CHAPTER 13
SECTION 6.1C

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (BASIS OF PAYMENT)

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I. APPLICABIITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

What is the basis of payment for the TRICARE/CHAMPUS DRG-based payment system?

III. POLICY

A. Hospital billing. Under the TRICARE/CHAMPUS DRG-based payment system, hospitals are required to submit claims (including itemized charges) in accordance with 32 CFR 199.7(b). The contractor will assign the appropriate DRG to the claim based on the information contained on the claim.

1. Hospital participation. As noted previously, all hospitals which participate in Medicare are required to participate on all inpatient claims.

2. Late charges. Any late charges received by the contractor for a claim which has been processed under the TRICARE/CHAMPUS DRG-based payment system are to be processed as an adjustment. Generally, late charges will not result in any additional payment, but they could affect payment by changing the DRG assigned to the claim or by causing the claim to qualify as an outlier, or they could affect the amount of the beneficiary's cost share.

3. Beneficiary-submitted claims. If a beneficiary submits a claim which is determined to be subject to the TRICARE/CHAMPUS DRG-based payment system (or for services from an exempt hospital which is Medicare-participating), whether for inpatient services or for related professional services rendered by a hospital-based professional, the claim is to be returned (uncontrolled) with the notation that all inpatient hospital claims must be submitted by the provider.

4. Effective July 11, 1995, the physician attestation form that requires doctors to certify the accuracy of all diagnoses and procedures before submitting claims for payment is no longer required.

B. Payment on a per discharge basis. Under the TRICARE/CHAMPUS DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to TRICARE/CHAMPUS beneficiaries.

C. Claims priced as of date of discharge. Except for interim claims submitted for qualifying outlier cases, all claims reimbursed under the TRICARE/CHAMPUS DRG-based payment system are to be priced as of the date of discharge (using the rules and weights and rates in effect on the date of admission) regardless of when the claim is submitted. Any adjustments to such claims will also be priced as of the date of discharge. In order to do this, contractors shall maintain at least three (3) years' weights and rates, including indirect medical education adjustment factors, wage indexes, etc., in the contractor's on-line system. If the claim filing deadline has been waived and the date of discharge is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest DRG weights and rates on the contractor's system.

D. Payment in full. The DRG-based amount paid for inpatient hospital services is the total TRICARE/CHAMPUS payment for the inpatient operating costs (as described in this Section) incurred in furnishing services covered by the TRICARE/CHAMPUS. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in Chapter 13, Section 6.1H for short-stay outliers. Thus, certain items related or incidental to the treatment of the patient, but which might not otherwise be covered, are included in the DRG-based payment. For example, patient education services such as nutrition counseling are not covered by TRICARE/CHAMPUS, but if they are provided incidental to covered services, they are to be considered included in the DRG-based payment. The hospital cannot bill the beneficiary for the services, since they are included in the overall treatment regimen for the admission. At the same time, the contractor is not to reduce the DRG-based payment simply because some non-covered services were rendered.

1. Services received from another hospital. In those cases in which the hospital obtains certain services from another hospital (e.g., computerized tomography services) no additional payment is to be made to either hospital for the technical component of the services. The technical component is to be considered part of the DRG-based payment, and it is the discharging hospital's responsibility to make suitable payment arrangements with the other hospital providing services. Of course, the professional component of such services can be billed separately by the second hospital.

2. Interim bills for unusually long lengths of stay. Because the DRG-based payment is the full payment for the claim, in most cases interim bills will not be accepted. If an interim bill is submitted for services subject to the TRICARE/CHAMPUS DRG-based payment system, it is to be denied. The only exception to this is for certain qualifying outlier cases.

a. Criteria for qualifying for interim payments. In order to qualify for interim payments the following conditions must be met. If a condition is not met, e.g., the claim is received out of chronological order, the claim is to be denied.

(1) It must be for a claim received on or after October 1, 1988.

(2) The patient has been in the hospital at least 60 days.

