acute-care hospitals that are paid under the TRICARE/ CHAMPUS DRG-based payment system shall report a Present on Admission (POA) indicator for both primary and secondary diagnoses on inpatient acute care hospital claims.

CHAPTER 7

2. Table of Contents - Mental Health. Section 3's Subject was corrected.

3. Section 1 (Hospital Reimbursement - TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System). TRICARE/CHAMPUS DRG-Based Payment System. Clarified that 896 is a mental health DRG.

4. Section 3 (Substance Use Disorder Rehabilitation Facilities (SUDRFs) Reimbursement). Clarified that payment is the lesser of the billed charge or the CHAMPUS Maximum Allowable Charge (CMAC). Clarification added for Outpatient Prospective Payment System (OPPS) applicability.

INDEX

5. Index Letter R. Corrected Reimbursment Of->Substance Use Disorder Rehabilitation Facilities (SUDRFs).

b. Number of interns and residents. Initially, the number of interns and residents will be derived from the most recently available audited Centers for Medicare and Medicaid Services (CMS) cost-report data (1984). Subsequent updates to the adjustment factor will be based on the count of interns and residents on the annual reports submitted by hospitals to the contractors (see above). The number of interns and residents is to be as of the date the report is submitted and is to include only those interns and residents actually furnishing services in the reporting hospital and only in those units subject to DRG-based reimbursement. The percentage of time used in calculating the full-time equivalents is to be based on the amount of time the interns and residents spend in the portion of the hospital subject to DRG-based payment or in the outpatient department of the hospital on the reporting date. Beginning in FY 1999, TRICARE/CHAMPUS will use the number of interns and residents from CMS most recently available Provider Specific File.

c. Number of beds. Initially, the number of beds will be those reported on the most recent AHA Annual Survey of Hospitals (1986). Subsequent updates to the adjustment factor will be based on the number of beds reported annually by hospitals to the contractors (see above). The number of beds in a hospital is determined by counting the number of available bed days during the period covered by the report, not including beds or bassinets assigned to healthy newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the reporting period. Beginning in FY 1999, TRICARE/CHAMPUS will use the number of beds from CMS's most recently available Provider Specific File.

d. Updates of indirect medical education factors. It is the contractor's responsibility to update the adjustment factors based on the data contained in the annual report. The effective date of the updated factor shall be the date payment is made to the hospital (check issued) for its capital and direct medical education costs, but in no case can it be later than 30 days after the hospital submits its annual report. The updated factor shall be applied to claims with a date of discharge on or after the effective date. Similarly, contractors may correct initial factors if the hospital submits information (for the same base periods) which indicates the factor provided by TMA is incorrect.

(1) Beginning in FY 1999, TRICARE/CHAMPUS will use the ratio of interns and residents to beds from CMS's most recently available Provider Specific File to update the IDME adjustment factors. The ratio will be provided to the contractors to update each hospital's IDME adjustment factor at the same time as the annual DRG update. The updated factors shall be applied to claims with a date of discharge on or after October 1 of each year. The contractor is no longer required to update a hospital's IDME factor based on data contained in the hospital's annual request for reimbursement for its capital and direct medical education costs.

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

e. Adjustment for children's hospitals. An indirect medical education adjustment factor will be applied to each payment to qualifying children's hospitals. The factors for children's hospitals will be calculated using the same formula as for other

hospitals. The initial factor will be based on the number of interns and residents and hospital bed size as reported by the hospital to the contractor. If the hospital provides the data to the contractor after payments have been made, the contractor will not make any retroactive adjustments to previously paid claims, but the amounts will be reconciled during the "hold harmless" process. At the end of its fiscal year, a children's hospital may request that its adjustment factor be updated by providing the contractor with the necessary information regarding its number of interns and residents and beds. The number of interns, residents, and beds must conform to the requirements above. The contractor is required to update the factor within 30 days of receipt of the request from the hospital, and the effective date shall conform to the policy contained above.

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

(2) The contractors shall send the updated ratios for children's hospitals to TMA, MB&RS, or designee, by April 1 of each year to be used in TMA's annual DRG update calculations.

