

## Hospital Reimbursement - Billed Charges Set Rates

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

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### 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 Defense Health Agency (DHA) 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

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reimbursed so long as they are uniformly charged to all patients and so long as the hospital is incapable of itemizing its bills.

**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.

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