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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 135
6010.55-M
JULY 5, 2011**

**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, MENTAL HEALTH PER DIEM HIGH VOLUME
PROVIDER DEFLATOR FACTOR

CONREQ: 15372

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): The deflator factor and percentage of change for high volume hospitals/units were added for the fiscal year mental health per diem update.

EFFECTIVE DATE: October 1, 2010.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

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ATTACHMENT(S): 6 PAGE(S)
DISTRIBUTION: 6010.55-M

CHANGE 135
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REMOVE PAGE(S)

CHAPTER 6

Section 8, pages 13 and 14

CHAPTER 7

Section 1, pages 5 through 8

INSERT PAGE(S)

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(ADJUSTMENTS TO PAYMENT AMOUNTS)

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 2011 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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federal fiscal year shall be published in the **Federal Register**. For FY 2007, Medicare has determined a market basket and subsequent update factor specific to psychiatric facilities.

FISCAL YEAR	UPDATE FACTOR	FISCAL YEAR	UPDATE FACTOR
1992	4.7%	2002	3.3%
1993	4.2%	2003	3.5%
1994	4.3%	2004	3.4%
1995	3.7%	2005	3.3%
1996	0%	2006	3.8%
1997	0%	2007	3.4%
1998	0%	2008	3.4%
1999	2.4%	2009	3.2%
2000	2.9%	2010	2.1%
2001	3.4%	2011	2.6%

F. Higher Volume Hospitals and Units.

1. Higher Volume of TRICARE Mental Health Discharges During the Base Period.

a. Any hospital or unit that had an annual rate of 25 or more TRICARE mental health discharges during the period July 1, 1987 through May 31, 1988, shall be considered a higher volume hospital or unit during federal FY 1989 and all subsequent fiscal years.

b. All other hospitals and units covered by the TRICARE/CHAMPUS inpatient mental health per diem payment system shall be considered lower volume hospitals and units.

2. Higher Volume of TRICARE Mental Health Discharges in Subsequent Fiscal Years and Hospital-Specific Per Diem Calculation.

a. In any federal fiscal year in which a hospital or unit not previously classified as a higher volume hospital or unit has 25 or more TRICARE mental health discharges, that hospital or unit shall be considered to be a higher volume hospital or unit during the next federal fiscal year and all subsequent fiscal years.

b. The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE mental health discharges and the base period. The base period amount, however, can not exceed the cap described in this section. Once a statistically valid rate is established based on a year in which the hospital or unit had at least

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25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem.

(1) The TRICARE contractor shall be requested at least annually to submit to the TMA Office of Medical Benefits and Reimbursement Systems within 30 days of the request a listing of high volume providers that qualified as high volume during the most recent government fiscal year. Periodically, additional information may be requested by TMA concerning high volume providers. This requested information will be used in the calculation of the Deflator Factor (DF).

(2) Percent of change and DF.

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 1992	85.81%	1.8581
September 30, 1993	94.48%	1.9448
September 30, 1994	106.94%	2.0694
September 30, 1995	117.20%	2.1720
September 30, 1996	123.83%	2.2383
September 30, 1997	126.20%	2.2620
September 30, 1998	116.93%	2.1693
September 30, 1999	129.19%	2.2919
September 30, 2000	128.82%	2.2882
September 30, 2001	131.83%	2.3183
September 30, 2002	141.57%	2.4157
September 30, 2003	159.90%	2.5990
September 30, 2004	171.39%	2.7139
September 30, 2005	185.93%	2.8593
September 30, 2006	200.58%	2.9724
September 30, 2007	205.85%	2.9785
September 30, 2008	233.63%	3.3363
September 30, 2009	246.31%	3.4631
September 30, 2010	234.40%	3.3440

3. New Hospitals and Units.

a. The inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under Tax Equity and Fiscal Responsibility Act (TEFRA) rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are DRG-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to

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the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE mental health discharges. This provision also applies to the preceding fiscal year (if it had any TRICARE patients during the preceding fiscal year). A retrospective payment shall be required if payments were originally made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the claims processing standards.

b. By definition, a new hospital is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the Medicare and or TRICARE programs under the present and previous ownership for less than 3 full years. A change in ownership in itself does not constitute a new hospital.

c. Such new hospitals must agree not to bill beneficiaries for any additional cost-share beyond that determined initially based on the regional rate.

4. Request for a Review of Higher or Lower Volume Classification. Any hospital or unit which TMA improperly fails to classify as a higher or lower volume hospital or unit may apply to the appropriate contractor for such a classification. The hospital or unit shall have the burden of proof.

G. Payment for Hospital Based Professional Services.

1. Lower Volume Hospitals and Units. Lower volume hospitals and units may not bill separately for hospital based professional services; payment for those services is included in the per diems.

2. Higher Volume Hospitals and Units. Higher volume hospitals and units, whether they billed separately for hospital based professional services or included those services in the hospital's or unit's charges, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to the appropriate contractor notice of its request to change its billing procedures for hospital-based professional services.

H. Leave Days.

1. No Payment. The government shall not pay (including holding charges) for days where the patient is absent on leave (including therapeutic absences) from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement.

2. Does not Constitute a Discharge/Do not Count Toward Day Limit. The government shall not count a patient's departure for a leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital.

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I. Exemptions from the TRICARE Inpatient Mental Health Per Diem Payment System.

1. Providers Subject to the DRG-Based Payment System. Providers of inpatient care which are neither psychiatric hospitals nor psychiatric units as described earlier, or which otherwise qualify under that discussion, are exempt from the inpatient mental health per diem payment system.

2. Services Which Group into Mental Health DRG. Admissions to psychiatric hospitals and units for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424 prior to October 1, 2008, or services which group into DRG 876 on or after October 1, 2008) are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

3. Non-Mental Health Procedures. Admissions for non-mental health procedures that group into non-mental health DRG, in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

4. Sole Community Hospital (SCH). Any hospital which has qualified for special treatment under the Medicare Prospective Payment System (PPS) as a SCH and has not given up that classification is exempt. For additional information on SCHs, refer to [Chapter 14, Section 1](#).

5. Hospital Outside the 50 United States, the District of Columbia, or Puerto Rico. A hospital is exempt if it is not located in one of the 50 United States, the District of Columbia, or Puerto Rico.

6. Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the DRG-based payment system or the inpatient mental health per diem payment system shall be determined on the basis of billed charges or set rates.

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