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TRICARE  
MANAGEMENT ACTIVITY

MB&RB

CHANGE 79  
6010.55-M  
JUNE 30, 2008

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:** SEVERITY DIAGNOSTIC RELATED GROUP (DRGs) AND  
PRESENT ON ADMISSION (POA) INDICATORS

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This package contains the changes that are necessary  
to implement the TRICARE/CHAMPUS DRG-based payment system that is  
modeled after the Medicare Severity DRG system. The change also provides the  
requirements for POA indicators which shall be implemented on October 1, 2009.

**EFFECTIVE DATE:** The Severity DRGs are effective October 1, 2008. The POA  
indicators are effective October 1, 2009.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 81, and Aug  
2002 TSM, Change No. 62.

Reta Michak  
Chief, Office of Medical Benefits  
and Reimbursement Branch

**ATTACHMENT(S):** 38 PAGE(S)

**DISTRIBUTION:** 6010.55-M

**CHANGE 79**  
**6010.55-M**  
**JUNE 30, 2008**

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 6**

Section 1, pages 1 and 2  
Section 2, pages 1 through 6  
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Section 1, pages 1 and 2  
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**CHAPTER 7**

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Section 1, pages 1 through 9

## HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (GENERAL)

ISSUE DATE: October 8, 1987

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

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### I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

### II. ISSUE

How is the TRICARE/CHAMPUS DRG-based payment system to be used in determining reimbursement for hospitals under TRICARE/CHAMPUS?

### III. POLICY

#### A. Statutory Background

1. Department of Defense Authorization Act, 1984. The Department of Defense Authorization Act, 1984, amended Title 10, Section 1079(j)(2)(A) and provided TRICARE/CHAMPUS with the statutory authority to reimburse institutional providers based on diagnosis-related groups (DRGs). Specifically, it provides that payments "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Title XVIII of the Social Security Act".

2. Consolidated Omnibus Budget Reconciliation Act, 1986. On April 7, 1986, the President signed the Consolidated Omnibus Budget Reconciliation Act which contained a provision requiring hospitals which participate in Medicare also to participate in TRICARE/CHAMPUS for inpatient services. Because of questions regarding the effect of this provision, it was amended by P.L. 99-514, Section 1895(B)(6), which was signed by the President on October 22, 1986. This amendment requires all providers participating in Medicare also to participate in TRICARE/CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 6, SECTION 1

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

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IV. EFFECTIVE DATE

A. Implementation of the TRICARE/CHAMPUS DRG-based payment system was effective for admissions occurring on or after October 1, 1987. Unless specified differently in sections of this instruction, this is to be considered the effective date for the TRICARE/CHAMPUS DRG-based payment system.

B. Implementation of the TRICARE/CHAMPUS DRG-based payment system modeled on the Medicare Severity DRG shall occur for admissions on or after October 1, 2008.

- END -

## HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (GENERAL DESCRIPTION OF SYSTEM)

ISSUE DATE: October 8, 1987

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

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### I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

### II. ISSUE

How is the TRICARE/CHAMPUS DRG-based payment system to be used in determining inpatient reimbursement for hospitals?

### III. POLICY

A. Scope. The TRICARE/CHAMPUS DRG-based payment system applies only to hospitals. Under the TRICARE/CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively determined rates and applied on a per discharge basis using Diagnosis Related Groups (DRGs). DRG payments will include an allowance for indirect medical education costs. Additional payments will be made for capital costs, direct medical education costs and outlier cases. Under the TRICARE/CHAMPUS DRG-based payment system, a hospital may keep the difference between its prospective payment rate and its operating costs incurred in furnishing inpatient services, and is at risk for operating costs that exceed its payment rate.