(3) Multiple claims for single individuals must be submitted in chronological order.

b. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill.

c. Contractor actions on interim claims. Contractors will process the initial claim as a complete claim and each subsequent claim as an adjustment. However, the interim claims are only a method of facilitating cash flow to providers, and the final bill is still the final accounting on the hospital stay. Therefore, upon receipt of the final bill, the contractor is required to review the entire claim to ensure that it has been correctly paid and to ensure that the cost-share has been correctly determined.

E. Inpatient operating costs. The TRICARE/CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

1. Operating costs for routine services, such as the costs of room, board, therapy services (physical, speech, etc.), and routine nursing services as well as supplies (e.g., pacemakers) necessary for the treatment of the patient;

2. Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients (the professional component of these services is not included and can be billed separately);

3. Take-home drugs for less than $40;

4. Special care unit operating costs; and

5. Malpractice insurance costs related to services furnished to inpatients.

F. Discharges and transfers.

1. Discharges. Subject to the provisions of paragraph III.F.2. and paragraph III.F.3. below, a hospital inpatient is considered discharged from a hospital paid under the TRICARE/CHAMPUS DRG-based payment system when:

a. The patient is formally released from the hospital; or

b. The patient dies in the hospital; or

c. The patient is transferred to a hospital or unit that is excluded from the TRICARE/CHAMPUS DRG-based payment system under the provisions of Chapter 13, Section 6.1D. Such cases can be identified by form locator 22 on the UB-92 claim form. For discharges with an admission date prior to October 1, 1998, if anything other than “02” is entered, the contractor is to process the claim as a discharge. All claims coded “02” are to be

processed as transfers unless there is specific reason for not doing so (e.g., the case is classified into DRG No. 601). For discharges with an admission date on or after October 1, 1998, such cases shall no longer be processed as a discharge, but as a transfer, if the claim contains one of the 10 qualifying DRGs listed in paragraph III.F.4. of this subsection, and the patient is transferred to one of the settings outlined in paragraph III.F.3. of this subsection.

2. Transfers - Basic rule. A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this subsection if the discharge is made under the following circumstances:

a. From a hospital included under the TRICARE/CHAMPUS DRG-based payment system to the care of another hospital that is:

(1) Paid under the TRICARE/CHAMPUS DRG-based payment system (such instances will result in two or more claims); or

(2) Excluded from being paid under the TRICARE/CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the TRICARE/CHAMPUS DRG-based payment system under Chapter 13, Section 6.1D (such instances will result in two or more claims); or

(3) Authorized as a uniformed services treatment facility or a Veterans Administration hospital.

b. From one inpatient area or unit of a hospital to another inpatient area or unit of the same hospital that is paid under the TRICARE/CHAMPUS DRG-based payment system (such instances will result in a single claim).

3. Transfers - Special 10 DRG rule. For discharges with an admission date on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this subsection when the patient's discharge is assigned to one of the qualifying DRGs listed in paragraph III.F.4. below and the discharge is made under any of the following circumstances:

a. To a hospital or distinct part hospital unit excluded from the TRICARE/CHAMPUS DRG-based payment system as described in Chapter 13, Section 6.1D. Claims shall be coded 05 in form locator 22 on the UB-92 claim form.

b. To a skilled nursing facility. Claims shall be coded 03 in form locator 22 on the UB-92 claim form.

c. To a home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge. Claims shall be coded 06 in form locator 22 on the UB-92 claim form. Claims coded 06 with a condition code of 42 or 43 in form locator 24 shall be processed as a discharge instead of a transfer.

4. Qualifying DRGs. The qualifying DRGs for purposes of paragraph III.F.3. of this subsection are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

5. Payment for discharges. The hospital discharging an inpatient (under paragraph III.F.1.) is paid in full in accordance with paragraph III.D. of this Policy.

