CHAPTER 6
SECTION 8

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (ADJUSTMENTS TO PAYMENT AMOUNTS)

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I. APPLICABILITY

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 the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

II. ISSUE

What are the adjustments to the TRICARE/CHAMPUS Diagnosis Related Group (DRG)-based payment amounts?

III. POLICY

A. Adjustments to the DRG-Based Payment Amounts. There are several adjustments to the basic DRG-based amounts (the weight multiplied by the Adjusted Standardized Amount (ASA)) which can be made.

B. Specific Adjustments.

1. Capital costs. TRICARE/CHAMPUS will reimburse hospitals for their capital costs as reported annually to the contractor (see below). Payment for capital costs will be made annually. See Chapter 3, Section 2 for the procedures for paying capital costs.

a. Required reductions in capital payments. The basic capital payments (as determined above) shall be reduced in accordance with the statutorily-required reductions for Medicare, and if they are legislatively-changed for Medicare, the TRICARE/CHAMPUS reductions will conform to the Medicare reductions. The required reductions and the periods to which they apply are:

3.5% for October 1 through November 20, 1987;

7% for November 21 through December 31, 1987;

12% for January 1 through September 30, 1988;

15% for Fiscal Year (FY) 1989;

2% for October 1 through December 31, 1989;

15% for January 1, 1990, through September 30, 1992;

10% beginning October 1, 1992, through September 30. 1995;

17.78% beginning October 1, 1997, through September 30, 2002; and

15.68% beginning October 1, 2002, through September 30, 2003.

The capital payments will be prorated for the different percentage reductions based on the days in the reporting period which fall into each category. For example, the capital costs for a cost-reporting period which runs from November 1, 1987, through October 31, 1988, would have the following reductions.

(1) November 1 through November 20 equals 5.5% of the year (20 days of 366 days).

(2) November 21 through December 31 equals 11.2% of the year (41 days of 366 days).

(3) January 1 through September 30 equals 74.9% of the year (274 days of 366 days).

(4) October 1 through October 31 equals 8.4% of the year (31 days of 366 days). Therefore, the contractor would determine the total capital amount applicable to TRICARE/CHAMPUS and reduce 5.5% of it by 3.5%, 11.2% of it by 7%, 74.9% of it by 12%, and 8.4% of it by 15%.

b. For days occurring on or after October 1, 1995, through September 30, 1997, and October 1, 2003, through present, TRICARE/CHAMPUS will reimburse 100% of capital-related costs.

c. Allowable capital costs are those specified in Medicare Regulation Section 413.130 of Title 42 CFR.

d. To obtain the total allowable capital costs from the Medicare cost reports prior to October 1992, the contractor shall add the figures from Worksheet D, Part I, Column 1, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, and line 33, to the costs from Worksheet D, Part II, Column 1, lines 37-63. The capital payment shall then be reduced by the applicable percentages and time periods outlined in paragraph III.B.1.a.

e. To obtain the total allowable capital costs from the Medicare cost reports as of October 1992, the contractor shall add the figures from Worksheet D, Part 1, Columns 3 and 6, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, and line 33, to the figures from Worksheet D, Part II, Columns 1 and 2, lines 37-63. The capital payment shall then be reduced by the applicable percentages and time periods outlined in paragraph III.B.1.a.

NOTE: The instructions provided in May 1996 TRICARE/CHAMPUS Policy Manual, Change 35, published on November 4, 1998, incorrectly eliminated allowable capital costs for lines 29 and 30 from Worksheet D, Part I, Column 1, and lines 60-63 from Worksheet D, Part II, Columns 1 and 2. The contractor is not required to identify those finalized reimbursement requests processed under the instructions outlined in May 1996 TRICARE/ CHAMPUS Policy Manual, Change 35, however, if the hospital requests reimbursement for the above listed costs, the contractor shall reprocess the request accordingly.

f. The instructions outlined in paragraph III.B.1.a. and e., are effective for initial and amended requests received on or after October 1, 1998.

g. Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Section 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

(1) The capital-related equipment is leased or rented by the provider;

(2) The capital-related equipment is located on the provider's premises; and

(3) The capital-related portion of the charge is separately specified in the charge to the provider.

2. Direct medical education costs. TRICARE/CHAMPUS will reimburse hospitals their actual direct medical education costs as reported annually to the contractor (see below). Such direct medical education costs must be for a teaching program approved under Medicare Regulation Section 413.85. Payment for direct medical education costs will be made annually and will be calculated using the same steps required for calculating capital payments below. Allowable direct medical education costs are those specified in Medicare Regulation Section 413.85. See Chapter 3, Section 2 for the procedures for paying direct medical education costs.

a. Direct medical education costs generally include:

(1) Formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution.

(2) Nursing schools.

(3) Medical education of paraprofessionals (e.g., radiological technicians).

b. Direct medical education costs do not include:

(1) On-the-job training or other activities which do not involve the actual operation or support, except through tuition or similar payments, of an approved education program.

(2) Patient education or general health awareness programs offered as a service to the community at large.

c. To obtain the total allowable direct medical education costs from the Medicare cost reports on all initial and amended requests, the contractor shall add the figures from Worksheet B, Part I, Columns 21-24, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, line 33, and lines 37-63. These instructions are effective for all initial and amended requests received on or after October 1, 1998.

