OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, CO 80011-9066

DEFENSE
HEALTH AGENCY

HPOD

CHANGE 166
6010.58-M
NOVEMBER 5, 2018

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: **CONSOLIDATED CHANGE 18-003**

CONREQ: 19562

SUMMARY OF CHANGE(S): See page 2.

EFFECTIVE DATE: See page 2.

IMPLEMENTATION DATE: December 6, 2018.

This change is made in conjunction with Feb 2008 TOM, Change No. 234.

LOZOYA.JOSE.L.1231416397

Digitally signed by LOZOYA.JOSE.L.1231416397
Date: 2018.10.30 13:30:28 -06'00'

Jose L. Lozoya
Chief, Manuals Change Section
Defense Health Agency (DHA)

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

CHANGE 166
6010.58-M
NOVEMBER 5, 2018

SUMMARY OF CHANGES

CHAPTER 2

1. Section 1. This change clarifies language on beneficiary population provisions and clarifies that provisions only pertain to readmissions to an acute care hospital. EFFECTIVE DATE: 11/05/2018.

2. Section 2. This change clarifies language on beneficiary population provisions and clarifies that provisions only pertain to readmissions to an acute care hospital. EFFECTIVE DATE: 11/05/2018.

CHAPTER 16

3. Section 1. This change adds Direct Medical Education (DME) reimbursement instructions and implements the final TRICARE rule which establishes new reimbursement methodologies for Long-Term Care Hospitals (LTCH's) and Inpatient Rehabilitation Facilities (IRF's). EFFECTIVE DATE: 10/01/2018.

CHAPTER 17

4. Section 1. This change adds Direct Medical Education (DME) reimbursement instructions and implements the final TRICARE rule which establishes new reimbursement methodologies for Long-Term Care Hospitals (LTCH's) and Inpatient Rehabilitation Facilities (IRF's). EFFECTIVE DATE: 10/1/2018.

1.5 Cost-Shares: Ambulance Services

1.5.1 For the basis of payment of ambulance services, see Chapter 1, Section 14.

1.5.2 Outpatient. The following are beneficiary copayment/cost-sharing requirements for medically necessary ambulance services when paid on an outpatient basis:

1.5.2.1 TRICARE Prime

1.5.2.1.1 For care provided prior to April 1, 2001, for ADFMs in pay grades E-1 through E-4, $10. For care provided on or after April 1, 2001, for ADFMs in pay grades E-1 through E-4, $0. See Addendum A for further information.

1.5.2.1.2 For care provided prior to April 1, 2001, for ADFMs in pay grades E-5 and above, $15. For care provided on or after April 1, 2001, for ADFMs in pay grades E-5 and above, $0. See Addendum A for further information.

1.5.2.1.3 For retirees and their family members, $20.

1.5.2.2 TRICARE Extra

1.5.2.2.1 A cost-share of 15% of the fee negotiated by the contractor for ADFMs.

1.5.2.2.2 A cost-share of 20% of the fee negotiated by the contractor for retirees, their family members, and survivors.

1.5.2.3 TRICARE Standard

1.5.2.3.1 A cost-share of 20% of the allowable charge for ADFMs.

1.5.2.3.2 A cost-share of 25% of the allowable charge for retirees, their family members, and survivors.

1.5.2.4 Inpatient: Non-Network Providers

1.5.2.4.1 ADFMs. No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

1.5.2.4.2 Other Beneficiary. The cost-share applicable to inpatient care for beneficiaries other than ADFMs is 25% of the allowable amount.

1.5.2.5 Exceptions

1.5.2.5.1 Inpatient Cost-Share Applicable To Each Separate Admission

Prior to January 1, 2018, for TRICARE ADFMs only, a separate cost-share amount is applicable to each separate beneficiary for each inpatient admission EXCEPT:

1.5.2.5.1.1 Any readmission to an acute care hospital which is not more than 60 days from the date of the last inpatient discharge shall be treated as one inpatient confinement with the last admission for cost-share amount determination.

1.5.2.5.1.2 Certain heart and lung hospitals are excepted from cost-share requirements. See Chapter 1, Section 27, entitled "Legal Obligation To Pay".

1.5.2.5.2 Inpatient Cost-Share: Maternity Care

See paragraph 1.3.3.3. All admissions related to a single maternity episode shall be considered one confinement regardless of the number of days between admissions. For ADFMs, the cost-share will be applied to the first institutional claim received.