6. Payment for transfers.

a. General Rule. Except as provided in paragraph III.F.6.b. and paragraph III.F.6.d. below, a hospital that transfers an inpatient under circumstances described in paragraph III.F.2. or paragraph III.F.3. of this subsection, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the TRICARE/CHAMPUS DRG-based payment amount that would have been paid if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate DRG rate by the geometric mean length of stay for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG amount. For neonatal claims, other than normal newborns, payment is graduated by paying twice the per diem amount for the first day of the stay, and 125 percent of the per diem rate for each subsequent day, up to the full DRG amount.

b. Special rule for DRGs 209, 210, and 211. A hospital that transfers an inpatient under the circumstances described in paragraph III.F.3. of this subsection and the transfer is assigned to DRGs 209, 210, and 211 is paid as follows:

(1) 50 percent of the DRG-based payment amount plus one-half of the per diem payment for the DRG for day one (one-half the usual transfer payment of double the per diem for day one).

(2) 50 percent of the per diem for each subsequent day up to the full DRG payment.

c. Outliers. A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers as described in Chapter 13, Section 6.1H, paragraph III.B.6.a. However, the total payment cannot exceed what would be paid under the provisions of paragraph III.F., above. For admissions on or after October 1, 1998, payment for transfer cases with cost outliers shall be calculated as follows.

Step 1: DRG Base Payment = ASA x DRG Weight x (Labor-Related Portion x Wage Index + Non-Labor Portion)

Step 2: DRG Base Payment ÷ Geometric Mean Length of Stay

Step 3: Calculation of Cost Outlier Threshold:

1. For all cases except DRGs 209, 210 and 211

A = DRG Base Payment x (1+IDME Factor)

B = (Fixed Loss Threshold x [(Labor-Related Share x Wage Index) + Non-Labor–Related Share] x National Operating Standard Costs as a Share of Total Costs)

C = LOS ÷ Geometric Mean

Cost Outlier Threshold = (A + B) x C

2. For DRGs 209, 210 and 211

A = DRG Base Payment x (1 + IDME Factor)

B = (Fixed Loss Threshold x [(Labor-Related Share x Wage Index) + Non-Labor–Related Share] x National Operating Standard Costs as a Share of Total Costs)

C = ((LOS ÷ Geometric Mean) + 1) x 0.5

Cost Outlier Threshold = (A + B) x C

Step 4: Calculation of Cost Outlier Payment:

1. For all cases except DRGs 209, 210 and 211

   ((Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold) x Marginal Cost Factor

2. For DRGs 209, 210 and 211

   ((Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold) x Marginal Cost Factor

3. For Children's Hospitals and Neonates using Cost Outlier Threshold for all cases except DRGs 209, 210 and 211

   ((Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold) x Marginal Cost Factor x Adjustment Factor

4. For Children's Hospitals and Neonates using Cost Outlier Threshold for DRGs 209, 210 and 211

   ((Billed Charges x Cost-to-charge Ratio – Cost Outlier Threshold) x Marginal Cost Factor x Adjustment Factor

NOTE: Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the cost-to-charge ratio.

Step 5: DRG payment:

1. For all transfer cases except DRGs 209, 210 and 211

   Cost outlier payment + the minimum of:

   a. DRG Base Payment x (1 + IDME Factor), or

   b. ((2 x Per Diem) + [((LOS - 1) x Per Diem]) x (1+ IDME Factor)

2. For DRGs 209, 210 and 211

   Cost outlier payment + the minimum of:

   a. DRG Base Payment x (1 + IDME Factor), or

b. ([(DRG Base Payment x 0.5) + Per Diem)] + ((LOS - 1) x Per Diem x 0.5)) x (1 + IDME Factor)

Following is an example transfer case with cost outlier:

Billed Charges	$30,000
Cost-to-charge Ratio	0.5562
Cost-to-charge Ratio for Children's Hospitals	0.6085
Adjustment Factor for Children's Hospitals	1.37
Fixed Loss Threshold	$10,129
LOS	5
Geometric Mean	10.0
Marginal Cost Factor	0.8
Wage Index	0.9000
IDME Factor	20.0%
Labor Portion	71.1%
Non-Labor Portion	28.9%
ASA	$3,000
DRG Weight	2.0000
National Operating Standard Cost as a Share of Total Costs	0.9130

