



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 66
6010.55-M
SEPTEMBER 27, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.55-M, issued August 2002.

CHANGE TITLE: FISCAL YEAR (FY) 2008 DRG REIMBURSEMENT UPDATE

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides the FY 2008 DRG update.

EFFECTIVE DATE: October 1, 2007.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TSM, Change No. 51.

A handwritten signature in black ink, appearing to read "Reta Michak".

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 36 PAGE(S)
DISTRIBUTION: 6010.55-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

REMOVE PAGE(S)

CHAPTER 2

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Addendum B (FY2005), page 1

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CHAPTER 2, SECTION 1

COST-SHARES AND DEDUCTIBLES

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.

(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.

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COST-SHARES AND DEDUCTIBLES

(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, 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.

(e) Determine any cost-sharing amounts which exceed 25% of the billed charge (see [paragraph I.C.3.d.\(2\)\(b\)1b](#) below) and divide this amount by the total number of patient days in [paragraph I.C.3.d.\(2\)\(b\)1a](#) above). Add this amount to the amount in [paragraph I.C.3.d.\(2\)\(b\)1a](#) above. This is the per diem cost-share to be used for these beneficiaries.

(2) The per diem amount will be required for each actual day of the beneficiary's hospital stay which the DRG-based payment covers except for the day of discharge. When the payment ends on a specific day because eligibility ends on either a long-stay or short-stay outlier day, the last day of eligibility is to be counted for determining the per diem cost-sharing amount. For claims involving a same-day discharge which qualify as an inpatient stay (e.g., the patient was admitted with the expectation of a stay of several days, but died the same day) the cost-share is to be based on a one-day stay. (The number of hospital days must contain one day in this situation.) Where long-stay outlier days are

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subsequently determined to be not medically necessary by a PRO, no cost-share will be required for those days, since payment for such days will be the beneficiary's responsibility entirely.

b Twenty-five percent (25%) of the billed charge. The billed charge to be used includes all inpatient institutional line items billed by the hospital minus any duplicate charges and any charges which can be billed separately (e.g., hospital-based professional services, outpatient services, etc.). The net billed charges for the cost-share computation include comfort and convenience items.

2 Under no circumstances can the cost-share exceed the DRG-based amount.

3 Where the dates of service span different fiscal years, the per diem cost-share amount for each year is to be applied to the appropriate days of the stay.

(3) TRICARE Extra.

(a) Cost-shares for ADFMs. The cost-sharing provisions for ADFMs are the same as those for TRICARE Standard.

(b) Cost-shares for beneficiaries other than ADFMs. The cost-sharing provisions for beneficiaries other than ADFMs is the same as those for TRICARE Standard, except the per diem copayment is \$250.

(4) TRICARE Prime. Cost-shares for ADFMs. The cost-sharing provision for ADFMs is the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or a per diem rate of \$11, whichever is greater. For care provided on or after April 1, 2001, for Prime ADFMs, cost-share is \$0. See attached Table 1 of this Policy for further information.

(5) Maternity Services. See [paragraph I.C.3.c.](#), for the cost-sharing provisions for maternity services.

e. Cost-Shares: Inpatient Mental Health Per Diem Payment System.

(1) General. These special cost-sharing procedures apply only to claims paid under the inpatient mental health per diem payment system. For inpatient claims exempt from this system, the procedures in [paragraph I.C.3.b.](#) or [paragraph I.C.3.d.](#) are to be followed.

(2) Cost-shares for ADFMs. Effective for care on or after October 1, 1995 and care on or prior to March 31, 2001, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission. This \$20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any residential treatment facility, any substance use disorder rehabilitation facility, and any partial hospitalization program providing mental health or substance use disorder rehabilitation services. For Prime ADFMs care provided on or after April 1, 2001, cost-share is \$0 per day. See Table 1 of this Policy for further information.

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COST-SHARES AND DEDUCTIBLES

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

(a) Higher volume hospitals and units. With respect to care paid for on the basis of a hospital specific per diem, the cost-share shall be 25% of the hospital specific per diem amount.

(b) Lower volume hospitals and units. For care paid for on the basis of a regional per diem, the cost-share shall be the lower of [paragraph I.C.3.e.\(3\)\(b\)1](#) or [paragraph I.C.3.e.\(3\)\(b\)2](#) below:

1 A fixed daily amount multiplied by the number of covered days. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the inpatient mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to [Chapter 7, Section 1](#). This fixed daily amount will also be furnished to contractors by TMA. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

a Fiscal Year 1997 - \$137 per day.

b Fiscal Year 1998 - \$137 per day.

c Fiscal Year 1999 - \$140 per day.

d Fiscal Year 2000 - \$144 per day.

e Fiscal Year 2001 - \$149 per day.

f Fiscal Year 2002 - \$154 per day.

g Fiscal Year 2003 - \$159 per day.

h Fiscal Year 2004 - \$164 per day.

i Fiscal Year 2005 - \$169 per day.

j Fiscal Year 2006 - \$175 per day.

k Fiscal Year 2007 - \$181 per day.

2 Twenty-five percent (25%) of the hospital's billed charges (less any duplicates).

(4) Claim which spans a period in which two separate per diems exist. A claim subject to the Inpatient Mental Health Per Diem Payment System which spans a period in which two separate per diems exist shall have the cost-share computed on the actual per diem in effect for each day of care.

DIAGNOSTIC RELATED GROUPS (DRGs)

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ADDENDUM C	(FY 2007) - 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 10/01/2006)
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CHAPTER 6, SECTION 3

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM
(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. For discharges with an admission date on or after October 1, 2006, the qualifying DRGs for purposes of [paragraph III.F.3.](#), are listed in Chapter 6, Addendum C (FY 2007).

f. For discharges with an admission date on or after October 1, 2007, the qualifying DRGs for purposes of [paragraph III.F.3.](#), are listed in Chapter 6, Addendum C (FY 2008).

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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HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (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 for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG amount. For neonatal claims, other than normal newborns, payment is graduated by paying twice the per diem amount for the first day of the stay, and 125% of the per diem rate for each subsequent day, up to the full DRG amount.

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

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

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

c. Special rule for DRGs meeting specific criteria. For discharges occurring on or after October 1, 2005, a hospital that transfers an inpatient under the circumstances described in [paragraph III.F.3.](#) and the transfer is assigned to DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, and 550 shall be paid under the provisions of [paragraph III.F.6.b.\(1\)](#) and [\(2\)](#). For discharges occurring on or after October 1, 2006, those DRGs subject to the special payment rule for transfers are listed in [Chapter 6, Addendum C \(FY 2007\)](#). **For discharges occurring on or after October 1, 2007, those DRGs subject to the special payment rule for transfers are listed in [Chapter 6, Addendum C \(FY 2008\)](#).**

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 length of stay (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:
$$\text{DRG Base Payment} = \text{ASA} \times \text{DRG Weight} \times (\text{Labor-Related Portion} \times \text{Wage Index} + \text{Non-Labor Portion})$$

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

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

STEP 3: Calculation of Cost Outlier Threshold:

1. For post acute care special pay transfer DRGs

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

$$B = (\text{Fixed Loss Threshold} \times [(\text{Labor-Related Share} \times \text{Wage Index}) + \text{Non-Labor-Related Share}] \times \text{National Operating Standard Costs as a Share of Total Costs})$$

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

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

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

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

$$B = (\text{Fixed Loss Threshold} \times [(\text{Labor-Related Share} \times \text{Wage Index}) + \text{Non-Labor-Related Share}] \times \text{National Operating Standard Costs as a Share of Total Costs})$$

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

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

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

$$((\text{Billed Charges} \times \text{Cost-to-charge Ratio}) - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor}$$

2. For post acute care special pay transfer DRGs

$$((\text{Billed Charges} \times \text{Cost-to-charge Ratio}) - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor}$$

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

$$((\text{Billed Charges} \times \text{Cost-to-charge Ratio}) - \text{Cost Outlier Threshold}) \times \text{Marginal Cost Factor} \times \text{Adjustment Factor}$$

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

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

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

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 FY99 variables:

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

STEP 1: $\text{DRG Base Payment} = \text{ASA} \times \text{DRG Weight} \times (\text{Labor-Related Portion} \times \text{Wage Index} + \text{Non-Labor Portion})$

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

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 TMA and specifically included in the network provider agreement.

