



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 128
6010.55-M
MARCH 1, 2011**

CORRECTED COPY

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: FISCAL YEAR (FY) 2011 DIAGNOSIS RELATED GROUP (DRG) UPDATE

CONREQ: 15177

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates the DRG rates, weights, and marginal cost factors for FY 2011 and includes the \$535 inpatient per diem as stated in the National Defense Authorization Act (NDAA) for FY 2011.

EFFECTIVE DATE: October 1, 2010.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 48 PAGE(S)
DISTRIBUTION: 6010.55-M**

**CHANGE 128
6010.55-M
MARCH 1, 2011**

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CHAPTER 2, SECTION 1

COST-SHARES AND DEDUCTIBLES

(Please reference daily rate chart below.) (For care provided on or after April 1, 2001, for Prime ADFMs, copayment is \$0.)

UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS

Use the daily charge (per diem rate) in effect for each day of the stay to calculate a cost-share for a stay which spans periods.

PERIOD	DAILY CHARGE
October 1, 1997 - September 30, 1998	\$10.20
October 1, 1998 - September 30, 1999	\$10.45
October 1, 1999 - September 30, 2000	\$10.85
October 1, 2000 - September 30, 2001	\$11.45
April 1, 2001 (for Prime ADFMs only)	\$0.00
October 1, 2001 - September 30, 2002 (for ADFMs not enrolled in Prime)	\$11.90
October 1, 2002 - September 30, 2003 (for ADFMs not enrolled in Prime)	\$12.72
October 1, 2003 - September 30, 2004 (for ADFMs not enrolled in Prime)	\$13.32
October 1, 2004 - September 30, 2005 (for ADFMs not enrolled in Prime)	\$13.90
October 1, 2005 - September 30, 2006 (for ADFMs not enrolled in Prime)	\$14.35
October 1, 2006 - September 30, 2007 (for ADFMs not enrolled in Prime)	\$14.80
October 1, 2007 - September 30, 2008 (for ADFMs not enrolled in Prime)	\$15.15
October 1, 2008 - September 30, 2009 (for ADFMs not enrolled in Prime)	\$15.65
October 1, 2009 - September 30, 2010 (for ADFMs not enrolled in Prime)	\$16.30
October 1, 2010 - September 30, 2011 (for ADFMs not enrolled in Prime)	\$16.85

(2) Other Beneficiaries: For services exempt from the DRG-based payment system and the mental health per diem payment system and services provided by institutions other than hospitals (i.e., RTCs), the cost-share shall be 25% of the allowable charges.

c. Cost-Shares: Maternity.

(1) Determination. Maternity care cost-share shall be determined as follows:

(a) Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded.

NOTE: Inpatient cost-share formula applies to prenatal and postnatal care provided in the office of a civilian physician or certified nurse-midwife in connection with maternity care ending in childbirth or termination of pregnancy in, or on the way to, a military treatment facility inpatient childbirth unit. ADFMs pay a per diem charge (or a \$25.00 minimum charge) for an admission and there is no separate cost-share for them for separately billed professional charges or prenatal or postnatal care.

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(b) Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted, and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

(c) Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

(d) Otherwise covered medical services and supplies directly related to "Complications of pregnancy", as defined in the Regulation, will be cost-shared on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

(2) Otherwise authorized services and supplies related to maternity care, including maternity related prescription drugs, shall be cost-shared on the same basis as the termination of pregnancy.

(3) Claims for pregnancy testing are cost-shared on an outpatient basis when the delivery is on an inpatient basis.

(4) Where the beneficiary delivers in a professional office birthing suite located in the office of a physician or certified nurse-midwife (which is not otherwise a TRICARE-approved birthing center) the delivery is to be adjudicated as an at-home birth.

(5) Claims for prescription drugs provided on an outpatient basis during the maternity episode but not directly related to the maternity care are cost-shared on an outpatient basis.

(6) Newborn cost-share. Effective for all inpatient admissions occurring on or after October 1, 1987, separate claims must be submitted for the mother and newborn. The cost-share for inpatient claims for services rendered to an beneficiary newborn is determined as follows:

(a) IN A DRG HOSPITAL:

1 Same newborn date of birth and date of admission.

2 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

3 For newborn family members of other than active duty members, unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of the number of hospital days minus three multiplied by the per diem amount, OR 25% of the total billed charges (less duplicates and DRG non-reimbursables such as hospital-based professional charges).

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4 Different newborn date of birth and date of admission. For family members of active duty members, there will be no cost-share during the period the newborn is deemed enrolled in Prime. For all other beneficiaries, the cost-share is applied to all days in the inpatient stay unless the newborn is deemed enrolled in Prime.

(b) IN DRG EXEMPT HOSPITAL:

1 Same newborn date of birth and date of admission.

2 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

3 For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

4 Different newborn date of birth and date of admission.

5 For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.

6 For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

(7) Maternity Related Care. Medically necessary treatment rendered to a pregnant woman for a non-obstetrical medical, anatomical, or physiological illness or condition shall be cost-shared as a part of the maternity episode when:

(a) The treatment is otherwise allowable as a benefit, and,

(b) Delay of the treatment until after the conclusion of the pregnancy is medically contraindicated, and,

(c) The illness or condition is, or increases the likelihood of, a threat to the life of the mother, or,

(d) The illness or condition will cause, or increase the likelihood of, a stillbirth or newborn injury or illness, or,

(e) The usual course of treatment must be altered or modified to minimize a defined risk of newborn injury or illness.

d. Cost-Shares: DRG-Based Payment System.

(1) General. These special cost-sharing procedures apply only to claims paid under the DRG-based payment system.

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(2) TRICARE Standard.

(a) Cost-shares for ADFMs.

1 Except in the case of mental health services, ADFMs or their sponsors are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

2 Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission.

(b) Cost-shares for beneficiaries other than ADFMs.

1 The cost-share will be the lesser of:

□ An amount based on a single, specific per diem amount which will not vary regardless of the DRG involved. The following is the DRG inpatient TRICARE Standard cost-sharing per diems for beneficiaries other than ADFMs.

For FY 2005, the daily rate is \$512.

For FY 2006, the daily rate is \$535.

For FY 2007, the daily rate is capped at the FY 2006 level of \$535, per Section 704 of NDAA FY 2007.

For FY 2008, FY 2009, FY 2010, and FY 2011, the daily rate is \$535.

(1) The per diem amount will be calculated as follows:

(a) Determine the total allowable DRG-based amounts for services subject to the DRG-based payment system and for beneficiaries other than ADFMs during the same database period used for determining the DRG weights and rates.

(b) Add in the allowance for capital and direct medical education which have been paid to hospitals during the same database period used for determining the DRG weights and rates.

(c) Divide this amount by the total number of patient days for these beneficiaries. This amount will be the average cost per day for these beneficiaries.

(d) Multiply this amount by 0.25. In this way total cost-sharing amounts will continue to be 25% of the allowable amount.

DIAGNOSTIC RELATED GROUPS (DRGs)

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	FIGURE 6-B-2009-1 - 69.7 Percent Labor Share/30.3 Percent Non-Labor Share If Wage Index Greater Than 1
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	FIGURE 6-B-2010-1 - 68.8 Percent Labor Share/31.2 Percent Non-Labor Share If Wage Index Greater Than 1

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SECTION	SUBJECT
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	FIGURE 6-B-2011-1 - 68.8 Percent Labor Share/31.2 Percent Non-Labor Share If Wage Index Greater Than 1
	FIGURE 6-B-2011-2 - 62 Percent Labor Share/38 Percent Non-Labor Share If Wage Index Less Than Or Equal To 1
ADDENDUM C	(FY 2009) - Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay, And Short-Stay Outlier Thresholds (Effective For Admissions On Or After 10/01/2008)
ADDENDUM C	(FY 2010) - Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay, And Short-Stay Outlier Thresholds (Effective For Admissions On Or After 10/01/2009)
ADDENDUM C	(FY 2011) - Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay, And Short-Stay Outlier Thresholds (Effective For Admissions On Or After 10/01/2010)

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(BASIS OF PAYMENT)

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.](#) 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 **current** fiscal year and the two **most recent** fiscal years.

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

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(BASIS OF PAYMENT)

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 all other years, those DRGs subject to the special rule for transfers shall be listed in Addendum C. Addendum C reflects the current fiscal year and the two most recent fiscal years.**

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: $\text{DRG Base Payment} = \text{Adjusted Standardized Amount (ASA)} \times \text{DRG Weight} \times (\text{Labor-Related Portion} \times \text{Wage Index} + \text{Non-Labor Portion})$

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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

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(BASIS OF PAYMENT)

4. For Children's Hospitals and Neonates using Cost Outlier Threshold for post acute care special pay transfer DRGs
$$((\text{Billed Charges} \times \text{CCR}) - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor} \times \text{Adjustment Factor}$$

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. $\text{DRG Base Payment} \times (1 + \text{IDME Factor})$, or
- b. $((2 \times \text{Per Diem}) + [(\text{LOS} - 1) \times \text{Per Diem}]) \times (1 + \text{IDME Factor})$

2. For post acute care special pay transfer DRGs

Cost outlier payment + the minimum of:

- a. $\text{DRG Base Payment} \times (1 + \text{IDME Factor})$, or
- b. $[(\text{DRG Base Payment} \times 0.5) + \text{Per Diem}] + ((\text{LOS} - 1) \times \text{Per Diem} \times 0.5) \times (1 + \text{IDME Factor})$

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

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

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

STEP 2: Per Diem = DRG Base Payment ÷ Geometric Mean LOS

$$\$5,573.40 \div 10 = \$557.34$$

STEP 3: Calculation of Cost Outlier Threshold:

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

$$A = \text{DRG Base Payment} \times (1 + \text{IDME Factor})$$

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

$$B = (\text{Fixed Loss Threshold} \times [(\text{Labor-Related Share} \times \text{Wage Index}) + \text{Non-Labor-Related Share}] \times \text{NOSCASTC})$$

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

$$C = \text{LOS} \div \text{Geometric Mean}$$

$$5 \div 10 = 0.5$$

$$\text{Cost Outlier Threshold} = (A + B) \times C$$

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

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

$$A = \text{DRG Base Payment} \times (1 + \text{IDME Factor})$$

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

$$B = (\text{Fixed Loss Threshold} \times [(\text{Labor-Related Share} \times \text{Wage Index}) + \text{Non-Labor-Related Share}] \times \text{NOSCASTC})$$

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

$$C = ((\text{LOS} \div \text{Geometric Mean}) + 1) \times 0.5$$

$$((5 \div 10) + 1) \times 0.5 = 0.75$$

$$\text{Cost Outlier Threshold} = (A + B) \times C$$

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

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).