NOTE: The instructions provided in the May 1996 TRICARE/CHAMPUS Policy Manual, Change 35, published on November 4, 1998, incorrectly eliminated allowable direct medical education costs for lines 60-63 from Worksheet B, Part I, Columns 21-24. The contractor is not required to identify those finalized reimbursement requests processed under the instructions outline in Policy Manual Change 35, however, if the hospital requests reimbursement for the above listed costs, the contractor shall reprocess the request accordingly.

3. Determining amount of Capital and Direct Medical Education (CAP/DME) payment. In order to account for payments by other health insurance, TRICARE/CHAMPUS' payment amounts for CAP/DME will be determined according to the following steps. Throughout these calculations claims on which TRICARE/CHAMPUS made no payment because other health insurance paid the full TRICARE/CHAMPUS-allowable amount are not to be counted.

STEP 1: Determine the ratio of TRICARE/CHAMPUS inpatient days to total inpatient days using the data described below. In determining total TRICARE/CHAMPUS inpatient days the following are not to be included:

(1) Any days determined to be not medically necessary, and

(2) Days included on claims for which TRICARE/CHAMPUS made no payment because other health insurance paid the full TRICARE/CHAMPUS-allowable amount.

STEP 2: Multiply the ratio from STEP 1 by total allowable capital costs.

STEP 3: Reduce the amount from STEP 2 by the appropriate capital reduction percentage(s). This is the total allowable TRICARE/CHAMPUS capital payment for DRG discharges.

STEP 4: Multiply the ratio from STEP 1 by total allowable direct medical education costs. This is the total allowable TRICARE/CHAMPUS direct medical education payment for DRG discharges.

STEP 5: Combine the amounts from STEP 3 and STEP 4.This is the amount of TRICARE/CHAMPUS payment due the hospital for CAP/DME.

4. Payment of CAP/DME costs.

a. General. All hospitals subject to the TRICARE/CHAMPUS DRG-based payment system, except for children's hospitals (see below), may be reimbursed for allowed CAP/DME costs by submitting a request and the applicable pages from the Medicare cost-report to the TRICARE/CHAMPUS contractor.

(1) Beginning October 1, 1998, initial requests for payment of CAP/DME shall be filed with the TRICARE/CHAMPUS contractor on or before the last day of the twelfth month following the close of the hospitals' 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 ending on or after March 1, 1998, 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, 1998, the request for payment shall be filed on or before June 30, 1999. Those hospitals that are not Medicare participating providers are to use an October 1 through September 30 fiscal year for reporting CAP/DME costs.

(a) An extension of the due date for filing the initial request may only be granted if an extension has been granted by 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.

(b) All costs reported to the TRICARE/CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. If the costs change as a result of a subsequent Medicare desk review, audit or appeal, the revised costs along with the applicable pages from the amended Medicare cost report shall be provided to the TRICARE/CHAMPUS contractor within 30 days of the date the hospital is notified of the change. The request must be signed by the hospital official responsible for verifying the amounts. The Medicare Notice of Program Reimbursement (NPR) letter should be submitted with the amended cost report.

(c) The 30 day period is a means of encouraging hospitals to report changes in its CAP/DME costs in a timely manner. If the contractor receives an amended

request beyond the 30 days, it shall process the adjustment and inform the provider of the importance of submitting timely amendments.

(d) The hospital official is certifying in the initial submission of the cost report that any changes resulting from a subsequent Medicare audit will be promptly reported. Failure to promptly report the changes resulting from a Medicare audit 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.

(2) Prior to October 1, 1998, TRICARE/CHAMPUS had no time limit for filing initial requests for reimbursement of CAP/DME, other than the six-year statute of limitations. The time limitation for filing claims does not apply to CAP/DME payment requests. To allow TRICARE/CHAMPUS contractors to close out prior year data, all initial payment requests for CAP/DME for cost-reporting periods ending before March 1, 1998, shall be filed with the TRICARE/CHAMPUS contractor no later than five months after October 1, 1998. Requests for reimbursement for these periods must be post-marked on or before March 1, 1999. During this 5 month period, the following criteria apply:

(a) If a hospital has documentation indicating it was underpaid based on the number of inpatient days reported on the initial request, the hospital may request separate reimbursement for these costs, however, it is the hospital's responsibility to provide documentation substantiating the number of TRICARE/CHAMPUS inpatient days.

(b) The contractor shall follow the instructions for processing initial requests as outlined in paragraph III.B.4.c.(1).

b. Information necessary for payment of CAP/DME costs. The following information must be reported to the contractor:

(1) The hospital's name.

(2) The hospital's address.

(3) The hospital's TRICARE/CHAMPUS provider number.

(4) The hospital's Medicare provider number.

(5) The period covered--this must correspond to the hospital's Medicare cost-reporting period.

(6) Total inpatient days provided to all patients in units subject to DRG-based payment.

(7) Total TRICARE/CHAMPUS inpatient days provided in units subject to DRG-based payment. (This is to be only days which were "allowed" for payment. Therefore, days which were determined to be not medically necessary are not to be included.)

