# Reimbursement of capital and direct medical education costs

Dear provider:

TRICARE authorizes regional contractors 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.

- Any hospital subject to the TRICARE Diagnostic Related Groups (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.
- 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 direct medical education costs.
- All amended requests as a result of a subsequent Medicare desk review, audit or appeal must be submitted along with a copy of the *Notice of Program Reimbursement (NPR)* 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.
- 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.

**Please be sure to include the following along with the two page request form:**

1. All applicable S-3 worksheets for total TRICARE inpatient days, residents/interns and total inpatient days.
2. All applicable D Part I and D Part II worksheets or B Part II and B Part III worksheets Critical Access Hospital (CAH) for capital costs.
3. All applicable B Part I worksheets for direct medical education costs.
4. Copy of the Notice of Program Reimbursement (NPR) letter for amended requests.
5. The request must contain a signature and the title of the signing official. A hospital official must sign the request for reimbursement, certifying that the information is accurate and based upon the Medicare Cost Report.

Please refer to the attached line item instructions for the Medicare Cost Report references. If you have questions, please send email to **CAPDME@wpsic.com**.

TRICARE East Region
Capital and Direct Medical Education Reimbursement
**CAPDME@wpsic.com**

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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. Hospital address** | Street address, city, state and ZIP Code |
| **3. Mailing address** | Please note: Reimbursement checks will be mailed to the billing/reimbursement address that we have documented in your provider file. It is important to keep your provider file up-to-date to ensure payments are received timely. |
| **4. TRICARE provider #** | The hospital's TRICARE provider number. This should correspond to the hospital's tax identification number. |
| **5. NPI** | The hospital's National Provider Identification Number (NPI). |
| **6. Medicare provider #** | The hospital's six digit Medicare provider number |
| **7. Period covered** | The hospital's fiscal year must correspond to the Medicare cost reporting period (mm/dd/yyyy) |
| **8. Total inpatient days** | Days provided to all patients in units subject to Diagnostic Related Groups (DRG) based payments swing bed days should not be included unless a Critical Access Hospital (CAH) prior to 12/1/2009:<br>• *Medicare Cost Report form CMS 2552-10, Worksheet S-3, Column 8, Line 14*<br>• *Medicare Cost Report form HCFA 2552-96, Worksheet S-3, Column 6, Line 12*<br>• *Medicare Cost Report form HCFA 2552-92, Worksheet S-3, Column 6, Line 8* |
| **9. Total TRICARE inpatient days** | Only include days which were inpatient days "allowed" for payment. Days which were determined to be not medically necessary, days which TRICARE made no payment because Other Health Insurance (OHI) paid the full allowable amount and any claims in which Medicare makes a payment TRICARE For Life (TFL) are not to be included. The discharge date should be within the reporting period |
| **9a. Total TRICARE active duty days** | Days provided to patients who were active duty claims members (mm/dd/yyyy) |
| **10. Total allowable capital cost** | Total allowable capital cost as reported on the *Medicare Cost Report*:<br>• *Medicare Cost Report form CMS 2552-10, Worksheet D, Part I, Column 3, Lines 30-33, 34 and 35* if the cost report reflects intensive care cost, and *Line 43* add to the figures from *Worksheet D, Part II, Column 1, Lines 50-76 and 88-93*<br>• *Medicare Cost Report form HCFA 2552-92 or 96, Worksheet D, Part I, Columns 3 and 6, Lines 25-28, 29 and 30* if it reflects intensive care cost, plus *Line 33* add to the figures from *Worksheet D, Part II, Columns 1 and 2, Lines 37- 63* |
| **11. Total Allowable DME Cost** | Total allowable direct medical education cost on the *Medicare Cost Report*:<br>• *Medicare Cost Report form CMS 2552-10, Worksheet B, Part I, Columns 20-23, Lines 30-33, 34 and 35* if the cost report reflects intensive care unit costs, Lines *43, 50-76 and 88-93*<br>• *Medicare Cost Report form HCFA 2552-92 or 96, Worksheet B, Part I, Columns 21-24, Lines 25-28, 29 and 30* if the cost report reflects intensive care unit costs, Lines 33, 37-63 |
| **12. Residents/Interns** | Total full-time equivalents for residents/interns on the *Medicare Cost Report*:<br>• *Medicare Cost Report form CMS 2552-10 Worksheet S-3, Part I, Column 9, Line 14*<br>• *Medicare Cost Report form HCFA 2552-92 or 96 Worksheet S-3, Part I, Column 7, Line 12* |
| **13. 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:<br>• *Medicare Cost Report form CMS 2552-10, Worksheet S-3, Column 2, Line 14,* minus any amount on *Line 13*<br>• *Medicare Cost Report form HCFA 2552-89 and 92, Worksheet S-3, Column 1, Line 8,* minus any amount on *Line 7*<br>• *Medicare Cost Report form HCFA 2552-96, Worksheet S-3, Column 1, Line 12,* minus any amount on *Line 11* |
| **14. Reporting date** | Date the request for reimbursement is completed |