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

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

a. Effective for admissions on or after October 1, 2009, 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 ICD-9-CM Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-9-CM Official Guidelines for Coding and Reporting.

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

Y = Indicates that the condition was present on admission.

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

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

U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.

1 = 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.

c. HACs. TRICARE shall adopt those HACs adopted by CMS. On or about September 2009, the HACs, and their respective diagnosis codes will be posted at http://www.tricare.mil/drgrates.

d. 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.

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

f. Exempt Providers.

(1) The following hospitals are exempt from POA reporting for TRICARE:

(a) Critical Access Hospitals (CAHs)

(b) Long Term Care (LTC) Hospitals

(c) Maryland Waiver Hospitals

(d) Cancer Hospitals

(e) Children's Inpatient Hospitals

(f) Inpatient Rehabilitation Hospitals

(g) Psychiatric Hospitals

(h) Sole Community Hospitals (SCHs)

(i) Veterans Administration (VA) Hospitals

(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.

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

h. 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.

i. Reports. Contractors shall create a monthly report listing all TRICARE Encounter Data (TED) records that had HACs. The report shall include, at a minimum, the TED Record Indicator, each HAC reported, the POA indicator for each HAC, the dates of service/admission, the DRG that was paid, the total amount paid by TRICARE, and the following provider data: Taxpayer Identification Number (TIN), Sub-Identifier (SUBID), Zip Code, Type of Institution, and National Provider Identifier (NPI). The report shall be provided to TMA by the 10th of each month in an Excel file and submitted via the E-Commerce Extranet. The first monthly report shall be due no later than November 10, 2009.

9. Replacement Devices.

a. 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:

(1) At reduced or no cost to the hospital; or

(2) With partial or full credit for the removed device.

b. The following condition codes 49 and 50 allow TRICARE to identify and track claims billed for replacement devices:

(1) Condition Code 49. Product replacement within product lifecycle. Condition code 49 is used to describe replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly - warranty.

(2) Condition Code 50. Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly. Condition code 50 is used to describe that the manufacturer or the U.S. Food and Drug Administration (FDA) has identified the product for recall and, therefore, replacement.

c. When a hospital receives a credit for a replaced device that is 50% or greater than the cost of the device, hospitals are required to bill the amount of the credit in the amount portion for value code **FD**.

d. Beginning with admissions on or after October 1, 2009, the contractor shall reduce hospital reimbursement for those DRGs subject to the replacement device policy, by the full or partial credit a provider received for a replaced device. The specific DRGs subject to the replacement device policy will be posted on TRICARE's DRG web page at

CHAPTER 7

MENTAL HEALTH

CHAPTER 7
SECTION 1

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM

ISSUE DATE: November 28, 1988
AUTHORITY: 32 CFR 199.14(a)

I. 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.

II. ISSUE

How is the TRICARE inpatient mental health per diem payment system to be used in determining reimbursement for psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the Diagnosis Related Group (DRG)-based payment system?

III. POLICY

A. Inpatient Mental Health Per Diem Payment System.

The inpatient mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the DRG-based payment system. The system uses two sets of per diems. One set of per diems applies to psychiatric hospitals and psychiatric units of general acute hospitals that have a relatively high number (25 or more per federal fiscal year) of TRICARE mental health discharges. For higher volume hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to psychiatric hospitals and units with a relatively low number (less than 25 per federal fiscal year) of TRICARE mental health discharges. For higher volume providers, the contractors are to maintain files which will identify when a provider becomes a high volume provider; the federal fiscal year when the provider had 25 or more TRICARE mental health discharges; the calculation of each provider's high volume rate; and the current high volume rate for the provider. For lower volume hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and indirect medical education (IDME) costs and additional pass-through payments for direct medical education costs.

