PGBA
A CELERIAN GROUP COMPANY

TRICARE North Region

SUBJECT: Reimbursement of Capital and Direct Medical Education Costs

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

1. Any hospital subject to the TRICARE 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 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 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 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 to 45 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 a signature and the title of the signing official. 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 one of the following persons:

North 1
Ines Watson
(803) 763-4908
ines.watson@pgba.com

North 2
Penny Cross
(803) 763-6795
penny.cross@pgba.com

Jacqueline Marvin
(803) 763-6594
Work Leader
jacqueline.marvin@pgba.com

Sincerely,
Robin Cooper
Manager, PGBA Finance

TRICARE North Region
PGBA, LLC

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	The name of the hospital making request
2. Address	The hospital street address, city, state and zip code
3. TRICARE Provider Number	The hospital's TRICARE 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	Total "Inpatient Days" provided to all patients in units subject to DRG-based payments. Reference Medicare Cost Report, **HCFA 2552-96** Worksheet S-3, Part 1, line 12, column 6 or Medicare Cost Report **CMS-2552-10** Worksheet S-3, Part 1, line 14, column 8 (Swing Beds days should not be included).
7. Total TRICARE/CHAMPUS Inpatient Days	Total "TRICARE Inpatient Days" provided in units subject to DRG-based payment. (This is to be only days which were "allowed" for payment. Therefore, days which were determined to be not medically necessary and days which TRICARE made no payment because of other health insurance paid the full allowable amounts, are not to be included. (The discharge date must be within the reporting period.)
8. Total Allowable Capital Cost	Total allowable capital cost as reported on the Medicare Cost Report. From the Medicare Cost Report, **HCFA 2552-92** or **2552-96** add the figures from Worksheet D, Part 1, Title XVIII, 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, Title XVIII, Hospital PPS, columns 1 and 2, lines 37-63. From the Medicare Cost Report **CMS-2552-10** add the figures from Worksheet D, Part I, Title XVIII, column 3, lines 30-33, lines 34 and 35 if the cost report reflects intensive care unit costs, and line 43, to the figures from Worksheet D, Part II, Title XVIII, Hospital PPS, column 1, lines 50-76 and 88-93.
9. Total Allowable Direct Medical Education Costs	Total Allowable Medical Education Costs as reported on the Medicare Cost Report. From the Medicare Cost Report, **HCFA 2552-92** or **2552-96** add the figures from

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	Worksheet B, Part I, columns 21 through 24, lines 25-28, lines 29 and 30 if it reflects intensive care costs, plus line 33 and 37-63. From the Medicare Cost Report, **CMS-2552-10** add the figures from Worksheet B, Part I, columns 20-23, lines 30-33, lines 34 and 35 if the cost report reflects intensive care costs, line 43, lines 50-76; and lines 88-93. Notes: Medical Education reimbursement can only be included if the hospital has a Medicare approved teaching program and is a "Low Volume" provider.
10. Residents/Interns	Total full-time equivalents for residents/interns as reported on the Medicare Cost Report. From the Medicare Cost Report **2552- 92** or **2552-96** use Worksheet S-3, Part I, line 12, column 7. From the Medicare Cost Report **2552-10** use Worksheet S-3, Part I, line 14, column 9 (Total Interns & Residents).
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 as reported on the Medicare Cost Report **HCFA 2552-92,** Worksheet S-3, Part 1, column 1, line 8, minus any amount on line 7. From the Medicare Cost Report **HCFA 2552-96**, Worksheet S-3, Part 1, column 1, line 12, minus any amount on line 11. From the Medicare Cost Report CMS 2552-10, Worksheet S-3, Part 1, column 2, line 14, minus any amount on line 13.
12. Reporting Date	The date the request for Reimbursement is completed.

MAIL REQUEST TO:

PGBA, LLC
PGBA Finance, AG-740
CAPITAL AND DIRECT MEDICAL EDUCATION REIMBURSEMENT
P.O. BOX 100245
COLUMBIA, SC 29202-3245

ADDRESS FOR FEDEX,
UPS AND AIRBORNE:

PGBA LLC
PGBA Finance, AG-740
CAPITAL AND DIRECT MEDICAL EDUCATION REIMBURSEMENT
2300 SPRINGDALE DR. BLDG. 2
CAMDEN, SC 29020 -1728

TRICARE North Region
PGBA, LLC

OMB control number: 0720-0017
Expiration: xx-xx-xxxx

RETURN TO: PGBA, LLC
Attn: PGBA Finance AG-740
Capital and Direct Medical Education Reimbursement, PO Box 100245, Columbia, SC 29202-3245

TRICARE REQUEST FOR REIMBURSEMENT OF CAPITAL AND DIRECT MEDICAL EDUCATION COSTS

1. HOSPITAL NAME:_____
2. HOSPITAL ADDRESS:_____
3. TRICARE 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 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 determined to be not medically necessary are not to be included)

7a. TOTAL TRICARE INPATIENT DAYS FOR ACTIVE DUTY CLAIMS:_____ (Provided in units subject to DRG-based payment. This is to be only days which were “allowed” for payment. Days which were determined to be not medically necessary are not to be included)

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 CMS. 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 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

Official’s Signature: _____ Official’s Title:_____

Official’s Printed Name: _____ Phone:_____

Official’s Mailing Address:_____