CHAPTER 6
SECTION 3

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

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AUTHORITY: 32 CFR 199.14(a)(1)

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 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, and instead of requiring a physician to sign an acknowledgement statement every year, a physician need only sign the statement upon receiving admitting privileges at a hospital.

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 6, Section 8 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. See the TRICARE Systems Manual (TSM), Chapter 2, Section 1.1, paragraph 7.0. for TRICARE Encounter Data (TED) record submission requirements for interim hospital billings.

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 (intensive care type unit services); 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 3., 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.

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 6, Section 4. Such cases can be identified by Form Locator (FL) 17 on the CMS 1450 UB-04 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 qualifying DRGs listed in paragraph III.F.4., and the patient is transferred to one of the settings outlined in paragraph III.F.3.

2. Acute care transfers. A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this subsection if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital is:

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

b. 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 6, Section 4 (such instances will result in two or more claims); or

c. Authorized as a Designated Provider (DP) [formerly Uniformed Services Treatment Facilities (USTFs)] or a Department of Veterans Affairs (DVA) hospital.

3. Postacute care transfers. 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., 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 6, Section 4. Claims shall be coded 05, 62, or 63 in FL 17 on the CMS 1450 UB-04 claim form. Effective April 1, 2004, claims shall be coded 65 in FL 17 for psychiatric hospitals and units.

b. To a Skilled Nursing Facility (SNF). Claims shall be coded 03 in FL 17 on the CMS 1450 UB-04 claim form.

c. To home under a written plan of care for the provision of home health services from a home health agency and those services begin within three days after the date of discharge. Claims shall be coded 06 in FL 17 on the CMS 1450 UB-04 claim form. Claims coded 06 with a condition code of 42 or 43 in FL 18 shall be processed as a discharge instead of a transfer.

4. Qualifying DRGs.

a. For discharges with an admission date on or after October 1, 1998 through September 30, 2003, the qualifying DRGs for purposes of paragraph III.F.3. are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

b. For discharges with an admission date on or after October 1, 2003 through September 30, 2004, the qualifying DRGs for purposes of paragraph III.F.3. are DRGs 12, 14, 24, 25, 88, 89, 90, 113, 121, 122, 127, 130, 131, 209, 210, 211, 236, 239, 277, 278, 294, 296, 297, 320, 321, 395, 429, 468, and 483.

c. For discharges with an admission date on or after October 1, 2004, the qualifying DRGs for purposes of paragraph III.F.3. are DRGs 12, 14, 24, 25, 88, 89, 90, 113, 121, 122, 127, 130, 131, 209, 210, 211, 236, 239, 277, 278, 294, 296, 297, 320, 321, 395, 429, 468, 541, and 542.

d. For discharges with an admission date on or after October 1, 2005, the qualifying DRGs for purposes of paragraph III.F.3. are listed below.

1	24	84	121	157	205	236	266	293	402	463	529	553
2	25	85	126	158	206	238	269	294	403	464	530	554
7	28	86	127	170	210	239	270	296	404	468	531	
8	29	89	130	171	211	240	271	297	415	471	532	
10	34	90	131	172	213	241	272	300	416	475	537	
11	35	92	144	173	216	244	273	301	418	477	538	
12	73	93	145	176	217	245	277	304	423	482	541	
13	75	101	146	180	218	250	278	305	429	485	542	
14	76	102	147	181	219	251	280	316	430	487	543	
15	77	104	148	188	225	253	281	320	440	497	544	
16	78	105	149	189	226	254	283	321	442	498	545	
17	79	108	150	191	227	256	284	331	443	501	547	
18	80	113	151	192	233	263	285	332	444	502	548	
19	82	114	154	197	234	264	287	395	445	521	549	
20	83	120	155	198	235	265	292	401	462	522	550	

e. The qualifying DRGs for purposes of paragraph III.F.3., for discharges with an admission date:

(1) On or after October 1, 2006, are listed on either the TRICARE DRG web site at http://www.tricare.mil/drgrates/ or listed in the applicable addendum for the respective fiscal year. Addendum C reflects the most recent fiscal year and the two fiscal years as indicated in the following paragraphs.

(2) On or after October 1, 2007, are listed in Chapter 6, Addendum C (FY 2008).

(3) On or after October 1, 2008, are listed in Chapter 6, Addendum C (FY 2009).

(4) On or after October 1, 2009, are listed in Chapter 6, Addendum C (FY 2010).