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

- 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
 $[(\$30,000 \times 0.5562) - \$7,639.17] \times 0.8 = \$7,237.46$
 2. For post acute care special pay transfer DRGs
[(Billed Charges x CCR) - Cost Outlier Threshold] x Marginal Cost Factor
 $[(\$30,000 \times 0.5562) - \$11,458.76] \times 0.8 = \$4,181.79$
 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
 $[(\$30,000 \times 0.6085) - \$7,639.17] \times 0.8 \times 1.37 = \$11,634.95$
 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
 $[(\$30,000 \times 0.6085) - \$11,458.76] \times 0.8 \times 1.37 = \$7,448.68$
- 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
 $\$5,573.40 \times (1 + 0.2) = \$6,688.08$
 - b. $((2 \times \text{Per Diem}) + [(\text{LOS} - 1) \times \text{Per Diem}]) \times (1 + \text{IDME Factor})$
 $((2 \times \$557.34) + [(5 - 1) \times \$557.34]) \times (1 + 0.2) = \$4,012.85$
 $\$7,237.46 + \$4,012.85 = \$11,250.31$
 2. For post acute care special pay transfer DRGs
Cost outlier payment + the minimum of:
 - a. DRG Base Payment x (1 + IDME Factor), or
 $\$5,573.40 \times (1 + 0.2) = \$6,688.08$

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

b.
$$[(\text{DRG Base Payment} \times 0.5) + \text{Per Diem}] + ((\text{LOS} - 1) \times \text{Per Diem} \times 0.5) \times (1 + \text{IDME Factor})$$
$$[(\$5,573.40 \times 0.5) + 557.34] + ((5 - 1) \times 557.34 \times 0.5) \times (1 + 0.2) = \$5,350.46$$
$$\$4,181.79 + \$5,350.46 = 9,532.25$$

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.

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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.

- END -

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(APPLICABILITY OF THE DRG SYSTEM)

7. All services related to Combined Liver-Kidney (CLKT) and Combined Heart-Kidney Transplant (CHKT) through July 31, 2003. Effective August 1, 2003, CLKTs and CHKTs shall be paid under the assigned DRG based on the procedure performed.

8. All services related to TRICARE/CHAMPUS covered solid organ transplants for which there is no DRG assignment.

9. All services provided by hospital-based professionals (physicians, psychologists, etc.) which, under normal TRICARE/CHAMPUS requirements, would be billed by the hospital. This does not include any therapy services (physical, speech, etc.), since these are included in the DRG-based payment. For radiology and pathology services provided by hospital-based physicians, any related non-professional (i.e., technical) component of these services is included in the DRG-based payment and cannot be billed separately. The services of hospital-based professionals which are employed by, or under contract to, a hospital must still be billed by the hospital and must be billed on a participating basis.

10. Anesthesia services provided by nurse anesthetists. This may be separately billed only when the nurse anesthetist is the primary anesthetist for the case.

NOTE: As a general rule, TRICARE/CHAMPUS will only pay for one anesthesia claim per case. When an anesthesiologist is paid for anesthesia services, a nurse anesthetist is not authorized to bill for those same services. Services which support the anesthesiologist in the operating room fall within the DRG allowed amount and are considered to be already included in the facility fee, even if the support services are provided by a nurse anesthetist. Charging for such services is considered an inappropriate billing practice.

11. All outpatient services related to inpatient stays.

NOTE: Payment for trauma services (e.g., revenue code 068X), is included in the TRICARE/CHAMPUS DRG-based payment system.

12. All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) bone marrow transplants which would otherwise be paid under **the DRGs for such transplants.**

13. All services related to discharges involving children (beneficiary less than 18 years old upon admission) who have been determined to be HIV seropositive.

14. All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) cystic fibrosis.

15. For admissions occurring on or after October 1, 1997, an additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a TRICARE/CHAMPUS patient who is a hemophiliac. Payment will be made for blood clotting factor when one of the following hemophilia ICD-9-CM diagnosis codes is listed on the claim:

286.0 Congenital Factor VIII Disorder;

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- 286.1 Congenital Factor IX Disorder;
- 286.2 Congenital Factor XI Deficiency;
- 286.3 Congenital Deficiency of Other Clotting Factors;
- 286.4 Von Willebrand's Disease;
- 286.5 Hemorrhagic Disorder Due to Circulating Anticoagulants; and
- 286.7 Acquired Coagulation Factor Deficiency.

c. For admissions occurring on or after October 1, 1994, and prior to admissions occurring on or after October 1, 1997, the cost of the blood clotting factor for hemophilia inpatients is no longer eligible for separate reimbursement.

b. Each unit billed on the hospital claim represents 100 payment units except Q0187, Factor VIIa. For example, if the hospital indicates that 25 units of Factor VIII were provided, this would represent 2,500 actual units of factor, and the payment would be \$1,600 (paid at \$0.64/unit - Factor VIII). For HCPCS Q0187, one billing unit represents 1.2mg.

NOTE: Since the costs of blood clotting factor are reimbursed separately for admissions occurring on or after October 1, 1997, for these claims all charges associated with the factor are to be subtracted from the total charges in determining applicability of a cost outlier. However, the charges for the blood clotting factor are to be included when calculating the cost-share based on billed charges.

c. For admissions occurring on or after October 1, 2000, through September 30, 2001, the following HCPCS codes and payment rates shall be used for blood clotting factors:

J7190 Factor VIII (antihemophilic factor - human)	\$0.85 per unit
J7191 Factor VIII (antihemophilic factor - porcine)	2.09 per unit
J7192 Factor VIII (antihemophilic factor - recombinant)	1.12 per unit
J7194 Factor IX (complex)	0.31 per unit
J7198 Anti-Inhibitor	1.43 per unit
Q0160 Factor IX (antihemophilic factor, purified, non-recombinant)	1.05 per unit
Q0161 Factor IX (antihemophilic factor, recombinant)	1.12 per unit

NOTE: HCPCS billing code J7198 replaces code J7196 (Other hemophilia clotting factors (e.g., anti-inhibitors)).

d. For admissions occurring on or after October 1, 2001, through September 30, 2002, the following HCPCS codes and payment rates shall be used for blood clotting factors:

J7190 Factor VIII (antihemophilic factor - human)	\$0.86 per unit
J7191 Factor VIII (antihemophilic factor - porcine)	2.09 per unit
J7192 Factor VIII (antihemophilic factor - recombinant)	1.12 per unit
J7194 Factor IX (complex)	0.31 per unit
J7198 Anti-Inhibitor	1.43 per unit
Q0160 Factor IX (antihemophilic factor, purified, non-recombinant)	1.05 per unit
Q0161 Factor IX (antihemophilic factor, recombinant)	1.12 per unit

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (ADJUSTED STANDARDIZED AMOUNTS)

ISSUE DATE: October 8, 1987

AUTHORITY: [32 CFR 199.14\(a\)\(1\)](#)

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 Adjusted Standardized Amounts (ASAs) under the TRICARE/CHAMPUS Diagnosis Related Group (DRG)-based payment system, and how are they used and calculated?

III. POLICY

A. General. The ASA represents the adjusted average operating cost for treating all TRICARE/CHAMPUS beneficiaries in all DRGs during the database period. During Fiscal Year (FY) 1988 the TRICARE/CHAMPUS DRG-based payment system used two ASAs--one for urban areas and one for rural areas. Beginning in FY 1989 (admissions on or after October 1, 1988), three ASAs are used--one for large urban areas, one for other urban areas, and one for rural areas. Effective October 1, 1994, rural hospitals will receive the same payment rate as other urban hospitals. Effective April 1, through September 30, 2003, and November 1, 2003 forward, hospitals located in other areas shall receive the same ASA payment rate as large urban hospitals.

B. Calculation of the ASA. The following procedures will be followed in calculating the TRICARE/CHAMPUS ASA.

1. Apply the Cost-To-Charge Ratio (CCR). In this step each charge is reduced to a representative cost by using the Medicare CCR. Effective FY 2009, the CCR is 0.3796. Effective FY 2010, the CCR is 0.3740. **Effective FY 2011, the CCR is 0.3664.**

2. Increase for bad debts. The base standardized amount will be increased by 0.01 in order to reimburse hospitals for bad debt expenses attributable to TRICARE/CHAMPUS

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beneficiaries. The base standardized amount will be increased by 0.0060 for FY 2000, 0.0055 for FY 2001, and through July 14, 2001, and by 0.0070 as of July 15, 2001 and subsequent years.

3. Update for inflation. Each record in the database will be updated to FY 1988 using a factor equal to 1.07. Thereafter, any recalculation of the ASA will use an inflation factor equal to the hospital market basket index used by the Centers of Medicare and Medicaid Services (CMS) in their Prospective Payment System (PPS).

4. Preliminary non-teaching standardized amount. At this point indirect medical education costs have been removed through standardization in the weight methodology and direct medical education costs have been removed through the application of the Medicare CCR which does not include direct medical education costs. Therefore, a non-teaching standardized amount will be computed by dividing aggregate costs by the number of discharges in the database.

5. Preliminary teaching standardized amounts. A separate standardized amount will be calculated for each teaching hospital to reimburse for indirect medical education expenses. This will be done by multiplying the non-teaching standardized amount by 1.0 plus each hospital's indirect medical education factor.

6. System standardization. The preliminary standardized amounts will be further standardized using a factor which equals total DRG payments using the preliminary standardized amounts divided by the sum of all costs in the database (updated for inflation). To achieve standardization, each preliminary standardized amount will be divided by this factor. This step is necessary so that total DRG system outlays, given the same distribution among hospitals and diagnoses, are equal whether based on DRGs or on charges reduced to costs.

7. Labor-related and nonlabor-related portions of the ASA. The ASA shall be divided into labor-related and nonlabor-related portions according to the ratio of these amounts in the national ASA under the Medicare PPS. Since October 1, 1997, the labor-related portion of the ASA equals 71.1% and the non-labor portion equals 28.9%. Effective October 1, 2004, and subsequent years, for wage indexes less than or equal to 1.0 the labor related portion of the ASA shall equal 62%. Effective October 1, 2005, and subsequent years, for wage index values greater than 1.0, the labor related portion of the ASA shall equal 69.7%. Effective October 1, 2009 and subsequent years, for wage index values greater than 1.0, the labor related portion of the ASA shall equal 68.8%.

8. Updating the standardized amounts. For years subsequent to the initial year, the standardized amounts will be updated by the final published Medicare annual update factor, unless the standardized amounts are recalculated.

- END -

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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.

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(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:

$$\text{Standard Cost} = (\text{Billed Charges} \times \text{CCR})$$

$$\text{Outlier Payment} = 80\% \text{ of } (\text{Standard Cost} - \text{Threshold})$$

$$\text{Total Payments} = \text{Outlier Payments} + (\text{DRG Base Rate} \times (1 + \text{IDME}))$$

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, 2008, is 0.3796. 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.**

(e) The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2009 is 0.925, for FY 2010 is 0.923, **and for FY 2010 is 0.920.**

(2) For FY 2009, a **TRICARE** fixed loss cost-outlier threshold is set of **\$18,671**. Effective October 1, 2008, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of **\$18,671** (also wage-adjusted).

(3) For FY 2010, a **TRICARE** fixed loss cost-outlier threshold is set of \$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).

(4) **For FY 2011, a TRICARE fixed loss cost-outlier threshold is set of \$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).**

The cost-outlier threshold shall be calculated as follows:

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

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

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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%.

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(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, 2008, the CCR was 0.4099. Effective October 1, 2009, the CCR was 0.4047. **Effective October 1, 2010, the CCR was 0.3974.** (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 2009, the marginal cost factor shall be adjusted by 1.14. 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.**

(f) The NOSCASTC for calculating the cost-outlier threshold for FY 2009 is 0.925. 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 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.)