II. ISSUE

What are the adjusted standardized amounts under the TRICARE/CHAMPUS DRG-based payment system, and how are they used and calculated?

III. POLICY

A. General. The adjusted standardized amount (ASA) represents the adjusted average operating cost for treating all TRICARE/CHAMPUS beneficiaries in all DRGs during the database period. During 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. In this step each charge is reduced to a representative cost by using the Medicare cost-to-charge ratio. Effective FY 2006, the cost-to-charge ratio is 0.4130. Effective FY 2007, the cost-to-charge ratio is 0.3967. Effective FY 2008, the cost-to-charge ratio is 0.3888.

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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CHAPTER 6, SECTION 7

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

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 fiscal year 1988 using a factor equal to 1.07. Thereafter, any recalculation of the adjusted standardized amount 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.

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 cost-to-charge ratio 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 adjusted standardized amount. The adjusted standardized amount 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 percent and the non-labor portion equals 28.9 percent. Effective October 1, 2004, for wage index values greater than 1.0, the labor related portion of the ASA shall equal 71.1 percent. 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 percent. 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 percent.

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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hospital's indirect medical education adjustment factor. For admissions occurring on or after October 1, 1997, the costs for indirect medical education are no longer standardized.

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

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

$$\text{Standard Cost} = (\text{Billed Charges} \times \text{Cost-to-Charge Ratio})$$

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

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

NOTE: Noncovered charges should continue to be subtracted from the billed charges prior to multiplying the billed charges by the cost-to-charge ratio.

(d) The cost-to-charge ratio for admissions occurring on or after October 1, 2005, is 0.4130. The cost-to-charge ratio for admissions occurring on or after October 1, 2006, is 0.3967. **The cost-to-charge ratio for admissions occurring on or after October 1, 2007, is 0.3888.**

(e) The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2006 is 0.923, for FY 2007 is 0.925, **and for FY 2008 is 0.925.**

(2) For FY 2006, a fixed loss cost-outlier threshold is set of \$21,783. Effective October 1, 2005, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$21,783 (also wage-adjusted).

(3) For FY 2007, a fixed loss cost-outlier threshold is set of \$22,649. Effective October 1, 2006, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$22,649 (also wage-adjusted).

(4) **For FY 2008, a fixed loss cost-outlier threshold is set of \$22,649. Effective October 1, 2007, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$22,649 (also wage-adjusted).**

The cost-outlier threshold shall be calculated as follows:

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

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

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

(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 indirect medical education) or \$13,500.

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

(c) Effective October 1, 2005, the cost-to-charge ratio was 0.4468. Effective October 1, 2006, the cost-to-charge ratio was 0.4282. Effective October 1, 2007, the cost-to-charge ratio is 0.4198. (This is equivalent to the Medicare cost-to-charge ratio increased to account for capital and direct medical education costs.)

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

(e) For admissions occurring during FY 2006, the marginal cost factor shall be adjusted by 1.21. For admissions occurring during FY 2007, the marginal cost factor shall be adjusted by 1.27. For admissions occurring during FY 2008, the marginal cost factor shall be adjusted by 1.26.

(f) The NOSCASTC for calculating the cost-outlier threshold for FY 2006, the NOSCASTC is 0.923, for FY 2007 the NOSCASTC is 0.925, and for FY 2008, the NOSCASTC is 0.925.

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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 Cost to Charge Ratio
(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the cost-to-charge ratio.)
- 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 cost-to-charge ratio of 0.64. Effective for admissions occurring on or after October 1, 2005, and subsequent years, the cost-to-charge ratio used to calculate cost outliers for neonates in acute care hospitals shall be reduced to the same cost-to-charge ratio used for all other acute care hospitals.

7. Indirect medical education adjustment.

α. 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 indirect medical education 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 2006, the same formula shall be used except the first number shall be 1.04.

For admissions occurring during FY 2007, the same formula shall be used except the first number shall be 1.00.

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

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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 Centers for Medicare and Medicaid Services (CMS) most recently available Provider Specific File.

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

d. Updates of indirect medical education 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 capital and direct medical education 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 capital and direct medical education 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 indirect medical education 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

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

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

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

f. TRICARE for Life (TFL). No adjustment for indirect medical education 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 indirect medical education in accordance with the provisions of this section.

- END -

FISCAL YEAR 2008 TRICARE/CHAMPUS ADJUSTED STANDARDIZED AMOUNTS

These amounts are effective for admissions occurring on or after October 1, 2007 through September 30, 2008.

FIGURE 6-B-2008-1 69.7 PERCENT LABOR SHARE/30.3 PERCENT NON-LABOR SHARE IF WAGE INDEX GREATER THAN 1

LABOR RELATED	NON-LABOR RELATED	TOTAL
\$3,120.15	\$1,356.39	\$4,476.54

FIGURE 6-B-2008-2 62 PERCENT LABOR SHARE/38 PERCENT NON-LABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1

LABOR RELATED	NON-LABOR RELATED	TOTAL
\$2,775.45	\$1,701.09	\$4,476.54

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

NOTE: The cost-share per diem for FY 2007 is capped at the FY 2006 level of \$535, per Section 704 of NDAA 2007. The cost-share per diem for FY 2008 continues to be \$535.

CHAPTER 6
ADDENDUM C (FY 2008)

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 10/01/2007)