B. Modeled on Medicare's Prospective Payment System (PPS). The TRICARE/CHAMPUS DRG-based payment system is modeled on the Medicare PPS. Although many of the procedures in the TRICARE/CHAMPUS DRG-based payment system are similar or identical to the procedures in the Medicare PPS, the actual payment amounts, DRG weights, and certain procedures are different. This is necessary because of the differences in the two programs, especially in the beneficiary population. While the vast majority of Medicare beneficiaries are over age 65, TRICARE/CHAMPUS beneficiaries are considerably younger (almost exclusively under age 65) and generally healthier. Moreover, some services, notably obstetric and pediatric services, which are nearly absent from Medicare claims comprise a large part of TRICARE/CHAMPUS services.

## TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

### CHAPTER 6, SECTION 2

#### HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (GENERAL DESCRIPTION OF SYSTEM)

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1. DRGs used. With **some** exceptions, the TRICARE/CHAMPUS DRG-based payment system uses the same DRGs used in the current Medicare Grouper. Although claims may be grouped into either DRG 469, Principal diagnosis invalid as discharge diagnosis, or DRG 470, Ungroupable, claims in these DRGs must be denied without development.

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

a. EXCEPTION 1. Beginning with admissions occurring on or after October 1, 1988, the TRICARE/CHAMPUS system has replaced DRG 435 (Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment Without Complications or Comorbidity) with two age-based DRGs. Any claim which groups into DRG 435 shall be grouped by the contractor into either DRG 900 (where the beneficiary is 21 years old or younger) or DRG 901 (where the beneficiary is over 21 years old). This grouping by the contractor shall be based on the patient's age, as shown on the claim, on the date of admission. Effective for admissions on or after October 1, 2001, DRG 435 has been replaced by DRG 523. Any claim which groups into DRG 523, shall be grouped by the contractor into either DRG 900 or 901 as specified above. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

b. EXCEPTION 2. For admissions occurring on or after April 1, 1989, the TRICARE/CHAMPUS DRG-based payment system uses Pediatric Modified-DRGs (PM-DRG) for all neonatal claims except those classified to DRGs 103, 391, 480, 495, 512, and 513. The PM-DRGs are DRGs 600 - 636. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

2. Assignment of discharges to DRGs. TMA uses a "Grouper" program to classify specific hospital discharges within DRGs so that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge. The TRICARE/CHAMPUS Grouper is developed by Health Information Systems, 3M Health Care, and is based on the Centers for Medicare and Medicaid Services (CMS) Grouper, but it also incorporates the PM-DRGs and DRGs 900 and 901.

a. The Medicare Code Editor (or other similar editor programs) is an integral part of the CMS Grouper and serves two functions. It helps to ensure that the claim discharge data is accurate and complete, so that it can be correctly grouped into a DRG. It also "edits" the claims data to identify cases which may not meet certain coverage requirements or which might involve inappropriate services. Contractors are not required to use any "Editor" program, but it is recommended since the first function will facilitate claims processing, and the second function may be useful in assessing coverage under TRICARE/CHAMPUS.

b. The classification of a particular discharge is based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status. (Contractors are required to use the expanded diagnosis and procedure code fields.) For neonatal claims (other than normal newborns), it also is based on the newborn's birth weight, surgery, and the presence of multiple, major and other problems

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which exist at birth. The birth weight is to be indicated through use of a fifth digit on the neonatal ICD-9-CM diagnosis code.

(1) In situations where the narrative diagnosis on the DRG claim does not correspond to the numerical diagnosis code, the contractor shall give precedence to the narrative and revise the numerical code accordingly. Contractors are not required to make this comparison on every claim. Precedence should be given to the narrative code in those cases where a difference is identified as the result of editing, prepayment review, or other action that would identify a discrepancy. If an adjustment is subsequently necessary because the numerical code was, in fact, correct, the adjustment should be submitted under an RPM a reason for adjustment code indicating that there was no contractor error.

(2) It is the hospital's responsibility to submit the information necessary for the contractor to assign a discharge to a DRG.

(3) When the discharge data is inadequate (i.e., the contractor is unable to assign a DRG based on the submitted data), the contractor is to develop the claim for the additional information.

(4) In some cases the "admitting diagnosis" may be different from the principal diagnosis. Although the admitting diagnosis is not required to assign a DRG to a claim, it may be needed to determine if a nonavailability statement (NAS) is required for mental health admissions (see the TRICARE Policy Manual, [Chapter 1, Section 6.1](#)).