Step 1: DRG Base Payment = ASA x DRG Weight x (Labor-Related Portion x Wage Index + Non-Labor Portion)

$3,000 x 2 x (0.711 x 0.9 + 0.289) = $5,573.40

Step 2: Per Diem = DRG Base Payment ÷ Geometric Mean Length of Stay

$5,573.40 ÷ 10 = $557.34

Step 3: Calculation of Cost Outlier Threshold:

1. For all cases except DRGs 209, 210 and 211

   A = DRG Base Payment x (1 + IDME Factor)

   $5,573.40 x (1 + 0.2) = $6,688.08

   B = (Fixed Loss Threshold x [(Labor-Related Share x Wage Index) + Non-Labor–Related Share] x National Operating Standard Costs as a Share of Total Costs)

   $10,129 x [(0.711 x 0.9) + 0.289] x 0.913 = $8,590.26

   C = LOS ÷ Geometric Mean

   5 ÷ 10 = 0.5

   Cost Outlier Threshold = (A + B) x C

   ($6,688.08 + $8,590.26) x 0.5 = $7,639.17

2. For DRGs 209, 210 and 211

A = DRG Base Payment x (1 + IDME Factor)

$5,573.40 x (1 + 0.2) = $6,688.08

B = (Fixed Loss Threshold x [(Labor-Related Share x Wage Index) + Non-Labor–Related Share] x National Operating Standard Costs as a Share of Total Costs)

10,129 x [(0.711 x 0.9) + 0.289] x 0.913 = $8,590.26

C = ((LOS ÷ Geometric Mean) + 1) x 0.5

((5 ÷ 10) + 1) x 0.5 = 0.75

Cost Outlier Threshold = (A + B) x C

($6,688.08 + $8,590.26) x 0.75 = $11,458.76

Step 4: Calculation of Cost Outlier Payment:

1. For all cases except DRGs 209, 210 and 211

   [(Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold] x Marginal Cost Factor

   [($30,000 x 0.5562) – $7,639.17] x 0.8 = $7,237.46

2. For DRGs 209, 210 and 211

   [(Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold] x Marginal Cost Factor

   [($30,000 x 0.5562) – $11,458.76] x 0.8 = $4,181.79

3. For Children's Hospitals and Neonates using Cost Outlier Threshold for all cases except DRGs 209, 210 and 211

   [(Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold] x Marginal Cost Factor x Adjustment Factor

   [($30,000 x 0.6085) – $7,639.17] x 0.8 x 1.37 = $11,634.95

4. For Children's Hospitals and Neonates using Cost Outlier Threshold for DRGs 209, 210 and 211

   [(Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold] x Marginal Cost Factor x Adjustment Factor

   [($30,000 x 0.6085) – $11,458.76] x 0.8 x 1.37 = $7,448.68

Step 5: DRG payment:

1. For all transfer cases except DRGs 209, 210 and 211

   Cost outlier payment + the minimum of:

   a. DRG Base Payment x (1 + IDME Factor), or

      $5,573.40 x (1 + 0.2) = $6,688.08

b. ((2 x Per Diem) + [(LOS - 1) x Per Diem]) x (1 + IDME Factor)

((2 x $557.34) + [(5 - 1) x $557.34]) x (1 + 0.2) = $4,012.85

$7,237.46 + $4,012.85 = $11,250.31

2. For DRGs 209, 210 and 211

Cost outlier payment + the minimum of:

a. DRG Base Payment x (1 + IDME Factor), or

$5,573.40 x (1 + 0.2) = $6,688.08

b. ([(DRG Base Payment x 0.5) + Per Diem)] + ((LOS - 1) x Per Diem x 0.5)) x (1 + IDME Factor)

([($5,573.40 x 0.5) + 557.34] + ((5 - 1) x 557.34 x 0.5)) x (1 + 0.2) = $5,350.46

$4,181.79 + $5,350.46 = 9,532.25

d. Transfer assigned to DRG 601. If a transfer is classified into DRG 601 (Neonate, transferred < 5 days old), the transferring hospital is paid in full. For admissions prior to October 1, 1998, if a discharge is classified into DRG 456 (Burns, Transferred to another acute care facility) the transferring hospital is paid in full. DRG 456 is no longer valid as of October 1, 1998.