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**Please select:**

☐ Initial request ☐ Amended request (attach copy of *Notice of Program Reimbursement* letter for amended requests)

1. **Hospital name:** _____
2. **Hospital address:** _____
3. **Mailing address:** _____
4. **TRICARE provider #:** _____
5. **National Provider Identifier (NPI):** _____
6. **Medicare provider #:** _____
7. **Period covered (mm/dd/yyyy):** _____ – _____
   (Must correspond to Medicare cost reporting period.)
8. **Total inpatient days:** _____
   (Attach the applicable S-3 worksheets from the corresponding *Medicare Cost Report*)
9. **Total TRICARE inpatient days for dep/retirees:** _____
   (Provided in units subject to Diagnostic Related Groups (DRG)-based payment. This is to be only days which were "allowed" for payment. Days which were paid by Other Health Insurance (OHI) or which were determined to be not medically necessary, and any claims that Medicare makes a payment TRICARE For Life (TFL) are not to be included).

9a. **Total TRICARE inpatient days for active duty members claims:** _____

10. **Total allowable capital costs:** _____
    (Attach the applicable *D Part I & II* worksheets from the corresponding *Medicare Cost Report* or B *Part II & B Part III* if Critical Access Hospital (CAH))
11. **Total allowable (direct medical education) costs:** _____
    (Attach the applicable *B Part I* worksheets from the corresponding *Medicare Cost Report*)
12. **Total full-time equivalents for residents/interns:** _____
    (Attach the applicable *S-3* worksheets from the corresponding *Medicare Cost Report*)
13. **Total inpatient beds:** _____
    (Attach the applicable S-3 worksheets from the corresponding *Medicare Cost Report*)
14. **Reporting date (mm/dd/yyyy):** _____

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| TRICARE capital and direct medical education reimbursement form checklist | |
|---|---|
| ☐ All applicable *S-3* worksheets for total TRICARE inpatient days, residents/interns, and total inpatient days | ☐ All applicable *D Part I and D Part II* worksheets or *B Part II and B Part III* worksheets CAH for capital costs |
| ☐ All applicable *B Part I* worksheets for DME costs | ☐ Copy of the *Notice of Program Reimbursement (NPR)* letter for amended requests |
| ☐ The request must contain a signature and the title of the signing official | ☐ The completed *Page 1* of the *TRICARE capital and direct medical education reimbursement form* and this signature page |

**Note:** If the applicable information is not received with the submitted request, the forms will be returned to the requestor unprocessed, which may result in a delay of timely filing.

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 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.

**Signature:** _____

**Title:** _____

**Typed name:** _____ **Phone:** _____

**Email:** _____

**Contact name:** _____

**Title:** _____ **Phone:** _____

**Email request to**: **CAPDME@wpsic.com**

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