(5) For neonatal claims only (other than normal newborns), the following rules apply.

(a) If a neonate (patient age 0 - 28 days at admission) is premature, the appropriate prematurity diagnosis code must be used as a principal or secondary diagnosis. The prematurity diagnosis codes are: ICD-9-CM code 764.0 - 764.9, slow fetal growth and fetal malnutrition, and 765.0 - 765.1, disorders relating to short gestation and unspecified low birth weight.

(b) Where a prematurity diagnosis code is used, a fifth digit value of 1 through 9 must be used in the principal or secondary diagnosis to specify the birth weight. A value of 0 will result in the claim being grouped to the "ungroupable" DRG, and the claim will be denied. If no fifth digit is used, the Grouper will ignore that diagnosis code and the claim will be denied.

(c) If a neonate is not premature, a prematurity diagnosis code must not be used. The Grouper will automatically assign a birth weight of "> 2499 grams" and assign the appropriate PM-DRG. If the birth weight is less than 2500 grams, the birth weight must be provided in the "remarks" section of the CMS 1450 UB-04.

(d) If there is more than one birth weight on the claim, the Grouper will assign the claim to the "ungroupable" DRG, and the claim will be denied.

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(e) All claims for beneficiaries less than 29 days old upon admission (other than normal newborns) will be assigned to a PM-DRG, except those classified to DRGs 103, 480, 495, 512, and 513. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

c. Each discharge will be assigned to only one DRG (related, except as provided in the next two paragraphs, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

d. When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the contractor is to develop the claim to assure that the data are not the result of miscoding by either the contractor or the hospital. Where the procedure and medical condition are supported by the services and the procedure is unrelated to the principal diagnosis, the claim will be assigned to **the** DRG, Unrelated OR Procedure.

e. When the discharge data submitted by a hospital result in assignment of a DRG which may need to be reviewed for coverage (e.g., abortion without dilation and curettage, which does not meet the TRICARE/CHAMPUS requirements for coverage), the contractor is to review the claim to determine if other diagnoses or procedures which were rendered concurrently are covered. If other covered services were rendered, the contractor shall change the principal diagnosis to the most logical alternative covered diagnosis, delete the abortion diagnosis and procedure from the claim so that it does not result in a more complex DRG, and regroup the claim.

For example, if a claim is grouped into **the** DRG **for an abortion** and the abortion is not covered, but a tubal ligation was performed concurrently, the contractor should change the principal diagnosis to that for the tubal and delete the abortion from the procedures performed. If no covered services were rendered, the claim must be denied, and all related ancillary and professional services which are submitted separately must also be denied.

(1) Contractors are not normally required to review all diagnoses and procedures to determine their coverage. Contractors are required to develop for medical necessity only if the principal diagnosis is generally not covered but potentially could be. Deletion of a diagnosis and/or procedure is required only when the principal diagnosis or procedure is not covered.

(2) The only exception to the above paragraph is for abortions. Since abortions are statutorily excluded from coverage in most cases, the contractor is to ensure that payment is not affected by a noncovered abortion diagnosis or procedure whether it is principal or secondary. In all cases where payment would be affected, the abortion data is to be deleted from the claim.

#### C. Beneficiary Eligibility

##### 1. Change of eligibility status.

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#### HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (GENERAL DESCRIPTION OF SYSTEM)

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a. Payment when eligibility changes. If a beneficiary is eligible for TRICARE/CHAMPUS coverage during any part of his/her inpatient confinement, except for the following cases, the claim shall be processed as if the beneficiary was eligible for the entire stay.

(1) Claims which qualify for the long-stay or short-stay outlier payment. The long-stay outlier was eliminated for all cases, except neonates and children's hospitals, for admissions occurring on or after October 1, 1997. The long-stay outlier was eliminated for neonates and children's hospitals for admissions occurring on or after October 1, 1998. See [paragraph III.C.1.c.](#) below.