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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.

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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

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

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.

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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

FISCAL YEAR 2011 TRICARE/CHAMPUS ADJUSTED STANDARDIZED AMOUNTS

These amounts are effective for admissions occurring on or after October 1, 2010 through September 30, 2011.

FIGURE 6-B-2011-1 68.8 PERCENT LABOR SHARE/31.2 PERCENT NON-LABOR SHARE IF WAGE INDEX GREATER THAN 1

LABOR RELATED	NON-LABOR RELATED	TOTAL
\$3,444.80	\$1,562.18	\$5,006.98

FIGURE 6-B-2011-2 62 PERCENT LABOR SHARE/38 PERCENT NON-LABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1

LABOR RELATED	NON-LABOR RELATED	TOTAL
\$3,104.33	\$1,902.65	\$5,006.98

FY 2011 cost-share per diem for beneficiaries other than dependents of active duty member \$535.00.

- END -

CHAPTER 6
ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS (EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

The second column labeled "PAC XFER" indicates whether the DRG is subject to the post acute care transfer policy. The third column labeled "PAC PAY" indicates whether the DRG is subject to the post acute care special payment provision.

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
1	No	No	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	25.3823	39.1	29.7	5
2	No	No	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	12.5238	20.0	18.0	7
3	Yes	No	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	19.5904	37.7	28.7	6
4	Yes	No	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	12.1023	28.6	22.7	5
5	No	No	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	11.5308	23.1	15.9	3
6	No	No	LIVER TRANSPLANT W/O MCC	5.4189	10.9	8.1	2
7	No	No	LUNG TRANSPLANT	11.5846	22.4	16.5	3
8	No	No	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.5092*	11.7	10.1	7
10	No	No	PANCREAS TRANSPLANT	4.1992*	9.7	8.6	5
11	No	No	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.7145	13.0	11.2	3
12	No	No	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.2815	9.4	7.2	1
13	No	No	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	2.6885	7.3	6.3	2
14	No	No	ALLOGENEIC BONE MARROW TRANSPLANT	12.8826	36.2	25.5	3
15	No	No	AUTOLOGOUS BONE MARROW TRANSPLANT	5.5725	18.8	16.8	6
20	No	No	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.9093	17.6	15.8	6
21	No	No	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.5751	14.4	12.7	4
22	No	No	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	4.3378	9.3	8.3	2
23	No	No	CRANIO W MAJOR DEV IMPL./ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	6.5113	13.3	9.2	1
24	No	No	CRANIO W MAJOR DEV IMPL./ACUTE COMPLEX CNS PDX W/O MCC	4.2771	10.2	6.7	1
25	No	No	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES AGE >17 W MCC	4.6711	9.7	7.4	1
26	No	No	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES AGE >17 W CC	3.1019	6.0	4.7	1
27	No	No	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES AGE >17 W/O CC/MCC	2.5609	3.7	2.9	1
28	Yes	Yes	SPINAL PROCEDURES W MCC	4.8236	8.7	6.7	1
29	Yes	Yes	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	3.2920	5.7	4.1	1
30	Yes	Yes	SPINAL PROCEDURES W/O CC/MCC	1.9829	3.4	2.5	1
31	No	No	VENTRICULAR SHUNT PROCEDURES AGE >17 W MCC	4.7668	13.5	9.7	1
32	No	No	VENTRICULAR SHUNT PROCEDURES AGE >17 W CC	1.9328	5.1	3.6	1
33	No	No	VENTRICULAR SHUNT PROCEDURES AGE >17 W/O CC/MCC	1.4864	3.0	2.0	1
34	No	No	CAROTID ARTERY STENT PROCEDURE W MCC	3.9119*	7.0	4.7	2
35	No	No	CAROTID ARTERY STENT PROCEDURE W CC	2.5844	2.9	1.9	1

Notes: (1) * = low volume DRG with fewer than 10 cases. The Medicare weights are used for these DRGs.
(2) # = PM-DRGs with fewer than 10 cases. An average weight over the past five years were used for these DRGs.
(3) w CC = with Complications or Comorbidities.
(4) w/o CC = without Complications or Comorbidities.

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CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARTH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
36	No	No	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	2.0574	1.9	1.4	1
37	No	No	EXTRACRANIAL PROCEDURES W MCC	3.6395	6.7	4.4	1
38	No	No	EXTRACRANIAL PROCEDURES W CC	1.9728	3.5	2.4	1
39	No	No	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.2017	1.6	1.4	1
40	Yes	Yes	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9935	10.5	7.3	1
41	Yes	Yes	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	1.9283	5.4	3.7	1
42	Yes	Yes	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.6866	2.5	1.9	1
52	No	No	SPINAL DISORDERS & INJURIES W CC/MCC	2.2852	10.1	5.5	1
53	No	No	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.7293	2.8	2.1	1
54	Yes	No	NERVOUS SYSTEM NEOPLASMS W MCC	1.5480	5.7	4.1	1
55	Yes	No	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0733	3.9	2.8	1
56	Yes	No	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1.6042	8.7	5.9	1
57	Yes	No	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1.1134	5.3	3.6	1
58	No	No	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.3830	4.9	4.3	1
59	No	No	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	1.0089	4.4	3.7	1
60	No	No	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.8473	3.5	2.9	1
61	No	No	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	2.5349	6.0	4.3	1
62	No	No	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	2.1396	5.4	4.8	1
63	No	No	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	1.4879	2.6	2.3	1
64	Yes	No	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	2.3332	7.0	5.0	1
65	Yes	No	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	1.3357	4.4	3.6	1
66	Yes	No	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	1.0142	2.9	2.4	1
67	No	No	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.2752	3.3	3.0	1
68	No	No	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	1.0983	2.9	2.3	1
69	No	No	TRANSIENT ISCHEMIA	0.8274	2.2	1.8	1
70	Yes	No	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	2.6668	9.4	5.8	1
71	Yes	No	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0971	4.7	3.4	1
72	Yes	No	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.8831	2.9	2.1	1
73	No	No	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	2.4019	9.1	4.9	1
74	No	No	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.9380	3.6	2.8	1
75	No	No	VIRAL MENINGITIS W CC/MCC	1.1859	4.3	3.5	1
76	No	No	VIRAL MENINGITIS W/O CC/MCC	0.6387	2.9	2.4	1
77	No	No	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.5557	5.5	4.0	1
78	No	No	HYPERTENSIVE ENCEPHALOPATHY W CC	0.9252	2.8	2.4	1
79	No	No	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	1.0987	3.2	2.8	1
80	No	No	NONTRAUMATIC STUPOR & COMA W MCC	1.2587	3.2	2.8	1
81	No	No	NONTRAUMATIC STUPOR & COMA W/O MCC	0.7918	2.7	1.9	1
82	No	No	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.8355	7.5	4.8	1
83	No	No	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.4891	3.8	2.7	1
84	No	No	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.7787	2.4	1.9	1
85	No	No	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W MCC	2.3770	7.4	5.0	1
86	No	No	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3150	4.2	3.1	1
87	No	No	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC/MCC	0.7635	2.2	1.8	1
88	No	No	CONCUSSION AGE >17 W MCC	1.8122	3.1	2.2	1
89	No	No	CONCUSSION AGE >17 W CC	1.0514	2.0	1.8	1
90	No	No	CONCUSSION AGE >17 W/O CC/MCC	0.8941	1.5	1.3	1
91	Yes	No	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.8320	6.5	3.9	1
92	Yes	No	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9635	3.7	2.6	1
93	Yes	No	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.7885	2.4	2.0	1

Notes: (1) * = low volume DRG with fewer than 10 cases. The Medicare weights are used for these DRGs.
(2) # = PM-DRGs with fewer than 10 cases. An average weight over the past five years were used for these DRGs.
(3) w CC = with Complications or Comorbidities.
(4) w/o CC = without Complications or Comorbidities.

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CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
94	No	No	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	4.5099	13.3	9.2	1
95	No	No	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	3.3418	7.3	5.9	1
96	No	No	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	2.2474	5.8	4.5	1
97	No	No	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	2.8527	9.2	7.9	2
98	No	No	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	2.7084	10.0	6.4	1
99	No	No	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.1026	4.2	3.3	1
100	No	No	SEIZURES AGE >17 W MCC	1.5076	4.6	3.5	1
101	No	No	SEIZURES AGE >17 W/O MCC	0.7784	2.9	2.4	1
102	No	No	HEADACHES AGE >17 W MCC	1.3510	5.2	3.6	1
103	No	No	HEADACHES AGE >17 W/O MCC	0.7691	3.1	2.4	1
104	No	No	CRANIOTOMY, VENTRICULAR SHUNT & ENDOVASC INTRACRANIAL PROC AGE 0-17	2.8195	6.4	3.6	1
105	No	No	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.4963	1.9	1.5	1
106	No	No	CONCUSSION AGE 0-17	0.5547	1.3	1.2	1
107	No	No	SEIZURES & HEADACHES AGE 0-17	0.5367	2.4	1.9	1
108	No	No	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	2.2347	9.6	3.8	1
109	No	No	OTHER DISORDERS OF THE EYE AGE 0-17	0.7063	4.0	2.3	1
110	No	No	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES AGE 0-17	0.8043	2.3	1.7	1
111	No	No	SINUS & MASTOID PROCEDURES AGE 0-17	1.6771	6.8	4.2	1
112	No	No	OTITIS MEDIA & URI AGE 0-17	0.3193	2.1	1.8	1
113	No	No	ORBITAL PROCEDURES W CC/MCC	1.9387	3.8	2.8	1
114	No	No	ORBITAL PROCEDURES W/O CC/MCC	1.0342	2.2	1.7	1
115	No	No	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	1.0459	3.6	2.6	1
116	No	No	INTRAOCULAR PROCEDURES W CC/MCC	1.4069*	4.4	3.0	2
117	No	No	INTRAOCULAR PROCEDURES W/O CC/MCC	0.8541	1.7	1.6	1
118	No	No	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.4446	2.4	2.0	1
119	No	No	DENTAL & ORAL DISEASES AGE 0-17	0.5353	2.9	2.3	1
120	No	No	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.7403	9.2	6.7	1
121	No	No	ACUTE MAJOR EYE INFECTIONS W CC/MCC	0.9050	4.0	3.1	1
122	No	No	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.5803	3.5	2.9	1
123	No	No	NEUROLOGICAL EYE DISORDERS	0.8563	2.7	2.2	1
124	No	No	OTHER DISORDERS OF THE EYE AGE >17 W MCC	0.8190#	2.1	2.3	2
125	No	No	OTHER DISORDERS OF THE EYE AGE >17 W/O MCC	0.6913	2.7	2.1	1
129	No	No	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	1.9658	3.5	2.6	1
130	No	No	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.2951	2.5	2.1	1
131	No	No	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.3984	3.9	2.9	1
132	No	No	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.3885	1.6	1.4	1
133	No	No	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES AGE >17 W CC/MCC	1.1496	3.4	2.5	1
134	No	No	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES AGE >17 W/O CC/MCC	0.9424	1.8	1.5	1
135	No	No	SINUS & MASTOID PROCEDURES AGE >17 W CC/MCC	2.1428	7.3	4.7	1
136	No	No	SINUS & MASTOID PROCEDURES AGE >17 W/O CC/MCC	1.1184	2.1	1.8	1
137	No	No	MOUTH PROCEDURES W CC/MCC	1.0520	3.4	3.0	1
138	No	No	MOUTH PROCEDURES W/O CC/MCC	0.7563	2.3	1.8	1
139	No	No	SALIVARY GLAND PROCEDURES	0.8963	1.5	1.4	1
140	No	No	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.4672	2.7	2.3	1
141	No	No	BRONCHITIS & ASTHMA AGE 0-17	0.4002	2.4	2.0	1
142	No	No	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	2.7449	8.1	3.4	1

Notes: (1) * = low volume DRG with fewer than 10 cases. The Medicare weights are used for these DRGs.
(2) # = PM-DRGs with fewer than 10 cases. An average weight over the past five years were used for these DRGs.
(3) w CC = with Complications or Comorbidities.
(4) w/o CC = without Complications or Comorbidities.

