Humana Military Healthcare Services

SUBJECT: Reimbursement of Capital and Direct Medical Education Costs

Dear Providers:

TRICARE/CHAMPUS authorizes Managed Care Support Contractors to reimburse hospitals for Allowed Capital and Direct Medical Education costs. Reimbursement is subject to the following regulations as outlined in the TRICARE/CHAMPUS Policy Manual, effective 10/01/98:

1. Any hospital subject to the TRICARE/CHAMPUS DRG-based payment system which wishes to be reimbursed for Allowed Capital and Direct Medical Education costs must submit a request for reimbursement to the TRICARE/CHAMPUS Contractor.

2. The initial request must be submitted on or before the last day of the twelfth month following the close of the hospital's cost-reporting period. The request must correspond to the hospital's Medicare cost-reporting period (dates and costs). Hospitals must submit their request forms and applicable pages from their Medicare Cost Reports to the TRICARE/CHAMPUS Contractor. Those hospitals that are not Medicare participating providers are to use October 1 through September 30 fiscal year for reporting Capital and DME Costs.

3. All amended requests as a result of a subsequent Medicare desk review, audit or appeal must be submitted along with a copy of the NPR (Notice of Program Report) and the applicable pages from the amended Medicare Cost Report to the TRICARE/CHAMPUS Contractor within 30 days of the date the hospital is notified of the change. Failure to promptly report the changes resulting from a Medicare desk review, audit or appeal is considered a misrepresentation of the cost report information. Such a practice can be considered fraudulent, which may result in criminal/civil penalties or administrative sanctions of suspension or exclusion as an authorized provider.

4. For more information providers may reference the Department of Defense Federal Register.

Properly completed requests will be processed within 30 days, based upon the information submitted on the enclosed form. All providers must submit the applicable pages from their Medicare Cost Report when requesting reimbursement from the Contractor. The request must contain original signature, copied signatures will not be accepted. Please refer to the attached line item instructions for the Medicare Cost Report references.

A hospital official must sign the request for reimbursement, certifying that the information is accurate and based upon the Medicare Cost Report. If you have questions, please contact a capital and direct medical education specialist at 502-301-6420 or email HMHSCapitalDirectMedEd@Humana.com.

EXPLANATION FOR REIMBURSEMENT OF TRICARE CAPITAL AND DIRECT MEDICAL EDUCATION COST

All information provided on the request must correspond to the information reported on the hospital's Medicare Cost Report.

1.	Hospital Name	Name of hospital making request
2.	Address	Street Address, City, State and Zip Code
3.	TRICARE/CHAMPUS Provider Number	The hospital's TRICARE/CHAMPUS Provider Number. The hospital's TRICARE/CHAMPUS Provider Number. This should correspond to the hospital's tax identification number.
4.	Medicare Provider Number	The hospital's 6 digit Medicare Provider Number.
5.	Period Covered	The hospital's fiscal year must correspond to the Medicare cost reporting period.
6.	Total Inpatient Days	Days provided to all patients in units subject to DRG based payments. Reference Medicare Cost Report, (HCFA 2552-92) Worksheet S-3, Line 8, column 6, or (HCFA 2552-96) Worksheet S-3 Line 12, column 6. (Swing Beds days should not be included.)
7.	Total TRICARE/CHAMPUS	Only include days which were Inpatient days "allowed" for payment. Therefore, days which were determined to be not medically necessary and days which TRICARE/CHAMPUS made no payment because other health insurance paid the full allowable amount are not to be included. The discharge date should be within the reporting period.
7A.	Total TRICARE/CHAMPUS Days	Days provided to patients who were Active for Active Duty Claims Duty members.
8.	Total Allowable Capital Cost	Total allowable capital cost as reported on the Medicare Cost Report. From the Medicare Cost Report, add the figures from Worksheet D, Part I, Columns 3 and 6, Lines 25-28, Lines 29 and 30 if it reflects intensive care cost, plus Line 33 to the figures from Worksheet D, Part II, Columns 1 and 2, Lines 37-63. (Ref. HCFA 2552-92 or 96) If the Medicare Cost Report is prior to 1992 the figures will only be added from Worksheet D, Column 1 on Part I and II. The same line items will be used.
9.	Total Allowable Direct Medical Education Cost	Total allowable direct medical education cost from the Medicare cost reports on all initial and amended request, add the figures from Worksheet B, Part I, Columns 21-24, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, line 33 and lines 37-63.
10.	Residents/Interns	Total full-time equivalents for residents/interns
11.	Total Inpatient Beds	The number of available beds during the period covered by the Medicare Cost Report, not including beds assigned to healthy newborns, custodial care, and excluding distinct part hospital units. (Reference HCFA 2552-89 and 92) Medicare Cost Report, Worksheet S-3, Line 8, Column 1 minus any amount on line 7. (Reference HCFA 2552-96) Worksheet S-3, Line 12, Column 1, minus any amount on line 11.
12.	Reporting Date	Date the Request for Reimbursement is completed.

TRICARE South Region
Capital and Direct Medical Education Reimbursement
Claims Oversight Department
500 W Main Street
Louisville, KY 40202

Humana Military Healthcare Services

TRICARE REQUEST FOR REIMBURSEMENT OF CAPITAL AND DIRECT MEDICAL EDUCATION COSTS

Mail Request to: Humana Military Healthcare Services
Attn: Claims Oversight Department – Vicki Shipp
500 W Main Street
Louisville, KY 40202

1. HOSPITAL NAME: ____

2. HOSPITAL ADDRESS: ____

3. TRICARE/CHAMPUS PROVIDER NUMBER: ____

4. MEDICARE PROVIDER NUMBER: ____

5. PERIOD COVERED FROM: ____________________________ TO: ____________________________
(Must correspond to Medicare cost-reporting period.)

6. TOTAL INPATIENT DAYS: _______________________________________
(Provided to all patients in units subject to DRG-based payment)

7. TOTAL TRICARE/CHAMPUS INPATIENT DAYS FOR DEP/RETIREES: __________________________
(Provided in units subject to DRG-based payment. This is to be only days which were “allowed” for payment. Days which were paid by other health insurance or which were determined to be not medically necessary are not to be included)

7a. TOTAL TRICARE/CHAMPUS INPATIENT DAYS FOR AD CLAIMS: _________________________
(Active Duty members)

8. TOTAL ALLOWABLE CAPITAL COSTS: ____________________________________
(Must correspond with the applicable pages from the Medicare Cost Report)

9. TOTAL ALLOWABLE DIRECT MEDICAL EDUCATION COSTS: _______________________
(Must correspond with the applicable pages from the Medicare Cost Report)

10. TOTAL FULL-TIME EQUIVALENTS FOR RESIDENTS/INTERNS: _________________

11. TOTAL INPATIENT BEDS: __________________

12. REPORTING DATE: ______________________________

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I certify the above information is accurate and based upon the hospital’s Medicare cost report submitted to HCFA. The cost report filed, together with any documentation are true, correct and complete based upon the books and records of the hospital. Misrepresentation or falsification of any of the information in the cost reports is punishable by fine and/or imprisonment. Any changes which are the result of a desk review, audit or appeal of the hospital’s Medicare cost report must be reported to the TRICARE/CHAMPUS contractor within 30 days of the date the hospital is notified of the change. Failure to report the changes can be considered fraudulent, which may result in criminal/civil penalties or administrative sanctions of suspension or exclusion as an authorized provider.

______ Initial Request ______ Amended Request

Signature ___________________________________ Title _____________________________________

Typed Name _________________________________ Phone: ___________________________________