(2) Claims which qualify for the cost outlier payment after August 1, 2003. See [paragraph III.C.1.c.](#) below.

(3) Claims where a beneficiary gains eligibility after admission. The DRG-based payment is calculated beginning on the first day of TRICARE/CHAMPUS eligibility.

(4) Claims where the loss of TRICARE/CHAMPUS eligibility results from gaining Medicare eligibility. The claim may still be processed by TRICARE/CHAMPUS, but it must be submitted to Medicare first and TRICARE/CHAMPUS payment will be determined under the normal double coverage procedures.

b. Transfer payments when eligibility status changes. Since payments to a transferring hospital are always based on a per diem amount, if the beneficiary's eligibility status changes while an inpatient in a transferring hospital, payment shall be made only for those days for which the beneficiary was eligible. The procedures below shall be followed in paying outlier amounts in cases involving transfers.

c. Outlier payments when eligibility status changes. For admissions prior to August 1, 2003, when requested, cost outlier payments are to be made in cases where the beneficiary gains or loses eligibility during an inpatient stay, and the contractor will not be required to determine which costs occurred outside the beneficiary's TRICARE/CHAMPUS eligibility. Since both long-stay and short-stay outlier payments are made on a per diem basis, no payment is to be made for any days of care which occurred after loss of eligibility and which result from either the long-stay or short-stay outlier. The hospital may bill the beneficiary for any services which would result in long-stay or short-stay outlier payments were it not for the beneficiary's loss of eligibility. For admissions on or after August 1, 2003, when computing the standardized costs for the cost outlier payment, any charges that occur after a beneficiary loses TRICARE/CHAMPUS eligibility, shall be subtracted from the billed charges prior to multiplying the billed charges by the cost-to-charge ratio when calculating the cost outlier payment. The contractor shall request an itemized bill from the hospital to identify these charges.

EXAMPLE 1: The beneficiary loses eligibility on day two where the short-stay outlier cutoff is three days. The beneficiary was discharged on the seventh day. TRICARE/CHAMPUS reimbursement will be made for two days on a short-stay outlier basis. The beneficiary's cost-

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#### HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (GENERAL DESCRIPTION OF SYSTEM)

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share will be based on the two paid days. The hospital may bill the beneficiary for all days of care beyond the second day.

EXAMPLE 2: The beneficiary is discharged on day ten and lost eligibility on day six. The short-stay outlier cutoff is day 2. TRICARE/CHAMPUS reimbursement will be based on the normal DRG payment which will apply to the entire length-of-stay (nine days). The beneficiary cost-share for a retiree would be based on the total covered days (nine days times the per diem), assuming this is not greater than 25 percent of the billed charge. An active-duty dependent's cost-share would be nine times the current active-duty per diem amount. The hospital cannot bill the beneficiary for any costs other than the cost-share.

EXAMPLE 3: The beneficiary gains eligibility after admission. The DRG calculation begins on the first day of TRICARE/CHAMPUS eligibility. For example, a beneficiary is admitted 03/06/1992 and discharged 05/16/1992, but was only TRICARE/CHAMPUS eligible starting 05/10/1992. The claim should be treated as if the beneficiary was admitted on 05/10/1992, and the base DRG rate calculated.

2. Change of sponsor status from active duty to retired during an active duty family member's inpatient stay. An inpatient claim is to be cost-shared as active duty whenever there is evidence that the sponsor was on active duty during any period of the active duty family member's inpatient stay.

3. Change of sponsor status from active duty to retired during an active duty member's inpatient stay. An inpatient claim is to be cost-shared as retired if an active duty service member's status changes to retired during an inpatient stay.

4. Professional claims. Since payment for related professional services are itemized and billed on a daily basis, the claim shall be paid for the days the beneficiary is TRICARE/CHAMPUS eligible and denied for the days the patient was not TRICARE/CHAMPUS eligible.

5. Infant of an unmarried family member. A child of an unmarried family member is not eligible, therefore, charges for an infant of an unmarried family member are not eligible for reimbursement.