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CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
143	No	No	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE 0-17	0.9589	4.1	3.0	1
144	No	No	HERNIA PROCEDURES AGE 0-17	0.6106	2.0	1.5	1
145	No	No	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.3994	2.5	1.9	1
146	No	No	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	1.3891	6.4	5.3	1
147	No	No	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.1795	6.0	4.6	1
148	No	No	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.8953*	3.3	2.4	3
149	No	No	DYSEQUILIBRIUM	0.7057	2.1	1.8	1
150	No	No	EPISTAXIS W MCC	1.4217*	5.0	3.7	2
151	No	No	EPISTAXIS W/O MCC	0.6255	2.3	1.9	1
152	No	No	OTITIS MEDIA & URI AGE >17 W MCC	0.7911	3.8	3.3	1
153	No	No	OTITIS MEDIA & URI AGE >17 W/O MCC	0.5345	2.5	2.1	1
154	No	No	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17 W MCC	0.9052	3.9	2.9	1
155	No	No	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17 W CC	0.6866	2.7	2.3	1
156	No	No	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17 W/O CC/MCC	0.5825	2.3	1.9	1
157	No	No	DENTAL & ORAL DISEASES AGE >17 W MCC	1.9074	6.0	4.3	1
158	No	No	DENTAL & ORAL DISEASES AGE >17 W CC	0.9269	3.6	2.7	1
159	No	No	DENTAL & ORAL DISEASES AGE >17 W/O CC/MCC	0.7379	2.6	2.0	1
160	No	No	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.5575	2.9	1.9	1
161	No	No	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.3546	3.1	2.4	1
162	No	No	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	0.9497	1.8	1.5	1
163	Yes	No	MAJOR CHEST PROCEDURES W MCC	4.5039	11.8	9.8	2
164	Yes	No	MAJOR CHEST PROCEDURES W CC	2.3144	6.3	5.3	1
165	Yes	No	MAJOR CHEST PROCEDURES W/O CC/MCC	1.6311	4.1	3.3	1
166	Yes	No	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.9375	11.4	8.3	1
167	Yes	No	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.1237	6.4	5.1	1
168	Yes	No	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2841	4.0	3.1	1
169	No	No	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH AGE 0-17	0.4413	1.5	1.3	1
170	No	No	CELLULITIS AGE 0-17	0.4250	2.5	2.1	1
171	No	No	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.6266	1.7	1.5	1
172	No	No	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.3334	2.5	1.9	1
173	No	No	URETHRAL PROCEDURES AGE 0-17	0.7732#	3.0	2.6	2
174	No	No	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4411	2.9	2.5	1
175	Yes	No	PULMONARY EMBOLISM W MCC	1.8252	6.6	5.4	1
176	Yes	No	PULMONARY EMBOLISM W/O MCC	0.9862	4.2	3.6	1
177	No	No	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W MCC	2.3630	9.3	7.1	1
178	No	No	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6396	6.8	5.5	1
179	No	No	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC/MCC	1.1450	5.2	3.8	1
180	No	No	RESPIRATORY NEOPLASMS W MCC	2.1110	7.7	5.7	1
181	No	No	RESPIRATORY NEOPLASMS W CC	1.2831	5.4	4.0	1
182	No	No	RESPIRATORY NEOPLASMS W/O CC/MCC	1.0069	4.2	3.1	1
183	No	No	MAJOR CHEST TRAUMA W MCC	1.5871	5.3	3.9	1
184	No	No	MAJOR CHEST TRAUMA W CC	0.9189	3.3	2.7	1
185	No	No	MAJOR CHEST TRAUMA W/O CC/MCC	0.7393	2.0	1.7	1
186	Yes	No	PLEURAL EFFUSION W MCC	1.5473	6.2	4.5	1
187	Yes	No	PLEURAL EFFUSION W CC	1.1369	4.3	3.3	1
188	Yes	No	PLEURAL EFFUSION W/O CC/MCC	0.8518	3.1	2.5	1
189	No	No	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2201	4.9	3.8	1
190	Yes	No	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.2035	5.2	4.1	1
191	Yes	No	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	1.0258	4.3	3.5	1
192	Yes	No	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7596	3.4	2.8	1

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
193	No	No	SIMPLE PNEUMONIA & PLEURISY AGE >17 W MCC	1.5532	6.0	4.9	1
194	No	No	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.9976	4.2	3.5	1
195	No	No	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC/MCC	0.6650	3.0	2.6	1
196	Yes	No	INTERSTITIAL LUNG DISEASE W MCC	1.6919	7.0	5.6	1
197	Yes	No	INTERSTITIAL LUNG DISEASE W CC	1.1322	4.4	3.7	1
198	Yes	No	INTERSTITIAL LUNG DISEASE W/O CC/MCC	1.0981	4.0	3.2	1
199	No	No	PNEUMOTHORAX W MCC	1.6490	6.1	5.0	1
200	No	No	PNEUMOTHORAX W CC	0.9180	3.8	3.1	1
201	No	No	PNEUMOTHORAX W/O CC/MCC	0.5965	3.1	2.5	1
202	No	No	BRONCHITIS & ASTHMA AGE >17 W CC/MCC	0.8868	4.0	3.1	1
203	No	No	BRONCHITIS & ASTHMA AGE >17 W/O CC/MCC	0.6032	2.8	2.4	1
204	No	No	RESPIRATORY SIGNS & SYMPTOMS	0.6465	2.3	1.8	1
205	Yes	No	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.2846	4.9	3.4	1
206	Yes	No	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.7694	2.5	1.9	1
207	Yes	No	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	5.9663	14.6	12.6	4
208	No	No	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	2.1737	5.7	4.2	1
209	No	No	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3291	1.6	1.4	1
210	No	No	URETHRAL STRICTURE AGE 0-17	0.4968#	1.9	1.9	2
211	No	No	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.7937	4.2	3.2	1
212	No	No	TESTES PROCEDURES AGE 0-17	0.6958	1.7	1.4	1
213	No	No	SPLENECTOMY AGE 0-17	1.3016	2.9	2.7	1
214	No	No	RED BLOOD CELL DISORDERS AGE 0-17	0.5430	3.5	2.7	1
215	No	No	OTHER HEART ASSIST SYSTEM IMPLANT	13.9955*	12.2	6.9	6
216	Yes	No	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	11.8954	17.7	14.9	4
217	Yes	No	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	7.1227	9.7	8.8	3
218	Yes	No	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.5332	7.8	6.8	2
219	Yes	Yes	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	7.3745	10.3	8.2	2
220	Yes	Yes	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.0798	6.7	6.0	2
221	Yes	Yes	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.5027	5.1	4.8	2
222	No	No	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.3613	10.4	8.7	2
223	No	No	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.7196	4.9	4.1	1
224	No	No	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	6.9256	8.1	6.8	2
225	No	No	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.9201	4.2	3.6	1
226	No	No	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.9348	8.0	4.8	1
227	No	No	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.1170	2.7	1.9	1
228	Yes	No	OTHER CARDIOTHORACIC PROCEDURES W MCC	6.3959	10.5	8.2	2
229	Yes	No	OTHER CARDIOTHORACIC PROCEDURES W CC	4.3948	6.7	5.4	1
230	Yes	No	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	3.1630	4.3	3.6	1
231	No	No	CORONARY BYPASS W PTCA W MCC	7.6904	10.9	9.7	3
232	No	No	CORONARY BYPASS W PTCA W/O MCC	6.6250	8.4	8.0	4
233	Yes	No	CORONARY BYPASS W CARDIAC CATH W MCC	7.1526	11.5	10.2	3
234	Yes	No	CORONARY BYPASS W CARDIAC CATH W/O MCC	5.0750	7.6	7.2	3
235	Yes	No	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.2944	8.2	7.5	3
236	Yes	No	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.9746	5.7	5.4	2

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
237	No	No	MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	5.7349	9.7	6.7	1
238	No	No	MAJOR CARDIOVASC PROCEDURES W/O MCC	2.9933	4.2	3.2	1
239	Yes	No	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	5.3150	13.4	9.6	1
240	Yes	No	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.7470	10.1	8.8	3
241	Yes	No	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/ MCC	1.6240*	6.0	5.0	7
242	Yes	No	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	4.0598	6.2	4.9	1
243	Yes	No	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	3.0637	4.0	3.1	1
244	Yes	No	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.2038	2.3	2.0	1
245	No	No	AICD GENERATOR PROCEDURES	4.6619	3.6	2.3	1
246	No	No	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/ STENTS	3.6812	3.9	2.8	1
247	No	No	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2.6203	2.1	1.8	1
248	No	No	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	3.3588	4.9	3.6	1
249	No	No	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	2.2823	2.4	2.0	1
250	No	No	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	3.1904	5.9	4.1	1
251	No	No	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	2.6135	2.3	1.8	1
252	No	No	OTHER VASCULAR PROCEDURES W MCC	3.5574	7.2	4.8	1
253	No	No	OTHER VASCULAR PROCEDURES W CC	2.7635	5.0	3.7	1
254	No	No	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.9762	2.4	1.9	1
255	Yes	No	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.7798*	9.2	7.0	4
256	Yes	No	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.3836	5.5	4.1	1
257	Yes	No	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/ MCC	1.0823*	4.3	3.4	4
258	No	No	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	3.2057*	7.0	5.2	2
259	No	No	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	2.0351*	3.2	2.4	2
260	No	No	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	2.3078	6.6	6.0	2
261	No	No	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.8469	4.9	3.3	1
262	No	No	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/ MCC	1.1623	2.8	2.1	1
263	No	No	VEIN LIGATION & STRIPPING	1.5683	3.6	2.6	1
264	Yes	No	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	3.2683	10.7	6.7	1
265	No	No	AICD LEAD PROCEDURES	3.5814	2.7	2.1	1
266	No	No	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	5.5898	16.3	9.7	1
267	No	No	VIRAL ILLNESS & FEVER AGE 0-17	0.3647	2.3	2.0	1
268	No	No	SEPTICEMIA OR SEVERE SEPSIS AGE 0-17	1.2551	5.5	3.9	1
269	No	No	TRAUMATIC INJURY AGE 0-17	0.4184	1.4	1.3	1
270	No	No	ALLERGIC REACTIONS AGE 0-17	0.2586	1.5	1.3	1
271	No	No	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.3733	1.8	1.4	1
280	Yes	No	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	2.2712	6.5	4.7	1
281	Yes	No	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1.3600	3.3	2.6	1
282	Yes	No	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	1.0568	2.0	1.7	1
283	No	No	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	2.2096	4.4	3.0	1
284	No	No	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.9866*	3.0	2.1	2
285	No	No	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.6340*	1.8	1.4	2
286	No	No	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	2.1289	5.5	4.0	1
287	No	No	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.2297	2.3	1.9	1
288	Yes	No	ACUTE & SUBACUTE ENDOCARDITIS W MCC	4.5787	12.9	9.7	1
289	Yes	No	ACUTE & SUBACUTE ENDOCARDITIS W CC	2.0526*	7.8	6.4	4

