

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.

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