- END -

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CHAPTER 6, SECTION 3

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

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

e. Transfer assigned to DRG 601. If a transfer is classified into DRG 601 (Neonate, transferred < 5 days old), the transferring hospital is paid in full. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

G. Leave of Absence Days.

1. General. Normally, a patient will leave a hospital which is subject to the DRG-based payment system only as a result of a discharge or a transfer. However, there are some circumstances where a patient is admitted for care, and for some reason is sent home temporarily before that care is completed. Hospitals may place patients on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples of such situations include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, further treatment is indicated following diagnostic tests but cannot begin immediately, a change in the patient's condition requires that scheduled surgery be delayed for a short time, or test results to confirm the need for surgery are delayed.

2. Billing for leave of absence days. In billing for inpatient stays which include a leave of absence, hospitals are to use the actual admission and discharge dates and are to identify all leave of absence days by using revenue code 18X for such days. Contractors are to disallow all leave of absence days. Neither the Program nor the beneficiary may be billed for days of leave.

3. DRG-based payments for stays including leave of absence days. Placing a patient on a leave of absence will not result in two DRG-based payments, nor can any payment be made for leave of absence days. Only one claim is to be submitted when the patient is formally discharged (as opposed to being placed on leave of absence), and only one DRG-based payment is to be made. The contractor should ensure that the leave of absence does not result in long-stay outlier days being paid and that it does not increase the beneficiary's cost-share.

4. Services received while on leave of absence. The technical component of laboratory tests obtained while on a leave of absence would be included in the DRG-based payment to the hospital. The professional component is to be cost-shared as inpatient. Tests performed in a physician's office or independent laboratory are also included in the DRG-based payment.

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

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5. Patient dies while on leave of absence. If patient should die while on leave of absence, the date the patient left the hospital shall be treated as the date of discharge.

H. Area Wage Indexes. The labor-related portion of the ASA will be adjusted to account for the differences in wages among geographic areas and will correspond to the labor market areas used in the Medicare PPS, and the actual indexes used will be those used in the Medicare PPS. The wage index used is to be the one for the hospital's actual address--not for the hospital's billing address.

I. Redesignation of Certain Hospitals to Other Wage Index Areas. TRICARE/CHAMPUS is simply following this statutory requirement for the Medicare Prospective Payment System, and the Centers for Medicare and Medicaid Services (CMS) determines the areas affected and wage indexes used.

1. Admissions occurring on or after October 1, 1988. A hospital located in a rural county adjacent to one or more urban areas shall be treated as being located in the urban area to which the greatest number of workers commute. The area wage index for the urban area shall be used for the rural county.

2. Admissions occurring on or after April 1, 1990. In order to correct inequities resulting from application of the rules in [paragraph III.I.1.](#) above, CMS modified the rules for those rural hospitals deemed to be urban. TRICARE/CHAMPUS has also adopted these changes. Some of these hospitals continue to use the urban area wage index, others use a wage index computed specifically for the rural county, and others use the statewide rural wage index.

3. Admissions occurring on or after October 1, 1991. P.L. 101-239 created the Medicare Geographic Classification Review Board (MGCRB) to reclassify individual hospitals to different wage index areas based on requests from the hospitals. These reclassifications are intended to eliminate the continuing inequities caused by the reclassification actions described in [paragraph III.I.1.](#) and [2.](#) above. TRICARE/CHAMPUS has adopted these hospital-specific reclassifications effective for admissions occurring on or after October 1, 1991.

4. Admissions occurring on or after October 1, 1997. The wage index for an urban hospital may not be lower than the statewide area rural wage index.

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

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

- END -

## HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (APPLICABILITY OF THE DRG SYSTEM)

ISSUE DATE: October 8, 1987

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

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### I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

### II. ISSUE

What providers and services are to be reimbursed under the TRICARE/CHAMPUS DRG-based payment system?