1.5.2.5.3 Special Cost-Share Provisions

1.5.2.5.3.1 For services provided prior to International Classification of Diseases, 10th Revision (ICD-10) implementation. Effective October 1, 1987, the inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories cannot exceed that which would have been imposed if the service were subject to the DRG-based payment system. This will not affect ADFMs. For all other beneficiaries, the cost-share shall be the lesser of:

- That calculated according to paragraph 1.3.3.2.2; or
- That calculated according to paragraph 1.3.3.4.2.

1.5.2.5.3.1.1 Child Bone Marrow Transplant (BMT)

All services related to discharges involving BMT for a beneficiary less than 18 years old as classified in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

1.5.2.5.3.1.2 Child Human Immunodeficiency Virus (HIV) Seropositivity

All services related to discharges involving HIV seropositive beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis codes 042, 079.53, and 795.71.

1.5.2.5.3.1.3 Child Cystic Fibrosis

All services related to discharges involving beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis code 277.0 (cystic fibrosis).

responsible for payment of the first one hundred and fifty dollars ($150.00) of the reasonable costs/charges for otherwise covered outpatient services and/or supplies provided in any one fiscal year (effective January 1, 2018, in any one calendar year). Although the law defines former spouses as family members of the member or former member, there is no legal familial relationship between the former spouse and the member or former member. Moreover, any TRICARE-eligible children of the former spouse will retain a legal familial relationship with the member or former member and shall be included in the member's or former member's family deductible. The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of that of any TRICARE-eligible children. In other words, a former spouse must independently meet the $150.00 deductible in any fiscal year (effective January 1, 2018, in any calendar year).

2.8.2 Cost-Share. An eligible former spouse is responsible for payment of cost-sharing amounts identical to those required for beneficiaries other than ADFMs.

2.9 Cost-Share Amount

Under discounted rate agreements. In cases where the cost-share is calculated as a percentage rather than a fixed amount, the percentage shall be applied to (after duplicates and noncovered charges are eliminated), the lowest of the billed charge, the prevailing charge, the maximum allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge. If the contractor learns that the participating provider has billed a beneficiary for a greater cost-share amount, based on the provider's usual billed charges, the contractor shall notify the provider that such an action is a violation of the provider's signed agreement.

2.10 Exceptions

2.10.1 Inpatient Cost-Share: Applicable To Each Separate Admission

On or after January 1, 2018, for TRICARE Select Group A ADFMs only, a separate cost-share amount is applicable to each separate beneficiary for each inpatient admission EXCEPT:

2.10.1.1 Any readmission to an acute care hospital which is not more than 60 days from the date of the last inpatient discharge shall be treated as one inpatient confinement with the last admission for cost-share amount determination.

2.10.1.2 Certain heart and lung hospitals are excepted from cost-share requirements. See Chapter 1, Section 27, entitled "Legal Obligation To Pay".

2.10.2 Inpatient Cost-Share: Maternity Care

All admissions related to a single maternity episode shall be considered one confinement regardless of the number of days between admissions. For ADFMs, the cost-share shall be applied to the first institutional claim received.

2.10.3 See Section 6 for waivers of cost-shares and deductibles.

2.11 Exclusions

TFL. See Section 1.

3.0 CATASTROPHIC LOSS PROTECTION

See Section 4.

- END -

CASE 4: PATIENT WITH NO ICU OR PROLONGED MECHANICAL VENTILATION	
Admitted on October 2, 2019	115% of the Site-Neutral Payment Rate
* The LTCH receives billed charges for this admission because the LTCH's cost reporting period during FY18 begins September 1, 2019.	

CASE 5: PATIENT WITH ACUTE ICU STAY OF OVER THREE DAYS	
Cost Reporting Period: LTCH with Cost Reporting Period in FY18 beginning **October 1, 2018**.	
Patient:	**TRICARE Pays:**
Admitted on November 2, 2018	135% of the Full LTCH Payment Rate
Admitted on January 2, 2019	135% of the Full LTCH Payment Rate
Admitted on July 2, 2019	135% of the Full LTCH Payment Rate
Admitted on September 2, 2019	135% of the Full LTCH Payment Rate
Admitted on October 2, 2019	115% of the Full LTCH Payment Rate

CASE 6: PATIENT WITH NO ICU OR PROLONGED MECHANICAL VENTILATION	
Cost Reporting Period: LTCH with Cost Reporting Period in FY18 beginning **October 1, 2018**.	
Patient:	**TRICARE Pays:**
Admitted on November 2, 2018	135% of the Site-Neutral Payment Rate
Admitted on January 2, 2019	135% of the Site-Neutral Payment Rate
Admitted on July 2, 2019	135% of the Site-Neutral Payment Rate
Admitted on September 2, 2019	135% of the Site-Neutral Payment Rate
Admitted on October 2, 2019	115% of the Site-Neutral Payment Rate

4.5 Preadmission Services

LTCHs paid under the LTCH PPS are subject to a one-day payment window, where any outpatient services or non-physician services provided one calendar day prior to the LTCH admission are included in the LTCH-DRG payment. This is known as the one-day payment rule. The one-day payment rule only applies to services that are diagnostic and furnished in connection with the principle diagnosis. Any other services not meeting the diagnostic criteria, or services provided outside of the one-day window will be paid separately according to current TRICARE policy.

