Reimbursement of Capital and Direct Medical Education (CAP DME) costs

Dear provider:

TRICARE authorizes regional contractors reimburse hospitals for allowed CAP DME costs. Reimbursement is subject to the following regulations as outlined in the TRICARE Reimbursement Manual (TRM), effective October 1, 1998.

- Any hospital subject to the TRICARE Diagnostic Related Groups (DRG)-based payment system, which wishes to be reimbursed for allowed CAP DME 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 CAP DME 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 (DoD) 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 email **T5EAST.CAPDME@PGBA.com** or call 803-763-6074.

Humana Military
Capital and Direct Medical Education
Reimbursement
T5EAST.CAPDME@PGBA.com

Mail the request to:
East CAPDME Reimbursement Request
PO Box 202156
Florence, SC 29502-2156

Overnight Address:
East CAPDME Reimbursement Request
2141 Westgate Place, Building 200
Florence, SC 29501-3932

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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: • *Medicare Cost Report form CMS 2552-10, Worksheet S-3, Column 8, Line 14* • *Medicare Cost Report form HCFA 2552-96, Worksheet S-3, Column 6, Line 12* • *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*: • *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* • *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*: • *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* • *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*: • *Medicare Cost Report form CMS 2552-10 Worksheet S-3, Part I, Column 9, Line 14* • *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: • *Medicare Cost Report form CMS 2552-10, Worksheet S-3, Column 2, Line 14,* minus any amount on *Line 13* • *Medicare Cost Report form HCFA 2552-89 and 92, Worksheet S-3, Column 1, Line 8,* minus any amount on *Line 7* • *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 (a Notice of Program Reimbursement (NPR) letter must be enclosed)

1. **Hospital name:** _____

2. **Hospital address:** _____

3. **Mailing address:** _____

4. **TRICARE provider #:** _____

5. **National Provider Identifier (NPI):** _____

6. **Medicare provider #:** _____
   (Must correspond to Medicare Cost Reporting Period)

7. **Period covered (mm/dd/yyyy):** _____ – _____
   (Corresponds with Worksheet S-3)

8. **Total inpatient days:** _____
   Only TRICARE inpatient days subject to Diagnostic Related Groups (DRG)-based codes are allowed payments.
   Other Health Insurance (OHI) claims, VA Payments and any TRICARE For Life (TFL) claims are not to be included.
   The discharge date must be within the reporting period.

9. **Total TRICARE inpatient days for dep/retirees:** _____
   (Only request psychiatric days if your facility has DME cost)

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

10. **Total allowable capital costs:** _____
    (Worksheet D Part I & II (Title XVIII) from the corresponding *Medicare Cost Report*)

11. **Total allowable (DME) costs:** _____
    (Worksheet B Part I from the corresponding Medicare Cost Report)

12. **Total full-time equivalents for residents/interns:** _____
    (S-3 worksheets from the corresponding Medicare Cost Report)

13. **Total inpatient beds:** _____
    (S-3 worksheets from the corresponding Medicare Cost Report)

14. **Reporting date (mm/dd/yyyy):** _____

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TRICARE CAP DME 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 Health Care Financing Administration (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: **T5EAST.CAPDME@PGBA.com**

OMB control number: 0720-0017
OMB expiration date: 7/31/2025

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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