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	Yes	No	CRANIOTOMY AGE >17 W CC	3.6716	7.7	5.3	1
2	Yes	No	CRANIOTOMY AGE >17 W/O CC	2.5102	3.9	3.1	1
3	No	No	CRANIOTOMY AGE 0-17	2.1615	5.8	3.3	1
4			NO LONGER VALID	-	-	-	-
5			NO LONGER VALID	-	-	-	-
6	No	No	CARPAL TUNNEL RELEASE	0.8780*	3.1	2.1	1
7	Yes	Yes	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.2662	6.5	3.8	1
8	Yes	Yes	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.6231	2.6	1.9	1
9	No	No	SPINAL DISORDERS & INJURIES	1.5169	7.7	3.9	1
10	Yes	No	NERVOUS SYSTEM NEOPLASMS W CC	1.3522	5.9	4.0	1
11	Yes	No	NERVOUS SYSTEM NEOPLASMS W/O CC	1.0061	4.8	2.8	1
12	Yes	No	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.1213	9.0	4.2	1
13	Yes	No	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.9762	5.1	3.7	1
14	Yes	No	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	1.3793	5.2	3.7	1
15	Yes	No	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.9915	4.5	2.6	1
16	Yes	No	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.3623	4.9	3.6	1
17	Yes	No	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.8230	2.7	2.2	1
18	Yes	No	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	1.0485	5.1	3.8	1
19	Yes	No	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.7505	3.1	2.2	1
20			NO LONGER VALID	-	-	-	-
21	No	No	VIRAL MENINGITIS	0.6620	3.2	2.7	1
22	No	No	HYPERTENSIVE ENCEPHALOPATHY	1.2908	3.9	3.0	1
23	No	No	NONTRAUMATIC STUPOR & COMA	0.7894	3.6	2.3	1
24			NO LONGER VALID	-	-	-	-
25			NO LONGER VALID	-	-	-	-
26	No	No	SEIZURE & HEADACHE AGE 0-17	0.4937	2.5	1.9	1
27	No	No	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3547	4.1	2.4	1
28	Yes	No	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3472	4.2	2.8	1
29	Yes	No	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.7371	2.3	1.9	1
30	No	No	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.7266	2.6	1.8	1
31	No	No	CONCUSSION AGE >17 W CC	0.9569	2.2	1.7	1
32	No	No	CONCUSSION AGE >17 W/O CC	0.7185	1.8	1.5	1
33	No	No	CONCUSSION AGE 0-17	0.5180	1.5	1.3	1
34	Yes	No	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0097	4.9	3.1	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 5 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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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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/ CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
35	Yes	No	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.7516	3.9	2.3	1
36	No	No	RETINAL PROCEDURES	0.8942*	1.9	1.4	1
37	No	No	ORBITAL PROCEDURES	1.6552	3.8	3.0	1
38	No	No	PRIMARY IRIS PROCEDURES	0.6876*	2.8	2.2	1
39	No	No	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.7172*	2.1	1.6	1
40	No	No	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.9295	2.8	2.2	1
41	No	No	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.6452	1.8	1.6	1
42	No	No	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7587	2.0	1.6	1
43	No	No	HYPHEMA	0.3058	1.8	1.6	1
44	No	No	ACUTE MAJOR EYE INFECTIONS	0.5276	3.4	2.8	1
45	No	No	NEUROLOGICAL EYE DISORDERS	0.7146	2.7	2.1	1
46	No	No	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7905	3.6	2.7	1
47	No	No	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4946	2.8	1.9	1
48	No	No	OTHER DISORDERS OF THE EYE AGE 0-17	0.5265	2.9	2.1	1
49	No	No	MAJOR HEAD & NECK PROCEDURES	1.8555	3.0	2.4	1
50	No	No	SIALOADENECTOMY	1.0031	1.5	1.3	1
51	No	No	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.9755*	2.7	1.9	1
52	No	No	CLEFT LIP & PALATE REPAIR	0.6810	1.5	1.3	1
53	No	No	SINUS & MASTOID PROCEDURES AGE >17	1.6662	3.5	2.5	1
54	No	No	SINUS & MASTOID PROCEDURES AGE 0-17	1.3005	4.4	3.1	1
55	No	No	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.6377	4.3	2.4	1
56	No	No	RHINOPLASTY	1.1313	2.1	1.5	1
57	No	No	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.7444	2.0	1.6	1
58	No	No	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.7585	3.7	2.5	1
59	No	No	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6454	1.9	1.6	1
60	No	No	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.5300	1.8	1.6	1
61	No	No	MYRINGOTOMY W TUBE INSERTION AGE >17	1.7746*	6.1	3.7	1
62	No	No	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.6580	1.9	1.6	1
63	No	No	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.0994	2.4	1.8	1
64	No	No	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1586	5.1	3.2	1
65	No	No	DYSEQUILIBRIUM	0.7096	2.3	1.9	1
66	No	No	EPISTAXIS	0.6263	2.5	2.0	1
67	No	No	EPIGLOTTITIS	0.6794	2.6	2.2	1
68	No	No	OTITIS MEDIA & URI AGE >17 W CC	0.5971	3.0	2.4	1
69	No	No	OTITIS MEDIA & URI AGE >17 W/O CC	0.4445	2.1	1.9	1
70	No	No	OTITIS MEDIA & URI AGE 0-17	0.3284	2.3	2.0	1
71	No	No	LARYNGOTRACHEITIS	0.2534	1.6	1.4	1
72	No	No	NASAL TRAUMA & DEFORMITY	0.8893	2.8	2.1	1
73	Yes	No	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7078	2.9	2.3	1
74	No	No	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.4554	3.7	2.2	1
75	Yes	No	MAJOR CHEST PROCEDURES	2.8217	7.8	6.1	1
76	Yes	No	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8362	8.8	6.3	1
77	Yes	No	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.3046	3.8	2.9	1
78	Yes	No	PULMONARY EMBOLISM	1.1545	5.1	4.3	1
79	Yes	No	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	2.0276	8.5	6.4	1
80	Yes	No	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	1.3266	6.5	5.0	1
81	No	No	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5743	7.8	5.8	1
82	Yes	No	RESPIRATORY NEOPLASMS	1.6599	6.7	4.6	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 5 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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GEOMETRIC MEAN LENGTHS-OF-STAY, AND SHORT-STAY OUTLIER THRESHOLDS
(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
83	Yes	No	MAJOR CHEST TRAUMA W CC	1.1021	4.9	3.5	1
84	Yes	No	MAJOR CHEST TRAUMA W/O CC	0.7647	2.3	1.9	1
85	Yes	No	PLEURAL EFFUSION W CC	1.1886	5.8	4.2	1
86	Yes	No	PLEURAL EFFUSION W/O CC	0.6544	3.0	2.3	1
87	No	No	PULMONARY EDEMA & RESPIRATORY FAILURE	1.5748	6.1	4.7	1
88	No	No	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.8883	4.3	3.4	1
89	Yes	No	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.9962	4.6	3.7	1
90	Yes	No	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.5814	2.9	2.5	1
91	No	No	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.4449	2.8	2.3	1
92	Yes	No	INTERSTITIAL LUNG DISEASE W CC	1.2538	5.4	4.1	1
93	Yes	No	INTERSTITIAL LUNG DISEASE W/O CC	0.9467	4.2	3.2	1
94	No	No	PNEUMOTHORAX W CC	1.0670	4.7	3.5	1
95	No	No	PNEUMOTHORAX W/O CC	0.5473	3.2	2.6	1
96	No	No	BRONCHITIS & ASTHMA AGE >17 W CC	0.7280	3.5	2.8	1
97	No	No	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5343	2.8	2.3	1
98	No	No	BRONCHITIS & ASTHMA AGE 0-17	0.3684	2.3	2.0	1
99	No	No	RESPIRATORY SIGNS & SYMPTOMS W CC	0.6909	2.7	2.0	1
100	No	No	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.4685	1.9	1.6	1
101	Yes	No	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	1.0236	3.6	2.6	1
102	Yes	No	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.6535	2.1	1.7	1
103	No	No	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	21.2690	35.4	21.0	2
104	Yes	No	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	8.8313	12.9	10.9	3
105	Yes	No	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	5.8150	7.6	6.5	2
106	No	No	CORONARY BYPASS W PTCA	7.1571	8.7	7.6	2
107			NO LONGER VALID	-	-	-	-
108	Yes	No	OTHER CARDIOTHORACIC PROCEDURES	4.3967	6.8	5.6	1
109			NO LONGER VALID	-	-	-	-
110	No	No	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.0306	7.4	5.3	1
111	No	No	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.9947	3.5	2.7	1
112			NO LONGER VALID	-	-	-	-
113	Yes	No	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	4.3964	14.6	10.4	2
114	Yes	No	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	2.3682	10.2	6.3	1
115			NO LONGER VALID	-	-	-	-
116			NO LONGER VALID	-	-	-	-
117	No	No	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.5181	3.4	2.5	1
118	No	No	CARDIAC PACEMAKER DEVICE REPLACEMENT	2.2283	2.7	2.0	1
119	No	No	VEIN LIGATION & STRIPPING	1.5810	2.7	1.8	1
120	Yes	No	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.3298	7.9	4.9	1
121	Yes	No	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	1.8700	5.1	3.6	1
122	No	No	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	1.1323	2.4	2.0	1
123	No	No	CIRCULATORY DISORDERS W AMI, EXPIRED	1.9751	4.3	2.5	1
124	No	No	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.3403	3.0	2.3	1
125	No	No	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.1709	2.1	1.8	1
126	Yes	No	ACUTE & SUBACUTE ENDOCARDITIS	1.8948	10.4	7.8	1