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
290	Yes	No	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.4384*	5.6	4.4	4
291	Yes	No	HEART FAILURE & SHOCK W MCC	1.6120	6.0	4.4	1
292	Yes	No	HEART FAILURE & SHOCK W CC	1.0280	4.3	3.5	1
293	Yes	No	HEART FAILURE & SHOCK W/O CC/MCC	0.7101	2.8	2.4	1
294	No	No	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	0.8088	6.0	4.2	1
295	No	No	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.7107*	4.0	3.4	3
296	No	No	CARDIAC ARREST, UNEXPLAINED W MCC	1.8271	3.6	2.0	1
297	No	No	CARDIAC ARREST, UNEXPLAINED W CC	1.3671	1.8	1.5	1
298	No	No	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4992*	1.2	1.1	2
299	Yes	No	PERIPHERAL VASCULAR DISORDERS W MCC	1.0973	4.6	3.7	1
300	Yes	No	PERIPHERAL VASCULAR DISORDERS W CC	0.8596	4.0	3.3	1
301	Yes	No	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.6427	3.1	2.5	1
302	No	No	ATHEROSCLEROSIS W MCC	1.0562	3.0	2.3	1
303	No	No	ATHEROSCLEROSIS W/O MCC	0.6357	1.8	1.6	1
304	No	No	HYPERTENSION W MCC	1.1617	4.5	3.4	1
305	No	No	HYPERTENSION W/O MCC	0.6397	2.2	1.8	1
306	No	No	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W MCC	1.0348	5.0	3.9	1
307	No	No	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O MCC	0.8185	2.7	2.2	1
308	No	No	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2481	4.7	3.6	1
309	No	No	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7581	2.8	2.2	1
310	No	No	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5386	1.9	1.6	1
311	No	No	ANGINA PECTORIS	0.5799	1.7	1.5	1
312	No	No	SYNCOPE & COLLAPSE	0.7602	2.3	1.9	1
313	No	No	CHEST PAIN	0.6174	1.6	1.4	1
314	Yes	No	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	2.1470	7.5	5.5	1
315	Yes	No	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0590	4.2	3.1	1
316	Yes	No	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.5950	2.1	1.8	1
326	No	No	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W MCC	5.6411	14.6	10.3	1
327	No	No	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC	2.5650	7.2	5.2	1
328	No	No	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W/O CC/MCC	1.5117	2.9	2.2	1
329	Yes	No	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	5.0604	14.0	10.7	2
330	Yes	No	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.4396	7.9	6.6	2
331	Yes	No	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6218	4.6	4.1	1
332	Yes	No	RECTAL RESECTION W MCC	7.5368	16.1	12.0	2
333	Yes	No	RECTAL RESECTION W CC	2.2769	6.5	5.7	2
334	Yes	No	RECTAL RESECTION W/O CC/MCC	1.7772	4.5	4.1	1
335	Yes	No	PERITONEAL ADHESIOLYSIS W MCC	3.7531	10.6	8.4	1
336	Yes	No	PERITONEAL ADHESIOLYSIS W CC	2.0781	7.0	5.6	1
337	Yes	No	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.3784	3.8	3.1	1
338	No	No	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	2.8156	8.1	6.7	1
339	No	No	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.9565	6.7	5.6	1
340	No	No	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.2818	3.5	3.0	1
341	No	No	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	1.6428	3.6	2.8	1
342	No	No	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.2897	2.8	2.2	1
343	No	No	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0.9932	1.6	1.4	1
344	No	No	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	2.8989	9.8	7.8	2
345	No	No	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.4233	5.8	4.9	1
346	No	No	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.1414	4.3	3.8	1
347	No	No	ANAL & STOMAL PROCEDURES W MCC	1.7875	6.1	4.7	1
348	No	No	ANAL & STOMAL PROCEDURES W CC	1.2010	4.0	3.0	1

Notes: (1) * = low volume DRG with fewer than 10 cases. The Medicare weights are used for these DRGs.
(2) # = PM-DRGs with fewer than 10 cases. An average weight over the past five years were used for these DRGs.
(3) w CC = with Complications or Comorbidities.
(4) w/o CC = without Complications or Comorbidities.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
349	No	No	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.8099	2.6	2.1	1
350	No	No	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W MCC	1.8753#	4.4	3.8	2
351	No	No	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.5769	3.5	2.7	1
352	No	No	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC/MCC	1.0882	2.0	1.7	1
353	No	No	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W MCC	3.1851	7.9	5.6	1
354	No	No	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.5813	4.1	3.4	1
355	No	No	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC/MCC	1.2460	2.6	2.2	1
356	Yes	No	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.6168	11.1	8.3	1
357	Yes	No	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.0852	6.3	4.8	1
358	Yes	No	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3122	3.5	2.9	1
368	No	No	MAJOR ESOPHAGEAL DISORDERS W MCC	2.0320	5.6	4.0	1
369	No	No	MAJOR ESOPHAGEAL DISORDERS W CC	0.7935	3.2	2.6	1
370	No	No	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.5991	2.2	1.9	1
371	Yes	No	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	2.2263	8.0	6.3	1
372	Yes	No	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.1336	5.3	4.2	1
373	Yes	No	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.7882	3.8	3.2	1
374	Yes	No	DIGESTIVE MALIGNANCY W MCC	2.6960	8.9	6.1	1
375	Yes	No	DIGESTIVE MALIGNANCY W CC	1.5774	5.6	4.1	1
376	Yes	No	DIGESTIVE MALIGNANCY W/O CC/MCC	0.8477	3.5	2.7	1
377	Yes	No	G.I. HEMORRHAGE W MCC	2.0022	6.1	4.3	1
378	Yes	No	G.I. HEMORRHAGE W CC	0.9653	3.5	2.9	1
379	Yes	No	G.I. HEMORRHAGE W/O CC/MCC	0.6773	2.4	2.1	1
380	Yes	No	COMPLICATED PEPTIC ULCER W MCC	1.4586	5.8	4.8	1
381	Yes	No	COMPLICATED PEPTIC ULCER W CC	1.1223	4.6	3.6	1
382	Yes	No	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.7632	3.3	2.6	1
383	No	No	UNCOMPLICATED PEPTIC ULCER W MCC	1.4165	6.4	3.7	1
384	No	No	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8924	3.2	2.5	1
385	No	No	INFLAMMATORY BOWEL DISEASE W MCC	1.7772	7.2	5.2	1
386	No	No	INFLAMMATORY BOWEL DISEASE W CC	1.0618	4.9	3.9	1
387	No	No	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.7778	3.6	3.1	1
388	Yes	No	G.I. OBSTRUCTION W MCC	1.7057	7.1	5.1	1
389	Yes	No	G.I. OBSTRUCTION W CC	0.8993	4.1	3.3	1
390	Yes	No	G.I. OBSTRUCTION W/O CC/MCC	0.5977	2.8	2.3	1
391	No	No	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W MCC	1.1536	4.5	3.4	1
392	No	No	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O MCC	0.7559	2.9	2.4	1
393	No	No	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W MCC	1.6041	6.3	4.5	1
394	No	No	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9159	4.0	3.1	1
395	No	No	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC/MCC	0.7223	2.8	2.2	1
405	Yes	No	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	6.1788	15.8	10.8	1
406	Yes	No	PANCREAS, LIVER & SHUNT PROCEDURES W CC	3.0704	7.4	6.2	1
407	Yes	No	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	1.8368	4.4	3.7	1
408	No	No	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	3.8154	10.0	8.3	2
409	No	No	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.2683	6.7	5.9	2
410	No	No	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.7087	5.8	5.2	2
411	No	No	CHOLECYSTECTOMY W C.D.E. W MCC	4.0868*	11.8	9.9	4
412	No	No	CHOLECYSTECTOMY W C.D.E. W CC	1.8713	5.9	4.5	1
413	No	No	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.4260	4.0	3.4	1

Notes: (1) * = low volume DRG with fewer than 10 cases. The Medicare weights are used for these DRGs.
(2) # = PM-DRGs with fewer than 10 cases. An average weight over the past five years were used for these DRGs.
(3) w CC = with Complications or Comorbidities.
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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARTH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
414	Yes	No	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.0202	8.6	7.4	2
415	Yes	No	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0853	5.9	5.1	1
416	Yes	No	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.3041	3.8	3.3	1
417	No	No	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	1.9923	5.0	4.0	1
418	No	No	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6894	4.0	3.2	1
419	No	No	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.2641	2.5	2.1	1
420	No	No	HEPATOBIILIARY DIAGNOSTIC PROCEDURES W MCC	4.4135	16.6	10.6	1
421	No	No	HEPATOBIILIARY DIAGNOSTIC PROCEDURES W CC	2.5789	8.7	5.6	1
422	No	No	HEPATOBIILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.2179	3.7	3.4	1
423	No	No	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES W MCC	5.9921	16.2	12.3	2
424	No	No	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES W CC	2.1920	6.7	5.4	1
425	No	No	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.8063*	5.7	4.4	7
432	No	No	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	2.0890	7.3	5.1	1
433	No	No	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	1.0872	5.3	4.0	1
434	No	No	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6829*	3.2	2.5	3
435	No	No	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS W MCC	1.5301	5.5	4.2	1
436	No	No	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS W CC	1.2586	4.9	3.7	1
437	No	No	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS W/O CC/MCC	1.2584	4.7	3.3	1
438	No	No	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	2.2308	8.1	5.9	1
439	No	No	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	1.0707	4.9	3.9	1
440	No	No	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.7411	3.3	2.7	1
441	Yes	No	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	2.5374	8.5	5.7	1
442	Yes	No	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.1311	4.6	3.5	1
443	Yes	No	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6564	3.0	2.5	1
444	No	No	DISORDERS OF THE BILIARY TRACT W MCC	1.4515	4.8	3.6	1
445	No	No	DISORDERS OF THE BILIARY TRACT W CC	0.9631	3.5	2.9	1
446	No	No	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.6916	2.3	1.9	1
453	No	No	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	11.3232	14.2	11.0	3
454	No	No	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	7.2705	5.2	4.4	1
455	No	No	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.3617	3.1	2.6	1
456	No	No	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	7.6248	10.4	8.4	2
457	No	No	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	6.6520	6.2	5.5	2
458	No	No	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	5.8243	4.3	4.0	1
459	Yes	No	SPINAL FUSION EXCEPT CERVICAL W MCC	6.2512	7.1	6.2	2
460	Yes	No	SPINAL FUSION EXCEPT CERVICAL W/O MCC	4.0602	3.1	2.7	1
461	No	No	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	5.4817*	8.2	6.7	3
462	No	No	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.3359	4.0	3.8	1
463	Yes	No	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	7.1312	20.8	13.6	2
464	Yes	No	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	3.4541	8.7	6.6	1
465	Yes	No	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.9088	4.3	3.4	1
466	Yes	No	REVISION OF HIP OR KNEE REPLACEMENT W MCC	5.4345	8.8	6.9	1
467	Yes	No	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.0888	4.0	3.6	1
468	Yes	No	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.5388	3.2	2.9	1
469	Yes	No	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	3.1526	6.1	5.2	1