(a) Total inpatient days provided to active duty members in units subject to DRG-based payment.

(8) Total allowable capital costs. This must correspond with the applicable pages from the Medicare cost-report.

(9) Total allowable direct medical education costs. This must correspond with the applicable pages from the Medicare cost-report.

(10) Total full-time equivalents for:

(a) Residents,

(b) Interns (see below).

(11) Total inpatient beds (see below).

(12) Title of official signing the report.

(13) Reporting date.

(14) The report must contain a certification statement that any changes to items (6), (7), (8), (9), and (10), which are a result of a review, audit, or appeal of the provider's Medicare cost-report, must be reported to the contractor within 30 days of the date the hospital is notified of the change.

(15) All cost reports must be certified by an officer or administrator of the provider. The general concept is to notify the certifying official that misrepresentation or falsification of any of the information in the cost report is punishable by fine and/or imprisonment. The signing official must acknowledge this as well as certify that the cost report filed, together with any supporting documentation, is true, correct and complete based upon the books and records of the provider.

c. Contractor actions.

(1) Initial requests for capital/direct medical education payment.

(a) The contractor may, but is not required, to provide inpatient day verification reports to hospitals prior to an initial request being submitted.

(b) The contractor shall verify the number of TRICARE/CHAMPUS and active duty inpatient days with its data. If the contractor's data represents a greater number of days than submitted on the hospital's request, payment shall be based on the contractor's data. If the hospital's request represents a greater number of days than the contractor's data, the contractor shall notify the hospital of the discrepancy and inform them payment will be based on the number of days it has on file unless they can provide documentation substantiating the additional days. The notification to the hospital must be

made within ten working days of identification of the discrepancy and include the inpatient day verification report.

(c) The contractor shall wait until the end of the following month to hear from the hospital. If the hospital does not respond, the contractor shall make payment based on its totals.

(d) The contractor shall verify the accuracy of the financial amounts listed for CAP/DME with the applicable pages of the Medicare cost report. If the financial amounts do not match, the contractor shall reimburse the hospital based on the figures in the cost-report and notify the hospital of the same.

(e) The contractor must make the CAP/DME payment to the hospital within 30 days of the initial request unless notification has been sent to the hospital regarding a discrepancy in the number of days as outlined in paragraph III.B.4.c.(1)(b).

(f) The TRICARE/CHAMPUS contractor shall be responsible for proactively researching the Medicare web site (http://www.cms.hhs.gov/costreports) to identify hospitals in their region that submitted amended Medicare cost reports, obtaining copies of the amended cost reports from hospitals that failed to submit them to the TRICARE contractor as required, recalculating the CAP/DME costs based on the revised cost report data, and initiating a collection action or notifying the hospital if an underpayment was identified based on the results of recalculation. The CMS post the Hospital Cost Report files 30 days after the end of each quarter.

(g) The contractor shall submit a yearly report "Annual Capital and Direct Medical Education Report" to the Contracting Officer (CO/Contracting Officer's Representative (COR) identifying the hospitals that submitted amended Medicare cost reports directly to the TRICARE contractor and those hospitals which failed to submit amended cost repairs to the TRICARE contractor identified from the CMS web site. The first report shall be for the first full (or partial) calendar year after start work. For example, if the start work date was April 1, 2011, then the first report would cover a partial year, i.e., the report period would be April 1 through December 31, 2011. The report is due no later than March 1 (the first day of the third month) after the end of the calendar year being reported. The report shall include the following data elements: the name(s) of the hospital(s), both those that submitted an amended cost report to the contractors and those that were identified by the contractors' review of the CMS cost report web sites; the report shall clearly distinguish the hospitals that submitted an amended cost report and the hospitals that were identified by the contractors' review of the CMS cost report web site; the amount identified as either an underpayment or overpayment, and the status of their overpayment collection efforts.

(h) For a period of one year following the report period, the "Quarterly Capital and Direct Medical Education Over and Under Payment Report" shall be updated on a calendar quarterly basis to reflect collections that are received, or underpayments refunded at the hospital's request, after the end of the previous calendar year report. The quarterly reports shall pertain only to cases initiated in the calendar year

being reported. For example, the calendar year 2011 initial report will be provided to the CO/COR NLT March 1, 2012. At the end of each quarter following the calendar year 2011 initial report, quarterly reports will be due to the CO/COR by the 15th of the month following the end of the report quarter. The Quarterly reports will be due on April 15, 2012 for the January through March quarter; on July 15, 2012 for the April through June quarter; on October 15, 2012 for the July through September quarter; and on January 15, 2013 for the October through December quarter. For each hospital on the initial calendar year report, the quarterly reports shall identify the: cumulative amount collected/refunded; amount still needing to be collected/refunded for each hospital; total collections; and total underpayments and the case status. All reports submitted shall contain totals for each of the financial fields on the report. A mutually-agreeable format of the annual and quarterly reports shall be developed under separate discussions with the TRICARE Regional Offices (TROs).

(2) Amended Requests for CAP/DME.

(a) The contractor may, but is not required, to provide inpatient day verification reports to hospitals prior to an amended request being submitted.