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
127	Yes	No	HEART FAILURE & SHOCK	1.0310	4.4	3.4	1
128	No	No	DEEP VEIN THROMBOPHLEBITIS	1.0271	4.3	3.7	1
129	No	No	CARDIAC ARREST, UNEXPLAINED	1.1339	2.5	1.7	1
130	Yes	No	PERIPHERAL VASCULAR DISORDERS W CC	0.9860	5.0	3.7	1
131	Yes	No	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5617	3.9	2.6	1
132	No	No	ATHEROSCLEROSIS W CC	0.7987	2.3	1.8	1
133	No	No	ATHEROSCLEROSIS W/O CC	0.8776	2.3	1.6	1
134	No	No	HYPERTENSION	0.6575	2.5	2.0	1
135	No	No	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	1.0489	3.6	2.5	1
136	No	No	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.5714	2.1	1.7	1
137	No	No	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	1.0980	5.7	2.6	1
138	No	No	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7411	2.9	2.3	1
139	No	No	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5056	2.0	1.6	1
140	No	No	ANGINA PECTORIS	0.4888	1.6	1.4	1
141	No	No	SYNCOPE & COLLAPSE W CC	0.7579	2.5	2.0	1
142	No	No	SYNCOPE & COLLAPSE W/O CC	0.6645	2.1	1.7	1
143	No	No	CHEST PAIN	0.5953	1.6	1.4	1
144	Yes	No	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.4634	5.5	3.8	1
145	Yes	No	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.6398	2.2	1.8	1
146	Yes	No	RECTAL RESECTION W CC	2.2753	7.2	6.3	2
147	Yes	No	RECTAL RESECTION W/O CC	1.9905	5.2	4.9	2
148			NO LONGER VALID	-	-	-	-
149	Yes	No	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.6138	4.9	4.4	1
150	Yes	No	PERITONEAL ADHESIOLYSIS W CC	2.3562	7.7	5.8	1
151	Yes	No	PERITONEAL ADHESIOLYSIS W/O CC	1.2888	3.9	3.1	1
152	No	No	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.5392	6.2	5.3	1
153	No	No	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1768	4.3	3.8	1
154			NO LONGER VALID	-	-	-	-
155	Yes	No	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.4619	3.0	2.2	1
156	No	No	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.9550	3.9	2.8	1
157	Yes	No	ANAL & STOMAL PROCEDURES W CC	1.5275	4.5	3.3	1
158	Yes	No	ANAL & STOMAL PROCEDURES W/O CC	0.7397	2.5	2.0	1
159	No	No	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.5481	4.1	3.2	1
160	No	No	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	1.1629	2.4	2.1	1
161	No	No	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.3677	3.3	2.6	1
162	No	No	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.9041	1.9	1.5	1
163	No	No	HERNIA PROCEDURES AGE 0-17	0.5807	1.9	1.5	1
164	No	No	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.8502	5.8	4.9	1
165	No	No	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2734	3.7	3.1	1
166	No	No	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.2653	2.8	2.3	1
167	No	No	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.9360	1.6	1.4	1
168	No	No	MOUTH PROCEDURES W CC	1.3829	3.9	3.2	1
169	No	No	MOUTH PROCEDURES W/O CC	0.9378	1.9	1.6	1
170	Yes	No	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.7974	9.0	6.6	1
171	Yes	No	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.3764	4.6	3.2	1
172	Yes	No	DIGESTIVE MALIGNANCY W CC	1.5616	6.2	4.4	1
173	Yes	No	DIGESTIVE MALIGNANCY W/O CC	1.1760	9.1	4.3	1
174	No	No	G.I. HEMORRHAGE W CC	0.9794	3.6	3.0	1

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/ CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT- STAY THRESHOLD
175	No	No	G.I. HEMORRHAGE W/O CC	0.6288	2.3	2.0	1
176	Yes	No	COMPLICATED PEPTIC ULCER	0.9506	3.6	2.9	1
177	No	No	UNCOMPLICATED PEPTIC ULCER W CC	0.9040	3.3	2.7	1
178	No	No	UNCOMPLICATED PEPTIC ULCER W/O CC	0.7398	2.6	2.2	1
179	No	No	INFLAMMATORY BOWEL DISEASE	0.9719	4.6	3.6	1
180	Yes	No	G.I. OBSTRUCTION W CC	0.8483	4.1	3.2	1
181	Yes	No	G.I. OBSTRUCTION W/O CC	0.5579	3.0	2.4	1
182	No	No	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8085	3.4	2.7	1
183	No	No	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.6253	2.5	2.0	1
184	No	No	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.3253	2.3	1.9	1
185	No	No	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8066	3.2	2.2	1
186	No	No	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.5532	3.1	2.1	1
187	No	No	DENTAL EXTRACTIONS & RESTORATIONS	0.8830	2.6	2.2	1
188	Yes	No	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0495	4.7	3.4	1
189	Yes	No	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.6754	3.1	2.3	1
190	No	No	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.5093	3.0	1.8	1
191	Yes	No	PANCREAS, LIVER & SHUNT PROCEDURES W CC	3.6266	10.4	8.0	1
192	Yes	No	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	2.1380	5.3	4.5	1
193	No	No	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	3.5463	10.5	8.7	2
194	No	No	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	2.0701	6.4	5.1	1
195	No	No	CHOLECYSTECTOMY W C.D.E. W CC	2.8365	8.0	6.4	1
196	No	No	CHOLECYSTECTOMY W C.D.E. W/O CC	1.5323	4.2	3.5	1
197	Yes	No	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0258	6.5	5.3	1
198	Yes	No	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.3115	3.4	3.0	1
199	No	No	HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	3.1030	10.5	7.0	1
200	No	No	HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	3.4291	8.3	5.2	1
201	No	No	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES	3.4016	9.0	6.4	1
202	No	No	CIRRHOIS & ALCOHOLIC HEPATITIS	1.5941	6.2	4.6	1
203	No	No	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS	1.6994	6.7	4.6	1
204	No	No	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.0306	4.6	3.6	1
205	Yes	No	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.3002	5.7	4.2	1
206	Yes	No	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.7329	3.5	2.5	1
207	No	No	DISORDERS OF THE BILIARY TRACT W CC	1.0972	4.0	3.1	1
208	No	No	DISORDERS OF THE BILIARY TRACT W/O CC	0.6807	2.5	2.0	1
209			NO LONGER VALID	-	-	-	-
210	Yes	Yes	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	2.3398	6.4	5.4	1
211	Yes	Yes	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.6542	3.6	3.1	1
212	No	No	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.1970	2.6	2.2	1
213	Yes	No	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.7741	6.2	4.3	1
214			NO LONGER VALID	-	-	-	-
215			NO LONGER VALID	-	-	-	-
216	Yes	No	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.1856	5.6	3.5	1
217	Yes	No	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	3.0987	10.4	6.3	1
218	Yes	No	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.9235	4.3	3.4	1