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
470	Yes	No	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.1474	3.1	2.9	1
471	No	No	CERVICAL SPINAL FUSION W MCC	4.0914	6.0	4.1	1
472	No	No	CERVICAL SPINAL FUSION W CC	2.6255	2.3	1.7	1
473	No	No	CERVICAL SPINAL FUSION W/O CC/MCC	2.0714	1.3	1.2	1
474	Yes	No	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.9748	13.8	11.1	2
475	Yes	No	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	1.8618	7.1	5.5	1
476	Yes	No	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.1273	2.9	2.2	1
477	Yes	Yes	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	4.2174	16.5	10.6	1
478	Yes	Yes	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.5175	6.9	4.9	1
479	Yes	Yes	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.7830	3.7	2.6	1
480	No	No	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W MCC	3.3865	7.2	5.9	1
481	No	No	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	2.2378	5.3	4.6	1
482	No	No	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC/MCC	1.5555	3.2	2.6	1
483	Yes	No	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	2.7277	3.0	2.5	1
484	Yes	No	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	1.9641	1.9	1.7	1
485	No	No	KNEE PROCEDURES W PDX OF INFECTION W MCC	2.6631	8.2	7.3	2
486	No	No	KNEE PROCEDURES W PDX OF INFECTION W CC	2.3673	7.3	5.9	1
487	No	No	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.2637	4.2	3.8	1
488	Yes	No	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	1.4872	3.1	2.8	1
489	Yes	No	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2966	2.1	1.8	1
490	No	No	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	2.0928	3.1	2.2	1
491	No	No	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.1762	1.5	1.3	1
492	No	No	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W MCC	3.7089	8.5	6.5	1
493	No	No	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	2.1035	4.3	3.5	1
494	No	No	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC/MCC	1.4121	2.6	2.2	1
495	Yes	Yes	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	3.8876	9.8	5.2	1
496	Yes	Yes	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.5981	4.0	3.1	1
497	Yes	Yes	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.1749	2.1	1.6	1
498	No	No	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	1.9931	4.8	3.5	1
499	No	No	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	0.9457	2.0	1.6	1
500	Yes	Yes	SOFT TISSUE PROCEDURES W MCC	3.1836	8.6	6.2	1
501	Yes	Yes	SOFT TISSUE PROCEDURES W CC	1.3571	4.3	3.2	1
502	Yes	Yes	SOFT TISSUE PROCEDURES W/O CC/MCC	1.1277	2.3	1.9	1
503	No	No	FOOT PROCEDURES W MCC	2.5318*	8.5	6.5	2
504	No	No	FOOT PROCEDURES W CC	1.8619	4.3	3.6	1
505	No	No	FOOT PROCEDURES W/O CC/MCC	1.2984	2.5	2.0	1
506	No	No	MAJOR THUMB OR JOINT PROCEDURES	1.1377	2.4	2.0	1
507	No	No	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.3731	3.6	3.3	1
508	No	No	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.3648	2.0	1.6	1
509	No	No	ARTHROSCOPY	1.4594*	3.5	2.3	1
510	Yes	No	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.4005	4.8	3.9	1
511	Yes	No	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.6780	2.6	2.2	1

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(3) w CC = with Complications or Comorbidities.
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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
512	Yes	No	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.1713	1.7	1.5	1
513	No	No	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.0886	2.7	2.1	1
514	No	No	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.9068	2.3	1.8	1
515	Yes	Yes	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.2624	8.7	5.1	1
516	Yes	Yes	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.3921	5.4	4.0	1
517	Yes	Yes	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.5681	2.7	2.2	1
533	Yes	No	FRACTURES OF FEMUR W MCC	1.7379*	6.5	4.9	2
534	Yes	No	FRACTURES OF FEMUR W/O MCC	0.5409	1.9	1.6	1
535	Yes	No	FRACTURES OF HIP & PELVIS W MCC	0.9346	3.9	3.1	1
536	Yes	No	FRACTURES OF HIP & PELVIS W/O MCC	0.6984	2.9	2.4	1
537	No	No	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.9185*	4.1	3.5	1
538	No	No	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.7157	2.0	1.6	1
539	Yes	No	OSTEOMYELITIS W MCC	2.0049	8.6	7.4	2
540	Yes	No	OSTEOMYELITIS W CC	1.4770	7.0	5.1	1
541	Yes	No	OSTEOMYELITIS W/O CC/MCC	0.7539	4.0	3.2	1
542	Yes	No	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	3.5084	12.1	8.2	1
543	Yes	No	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.4344	6.0	4.3	1
544	Yes	No	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.9903	3.7	2.9	1
545	Yes	No	CONNECTIVE TISSUE DISORDERS W MCC	3.7800	11.2	6.8	1
546	Yes	No	CONNECTIVE TISSUE DISORDERS W CC	1.2652	4.9	3.8	1
547	Yes	No	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.8528	3.3	2.5	1
548	No	No	SEPTIC ARTHRITIS W MCC	2.1809*	8.8	6.7	3
549	No	No	SEPTIC ARTHRITIS W CC	0.9696	4.8	4.0	1
550	No	No	SEPTIC ARTHRITIS W/O CC/MCC	0.6160	3.7	3.2	1
551	Yes	No	MEDICAL BACK PROBLEMS W MCC	1.6331	5.4	3.9	1
552	Yes	No	MEDICAL BACK PROBLEMS W/O MCC	0.7354	2.8	2.3	1
553	No	No	BONE DISEASES & ARTHROPATHIES W MCC	1.2604*	5.5	4.3	3
554	No	No	BONE DISEASES & ARTHROPATHIES W/O MCC	0.7529	2.9	2.4	1
555	No	No	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	0.8099	3.1	2.5	1
556	No	No	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.6979	2.7	2.0	1
557	Yes	No	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.1567	5.7	4.3	1
558	Yes	No	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.6780	3.3	2.6	1
559	Yes	No	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.5719	5.8	4.1	1
560	Yes	No	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	0.6897	3.6	2.6	1
561	Yes	No	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.6111	2.0	1.6	1
562	No	No	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH AGE >17 W MCC	1.6984	6.0	4.1	1
563	No	No	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH AGE >17 W/O MCC	0.7768	2.6	2.0	1
564	No	No	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	2.4093	7.7	4.3	1
565	No	No	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9419	3.4	2.6	1
566	No	No	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.5162	2.0	1.7	1
573	Yes	No	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W MCC	2.7862	11.4	8.4	1
574	Yes	No	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.8453	7.7	5.9	1

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
575	Yes	No	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC/MCC	1.0051	4.1	3.4	1
576	No	No	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W MCC	4.3565*	13.0	9.1	2
577	No	No	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W CC	2.3029	6.4	4.7	1
578	No	No	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.4190	2.8	2.1	1
579	Yes	No	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.5010	8.4	6.3	1
580	Yes	No	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.5354	3.8	2.7	1
581	Yes	No	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	1.3973	2.3	1.9	1
582	No	No	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.7358	2.3	1.9	1
583	No	No	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	1.6393	1.9	1.7	1
584	No	No	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.8496	3.4	2.5	1
585	No	No	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.5306	2.2	1.8	1
592	Yes	No	SKIN ULCERS W MCC	1.1412	5.2	4.2	1
593	Yes	No	SKIN ULCERS W CC	0.9183	5.3	4.4	1
594	Yes	No	SKIN ULCERS W/O CC/MCC	0.7913	3.5	3.0	1
595	No	No	MAJOR SKIN DISORDERS W MCC	2.0746*	7.8	5.9	3
596	No	No	MAJOR SKIN DISORDERS W/O MCC	0.7335	4.0	3.0	1
597	No	No	MALIGNANT BREAST DISORDERS W MCC	1.3925	7.9	6.4	1
598	No	No	MALIGNANT BREAST DISORDERS W CC	0.8670	4.7	3.4	1
599	No	No	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6954*	3.2	2.5	3
600	No	No	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.8828	4.2	3.5	1
601	No	No	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.5032	2.9	2.5	1
602	No	No	CELLULITIS AGE >17 W MCC	1.3114	6.0	4.8	1
603	No	No	CELLULITIS AGE >17 W/O MCC	0.6995	3.7	3.1	1
604	No	No	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W MCC	1.1712	3.7	2.7	1
605	No	No	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O MCC	0.8092	1.9	1.5	1
606	No	No	MINOR SKIN DISORDERS W MCC	1.4776	6.5	3.9	1
607	No	No	MINOR SKIN DISORDERS W/O MCC	0.4558	2.8	2.3	1
608	No	No	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD	1.5275#	11.2	9.0	5
609	No	No	OTHER RESPIRATORY PROBLEMS AFTER BIRTH	0.9060#	6.0	4.5	3
610	No	No	NEONATE, DIED W/IN ONE DAY OF BIRTH	0.1962	1.0	1.0	1
611	No	No	NEONATE, TRANSFERRED <5 DAYS OLD	0.2588	1.2	1.1	1
612	No	No	NEONATE, BIRTHWT <750G, DISCHARGED ALIVE	27.9016	95.8	78.3	16
613	No	No	NEONATE, BIRTHWT <750G, DIED	4.2947	9.7	3.3	1
614	No	No	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.0767	4.3	3.6	1
615	No	No	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.5796	2.8	2.5	1
616	Yes	No	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.9877*	15.6	12.4	4
617	Yes	No	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.2303	7.0	6.0	2
618	Yes	No	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.3327*	5.1	4.1	4
619	No	No	O.R. PROCEDURES FOR OBESITY W MCC	3.4812	4.8	3.8	1
620	No	No	O.R. PROCEDURES FOR OBESITY W CC	2.1568	2.8	2.3	1
621	No	No	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.7503	1.7	1.5	1
622	Yes	No	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.7924*	12.5	9.4	4
623	Yes	No	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.6711	6.0	5.2	1
624	Yes	No	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.1235*	4.7	3.8	4