(b) The contractor shall process amended payment requests based on changes in the Medicare cost-report as a result of desk reviews, audits and appeals. An adjustment will not be processed unless there are changes to items 6 through 10 on the initial CAP/DME reimbursement request. The contractor will not process amended requests for days only.

(c) The contractor shall verify the number of TRICARE/CHAMPUS and active duty inpatient days with its data. If the contractor's data represents a greater number of days than submitted on the hospital's request, payment shall be based on the contractor's data. If the hospital's request represents a greater number of days than the contractor's data, the contractor shall notify the hospital of the discrepancy and inform them payment will be based on the number of days it has on file unless they can provide documentation substantiating the additional days. The notification to the hospital must be made within ten working days of identification of the discrepancy and include the inpatient day verification report.

(d) The contractor shall wait until the end of the following month to hear from the hospital. If the hospital does not respond, the contractor shall make payment based on its totals.

(e) The contractor shall verify the accuracy of the financial amounts listed for CAP/DME with the applicable pages of the amended Medicare cost report. If the financial amounts do not match, the contractor shall reimburse the hospital based on the figures in the cost-report and notify the hospital of the same.

(f) The contractor must make the CAP/DME payment to the hospital within 30 days of the amended request unless notification has been sent to the hospital regarding a discrepancy in the number of days as outlined in paragraph III.B.4.c.(2)(b).

(3) The contractor shall prepare a voucher in accordance with the requirements of the TRICARE Operations Manual (TOM) and send it to the TMA Contract Resource Management Directorate (CRM) for clearance before releasing the checks.

(4) Requests for reimbursement of DRG CAP/DME costs shall be paid as pass-through costs. The Managed Care Support (MCS) contractors are non-financially underwritten for these costs.

d. Negotiated Rates. If a contract between the MCS prime contractor and a subcontractor or institutional network provider does not specifically state the negotiated rate includes all costs that would otherwise be eligible for additional payment, such as CAP/DME, the MCS prime contractor is responsible for reimbursing these costs to the subcontractors and institutional network providers if a request for reimbursement is made.

e. CAP/DME costs for children's hospitals. Amounts for CAP/DME are included in both the hospital-specific and the national children's hospital differentials (see below). The amounts are based on national average costs. No separate or additional payment is allowed.

f. CAP/DME costs under TRICARE for Life (TFL). TRICARE will make no payments for CAP/DME costs for any claims on which Medicare makes payment. These costs are included in the Medicare payment. TRICARE CAP/DME cost payments will be made only on claims on which TRICARE is the primary payer (e.g., claims for stays beyond 150 days), and in those cases payment will be made following the procedures described above.

5. Children's Hospital Differential.

a. General. All DRG-based payments to children's hospitals for admissions occurring on or after April 1, 1989, are to be increased by adding the applicable children's hospital differential to the appropriate ASA prior to multiplying by the DRG weight.

b. Qualifying for the children's hospital differential. In order to qualify for a children's hospital differential adjustment, the hospital must be exempt from the Medicare PPS as a children's hospital. If the hospital is not Medicare-participating, it must meet the criteria in 32 CFR 199.6(b)(4)(i). In addition, more than half of its inpatients must be individuals under the age of 18.

c. Calculation of the children's hospital differentials. The differentials will be equal to the difference between a specially-calculated ASA for children's hospitals (using the procedures described in Chapter 6, Section 7) and the ASA for FY 1988 which would otherwise be applicable. They will be calculated so that they are "revenue neutral" for children's hospitals; that is, for FY 1988 overall TRICARE/CHAMPUS payments to children's hospitals under the DRG-based payment system would have been equal to those under the old payment system. To accomplish this, TMA (the Office of Program Development) calculated separate ASAs for childrens' hospitals. Normally in calculating ASAs, TMA reduces the adjusted charges according to the Medicare Cost-To-Charge Ratio

(CCR) (0.66 during FY 1988). However, in recognition of the higher costs of children's hospitals, we do not use this step in calculating the children's hospital differentials. We subtract the appropriate ASA from the children's hospital ASAs, and these amounts are the children's hospital differentials. The differentials will not be subject to annual inflation updates nor will they be recalculated except as provided below.

d. Differential amounts.

(1) Admissions prior to April 1, 1992. High volume children's hospitals (those children's hospitals with 50 or more TRICARE/CHAMPUS discharges during FY 1988) have a hospital-specific differential for a three-year transition period ending April 1, 1992. All other children's hospitals use national differentials. There are two national differentials--one for large urban areas and one for other urban areas.

(a) Calculation of the national children's hospital differentials. These differentials are calculated using the procedures described in paragraph III.B.5.c., but based on a database of only low-volume children's hospitals. They were calculated initially using a database of claims processed from July 1, 1987, through June 30, 1988 and updated to FY 1988 using the hospital market basket. They were subsequently finalized based on claims processed from April 1, 1989, through March 31, 1990.

(b) Calculation of the hospital-specific differentials for high-volume children's hospitals. The hospital-specific differentials were calculated using the same procedures used for calculating the national differentials, except that the database used was limited to claims from the specific high-volume children's hospital.