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
219	Yes	No	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1.3491	2.8	2.3	1
220	No	No	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	0.9167	1.8	1.6	1
221			NO LONGER VALID	-	-	-	-
222			NO LONGER VALID	-	-	-	-
223	No	No	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.3642	2.9	2.1	1
224	No	No	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.9196	1.7	1.5	1
225	Yes	No	FOOT PROCEDURES	1.2225	2.9	2.2	1
226	Yes	No	SOFT TISSUE PROCEDURES W CC	1.5279	5.5	3.7	1
227	Yes	No	SOFT TISSUE PROCEDURES W/O CC	1.0436	2.5	1.9	1
228	No	No	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	1.3801	3.5	2.5	1
229	No	No	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.9133	2.5	2.0	1
230	No	No	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.2471	3.2	2.4	1
231			NO LONGER VALID	-	-	-	-
232	No	No	ARTHROSCOPY	1.0569	2.9	1.8	1
233	Yes	Yes	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.3116	5.6	4.0	1
234	Yes	Yes	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.6507	2.9	2.2	1
235	Yes	No	FRACTURES OF FEMUR	0.4950	3.0	1.9	1
236	Yes	No	FRACTURES OF HIP & PELVIS	0.7629	4.2	3.3	1
237	No	No	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4811	1.8	1.5	1
238	Yes	No	OSTEOMYELITIS	1.1281	8.6	5.4	1
239	Yes	No	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.3265	6.8	4.6	1
240	Yes	No	CONNECTIVE TISSUE DISORDERS W CC	2.0303	7.2	4.8	1
241	Yes	No	CONNECTIVE TISSUE DISORDERS W/O CC	0.8224	4.1	2.6	1
242	No	No	SEPTIC ARTHRITIS	0.9550	6.4	4.1	1
243	No	No	MEDICAL BACK PROBLEMS	0.7470	3.2	2.5	1
244	Yes	No	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.8233	4.8	3.6	1
245	Yes	No	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.6708	6.3	3.9	1
246	No	No	NON-SPECIFIC ARTHROPATHIES	0.5593	3.7	2.3	1
247	No	No	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5598	4.3	2.3	1
248	No	No	TENDONITIS, MYOSITIS & BURSITIS	0.6716	4.0	2.9	1
249	No	No	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.5232	16.8	9.8	1
250	Yes	No	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.7672	3.2	2.3	1
251	Yes	No	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4546	1.7	1.4	1
252	No	No	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.3659	1.2	1.1	1
253	Yes	No	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.9504	5.0	3.2	1
254	Yes	No	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.5510	4.0	2.1	1
255	No	No	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.4313	1.5	1.3	1
256	Yes	No	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7715	3.7	2.3	1
257	No	No	TOTAL MASTECTOMY FOR MALIGNANCY W CC	1.3812	2.2	1.8	1
258	No	No	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	1.3299	1.9	1.6	1
259	No	No	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9785	1.9	1.4	1
260	No	No	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	1.1227	1.2	1.1	1
261	No	No	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	1.2268	1.7	1.4	1
262	No	No	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	1.2330	4.2	3.1	1
263	Yes	No	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.2555	9.6	6.8	1

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 6, ADDENDUM C (FY 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
264	Yes	No	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	0.9432	4.3	3.5	1
265	Yes	No	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.4542	3.5	2.7	1
266	Yes	No	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	1.2393	2.5	2.1	1
267	No	No	PERIANAL & PILONIDAL PROCEDURES	0.8579	2.6	2.2	1
268	No	No	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.2652	2.3	1.9	1
269	Yes	No	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7936	6.6	4.6	1
270	Yes	No	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8869	3.3	2.6	1
271	Yes	No	SKIN ULCERS	1.1402	17.7	6.7	1
272	Yes	No	MAJOR SKIN DISORDERS W CC	1.3092	6.5	4.1	1
273	Yes	No	MAJOR SKIN DISORDERS W/O CC	0.5197	3.3	2.8	1
274	No	No	MALIGNANT BREAST DISORDERS W CC	0.8977	5.9	4.0	1
275	No	No	MALIGNANT BREAST DISORDERS W/O CC	0.8121	7.0	4.3	1
276	No	No	NON-MALIGNANT BREAST DISORDERS	0.5505	4.5	3.0	1
277	Yes	No	CELLULITIS AGE >17 W CC	0.8941	4.8	3.8	1
278	Yes	No	CELLULITIS AGE >17 W/O CC	0.5344	3.4	2.8	1
279	No	No	CELLULITIS AGE 0-17	0.3971	2.8	2.3	1
280	Yes	No	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7135	2.7	2.0	1
281	Yes	No	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.5282	2.8	1.7	1
282	No	No	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.5059	1.7	1.4	1
283	Yes	No	MINOR SKIN DISORDERS W CC	0.6170	3.3	2.6	1
284	Yes	No	MINOR SKIN DISORDERS W/O CC	0.3443	2.7	2.0	1
285	Yes	No	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.1613	8.5	6.7	1
286	No	No	ADRENAL & PITUITARY PROCEDURES	2.0319	4.0	3.2	1
287	Yes	No	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.7534	9.0	6.9	1
288	No	No	O.R. PROCEDURES FOR OBESITY	1.8942	2.5	2.2	1
289	No	No	PARATHYROID PROCEDURES	0.9407	1.7	1.3	1
290	No	No	THYROID PROCEDURES	0.9616	1.5	1.3	1
291	No	No	THYROGLOSSAL PROCEDURES	0.6492*	1.5	1.3	1
292	Yes	No	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.8687	8.5	5.7	1
293	Yes	No	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.6069	3.2	2.2	1
294	Yes	No	DIABETES AGE >35	0.7446	3.9	2.8	1
295	No	No	DIABETES AGE 0-35	0.4952	2.5	2.1	1
296	Yes	No	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7886	3.8	2.8	1
297	Yes	No	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5550	2.9	2.1	1
298	No	No	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.2868	2.4	1.8	1
299	No	No	INBORN ERRORS OF METABOLISM	0.8716	3.8	2.8	1
300	Yes	No	ENDOCRINE DISORDERS W CC	1.0578	4.5	3.4	1
301	Yes	No	ENDOCRINE DISORDERS W/O CC	0.4972	2.1	1.8	1
302	No	No	KIDNEY TRANSPLANT	2.8716	6.2	5.5	2
303	No	No	KIDNEY AND URETER PROCEDURES FOR NEOPLASM	1.7939	4.5	3.8	1
304	Yes	No	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W CC	1.7028	4.8	3.7	1
305	Yes	No	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W/O CC	1.1674	2.5	2.2	1
306	No	No	PROSTATECTOMY W CC	1.5832	7.1	4.0	1
307	No	No	PROSTATECTOMY W/O CC	0.9327	1.4	1.3	1
308	No	No	MINOR BLADDER PROCEDURES W CC	1.2403	3.0	2.2	1
309	No	No	MINOR BLADDER PROCEDURES W/O CC	0.9157	1.5	1.3	1
310	No	No	TRANSURETHRAL PROCEDURES W CC	1.1176	2.6	2.0	1