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
625	No	No	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.5604	6.5	4.8	1
626	No	No	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.2444	2.0	1.7	1
627	No	No	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	0.9802	1.4	1.2	1
628	Yes	No	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	5.3336	11.9	7.0	1
629	Yes	No	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.9506	7.0	5.6	1
630	Yes	No	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.7619	3.3	2.5	1
631	No	No	NEONATE, BIRTHWT 750-999G, DISCHARGED ALIVE	16.6234	74.3	66.6	23
632	No	No	NEONATE, BIRTHWT 750-999G, DIED	6.9116#	16.0	12.1	9
633	No	No	NEONATE, BIRTHWT 1000-1499G, W SIGNIF O.R. PROC, DISCHARGED ALIVE	18.0062	79.1	73.8	35
634	No	No	NEONATE, BIRTHWT 1000-1499G, W/O SIGNIF O.R. PROC, DISCHARGED ALIVE	7.9711	42.3	37.6	13
635	No	No	NEONATE, BIRTHWT 1000-1499G, DIED	5.5977	11.6	4.6	1
636	No	No	NEONATE, BIRTHWT 1500-1999G, W SIGNIF O.R. PROC, W MULT MAJOR PROB	14.4921	51.4	39.7	8
637	Yes	No	DIABETES W MCC	1.6803	6.2	4.4	1
638	Yes	No	DIABETES W CC	0.7471	3.4	2.7	1
639	Yes	No	DIABETES W/O CC/MCC	0.4802	2.3	2.0	1
640	No	No	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W MCC	1.1553	4.7	3.4	1
641	No	No	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O MCC	0.6244	2.9	2.3	1
642	No	No	INBORN ERRORS OF METABOLISM	0.9953	3.9	2.7	1
643	Yes	No	ENDOCRINE DISORDERS W MCC	1.6949	6.2	4.7	1
644	Yes	No	ENDOCRINE DISORDERS W CC	0.9404	4.1	3.1	1
645	Yes	No	ENDOCRINE DISORDERS W/O CC/MCC	0.5704	2.4	2.0	1
646	No	No	NEONATE, BIRTHWT 1500-1999G, W SIGNIF O.R. PROC, W/O MULT MAJOR PROB	5.0203#	26.7	23.6	13
647	No	No	NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF O.R. PROC, W MULT MAJOR PROB	5.8576	27.7	23.0	5
648	No	No	NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF O.R. PROC, W MAJOR PROB	3.6052	21.8	19.0	6
649	No	No	NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF O.R. PROC, W MINOR PROB	1.7482	16.5	14.2	4
650	No	No	NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF O.R. PROC, W OTHER PROB	1.9593	14.3	11.0	2
651	No	No	NEONATE, BIRTHWT 2000-2499G, W SIGNIF O.R. PROC, W MULT MAJOR PROB	6.6692	29.4	25.1	8
652	No	No	KIDNEY TRANSPLANT	3.0197	5.9	5.4	2
653	Yes	No	MAJOR BLADDER PROCEDURES W MCC	5.3633	13.5	11.5	3
654	Yes	No	MAJOR BLADDER PROCEDURES W CC	2.6525	7.8	6.7	2
655	Yes	No	MAJOR BLADDER PROCEDURES W/O CC/MCC	1.6319	4.5	3.7	1
656	No	No	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.7968	8.8	6.7	1
657	No	No	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	2.1092	4.7	4.2	1
658	No	No	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.5461	3.2	2.8	1
659	Yes	No	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	2.8432	9.1	6.7	1
660	Yes	No	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.5936	3.9	3.0	1
661	Yes	No	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.2810	2.2	1.9	1
662	No	No	MINOR BLADDER PROCEDURES W MCC	3.3475*	10.7	7.5	2
663	No	No	MINOR BLADDER PROCEDURES W CC	0.8818	2.5	2.1	1
664	No	No	MINOR BLADDER PROCEDURES W/O CC/MCC	1.1477	1.6	1.4	1
665	No	No	PROSTATECTOMY W MCC	3.1805*	11.3	8.7	3
666	No	No	PROSTATECTOMY W CC	1.8248*	6.4	4.5	3
667	No	No	PROSTATECTOMY W/O CC/MCC	0.8546	1.7	1.5	1
668	No	No	TRANSURETHRAL PROCEDURES W MCC	2.1447	6.0	4.3	1
669	No	No	TRANSURETHRAL PROCEDURES W CC	1.1283	2.5	2.0	1
670	No	No	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.8618	1.7	1.5	1
671	No	No	URETHRAL PROCEDURES AGE >17 W CC/MCC	1.2872#	3.3	3.1	2

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
672	No	No	URETHRAL PROCEDURES AGE >17 W/O CC/MCC	0.8452	1.7	1.4	1
673	No	No	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	3.5976	9.9	5.4	1
674	No	No	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.1493	6.1	4.1	1
675	No	No	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.5745	1.9	1.4	1
676	No	No	NEONATE, BIRTHWT 2000-2499G, W SIGNIF O.R. PROC, W/O MULT MAJOR PROB	4.0160#	20.5	17.6	11
677	No	No	NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF O.R. PROC, W MULT MAJOR PROB	3.5567	17.0	13.3	3
678	No	No	NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF O.R. PROC, W MAJOR PROB	1.9885	12.2	10.4	3
679	No	No	NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF O.R. PROC, W MINOR PROB	1.4745	10.5	8.0	1
680	No	No	NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF O.R. PROC, W OTHER PROB	0.9344	7.0	5.1	1
681	No	No	NEONATE, BIRTHWT >2499G, W SIGNIF O.R. PROC, W MULT MAJOR PROB	8.9744	30.8	20.5	3
682	Yes	No	RENAL FAILURE W MCC	1.8341	6.7	4.8	1
683	Yes	No	RENAL FAILURE W CC	0.9848	4.3	3.4	1
684	Yes	No	RENAL FAILURE W/O CC/MCC	0.6645	2.8	2.3	1
685	No	No	ADMIT FOR RENAL DIALYSIS	0.8841	3.6	2.8	1
686	No	No	KIDNEY & URINARY TRACT NEOPLASMS W MCC	2.3763	8.6	6.5	1
687	No	No	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.9439	3.3	2.8	1
688	No	No	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.6350	2.3	1.8	1
689	No	No	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W MCC	1.1646	5.1	4.0	1
690	No	No	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O MCC	0.7020	3.2	2.6	1
691	No	No	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.1964	2.5	2.0	1
692	No	No	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1111	1.8	1.5	1
693	No	No	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.1523	3.4	2.9	1
694	No	No	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.6611	1.9	1.6	1
695	No	No	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W MCC	0.8884#	3.2	3.2	2
696	No	No	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O MCC	0.7496	3.2	2.4	1
697	No	No	URETHRAL STRICTURE AGE >17	0.6383	2.3	1.8	1
698	No	No	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W MCC	1.7733	7.1	4.9	1
699	No	No	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0091	4.1	3.2	1
700	No	No	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC/MCC	0.7272	2.5	2.0	1
707	No	No	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.9848	3.1	2.5	1
708	No	No	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.5846	1.6	1.4	1
709	No	No	PENIS PROCEDURES W CC/MCC	1.2562	2.8	1.9	1
710	No	No	PENIS PROCEDURES W/O CC/MCC	1.3823	1.7	1.4	1
711	No	No	TESTES PROCEDURES AGE >17 W CC/MCC	1.9352	4.9	4.1	1
712	No	No	TESTES PROCEDURES AGE >17 W/O CC/MCC	0.8316	1.5	1.3	1
713	No	No	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.0232	2.8	2.1	1
714	No	No	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.7768	1.5	1.4	1
715	No	No	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	1.9351*	6.0	4.1	1
716	No	No	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.2906	1.6	1.4	1
717	No	No	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.7913*	6.4	4.6	3
718	No	No	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	0.8929*	2.6	2.0	3
722	No	No	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.8749*	7.7	5.4	3
723	No	No	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.1311*	5.1	3.9	3
724	No	No	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6894*	2.7	2.1	3
725	No	No	BENIGN PROSTATIC HYPERTROPHY W MCC	1.4144*	6.1	4.7	2

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DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARTH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
726	No	No	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.4548	2.4	2.0	1
727	No	No	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.3444	7.7	4.9	1
728	No	No	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.5737	2.8	2.4	1
729	No	No	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	0.7462	2.4	2.2	1
730	No	No	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.7120*	2.9	2.3	2
734	No	No	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.1364	4.8	3.9	1
735	No	No	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.4709	2.2	1.9	1
736	No	No	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.5892	14.2	11.3	2
737	No	No	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	1.9881	6.0	5.0	1
738	No	No	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.3593	3.1	2.7	1
739	No	No	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	2.8145	6.3	5.3	1
740	No	No	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.6058	4.0	3.3	1
741	No	No	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.1834	2.0	1.8	1
742	No	No	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.3875	3.1	2.6	1
743	No	No	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	1.0680	1.9	1.7	1
744	No	No	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.0852	3.0	2.1	1
745	No	No	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	1.0248	2.0	1.6	1
746	No	No	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.2458	3.3	2.5	1
747	No	No	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	1.0008	1.7	1.5	1
748	No	No	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.0934	1.5	1.3	1
749	No	No	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.1814	6.4	5.4	1
750	No	No	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2134	2.6	2.3	1
754	No	No	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	2.2298	8.2	5.3	1
755	No	No	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1581	5.1	3.9	1
756	No	No	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7061*	3.1	2.3	3
757	No	No	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.8387*	7.8	6.0	2
758	No	No	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	0.9352	4.4	3.5	1
759	No	No	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.5316	2.6	2.2	1
760	No	No	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.7372	2.5	2.1	1
761	No	No	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.5013	1.7	1.5	1
765	No	No	CESAREAN SECTION W CC/MCC	0.8684	4.3	3.6	1
766	No	No	CESAREAN SECTION W/O CC/MCC	0.6787	2.9	2.8	1
767	No	No	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7079	2.4	2.2	1
768	No	No	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.0659	3.4	2.9	1
769	No	No	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.4133	3.8	3.0	1
770	No	No	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5719	1.4	1.2	1
774	No	No	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4960	2.7	2.4	1
775	No	No	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3995	2.1	1.9	1
776	No	No	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.5635	2.8	2.3	1
777	No	No	ECTOPIC PREGNANCY	0.8509	1.8	1.6	1
778	No	No	THREATENED ABORTION	0.4619	3.6	2.3	1
779	No	No	ABORTION W/O D&C	0.3543	1.5	1.3	1
780	No	No	FALSE LABOR	0.1865	1.3	1.2	1
781	No	No	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5191	3.1	2.2	1