(c) Administrative corrections. Any children's hospital that believed TMA erroneously failed to classify the hospital as a high-volume hospital or correctly calculate (in the case of a high-volume hospital) the hospital's differential could obtain administrative corrections by submitting appropriate documentation to TMA. The corrected differential was effective retroactively to April 1, 1989, so this process included adjustments, by the contractor, to any previously processed claims which were processed using an incorrect differential.

(2) Admissions on or after April 1, 1992. These claims are reimbursed using a single set of differentials which do not distinguish high-volume and low-volume children's hospitals. The differentials are:

Large Urban Areas	
Labor portion	$1,945.99
Non-labor portion	689.42
	$2,635.41
Other Areas	
Labor portion	$1,483.21
Non-labor portion	525.47
	$2,008.68

(3) Admissions on or after October 1, 2004. Children's hospitals located in other areas shall receive the same differential payment as large urban area hospitals.

e. Hold harmless provision. At such time as the weights initially assigned to neonatal DRGs are recalibrated based on a sufficient volume of TRICARE/CHAMPUS claims records, TMA will recalculate children's hospital differentials and appropriate retrospective and prospective adjustments will be made. To the extent possible, the recalculation will also include reestimated values of other factors (including, but not limited to, direct and Indirect Medical Education (IDME) and capital costs) for which more accurate data become available. This will probably occur about one year after implementation of the neonatal DRGs, and it will not require any actions by the contractors.

6. Outliers.

a. General. TRICARE/CHAMPUS will adjust the DRG-based payment to a hospital for atypical cases. These outliers are those cases that have either an unusually short Length-Of-Stay (LOS) or extremely long LOS or that involve extraordinarily high costs when compared to most discharges classified in the same DRG. Recognition of these outliers is particularly important, since the number of TRICARE/CHAMPUS cases in many hospitals is relatively small, and there may not be an opportunity to "average out" DRG-based payments over a number of claims. Contractors will not be required to document or verify the medical necessity of outliers prior to payment, since outlier review will be part of the admission and quality review system. However, in determining additional cost outlier payments on all claims qualifying as a cost outlier, the contractor must identify and reduce the billed charge for any non-covered items such as comfort and convenience items (line N), as well as any duplicate charges (line X) and services which can be separately billed (line 7) such as professional fees, outpatient services, and solid organ transplant acquisition costs. Comfort and convenience items are defined as those optional items which the patient may elect at an additional charge (i.e., television, guest trays, beautician services, etc.), but are not medically necessary in the treatment of a patient's condition.

b. Payment of outliers. For all admissions occurring before October 1, 1988, if the claim qualifies as both a LOS outlier and a cost outlier, payment shall be based on the LOS outlier. For admissions occurring on or after October 1, 1988, claims which qualify as both a LOS outlier and a cost outlier shall be paid at whichever outlier calculation results in the greater payment. For information on calculating outlier payments when a beneficiary's eligibility status changes, refer to Chapter 6, Section 2, paragraph III.C.1.

c. Provider Reporting of outliers. The provider is to identify outliers on the UB-92, form locator 24 - 30. Code 60 is to be used to report LOS outliers, and code 66 is to be used to signify that a cost outlier is not being requested. If a claim qualifies as a cost outlier and code 66 is not entered in the appropriate form locator (i.e., it is blank or code 61), the contractor is to accept this as a request for cost outlier payment by the hospital.

d. LOS outliers. The TRICARE/CHAMPUS DRG-based payment system uses both short-stay and long-stay outliers, and both are reimbursed using a per diem amount. All

LOS outliers must be identified by the contractor when the claims are processed, and necessary adjustments to the payment amounts must be made automatically.

(1) Short-stay outliers.

(a) Any discharge which has a LOS less than or equal to the greater of 1 or 1.94 standard deviations below the arithmetic mean LOS for that DRG shall be classified as a short-stay outlier. In determining the actual short-stay threshold, the calculation will be rounded down to the nearest whole number, and any stay equal to or less than the short-stay threshold will be considered a short-stay outlier.

(b) Short-stay outliers will be reimbursed at 200% of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the wage-adjusted DRG amount divided by the arithmetic mean LOS for the DRG. The per diem rate is to be calculated before the DRG-based amount is adjusted for IDME. Cost outlier payments shall be paid on short stay outlier cases that qualify as a cost outlier.

(c) Any stay which qualifies as a short-stay outlier (a transfer cannot qualify as a short-stay outlier), even if payment is limited to the normal DRG amount, is to be considered and reported on the payment records as a short-stay outlier. This will ensure that outlier data is accurate and will prevent the beneficiary from paying an excessive cost-share in certain circumstances.

(2) Long-stay outliers.

(a) For admissions occurring on or after October 1, 1997, payment for long-stay outliers has been eliminated for all cases, except neonates and childrens' hospitals.

(b) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated for all neonates and childrens' hospitals.

e. Cost outliers.

(1) Any discharge which has standardized costs that exceed the thresholds outlined below, will be classified as a cost outlier.

(a) For admissions occurring prior to October 1, 1997, the standardized costs will be calculated by first subtracting the noncovered charges, multiplying the total charges (less lines 7, N, and X) by the CCR and adjusting this amount for IDME costs by dividing the amount by one (1) plus the hospital's IDME adjustment factor. For admissions occurring on or after October 1, 1997, the costs for IDME are no longer standardized.