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

6. Payment for transfers.

a. General Rule. Except as provided in paragraph III.F.6.b. and e., a hospital that transfers an inpatient under circumstances described in paragraph III.F.2. or 3., 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 (LOS) 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% of the per diem rate for each subsequent day, up to the full DRG amount.

b. Special rule for DRGs 209, 210, and 211 for fiscal years prior to FY 2006. For fiscal years prior to FY 2006, a hospital that transfers an inpatient under the circumstances described in paragraph III.F.3. and the transfer is assigned to DRGs 209, 210, and 211 is paid as follows:

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

c. Special rule for DRGs meeting specific criteria. For discharges occurring on or after October 1, 2005, a hospital that transfers an inpatient under the circumstances described in paragraph III.F.3. and the transfer is assigned to DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, and 550 shall be paid under the provisions of paragraph III.F.6.b.(1) and (2). For discharges occurring on or after October 1, 2007, those DRGs subject to the special payment rule for transfers are listed in Chapter 6, Addendum C (FY 2008). For discharges occurring on or after October 1, 2008, those DRGs subject to the special payment rule for transfers are listed in Chapter 6, Addendum C (FY 2009). For discharges occurring on or after October 1, 2009, those DRGs subject to the special payment rule for transfers are listed in Chapter 6, Addendum C (FY 2010).

d. 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 6, Section 8, paragraph III.B.6.a. For admissions on or after October 1, 1995, when calculating the cost outlier payment, if the LOS exceeds the geometric mean LOS, the cost outlier threshold shall be limited to the DRG-based payment plus the fixed loss amount. The contractor shall readjudicate claims affected by this change if brought to their attention by any source. For the period October 1, 1995, through September 30, 2001, these costs shall be paid as pass-through costs and the contractor is not-at-risk. For the period October 1, 2001, forward, the contractor is at-risk for these health care dollars.

STEP 1: DRG Base Payment = Adjusted Standardized Amount (ASA) x DRG Weight x (Labor-Related Portion x Wage Index + Non-Labor Portion)

STEP 2: DRG Base Payment ÷ Geometric Mean LOS

STEP 3: Calculation of Cost Outlier Threshold:

1. For post acute care special pay transfer DRGs

A = DRG Base Payment x (1 + Indirect Medical Education (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 (NOSCASTC))

C = LOS ÷ Geometric Mean

Cost Outlier Threshold = (A + B) x C

NOTE: If the LOS exceeds the geometric mean LOS, the outlier threshold shall be limited to the DRG base payment plus the fixed loss threshold (wage-adjusted).

2. For post acute care special pay transfer DRGs

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

B = (Fixed Loss Threshold x [(Labor-Related Share x Wage Index) + Non-Labor-Related Share] x NOSCASTC)

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

Cost Outlier Threshold = (A + B) x C

NOTE: If the LOS exceeds the geometric mean LOS, the outlier threshold shall be limited to the DRG base payment plus the fixed loss threshold (wage-adjusted).

STEP 4: Calculation of Cost Outlier Payment:

1. For all cases except post acute care special pay transfer DRGs

   ((Billed Charges x Cost-to-Charge Ratio (CCR)) - Cost Outlier Threshold) x Marginal Cost Factor

2. For post acute care special pay transfer DRGs

   ((Billed Charges x CCR) - Cost Outlier Threshold) x Marginal Cost Factor

3. For Children's Hospitals and Neonates using Cost Outlier Threshold for all cases except post acute care special pay transfer DRGs

   ((Billed Charges x CCR) - Cost Outlier Threshold) x Marginal Cost Factor x Adjustment Factor

4. For Children's Hospitals and Neonates using Cost Outlier Threshold for post acute care special pay transfer DRGs

   ((Billed Charges x CCR) - 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 CCR.

STEP 5: DRG payment:

1. For all transfer cases except post acute care special pay transfer DRGs

   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 post acute care special pay transfer DRGs

   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 using FY 1999 variables:

Billed Charges	$30,000
CCR	0.5562
CCR 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
NOSCASTC	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 LOS

$5,573.40 ÷ 10 = $557.34

STEP 3: Calculation of Cost Outlier Threshold:

1. For all cases except post acute care special pay transfer DRGs

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 NOSCASTC)

$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

NOTE: If the LOS exceeds the geometric mean LOS, the outlier threshold shall be limited to the DRG base payment plus the fixed loss threshold (wage-adjusted).

2. For post acute care special pay transfer DRGs

   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 NOSCASTC)

   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

NOTE: If the LOS exceeds the geometric mean LOS, the outlier threshold shall be limited to the DRG base payment plus the fixed loss threshold (wage-adjusted).

STEP 4: Calculation of Cost Outlier Payment:

1. For all cases except post acute care special pay transfer DRGs

   [(Billed Charges x CCR) - Cost Outlier Threshold] x Marginal Cost Factor

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

2. For post acute care special pay transfer DRGs

   [(Billed Charges x CCR) - 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 post acute care special pay transfer DRGs

   [(Billed Charges x CCR) - 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 post acute care special pay transfer DRGs

   [(Billed Charges x CCR) - 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 post acute care special pay transfer DRGs

   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 post acute care special pay transfer DRGs

   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

e. 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. Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at http://www.tricare.mil/drgrates/.

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 and will correspond to the labor market 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 Centers for Medicare and Medicaid Services (CMS) 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., CMS 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.

3. Admissions occurring on or after October 1, 1991. Public Law 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 2. 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.

J. Admissions occurring on or after October 1, 2004. TRICARE/CHAMPUS has adopted the revisions CMS has made to the labor market areas and the wage index changes outlined in CMS' August 11, 2004, Final Rule, including the out-commuting wage index adjustment.

K. Refer to TMA's DRG home page at http://www.tricare.osd.mil/drgrates/ for annual DRG wage index updates.

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