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(2) # = PM-DRGs with fewer than 10 cases. An average weight over the past five years were used for these DRGs.
(3) w CC = with Complications or Comorbidities.
(4) w/o CC = without Complications or Comorbidities.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
782	No	No	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4177	2.9	1.9	1
787	No	No	NEONATE, BIRTHWT >2499G, W SIGNIF O.R. PROC, W/O MULT MAJOR PROB	1.8209	7.1	4.9	1
788	No	No	NEONATE, BIRTHWT >2499G, W MINOR ABDOM PROCEDURE	0.5545	2.4	2.2	1
789	No	No	NEONATE, BIRTHWT >2499G, W/O SIGNIF O.R. PROC, W MULT MAJOR PROB	2.2042	9.4	6.5	1
790	No	No	NEONATE, BIRTHWT >2499G, W/O SIGNIF O.R. PROC, W MAJOR PROB	0.7815	4.8	3.7	1
791	No	No	NEONATE, BIRTHWT >2499G, W/O SIGNIF O.R. PROC, W MINOR PROB	0.3693	3.1	2.6	1
792	No	No	NEONATE, BIRTHWT >2499G, W/O SIGNIF O.R. PROC, W OTHER PROB	0.2128	2.6	2.3	1
793	No	No	NEONATAL AFTERCARE FOR WEIGHT GAIN	0.4902#	7.9	7.2	5
794	No	No	NEONATAL DIAGNOSIS, AGE > 28 DAYS	3.1187	15.1	7.3	1
795	No	No	NORMAL NEWBORN	0.1105	2.0	1.9	1
796	No	No	MULTIPLE, OTHER AND UNSPECIFIED CONGENITAL ANOMALIES, W CC/ MCC	1.3776#	7.0	6.6	5
797	No	No	MULTIPLE, OTHER AND UNSPECIFIED CONGENITAL ANOMALIES, W/O CC/ MCC	0.6816#	3.5	4.9	5
799	No	No	SPLENECTOMY AGE >17 W MCC	4.1623#	9.8	8.5	4
800	No	No	SPLENECTOMY AGE >17 W CC	2.6942	6.3	5.2	1
801	No	No	SPLENECTOMY AGE >17 W/O CC/MCC	1.6294	3.9	3.2	1
802	No	No	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	4.0150*	12.1	8.5	3
803	No	No	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.9198	6.2	4.3	1
804	No	No	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/ MCC	1.1298	2.7	2.2	1
808	No	No	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.3169	8.2	6.0	1
809	No	No	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.1693	4.7	3.8	1
810	No	No	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.6641	3.2	2.7	1
811	No	No	RED BLOOD CELL DISORDERS AGE >17 W MCC	1.6032	6.1	4.3	1
812	No	No	RED BLOOD CELL DISORDERS AGE >17 W/O MCC	0.7477	3.4	2.5	1
813	No	No	COAGULATION DISORDERS	1.2216	3.2	2.4	1
814	No	No	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	4.2117	10.1	5.4	1
815	No	No	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9229	3.9	2.8	1
816	No	No	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.6031	3.0	2.4	1
820	No	No	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	8.2974	20.8	13.8	1
821	No	No	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.6039	7.7	5.5	1
822	No	No	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2984	2.8	2.1	1
823	No	No	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	6.4923	19.6	15.2	3
824	No	No	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.1032	6.5	5.1	1
825	No	No	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	1.7235	3.5	2.4	1
826	No	No	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	5.0160	15.1	11.6	2
827	No	No	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.3412	7.1	5.6	1
828	No	No	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/ MCC	2.0113	4.4	3.1	1
829	No	No	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/ MCC	2.9785	10.0	6.4	1
830	No	No	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	1.3471	3.7	3.0	1
834	No	No	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17 W MCC	8.2002	25.0	16.7	2
835	No	No	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17 W CC	4.9904	19.5	11.5	1
836	No	No	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17 W/O CC/MCC	1.9859	7.8	3.9	1
837	No	No	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	6.2365	22.4	16.4	3
838	No	No	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	2.8065	10.2	6.8	1

Notes: (1) * = low volume DRG with fewer than 10 cases. The Medicare weights are used for these DRGs.
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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARTH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
839	No	No	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.1596	5.3	4.3	1
840	Yes	No	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	4.6953	14.7	10.1	1
841	Yes	No	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.9900	6.7	4.7	1
842	Yes	No	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.2723	4.2	2.8	1
843	No	No	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	2.4031	8.2	6.3	1
844	No	No	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3085	5.5	3.8	1
845	No	No	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8724	3.9	3.0	1
846	No	No	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	3.1127	9.7	6.7	1
847	No	No	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.0674	3.7	3.1	1
848	No	No	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	1.1092	3.5	2.8	1
849	No	No	RADIOTHERAPY	0.9861	5.1	2.7	1
853	Yes	No	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	6.5981	15.8	12.2	2
854	Yes	No	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.5605	8.2	6.9	2
855	Yes	No	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.3892	4.7	3.9	1
856	Yes	No	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	5.0426	14.1	9.4	1
857	Yes	No	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	1.8205	6.4	4.7	1
858	Yes	No	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.2496	4.4	3.6	1
862	Yes	No	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.5725	6.2	4.8	1
863	Yes	No	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.8251	3.9	3.2	1
864	No	No	FEVER AGE >17	0.8306	3.3	2.6	1
865	No	No	VIRAL ILLNESS AGE >17 W MCC	2.0599	5.5	4.1	1
866	No	No	VIRAL ILLNESS AGE >17 W/O MCC	0.7309	3.1	2.5	1
867	Yes	No	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.5722	8.3	6.3	1
868	Yes	No	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	0.8620	3.8	3.3	1
869	Yes	No	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.8912	3.5	2.9	1
870	No	No	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS AGE >17	7.0338	15.2	13.2	4
871	No	No	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS AGE >17 W MCC	2.1547	6.7	5.0	1
872	No	No	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS AGE >17 W/O MCC	1.0672	4.5	3.7	1
876	No	No	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3.1239*	12.7	8.1	5
880	No	No	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6997	3.2	2.2	1
881	No	No	DEPRESSIVE NEUROSES	0.3570	4.0	3.0	1
882	No	No	NEUROSES EXCEPT DEPRESSIVE	0.3894	4.2	2.9	1
883	No	No	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.0887	11.5	6.1	1
884	Yes	No	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.9649	7.8	3.4	1
885	No	No	PSYCHOSES	0.6334	7.0	5.1	1
886	No	No	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.7596	11.1	7.6	1
887	No	No	OTHER MENTAL DISORDER DIAGNOSES	1.2462	14.5	6.6	1
894	No	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.3874	4.1	2.3	1
895	No	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	0.7557	16.0	12.5	2
896	Yes	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.5404	5.8	4.4	1
898	No	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY AGE >21 W/O MCC	0.4312	5.1	3.6	1
899	No	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY AGE <=21 W/O MCC	0.2981	5.8	3.8	1
901	No	No	WOUND DEBRIDEMENTS FOR INJURIES W MCC	5.1987	21.1	13.2	1
902	No	No	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.6457	5.9	4.2	1

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CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
903	No	No	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.2182	4.2	2.9	1
904	No	No	SKIN GRAFTS FOR INJURIES W CC/MCC	4.8632	14.7	7.1	1
905	No	No	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.2334	4.3	2.9	1
906	No	No	HAND PROCEDURES FOR INJURIES	1.2243	2.8	2.2	1
907	Yes	No	OTHER O.R. PROCEDURES FOR INJURIES W MCC	4.8845	11.8	8.0	1
908	Yes	No	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.9817	5.8	4.0	1
909	Yes	No	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.1736	2.6	2.1	1
913	No	No	TRAUMATIC INJURY AGE >17 W MCC	1.2178#	4.0	3.5	2
914	No	No	TRAUMATIC INJURY AGE >17 W/O MCC	0.7616	2.0	1.7	1
915	No	No	ALLERGIC REACTIONS AGE >17 W MCC	1.4817	4.1	3.0	1
916	No	No	ALLERGIC REACTIONS AGE >17 W/O MCC	0.4701	2.0	1.6	1
917	No	No	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W MCC	1.4386	4.0	2.9	1
918	No	No	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O MCC	0.5248	2.0	1.6	1
919	No	No	COMPLICATIONS OF TREATMENT W MCC	1.4877	5.2	3.5	1
920	No	No	COMPLICATIONS OF TREATMENT W CC	0.8962	3.8	2.7	1
921	No	No	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.5403	2.4	1.9	1
922	No	No	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.9380	4.6	3.2	1
923	No	No	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.6915	2.2	1.5	1
927	No	No	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	14.7971	33.1	20.2	2
928	No	No	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	4.6496	15.4	10.9	2
929	No	No	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	1.4761	6.3	4.0	1
933	No	No	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	2.4397*	5.1	2.3	3
934	No	No	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	0.8339	4.1	2.7	1
935	No	No	NON-EXTENSIVE BURNS	0.9042	3.6	2.4	1
939	No	No	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	6.4514	34.6	20.6	2
940	No	No	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	2.8806	11.3	5.6	1
941	No	No	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.7632	3.1	2.3	1
945	Yes	No	REHABILITATION W CC/MCC	1.6369	13.4	9.7	1
946	Yes	No	REHABILITATION W/O CC/MCC	0.7428	6.0	5.0	1
947	Yes	No	SIGNS & SYMPTOMS W MCC	1.1731	5.3	3.8	1
948	Yes	No	SIGNS & SYMPTOMS W/O MCC	0.6867	3.0	2.2	1
949	No	No	AFTERCARE W CC/MCC	1.9372	9.7	3.6	1
950	No	No	AFTERCARE W/O CC/MCC	1.5126	6.3	2.5	1
951	No	No	OTHER FACTORS INFLUENCING HEALTH STATUS	0.3789	2.3	1.9	1
955	No	No	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.7663	9.1	6.1	1
956	Yes	No	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	5.6344	10.5	8.2	1
957	No	No	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	7.3915	14.1	9.2	1
958	No	No	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	4.2992	9.3	7.3	1
959	No	No	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.5209	5.0	4.2	1
963	No	No	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	3.1265	6.3	4.3	1
964	No	No	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.5877	5.1	4.1	1
965	No	No	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	1.1512	3.5	2.8	1
969	No	No	HIV W EXTENSIVE O.R. PROCEDURE W MCC	6.1131*	17.1	12.0	8
970	No	No	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.9698*	8.6	6.3	8
974	No	No	HIV W MAJOR RELATED CONDITION W MCC	3.3267	11.1	8.9	2
975	No	No	HIV W MAJOR RELATED CONDITION W CC	2.0818	7.7	6.0	1

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CHAPTER 6, ADDENDUM C (FY 2011)

DIAGNOSIS RELATED GROUPS (DRGs), DRG RELATIVE WEIGHTS, ARITHMETIC AND
GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2010)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARTH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
976	No	No	HIV W MAJOR RELATED CONDITION W/O CC/MCC	1.5323	4.2	3.1	1
977	No	No	HIV W OR W/O OTHER RELATED CONDITION	1.0410	3.9	3.3	1
981	Yes	No	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	5.2064	14.0	9.7	1
982	Yes	No	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.6339	7.1	5.1	1
983	Yes	No	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.3742	3.0	2.2	1
984	No	No	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.6899*	13.3	10.5	4
985	No	No	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.3874*	9.0	6.8	4
986	No	No	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.2365*	4.0	2.7	4
987	Yes	No	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4.4091	11.5	6.8	1
988	Yes	No	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.6854	5.5	3.7	1
989	Yes	No	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.1476	2.6	2.0	1
998	No	No	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000*	0.0	0.0	1
999	No	No	UNGROUPABLE	0.0000*	0.0	0.0	1

Notes: (1) * = low volume DRG with fewer than 10 cases. The Medicare weights are used for these DRGs.
(2) # = PM-DRGs with fewer than 10 cases. An average weight over the past five years were used for these DRGs.
(3) w CC = with Complications or Comorbidities.
(4) w/o CC = without Complications or Comorbidities.

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