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(2)# = PM-DRGs with fewer than 10 cases. An average weight over the past 5 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 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/ CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
311	No	No	TRANSURETHRAL PROCEDURES W/O CC	0.8282	1.7	1.5	1
312	No	No	URETHRAL PROCEDURES, AGE >17 W CC	1.3161	3.4	2.4	1
313	No	No	URETHRAL PROCEDURES, AGE >17 W/O CC	0.7444	2.0	1.7	1
314	No	No	URETHRAL PROCEDURES, AGE 0-17	0.5634*	2.3	2.3	1
315	No	No	OTHER KIDNEY & URINARY TRACT PROCEDURES	2.1953	5.8	3.4	1
316	Yes	No	RENAL FAILURE	1.2540	5.3	3.8	1
317	No	No	ADMIT FOR RENAL DIALYSIS	0.6814	2.1	1.9	1
318	No	No	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.2817	5.0	3.7	1
319	No	No	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.5812	2.1	1.8	1
320	Yes	No	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.7736	3.7	3.0	1
321	Yes	No	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5854	2.9	2.4	1
322	No	No	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4068	2.9	2.5	1
323	No	No	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.7500	2.1	1.8	1
324	No	No	URINARY STONES W/O CC	0.4871	1.8	1.5	1
325	No	No	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.7074	3.2	2.6	1
326	No	No	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.5109	2.3	1.8	1
327	No	No	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3032	1.7	1.5	1
328	No	No	URETHRAL STRICTURE AGE >17 W CC	0.8096*	3.4	2.6	1
329	No	No	URETHRAL STRICTURE AGE >17 W/O CC	0.5770*	1.7	1.4	1
330	No	No	URETHRAL STRICTURE AGE 0-17	0.3627*	1.6	1.6	1
331	Yes	No	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.2004	5.0	3.5	1
332	Yes	No	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.7395	3.4	2.2	1
333	No	No	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.5145	2.9	2.2	1
334	No	No	MAJOR MALE PELVIC PROCEDURES W CC	1.6182	3.1	2.6	1
335	No	No	MAJOR MALE PELVIC PROCEDURES W/O CC	1.3911	2.1	1.9	1
336	No	No	TRANSURETHRAL PROSTATECTOMY W CC	0.8166	2.3	1.9	1
337	No	No	TRANSURETHRAL PROSTATECTOMY W/O CC	0.7077	1.7	1.5	1
338	No	No	TESTES PROCEDURES, FOR MALIGNANCY	1.5315*	5.8	3.8	1
339	No	No	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.8443	2.9	1.7	1
340	No	No	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.7010	1.8	1.4	1
341	No	No	PENIS PROCEDURES	1.7052	1.9	1.5	1
342			NO LONGER VALID	-	-	-	-
343			NO LONGER VALID	-	-	-	-
344	No	No	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.2347	1.5	1.3	1
345	No	No	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.1720	4.1	2.2	1
346	No	No	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.1445	4.5	3.3	1
347	No	No	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5977*	2.7	2.0	1
348	No	No	BENIGN PROSTATIC HYPERTROPHY W CC	0.6449	2.3	2.0	1
349	No	No	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.5123*	2.6	2.1	1
350	No	No	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.5853	3.4	2.8	1
351	No	No	STERILIZATION, MALE	0.2688*	1.3	1.3	1
352	No	No	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.8896	4.2	2.6	1
353	No	No	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.7930	4.4	3.5	1
354	No	No	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.4308	4.0	3.3	1
355	No	No	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.0621	2.3	2.1	1
356	No	No	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.9297	1.6	1.4	1

Notes: (1)* = low volume DRG with fewer than 10 cases. The Medicare weights are used for these DRGs.
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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 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
357	No	No	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	2.0494	5.7	4.4	1
358	No	No	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1945	2.9	2.5	1
359	No	No	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.9872	2.0	1.9	1
360	No	No	VAGINA, CERVIX & VULVA PROCEDURES	1.0362	2.1	1.7	1
361	No	No	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.0530	2.1	1.9	1
362	No	No	ENDOSCOPIC TUBAL INTERRUPTION	0.3437*	1.4	1.4	1
363	No	No	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	1.0251	2.2	1.9	1
364	No	No	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.8228	1.9	1.7	1
365	No	No	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.3561	3.8	2.9	1
366	No	No	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.4927	6.3	4.2	1
367	No	No	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.4174	6.4	2.4	1
368	No	No	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7385	3.8	2.9	1
369	No	No	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.5816	2.9	1.6	1
370	No	No	CESAREAN SECTION W CC	0.8393	4.2	3.6	1
371	No	No	CESAREAN SECTION W/O CC	0.6970	3.2	3.0	1
372	No	No	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4869	2.7	2.4	1
373	No	No	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3927	2.1	1.9	1
374	No	No	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.6928	2.3	2.1	1
375	No	No	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.6274	3.0	2.5	1
376	No	No	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.4919	2.8	2.2	1
377	No	No	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.1353	3.6	2.7	1
378	No	No	ECTOPIC PREGNANCY	0.8794	1.9	1.6	1
379	No	No	THREATENED ABORTION	0.4358	3.4	2.3	1
380	No	No	ABORTION W/O D&C	0.3500	1.5	1.3	1
381	No	No	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5534	1.6	1.4	1
382	No	No	FALSE LABOR	0.2397	1.8	1.4	1
383	No	No	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.4438	2.9	2.2	1
384	No	No	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4059	3.1	1.9	1
385			NO LONGER VALID	-	-	-	-
386			NO LONGER VALID	-	-	-	-
387			NO LONGER VALID	-	-	-	-
388			NO LONGER VALID	-	-	-	-
389			NO LONGER VALID	-	-	-	-
390			NO LONGER VALID	-	-	-	-
391	No	No	NORMAL NEWBORN	0.1100	2.0	1.9	1
392	No	No	SPLENECTOMY AGE >17	1.9036	5.3	4.1	1
393	No	No	SPLENECTOMY AGE 0-17	1.4374	3.2	2.7	1
394	No	No	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.4012	4.3	3.3	1
395	Yes	No	RED BLOOD CELL DISORDERS AGE >17	0.8163	3.8	2.8	1
396	No	No	RED BLOOD CELL DISORDERS AGE 0-17	0.5847	3.6	2.8	1
397	No	No	COAGULATION DISORDERS	1.3079	4.1	2.7	1
398	Yes	No	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.1315	4.9	3.6	1
399	Yes	No	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.5958	2.9	2.4	1
400			NO LONGER VALID	-	-	-	-
401	Yes	No	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	3.5352	11.0	7.6	1
402	Yes	No	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	2.3903	4.3	2.7	1
403	Yes	No	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	2.6923	8.7	5.6	1
404	Yes	No	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	1.7773	8.6	4.0	1