G. Leave of Absence Days.

1. General. Normally, a patient will leave a hospital which is subject to the DRG-based payment system only as a result of a discharge or a transfer. However, there are some circumstances where a patient is admitted for care, and for some reason is sent home temporarily before that care is completed. Hospitals may place patients on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples of such situations include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, further treatment is indicated following diagnostic tests but cannot begin immediately, a change in the patient's condition requires that scheduled surgery be delayed for a short time, or test results to confirm the need for surgery are delayed.

2. Billing for leave of absence days. In billing for inpatient stays which include a leave of absence, hospitals are to use the actual admission and discharge dates and are to identify all leave of absence days by using revenue code 18X for such days. Contractors are to disallow all leave of absence days. Neither the Program nor the beneficiary may be billed for days of leave.

3. DRG-based payments for stays including leave of absence days. Placing a patient on a leave of absence will not result in two DRG-based payments, nor can any payment be made for leave of absence days. Only one claim is to be submitted when the patient is formally discharged (as opposed to being placed on leave of absence), and only one DRG-

based payment is to be made. The contractor should ensure that the leave of absence does not result in long-stay outlier days being paid and that it does not increase the beneficiary's cost-share.

4. Services received while on leave of absence. The technical component of laboratory tests obtained while on a leave of absence would be included in the DRG-based payment to the hospital. The professional component is to be cost-shared as inpatient. Tests performed in a physician's office or independent laboratory are also included in the DRG-based payment.

5. Patient dies while on leave of absence. If patient should die while on leave of absence, the date the patient left the hospital shall be treated as the date of discharge.

H. Area Wage Indexes. The labor-related portion of the ASA will be adjusted to account for the differences in wages among geographic areas. The areas used will correspond to the Metropolitan Statistical Areas (MSAs) and rural areas used in the Medicare PPS, and the actual indexes used will be those used in the Medicare PPS. The wage index used is to be the one for the hospital's actual address--not for the hospital's billing address.

I. Redesignation of Certain Hospitals to Other Wage Index Areas. TRICARE/CHAMPUS is simply following this statutory requirement for the Medicare Prospective Payment System, and the Health Care Financing Administration determines the areas affected and wage indexes used.

1. Admissions occurring on or after October 1, 1988. A hospital located in a rural county adjacent to one or more urban areas shall be treated as being located in the urban area to which the greatest number of workers commute. The area wage index for the urban area shall be used for the rural county.

2. Admissions occurring on or after April 1, 1990. In order to correct inequities resulting from application of the rules in paragraph III.I.1. above, the Health Care Financing Administration modified the rules for those rural hospitals deemed to be urban. TRICARE/CHAMPUS has also adopted these changes. Some of these hospitals continue to use the urban area wage index, others use a wage index computed specifically for the rural county, and others use the statewide rural wage index. The appropriate wage indexes are provided in the addendums to this Chapter which provide the annual updated rates and weights.

3. Admissions occurring on or after October 1, 1991. P.L. 101-239 created the Medicare Geographic Classification Review Board (MGCRB) to reclassify individual hospitals to different wage index areas based on requests from the hospitals. These reclassifications are intended to eliminate the continuing inequities caused by the reclassification actions described in paragraph III.I.1. and paragraph III.I.2. above. TRICARE/CHAMPUS has adopted these hospital-specific reclassifications effective for admissions occurring on or after October 1, 1991.

4. Admissions occurring on or after October 1, 1997. The wage index for an urban hospital may not be lower than the statewide area rural wage index.

- END -