### III. POLICY

A. Areas affected. The TRICARE/CHAMPUS DRG-based payment system shall apply to hospital services in the fifty states, the District of Columbia, and Puerto Rico. The DRG-based payment system shall not be used with regard to services rendered outside the fifty states, the District of Columbia, or Puerto Rico.

1. State waivers. Any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs may be exempt from the TRICARE/CHAMPUS DRG-based payment system under the following circumstances:

a. The following requirements must be met in order for a state to be exempt.

(1) The state must be exempt from the Medicare PPS;

(2) The state must request, in writing to TMA, that it be exempt from the TRICARE/CHAMPUS DRG-based payment system; and

(3) Payments in the state must continue to be at a level to maintain savings comparable to those which would be achieved under the TRICARE/CHAMPUS DRG-based payment system. TMA will monitor reimbursement levels in any exempted state to ensure that payment levels there do not exceed those under the TRICARE/CHAMPUS DRG-based payment system. If they do exceed that level, TMA will work with the state to resolve the

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### CHAPTER 6, SECTION 4

#### HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (APPLICABILITY OF THE DRG SYSTEM)

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problem. However, if a satisfactory solution cannot be found, TMA will terminate the exemption after due notice has been given to the state.

b. The only states which have been exempted are Maryland and New Jersey. The exemption for New Jersey ended for discharges occurring on or after January 1, 1989.

B. Services subject to the DRG-based payment system. Unless exempt, all normally covered inpatient hospital services furnished to TRICARE/CHAMPUS beneficiaries are subject to the TRICARE/CHAMPUS DRG-based payment system.

C. Services exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the TRICARE/CHAMPUS DRG-based payment system, are exempt from the TRICARE/CHAMPUS DRG-based payment system and shall be reimbursed under the appropriate procedures.

1. Services provided by hospitals exempt from the DRG-based payment system as defined in [paragraph III.F](#) below.

2. All services related to solid organ acquisition, including the costs of the donor's inpatient stay for TRICARE/CHAMPUS covered transplants by TRICARE/CHAMPUS-authorized transplantation centers.

3. All services related to **Pancreas Transplant Alone (PTA)**, **Pancreas After Kidney (PAK)** and **Simultaneous Pancreas-Kidney (SPK)** transplant through September 30, 1999. Effective October 1, 1999, SPK, PTA and PAK will be paid under the appropriate DRG. Acquisition costs will continue to be paid on a reasonable cost basis and are not included in the DRG. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

4. All services related to heart, heart-lung, and liver transplantation through September 30, 1998. Effective October 1, 1998, heart and heart-lung transplants will be paid under DRG 103 and liver transplants will be paid under DRG 480. Acquisition costs related to these transplants will continue to be paid on a reasonable cost basis and are not included in the DRG. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

5. All services related to a lung transplantation through September 30, 1994. Effective October 1, 1994, lung transplants will be paid under DRG 495. Acquisition costs related to the lung transplant will continue to be paid on a reasonable cost basis and are not included in the DRG. **Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at <http://www.tricare.mil/drgrates/>.**

6. All services related to small intestine, combined small intestine/liver and multivisceral transplants through September 30, 2001. Effective October 1, 2001, these transplants shall be paid under the appropriate DRG. Acquisition costs related to these transplants shall continue to be paid on a reasonable cost basis and are not included in the DRG.

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 6, SECTION 4

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

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7. All services related to **C**ombined **L**iver-**K**idney (CLKT) and **C**ombined **H**ear**t**-**K**idney **T**ransplant (CHKT) through July 31, 2003. Effective August 1, 2003, CLKTs and CHKTs shall be paid under the assigned DRG based on the procedure performed.

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

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

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

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

11. All outpatient services related to inpatient stays.

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

12. All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) bone marrow transplants which would otherwise be paid under DRG 481.