4.6 LTCH Data

4.6.1 The MS-LTC-DRG rates and weights and the IPPS rates and weights are posted to the CMS website in August of each year. The contractor shall use the most current version of the files (to include any corrections made) for each fiscal year (October 1) update.

4.6.2 The MS-LTC-DRG relative weights, wage index files and other related files are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html.

4.6.3 The IPPS relative weight, wage index files and other related files for processing Site-Neutral LTCH claims are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

4.6.4 The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)/Procedure Coding System (PCS) MS-DRG Definitions Manual for the PPS Grouper is available at https://www.cms.gov/ICD10Manual/version35-fullcode-cms/fullcode_cms/P0001.html.

4.6.5 The LTCH Pricer is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/LTCH.html.

4.6.6 The LTCH Medicare Provider ID numbers are available at: https://data.medicare.gov/.

4.6.7 The LTCH cost reporting periods are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/psf_text.html.

4.7 Billing and Coding Requirements

4.7.1 The contractors shall use type of institution 73 for LTCHs.

4.7.2 The contractors shall use Pricing Rate Code (PRC) **LT** for Standard LTCH claims priced using the MS-LTC-DRG payment rates and PRC **SN** for LTCH claims priced using the site-neutral LTCH PPS payment rates.

4.8 Direct Medical Education

DHA will reimburse LTCHs who file a request for their direct medical education costs in a timely manner, as outlined in Chapter 6, Section 8. Although the procedures listed in Chapter 6, Section 8 pertain to DRGs, those same procedures are to be used to reimburse LTCHs for direct medical education costs.

4.9 Dual Eligible

When the Medicare hospital day limit is exhausted for a TRICARE beneficiary, who is also eligible for Medicare (i.e., TRICARE for Life (TFL) beneficiaries), TRICARE is the primary payer.

5.0 EXCLUSIONS

5.1 The TRICARE LTCH PPS methodology does not apply to hospitals in states that are reimbursed by Medicare and TRICARE under a cost containment waiver that exempts them from Medicare's IPPS or the TRICARE DRG-based payment system.

5.2 Children's hospitals are excluded from the TRICARE LTCH PPS methodology.

5.3 VA hospitals are excluded from the TRICARE LTCH PPS methodology.

5.4 The TRICARE LTCH PPS methodology does not apply to any costs of physician services or other professional services provided to LTCH patients.

5.5 Custodial or domiciliary care is not coverable under the TRICARE program, even if rendered in an otherwise authorized LTCH.

6.0 EFFECTIVE DATE

Implementation of the TRICARE LTCH PPS methodology is effective for admissions on or after October 1, 2018.

- END -

4.9.2 The IRF shall bill using Bill Type **11X** along with Revenue Code **0024**.

4.9.3 Contractors shall process the claim using Type Of Institution **46** for IRFs.

4.9.4 The contractors shall use Pricing Rate Code (PRC) **CI** for CAH IRF reimbursement and **RF** for all other IRF reimbursement.

4.10 Direct Medical Education

DHA will reimburse IRFs who file a request for their direct medical education costs in a timely manner, as outlined in Chapter 6, Section 8. Although the procedures listed in Chapter 6, Section 8 pertain to DRGs, those same procedures are to be used to reimburse IRFs for direct medical education costs.

5.0 EXCLUSIONS

5.1 The TRICARE IRF PPS methodology does not apply to hospitals in States that are reimbursed by Medicare and TRICARE under a waiver that exempts them from Medicare's Inpatient Prospective Payment System (IPPS) or the TRICARE DRG-based payment system.

5.2 Children's hospitals are excluded from the TRICARE IRF PPS methodology.

5.3 Department of Veterans Affairs (VA) hospitals are excluded from the TRICARE IRF PPS methodology.

5.4 The IRF PPS reimbursement method does not apply to any costs of physician services or other professional services provided to IRF patients.

6.0 EFFECTIVE DATE

Implementation of the IRF PPS reimbursement method for inpatient services is effective for admissions on or after October 1, 2018.

- END -