OMB Control Number: 0720-0017
Expiration Date: 7/31/2025

TRICARE T5 West Region

Requesting Reimbursement of Capital and Direct Medical Education Costs

TRICARE 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 February 2021.

- 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.

- Initial requests for payment of CAP/DME shall be filed with the TRICARE contractor on or before the last day of the 12th month following the close of the hospital's cost-reporting period. The request shall cover the one year period corresponding to the hospital's Medicare cost-reporting period. Thus, for cost-reporting periods, requests for payment of CAP/DME must be filed no later than 12 months following the close of the cost-reporting period. For example, if a hospital's cost-reporting period ends on June 30, 2016, the request for payment shall be filed on or before June 30, 2017. Those hospitals that are not Medicare participating providers are to use an October 1 through September 30 fiscal year for reporting CAP/DME costs.

- An extension of the due date for filing the initial request may only be granted if an extension has been granted by the Centers for Medicare and Medicaid Services (CMS) due to a provider's operations being significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire, as described in Section 413.24 of Title 42 CFR.

- 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.

- A properly completed request will be processed within 30 to 45 days, based upon the information submitted on the enclosed form. All providers must submit the applicable worksheet pages from their Medicare Cost Report when requesting reimbursement from the Contractor. The request must contain an official's signature and the official's title to certify that the information is accurate and based off of the Medicare Cost Report. Please refer to the attached line item instructions for the Medicare Cost Report references.

If you have questions, please reference the TRICARE Reimbursement Manual (TRM). Information can be retrieved in Chapter 6 Section 8 in paragraphs 3.2.4.1 – 3.2.4.2.15.

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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 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	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 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 Inpatient Days	Only include days, which were TRICARE Inpatient days "allowed" for payment. Therefore, days, which were determined to be not medically necessary and days which TRICARE made no payment because other health insurance paid the full allowable amounts, are not to be included. The discharge date must be within the reporting period.
7a. Total TRICARE Active Duty Days	Days provided to patients who were Active Duty claims members
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.

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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 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.
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

Email your reimbursement requests to T5WEST.CAPDME@pgba.com. You may also submit requests via postal mail to the below address.

Should you have additional questions, please contact us at T5WEST.CAPDME@pgba.com or 803-763-6075.

Mail the request to:

TRICARE CAPDME West Region
PO BOX 202172
Florence, SC 29502-2172

Overnight the request to:

TRICARE CAPDME West Region
2141 Westgate Place, Building 200
Florence, SC 29501

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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: _____ Date: _____

Official's Printed Name: _____ Phone: _____

Official's Title: _____

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AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information, 0720-0017, is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

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