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CHAPTER 6, ADDENDUM C (FY 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
405	No	No	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	2.6297	10.0	5.7	1
406	No	No	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	4.2925	12.6	7.7	1
407	No	No	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.7131	4.5	3.7	1
408	No	No	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	3.1445	9.6	4.4	1
409	No	No	RADIOTHERAPY	1.0583	4.8	3.0	1
410	No	No	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1574	3.8	3.0	1
411	No	No	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.4086*	4.7	4.7	1
412	No	No	HISTORY OF MALIGNANCY W ENDOSCOPY	0.9500*	2.0	2.0	1
413	No	No	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.5654	5.8	4.2	1
414	No	No	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	1.3351	5.4	3.4	1
415			NO LONGER VALID	-	-	-	-
416			NO LONGER VALID	-	-	-	-
417	No	No	SEPTICEMIA AGE 0-17	1.1006	5.3	3.7	1
418	Yes	No	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.9416	5.8	3.9	1
419	No	No	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.9304	3.8	3.0	1
420	No	No	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.5894	2.7	2.2	1
421	No	No	VIRAL ILLNESS AGE >17	0.6663	3.0	2.5	1
422	No	No	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.3584	2.2	1.9	1
423	Yes	No	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.8020	6.8	4.5	1
424	No	No	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4961*	11.5	7.4	1
425	No	No	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6031	2.6	2.1	1
426	No	No	DEPRESSIVE NEUROSES	0.3828	3.9	2.8	1
427	No	No	NEUROSES EXCEPT DEPRESSIVE	0.4456	5.0	3.2	1
428	No	No	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.9891	9.9	6.0	1
429	Yes	No	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8972	13.5	5.3	1
430	Yes	No	PSYCHOSES	0.6124	6.7	4.9	1
431	No	No	CHILDHOOD MENTAL DISORDERS	0.5630	23.5	8.3	1
432	No	No	OTHER MENTAL DISORDER DIAGNOSES	2.2278	15.7	8.4	1
433	No	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.2767	3.1	2.1	1
434			NO LONGER VALID	-	-	-	-
435			NO LONGER VALID	-	-	-	-
436			NO LONGER VALID	-	-	-	-
437			NO LONGER VALID	-	-	-	-
438			NO LONGER VALID	-	-	-	-
439	No	No	SKIN GRAFTS FOR INJURIES	2.1312	7.6	5.0	1
440	Yes	No	WOUND DEBRIDEMENTS FOR INJURIES	1.5676	6.4	4.0	1
441	No	No	HAND PROCEDURES FOR INJURIES	0.9540	2.7	2.0	1
442	Yes	No	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.5389	6.7	4.6	1
443	Yes	No	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.1357	3.0	2.1	1
444	Yes	No	TRAUMATIC INJURY AGE >17 W CC	0.7063	3.4	2.0	1
445	Yes	No	TRAUMATIC INJURY AGE >17 W/O CC	0.7006	6.3	2.2	1
446	No	No	TRAUMATIC INJURY AGE 0-17	0.3751	1.5	1.3	1
447	No	No	ALLERGIC REACTIONS AGE >17	0.4068	2.0	1.6	1
448	No	No	ALLERGIC REACTIONS AGE 0-17	0.2186	1.6	1.3	1
449	No	No	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.9457	3.2	2.3	1
450	No	No	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4101	1.6	1.4	1
451	No	No	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.4365	1.9	1.5	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 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
452	No	No	COMPLICATIONS OF TREATMENT W CC	0.9385	5.4	3.1	1
453	No	No	COMPLICATIONS OF TREATMENT W/O CC	0.5574	4.2	2.2	1
454	No	No	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	1.1713	3.8	2.5	1
455	No	No	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.4746	2.1	1.4	1
456			NO LONGER VALID	-	-	-	-
457			NO LONGER VALID	-	-	-	-
458			NO LONGER VALID	-	-	-	-
459			NO LONGER VALID	-	-	-	-
460			NO LONGER VALID	-	-	-	-
461	No	No	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.9124	5.5	3.4	1
462	Yes	No	REHABILITATION	1.2856	20.0	13.2	2
463	Yes	No	SIGNS & SYMPTOMS W CC	0.7696	4.8	3.0	1
464	Yes	No	SIGNS & SYMPTOMS W/O CC	0.5386	3.5	2.0	1
465	No	No	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.4439	11.3	5.7	1
466	No	No	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.3552	27.3	13.6	1
467	No	No	OTHER FACTORS INFLUENCING HEALTH STATUS	0.3047	10.9	3.8	1
468	Yes	No	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.4242	8.9	5.1	1
469			PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	-	-	-	-
470			UNGROUPABLE	-	-	-	-
471	Yes	Yes	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.4581	4.8	4.2	1
472			NO LONGER VALID	-	-	-	-
473	No	No	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	6.8433	20.3	11.7	1
474			NO LONGER VALID	-	-	-	-
475			NO LONGER VALID	-	-	-	-
476	No	No	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.3007	5.0	3.4	1
477	Yes	No	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.0129	6.4	4.0	1
478			NO LONGER VALID	-	-	-	-
479	No	No	OTHER VASCULAR PROCEDURES W/O CC	1.7995	2.2	1.7	1
480	No	No	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	9.9284	18.2	12.9	2
481	No	No	BONE MARROW TRANSPLANT	7.9175	23.2	18.1	3
482	Yes	No	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.0632	9.5	7.3	1
483			NO LONGER VALID	-	-	-	-
484	No	No	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	7.7646	15.9	10.3	1
485	Yes	No	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	5.3473	11.2	8.5	1
486	No	No	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	5.1343	10.7	7.5	1
487	Yes	No	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.7201	5.9	4.2	1
488	No	No	HIV W EXTENSIVE O.R. PROCEDURE	5.6941*	17.7	12.2	1
489	No	No	HIV W MAJOR RELATED CONDITION	2.2935	8.4	6.3	1
490	No	No	HIV W OR W/O OTHER RELATED CONDITION	0.9136	4.2	3.4	1
491	No	No	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	2.0085	2.3	1.9	1
492	No	No	CHEMO W ACUTE LEUKEMIA AS SDX OR W USE OF HIGH DOSE CHEMO AGENT	2.4954	8.9	5.5	1
493	No	No	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.7256	4.4	3.5	1
494	No	No	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1712	2.4	2.0	1
495	No	No	LUNG TRANSPLANT	12.4052	23.1	17.1	4
496	No	No	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	6.1864	4.8	3.9	1

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CHAPTER 6, ADDENDUM C (FY 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
497	Yes	Yes	SPINAL FUSION EXCEPT CERVICAL W CC	4.7446	4.8	4.1	1
498	Yes	Yes	SPINAL FUSION EXCEPT CERVICAL W/O CC	3.9852	3.2	2.8	1
499	No	No	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.5347	3.2	2.3	1
500	No	No	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.1127	1.7	1.4	1
501	Yes	No	KNEE PROCEDURES W PDX OF INFECTION W CC	2.3283	7.1	6.1	2
502	Yes	No	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4170	5.3	4.4	1
503	No	No	KNEE PROCEDURES W/O PDX OF INFECTION	1.4081	2.4	1.9	1
504	No	No	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	8.8813	20.9	18.2	6
505	No	No	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	2.9226*	6.9	2.8	1
506	No	No	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	3.8471	12.5	10.5	2
507	No	No	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	1.7039	6.7	4.8	1
508	No	No	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.7671	10.8	4.0	1
509	No	No	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.9331	4.4	3.0	1
510	No	No	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.3762	5.1	3.4	1
511	No	No	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6412	3.2	2.1	1
512	No	No	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	6.9473*	13.6	11.1	1
513	No	No	PANCREAS TRANSPLANT	4.4146*	10.6	8.9	1
514			NO LONGER VALID	-	-	-	-
515	No	No	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.1932	2.7	1.7	1
516			NO LONGER VALID	-	-	-	-
517			NO LONGER VALID	-	-	-	-
518	No	No	PERCUTANEOUS CARDIOVASC PROC W/O CORONARY ARTERY STENT OR AMI	2.1483	2.0	1.5	1
519	No	No	CERVICAL SPINAL FUSION W CC	2.4906	2.5	1.8	1
520	No	No	CERVICAL SPINAL FUSION W/O CC	2.0835	1.5	1.3	1
521	Yes	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.7746	5.5	3.6	1
522	Yes	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	0.8100	15.0	12.0	2
523			NO LONGER VALID	-	-	-	-
524	No	No	TRANSIENT ISCHEMIA	0.7936	2.2	1.9	1
525	No	No	OTHER HEART ASSIST SYSTEM IMPLANT	13.5717*	14.3	7.7	1
526			NO LONGER VALID	-	-	-	-
527			NO LONGER VALID	-	-	-	-
528	No	No	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE	7.8586	15.6	12.5	2
529	Yes	No	VENTRICULAR SHUNT PROCEDURES W CC	2.5675	8.5	4.1	1
530	Yes	No	VENTRICULAR SHUNT PROCEDURES W/O CC	1.5499	2.8	2.2	1
531	Yes	No	SPINAL PROCEDURES W CC	3.1257	7.8	5.4	1
532	Yes	No	SPINAL PROCEDURES W/O CC	1.8369	3.5	2.7	1
533	No	No	EXTRACRANIAL PROCEDURES W CC	1.6765	3.1	2.1	1
534	No	No	EXTRACRANIAL PROCEDURES W/O CC	1.2379	1.6	1.4	1
535	No	No	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	7.4266	7.2	5.2	1
536	No	No	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	7.4896	7.3	5.5	1
537	Yes	No	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W CC	1.6853	4.1	3.0	1
538	Yes	No	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W/O CC	1.1632	2.5	2.0	1