(b) Cost outliers will be reimbursed the DRG-based amount plus 80% effective October 1, 1994 of the standardized costs exceeding the threshold.

(c) For admissions occurring on or after October 1, 1997, the following steps shall be followed when calculating cost outlier payments for all cases other than neonates and children's hospitals:

Standard Cost = (Billed Charges x CCR)

Outlier Payment = 80% of (Standard Cost - Threshold)

Total Payments = Outlier Payments + (DRG Base Rate x (1 + IDME))

NOTE: Noncovered charges should continue to be subtracted from the billed charges prior to multiplying the billed charges by the CCR.

(d) The CCR for admissions occurring on or after October 1, 2009, is 0.3740. The CCR for admissions occurring on or after October 1, 2010, is 0.3664. The CCR for admissions occurring on or after October 1, 2011, is 0.3460.

(e) The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2010 is 0.923, for FY 2011 is 0.920, and for FY 2012 is 0.919.

(2) For FY 2010, a TRICARE fixed loss cost-outlier threshold is set at $21,358. Effective October 1, 2009, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $21,358 (also wage-adjusted).

(3) For FY 2011, a TRICARE fixed loss cost-outlier threshold is set at $21,229. Effective October 1, 2010, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $21,229 (also wage-adjusted).

(4) For FY 2012, a TRICARE fixed loss cost-outlier threshold is set at $21,482. Effective October 1, 2011, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $21,482 (also wage-adjusted).

The cost-outlier threshold shall be calculated as follows:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + (DRG Base Payment (wage-adjusted) x (1 + IDME))}

EXAMPLE: Using FY 1999 figures {[10,129 x ((0.7110 x Applicable wage index) + 0.2890) x 0.913] + (DRG Based Payment (wage-adjusted) x (1 + IDME))}

f. Burn outliers. Burn outliers generally will be subject to the same outlier policies applicable to the CHAMPUS DRG-based payment system except as indicated below. For admissions prior to October 1, 1998, there are six DRGs related to burn cases. They are:

456 - Burns, transferred to another acute care facility
457 - Extensive burns w/o O.R. procedure
458 - Non-extensive burns with skin graft
459 - Non-extensive burns with wound debridement or other O.R. procedure
460 - Non-extensive burns w/o O.R. procedure
472 - Extensive burns with O.R. procedure

Effective for admissions on or after October 1, 1998, the above listed DRGs are no longer valid.

For admissions on or after October 1, 1998, there are eight DRGs related to burn cases. They are:

504 - Extensive 3rd degree burn w skin graft
505 - Extensive 3rd degree burn w/o skin graft
506 - Full thick burn w sk graft or inhal inj w cc or sig tr
507 - Full thick burn w sk graft or inhal inj w/o cc or sig tr
508 - Full thick burn w/o sk graft or inhal inj w cc or sig tr
509 - Full thick burn w/o sk graft or inhal inj w/o cc or sig tr
510 - Non-extensive burns w cc or significant trauma
511 - Non-extensive burns w/o cc or significant trauma

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

(1) For burn cases with admissions occurring prior to October 1, 1988, there are no special procedures. The marginal cost factor for outliers for all such cases will be 60%.

(2) Burn cases which qualify as short-stay outliers, regardless of the date of admission, will be reimbursed according to the procedures for short-stay outliers.

(3) Burn cases with admissions occurring on or after October 1, 1988, which qualify as cost outliers will be reimbursed using a marginal cost factor of 90%.

(4) Burn cases which qualify as long-stay outliers will be reimbursed as follows.

(a) Admissions occurring from October 1, 1988, through September 30, 1990 will be reimbursed using a marginal cost factor of 90%.

(b) Admissions occurring on or after October 1, 1990, will be reimbursed using a marginal cost factor of 60%.

(5) For admissions occurring on or after October 1, 1997, payment for long-stay outliers has been eliminated for all cases, except neonates and children's hospitals.

(6) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated for all neonates and children's hospitals.

(7) For a burn outlier in a children's hospital, the appropriate children's hospital outlier threshold is to be used (see below), but the marginal cost factor is to be either 60% or 90% according to the criteria above.

g. Children's hospital outliers. Children's hospitals will be subject to the same outlier policies applicable to other hospitals except that:

(1) For long-stay outliers the threshold shall be the lesser of 1.94 standard deviations or 17 days from the DRG's geometric mean LOS. (See the addenda to this chapter for the actual outlier thresholds and their effective dates.) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated.

(2) The following special provisions apply to cost outliers.

(a) The threshold shall be the greater of two times the DRG-based amount (wage-adjusted but prior to adjustment for IDME) or $13,500.

(b) Effective October 1, 1998, the threshold shall be the same as that applied to other hospitals.

(c) Effective October 1, 2009, the CCR was 0.4047. Effective October 1, 2010, the CCR was 0.3974. Effective October 1, 2011, the CCR was 0.3757. (This is equivalent to the Medicare CCR increased to account for CAP/DME costs.)

(d) The marginal cost factor shall be 80%.

(e) For admissions occurring during FY 2010, the marginal cost factor shall be adjusted by 1.10. For admissions occurring during FY 2011, the marginal cost factor shall be adjusted by 1.00. For admissions occurring during FY 2012, the marginal cost factor shall be adjusted by 1.02.