B. Applicability of the Inpatient Mental Health Per Diem Payment System.

1. Facilities. The inpatient mental health per diem payment system applies to services covered that are provided in a Medicare DRG-exempt psychiatric hospitals and a Medicare DRG-exempt unit of a hospital. In addition, any psychiatric hospital that does not participate in Medicare, or any hospital that has a psychiatric unit that has not been so designated for exemption from Medicare DRG because the hospital does not participate in Medicare, must be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the inpatient mental health per diem payment system upon demonstrating that it meets the same Medicare criteria. The contractor is responsible for requesting from a hospital that does not participate in Medicare sufficient information from that hospital which will allow it to make a determination as to whether the hospital meets the Medicare criteria in order to designate it as a DRG-exempt hospital or unit. The inpatient mental health per diem payment system does not apply to mental health services provided in non-psychiatric hospitals or non-psychiatric units. Substance use disorder rehabilitation facilities are not reimbursed under the inpatient mental health per diem payment system (see Chapter 7, Section 3).

2. DRGs. All psychiatric hospitals' and psychiatric units' covered inpatient claims which are classified into a mental health DRG of 425 - 432 or a substance use disorder DRG of 433, DRGs 521 - 523, and DRGs 900 and 901 shall be subject to the TRICARE inpatient mental health per diem payment system.Effective October 1, 2008, all psychiatric hospitals and psychiatric units covered claims which are classified into a mental health DRG of 880 - 887 or a substance use disorder DRG of 894 - 896, 898, and 899 shall be subject to the TRICARE inpatient mental health per diem system.

3. 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.

C. Hospital-Specific Per Diems for Higher Volume Psychiatric Hospitals and Units.

1. Hospital-Specific Per Diem. A hospital-specific per diem amount shall be calculated for each hospital or unit with a higher volume of TRICARE mental health discharges. The base period per diem amount shall be equal to the hospital's average daily charge for charges allowed by the government in the base period (July 1, 1987 through May 31, 1988). The average daily charge in the base period shall be calculated by reference to all TRICARE claims paid (processed) during the base period. The base period amount, however, may not exceed the cap.

2. Cap Amount. Effective for care on or after April 6, 1995, the cap amount is established at the 70th percentile.

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
645	10/01/1997 through 09/30/1998
660	10/01/1998 through 09/30/1999

CHAPTER 7
SECTION 3

SUBSTANCE USE DISORDER REHABILITATION FACILITIES (SUDRFS) REIMBURSEMENT

ISSUE DATE: June 26, 1995
AUTHORITY: 32 CFR 199.14(a)(1)(ii)(E) and (a)(2)(ix)

I. APPLICABILITY

A. 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.

B. The following reimbursement methodology will be used for payment of all Substance Use Disorder Rehabilitation Facilities (SUDRFs) prior to implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of Outpatient Prospective Payment System (OPPS). Thereafter, this methodology will only be used in the reimbursement of freestanding SUDRFs.

II. ISSUE

Reimbursement of SUDRFs. This includes reimbursement for both inpatient and partial hospitalization for the treatment of substance use disorder rehabilitation care.

III. POLICY

A. Inpatient SUDRFs. Effective with admissions on or after July 1, 1995, authorized SUDRFs are subject to the DRG-based payment system.

B. Partial hospitalization for the treatment of substance use disorders. Substance use disorder rehabilitation partial hospitalization services are reimbursed on the basis of prospectively determined all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, routine nursing services, ancillary services (includes art, music, dance, occupational and other such therapies), psychological testing and assessments, overhead and any other services for the customary practice among similar providers is included as part of the institutional charges.

C. Outpatient professional services will be reimbursed using the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Payment is the lesser of the billed charge or the CHAMPUS Maximum Allowable Charge (CMAC).

D. Family therapy provided on an inpatient or outpatient basis will be reimbursed under the CMAC for the procedure code(s) billed.

E. Cost-sharing. Effective for care on or after October 1, 1995, the cost-share for active duty dependents for inpatient substance use disorder services is $20.00 per day for each day of the inpatient admission. The $20.00 cost-share amount also applies to substance use disorder rehabilitation care provided in a partial hospitalization setting. The inpatient cost-share applies to the associated services billed separately by the individual professional providers. For care prior to October 1, 1995, the cost-share will be the daily rate or $25.00, whichever is greater. For retirees and their dependents, the cost-share is 25% of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for active duty dependents is to be taken from the partial hospitalization facility claim.

- END -