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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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
539	No	No	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	3.3867	10.6	5.3	1
540	No	No	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC	1.8637	3.8	2.6	1
541	Yes	No	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	20.3360	40.9	33.5	9
542	Yes	No	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	14.1681	30.8	25.4	7
543	Yes	No	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX	5.4896	11.8	8.1	1
544	Yes	No	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	2.2699	3.6	3.4	1
545	Yes	Yes	REVISION OF HIP OR KNEE REPLACEMENT	2.8654	4.4	3.8	1
546	No	No	SPINAL FUSION EXC CERVICAL W CURV OF SPINE/INFECT/MALIG OR 9+ FUSION	5.9696	6.3	5.5	2
547	Yes	No	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	6.3197	9.9	8.8	3
548	Yes	No	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	5.1150	7.5	7.1	3
549	Yes	Yes	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	5.0453	8.1	7.0	2
550	Yes	Yes	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	4.1317	5.7	5.4	2
551	No	No	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	3.5313	5.2	3.4	1
552	No	No	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	2.3922	2.7	2.1	1
553	Yes	No	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	3.0484	6.4	4.2	1
554	Yes	No	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	2.3634	4.4	3.0	1
555	No	No	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	2.4969	3.3	2.7	1
556	No	No	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	2.0676	1.6	1.4	1
557	No	No	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	2.9569	2.9	2.4	1
558	No	No	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	2.4750	1.6	1.4	1
559	No	No	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	2.1506	5.0	4.0	1
560	No	No	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	2.4721	8.8	6.4	1
561	No	No	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS	1.9573	7.3	5.3	1
562	Yes	No	SEIZURE AGE >17 W CC	0.9447	3.7	2.8	1
563	Yes	No	SEIZURE AGE >17 W/O CC	0.6888	2.9	2.4	1
564	No	No	HEADACHES AGE >17	0.7292	3.0	2.3	1
565	Yes	No	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS	6.0680	15.1	12.7	3
566	Yes	No	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT <96 HOURS	2.2857	6.3	4.4	1
567	Yes	No	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W MAJOR GI DX	5.4014	13.2	9.4	1
568	Yes	No	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W/O MAJOR GI DX	2.8894	8.2	5.8	1
569	Yes	No	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX	3.9648	11.9	9.4	2
570	Yes	No	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX	2.4350	7.6	6.5	2
571	No	No	MAJOR ESOPHAGEAL DISORDERS	0.9892	3.5	2.6	1
572	Yes	No	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS	1.0633	5.1	4.0	1
573	Yes	No	MAJOR BLADDER PROCEDURES	3.1089	8.8	7.2	1
574	No	No	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	1.4223	5.5	4.1	1

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CHAPTER 6, ADDENDUM C (FY 2008)

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 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/ CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT- STAY THRESHOLD
575	Yes	No	SEPTICEMIA W MV 96+ HOURS AGE >17	8.3319	17.2	13.4	3
576	Yes	No	SEPTICEMIA W/O MV 96+ HOURS AGE >17	1.9211	6.8	5.0	1
577	No	No	CAROTID ARTERY STENT PROCEDURE	1.9534	1.9	1.4	1
578	Yes	No	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE	6.7692	16.8	11.5	1
579	Yes	No	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROCEDURE	2.2564	7.9	5.5	1
580	No	No	CRANIAL/FACIAL PROCEDURES	1.5162	2.5	1.9	1
600	No	No	NEONATE, DIED W/IN ONE DAY OF BIRTH	0.3282	1.0	1.0	1
601	No	No	NEONATE, TRANSFERRED <5 DAYS OLD	0.3035	1.3	1.2	1
602	No	No	NEONATE, BIRTHWT <750G, DISCHARGED ALIVE	21.7025	83.3	65.1	11
603	No	No	NEONATE, BIRTHWT <750G, DIED	14.9019	41.5	17.2	1
604	No	No	NEONATE, BIRTHWT 750-999G, DISCHARGED ALIVE	16.0078	69.4	62.5	23
605	No	No	NEONATE, BIRTHWT 750-999G, DIED	9.3714#	23.2	10.0	1
606	No	No	NEONATE, BIRTHWT 1000-1499G, W SIGNIF OR PROC, DISCHARGED ALIVE	19.9961	81.6	72.6	29
607	No	No	NEONATE, BIRTHWT 1000-1499G, W/O SIGNIF OR PROC, DISCHARGED ALIVE	7.2009	40.0	35.1	11
608	No	No	NEONATE, BIRTHWT 1000-1499G, DIED	5.9729#	19.9	9.8	1
609	No	No	NEONATE, BIRTHWT 1500-1999G, W SIGNIF OR PROC, W MULT MAJOR PROB	14.0811	47.5	35.8	8
610	No	No	NEONATE, BIRTHWT 1500-1999G, W SIGNIF OR PROC, W/O MULT MAJOR PROB	3.0545#	23.7	22.5	12
611	No	No	NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W MULT MAJOR PROB	5.5054	27.4	23.0	6
612	No	No	NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W MAJOR PROB	2.9600	19.5	16.4	4
613	No	No	NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W MINOR PROB	3.2450	18.1	14.1	3
614	No	No	NEONATE, BIRTHWT 1500-1999G, W/O SIGNIF OR PROC, W OTHER PROB	2.0492	14.4	11.4	2
615	No	No	NEONATE, BIRTHWT 2000-2499G, W SIGNIF OR PROC, W MULT MAJOR PROB	9.6787	34.0	28.8	8
616	No	No	NEONATE, BIRTHWT 2000-2499G, W SIGNIF OR PROC, W/O MULT MAJOR PROB	4.1268#	21.2	17.8	5
617	No	No	NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W MULT MAJOR PROB	3.0689	15.0	12.5	3
618	No	No	NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W MAJOR PROB	1.8294	11.2	9.1	2
619	No	No	NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W MINOR PROB	1.2285	8.4	6.6	1
620			NO LONGER VALID	-	-	-	-
621	No	No	NEONATE, BIRTHWT 2000-2499G, W/O SIGNIF OR PROC, W OTHER PROB	0.8008	6.2	4.6	1
622	No	No	NEONATE, BIRTHWT >2499G, W SIGNIF OR PROC, W MULT MAJOR PROB	11.5624	33.0	19.6	2
623	No	No	NEONATE, BIRTHWT >2499G, W SIGNIF OR PROC, W/O MULT MAJOR PROB	2.1959	8.3	5.2	1
624	No	No	NEONATE, BIRTHWT >2499G, W MINOR ABDOM PROCEDURE	0.5448	2.6	2.4	1
625			NO LONGER VALID	-	-	-	-
626	No	No	NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MULT MAJOR PROB	2.3625	9.7	6.4	1
627	No	No	NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MAJOR PROB	0.7568	4.8	3.6	1
628	No	No	NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MINOR PROB	0.3564	3.2	2.7	1
629			NO LONGER VALID	-	-	-	-

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(EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/01/2007)

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE/CHAMPUS WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
630	No	No	NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W OTHER PROB	0.2124	2.6	2.3	1
631	No	No	BPD AND OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD	1.8782	9.5	7.3	1
632	No	No	OTHER RESPIRATORY PROBLEMS AFTER BIRTH	0.4856	3.3	2.4	1
633	No	No	MULTIPLE, OTHER AND UNSPECIFIED CONGENITAL ANOMALIES, W CC	0.9959#	10.8	5.6	3
634	No	No	MULTIPLE, OTHER AND UNSPECIFIED CONGENITAL ANOMALIES, W/O CC	0.8487#	5.7	3.5	2
635	No	No	NEONATAL AFTERCARE FOR WEIGHT GAIN	0.3463#	5.1	5.1	5
636	No	No	NEONATAL DIAGNOSIS, AGE > 28 DAYS	5.9861	23.7	10.9	1
900	No	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY AGE <= 21 W/O CC	0.3266	6.5	4.7	1
901	No	No	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY AGE > 21 W/O CC	0.3452	6.2	4.5	1

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(3)w CC = with Complications or Comorbidities.
(4)w/o CC = without Complications or Comorbidities.

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T

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