(f) The NOSCASTC for calculating the cost-outlier threshold for FY 2010 is 0.923. The NOSCASTC for calculating the cost-outlier threshold for FY 2011 is 0.920. The NOSCASTC for calculating the cost-outlier threshold for FY 2012 is 0.919. The following calculation shall be used in determining cost outlier payments for children's hospitals and neonates:

STEP 1: Computation of Standardized Costs:
Billed Charges x CCR
(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the CCR.)

STEP 2: Determination of Cost-Outlier Threshold:
{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + [DRG Based Payment (wage-adjusted) x (1 + IDME)]}

STEP 3: Determination of Cost Outlier Payment
[{(Standardized costs - Cost-Outlier Threshold) x Marginal Cost Factor} x Adjustment Factor]

STEP 4: Total Payments = Outlier Payments + [DRG Base Rate x (1 + IDME)]

h. Neonatal outliers. Neonatal outliers in hospitals subject to the CHAMPUS DRG-based payment system (other than children's hospitals) shall be determined under the same rules applicable to children's hospitals, except that the standardized costs for cost outliers shall be calculated using the CCR of 0.64. Effective for admissions occurring on or after October 1, 2005, and subsequent years, the CCR used to calculate cost outliers for neonates in acute care hospitals shall be reduced to the same CCR used for all other acute care hospitals.

7. IDME adjustment.

a. General. The DRG-based payments for any hospital which has a teaching program approved under Medicare Regulation Section 413.85, Title 42 CFR shall be adjusted to account for IDME costs. The adjustment factor used shall be the one in effect on the date of discharge (see below). The adjustment will be made by multiplying the total DRG-based amount by 1.0 plus a hospital-specific factor equal to:

$$1.43 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{0.5795} - 1.0 \right]$$

For admissions occurring during FY 2008 and subsequent years, the same formula shall be used except the first number shall be 1.02.

b. Number of interns and residents. Initially, the number of interns and residents will be derived from the most recently available audited CMS cost-report data (1984). Subsequent updates to the adjustment factor will be based on the count of interns and residents on the annual reports submitted by hospitals to the contractors (see above). The number of interns and residents is to be as of the date the report is submitted and is to include only those interns and residents actually furnishing services in the reporting hospital and only in those units subject to DRG-based reimbursement. The percentage of time used in calculating the full-time equivalents is to be based on the amount of time the interns and residents spend in the portion of the hospital subject to DRG-based payment or in the outpatient department of the hospital on the reporting date. Beginning in FY 1999, TRICARE/CHAMPUS will use the number of interns and residents from CMS most recently available Provider Specific File.

c. Number of beds. Initially, the number of beds will be those reported on the most recent AHA Annual Survey of Hospitals (1986). Subsequent updates to the adjustment factor will be based on the number of beds reported annually by hospitals to the contractors (see above). The number of beds in a hospital is determined by counting the number of available bed days during the period covered by the report, not including beds or bassinets assigned to healthy newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the reporting period. Beginning in FY 1999, TRICARE/CHAMPUS will use the number of beds from CMS's most recently available Provider Specific File.

d. Updates of IDME factors. It is the contractor's responsibility to update the adjustment factors based on the data contained in the annual report. The effective date of the updated factor shall be the date payment is made to the hospital (check issued) for its CAP/DME costs, but in no case can it be later than 30 days after the hospital submits its annual report. The updated factor shall be applied to claims with a date of discharge on or after the effective date. Similarly, contractors may correct initial factors if the hospital submits information (for the same base periods) which indicates the factor provided by TMA is incorrect.

(1) Beginning in FY 1999, TRICARE/CHAMPUS will use the ratio of interns and residents to beds from CMS's most recently available Provider Specific File to update the IDME adjustment factors. The ratio will be provided to the contractors to update each hospital's IDME adjustment factor at the same time as the annual DRG update. The updated factors shall be applied to claims with a date of discharge on or after October 1 of each year. The contractor is no longer required to update a hospital's IDME factor based on data contained in the hospital's annual request for reimbursement for its CAP/DME costs.

(2) This alternative updating method shall only apply to those hospitals subject to the Medicare PPS as they are the only ones included in the Provider Specific File.

e. Adjustment for children's hospitals. An IDME adjustment factor will be applied to each payment to qualifying children's hospitals. The factors for children's hospitals will be calculated using the same formula as for other hospitals. The initial factor will be based on the number of interns and residents and hospital bed size as reported by the hospital to the contractor. If the hospital provides the data to the contractor after payments have been made, the contractor will not make any retroactive adjustments to previously paid claims, but the amounts will be reconciled during the "hold harmless" process. At the end of its fiscal year, a children's hospital may request that its adjustment factor be updated by providing the contractor with the necessary information regarding its number of interns and residents and beds. The number of interns, residents, and beds must conform to the requirements above. The contractor is required to update the factor within 30 days of receipt of the request from the hospital, and the effective date shall conform to the policy contained above.

(1) Beginning in August 1998, and each subsequent year, the contractor shall send a notice to each children's hospital in its Region, who have not provided the contractor with updated information on its number of interns, residents and beds since the

previous October 1 and advise them to provide the updated information by October 1 of that same year.

(2) The contractors shall send the updated ratios for children's hospitals to TMA, MB&RS, or designee, by April 1 of each year to be used in TMA's annual DRG update calculations.

f. TFL. No adjustment for IDME costs is to be made on any TFL claim on which Medicare has made any payment. If TRICARE is the primary payer (e.g., claims for stays beyond 150 days) payments are to be adjusted for IDME in accordance with the provisions of this section.

8. Present On Admission (POA) Indicators and Hospital Acquired Conditions (HACs).

a. Effective for admissions on or after October 1, 2009, those inpatient acute care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a POA indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. Providers shall report POA indicators to TRICARE in the same manner they report to the CMS, and in accordance with the UB-04 Data Specifications Manual, and ICD-9-CM Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-9-CM Official Guidelines for Coding and Reporting.

b. There are five POA indicator reporting options, as defined by the ICD-9-CM Official Coding Guidelines for Coding and Reporting:

Y = Indicates that the condition was POA.

W = Affirms that the provider has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.

N = Indicates that the condition was not POA.

U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.

1 = (Definition prior to FY 2011.) Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.

1 = (Definition for FY 2011 and subsequent years.) Unreported/not used. Exempt from POA reporting.
(This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.

c. HACs. TRICARE shall adopt those HACs adopted by CMS. The HACs, and their respective diagnosis codes, are posted at http://www.tricare.mil/drgrates/.

d. Provider responsibilities and reporting requirements. For non-exempt providers, issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA.

e. The TRICARE/CHAMPUS contractor shall accept, validate, retain, pass, and store the POA indicator.

f. Exempt Providers.

(1) The following hospitals are exempt from POA reporting for TRICARE:

(a) Critical Access Hospitals (CAHs)

(b) Long Term Care (LTC) Hospitals

(c) Maryland Waiver Hospitals

(d) Cancer Hospitals

(e) Children's Inpatient Hospitals

(f) Inpatient Rehabilitation Hospitals

(g) Psychiatric Hospitals and Psychiatric Units

(h) Sole Community Hospitals (SCHs)

(i) Department of Veterans Affairs (DVA) Hospitals

(2) Contractors shall identify claims from those hospitals that are exempt from POA reporting, and shall take the actions necessary to be sure that the TRICARE grouper software does not apply HAC logic to the claim.

g. The DRG payment is considered payment in full, and the hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complication or charges because the DRG was demoted to a lesser-severity level.

h. Effective October 1, 2009, claims will be denied if a non-exempt hospital does not report a valid POA indicator for each diagnosis on the claim.

i. Reports. Contractors shall create a monthly report listing all TRICARE Encounter Data (TED) records that had HACs. The report shall include, at a minimum, the

TED Record Indicator, each HAC reported, the POA indicator for each HAC, the dates of service/admission, the DRG that was paid, the total amount paid by TRICARE, and the following provider data: Taxpayer Identification Number (TIN), Sub-Identifier (SUBID), Zip Code, Type of Institution, and National Provider Identifier (NPI). The report shall be provided to TMA by the 10th of each month in an Excel file and submitted via the E-Commerce Extranet. The first monthly report shall be due no later than November 10, 2009.

9. Replacement Devices.

a. TRICARE is not responsible for the full cost of a replaced device if a hospital receives a partial or full credit, either due to a recall or service during the warranty period. Reimbursement in cases in which an implanted device is replaced shall be made:

(1) At reduced or no cost to the hospital; or

(2) With partial or full credit for the removed device.

b. The following condition codes 49 and 50 allow TRICARE to identify and track claims billed for replacement devices:

(1) Condition Code 49. Product replacement within product lifecycle. Condition code 49 is used to describe replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly - warranty.

(2) Condition Code 50. Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly. Condition code 50 is used to describe that the manufacturer or the U.S. Food and Drug Administration (FDA) has identified the product for recall and, therefore, replacement.

c. When a hospital receives a credit for a replaced device that is 50% or greater than the cost of the device, hospitals are required to bill the amount of the credit in the amount portion for value code **FD**.

d. Beginning with admissions on or after October 1, 2009, the contractor shall reduce hospital reimbursement for those DRGs subject to the replacement device policy, by the full or partial credit a provider received for a replaced device. The specific DRGs subject to the replacement device policy will be posted on TRICARE's DRG web page at http://www.tricare.mil/drgrates/. As necessary, the DRGs subject to the replacement device policy will be updated as part of the annual DRG update.

e. Hospitals must use the combination of condition code 49 or 50, along with value code **FD** to correctly bill for a replacement device that was provided with a credit or no cost. The condition code 49 or 50 will identify a replacement device while value code **FD** will communicate to TRICARE the amount of the credit, or cost reduction, received by the hospital for the replaced device.

f. The contractor shall deduct the partial/full credit amount, reported in the amount for value code **FD** from the final DRG reimbursement when the assigned DRG is one of the DRGs subject to the replacement device policy.

g. Once a DRG rate is determined, any full/partial credit amount is deducted from the DRG reimbursement rate. The beneficiary copayment/cost-share is then determined based on the reduced rate.

- END -