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

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

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

286.0 Congenital Factor VIII Disorder;

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

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

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

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

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

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

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

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

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

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e. For admissions occurring on or after October 1, 2002, through September 30, 2003, the following HCPCS codes and payment rates shall be used for blood clotting factors:

J7190 Factor VIII (antihemophilic factor - human), per IU	\$0.86 per unit
J7191 Factor VIII (antihemophilic factor - porcine), per IU	2.04 per unit
J7192 Factor VIII (antihemophilic factor - recombinant), per IU	1.24 per unit
J7193 Factor IX (antihemophilic factor, purified - non-recombinant), per IU	1.05 per unit
J7194 Factor IX (complex), per IU	0.33 per unit
J7195 Factor IX (antihemophilic factor - recombinant), per IU	1.12 per unit
J7198 Anti-Inhibitor, per IU	1.43 per unit
J7199 Hemophilia Clotting Factor, not otherwise classified (the provider must report the name of the drug and how the drug is dispensed in the remarks section of the claim)	
Q0187 Factor VIIa (coagulation factor - recombinant) one billing unit per 1.2mg	1,596 per unit
Q2022 Von Willebrand Factor (complex - human) per IU	0.95 per unit

f. For admissions occurring on or after October 1, 2003, contractors shall use the "J" code pricing file to price blood clotting factor. For pricing of blood clotting factor that is not listed in the "J" code pricing file, the contractor shall use 95 percent of the median AWP.

g. For admissions occurring on or after October 1, 2005, contractors shall make payment for blood clotting factor using Average Sale Price (ASP) plus 6 percent, using the Medicare Part B Drug Pricing file. The price allows for payment of a furnishing fee and is included in the ASP per unit.

D. Hospitals subject to the TRICARE/CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are authorized to provide services to TRICARE/CHAMPUS beneficiaries are subject to the DRG-based payment system except for those hospitals and hospital units below.

E. Substance Use Disorder Rehabilitation Facilities. With admissions on or after July 1, 1995, substance use disorder rehabilitation facilities, are subject to the DRG-based system.

F. The following types of hospitals or units which are exempt from the Medicare PPS, are exempt from the TRICARE CHAMPUS DRG-based payment system. In order for hospitals and units which do not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system, they must meet the same criteria (as determined by the TRICARE Management Activity, or designee) as required for exemption from the Medicare PPS as contained in Section 412 of Title 42 CFR.

1. Hospitals within hospitals.
2. Psychiatric hospitals.

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3. Rehabilitation hospitals.
4. Psychiatric and rehabilitation units (distinct parts).
5. Long-term hospitals.

6. Sole Community Hospitals (SCHs). Any hospital which has qualified for special treatment under the Medicare PPS as a sole community hospital and has not given up that classification is exempt from the TRICARE/CHAMPUS DRG-based payment system. For additional information on SCHs, refer to [Chapter 14, Section 1](#).

7. Christian Science sanitariums.

8. Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare PPS is exempt from the TRICARE/CHAMPUS DRG-based payment system.

9. Hospitals outside the 50 United States, the District of Columbia, and Puerto Rico.

10. Satellite facilities.

G. Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized TRICARE/CHAMPUS provider. However, any hospital which is subject to the TRICARE/CHAMPUS DRG-based payment system and which otherwise meets TRICARE/CHAMPUS requirements but which is not a Medicare-participating provider (having completed a CMS 1561, Health Insurance Benefit Agreement, and a CMS 1514, Hospital Request for Certification in the Medicare/Medicaid Program) must complete a participation agreement ([Chapter 6, Addendum A](#)) with TMA. By completing the participation agreement, the hospital agrees to participate on all inpatient claims and to accept the TRICARE/CHAMPUS-determined allowable amount as payment in full for its services. Any hospital which does not participate in Medicare and does not complete a participation agreement with TMA will not be authorized to provide services to program beneficiaries.

H. Critical Access Hospitals (CAHs). CAHs are subject to the DRG-based payment system. For additional information on CAHs, refer to [Chapter 15, Section 1](#).

- END -

## HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (DRG WEIGHTING FACTORS)

ISSUE DATE: October 6, 1987

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

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### I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

### II. ISSUE

What is the purpose of DRG weighting factors under the TRICARE/CHAMPUS DRG-based payment system, and how will they be calculated, used, and updated?

### III. POLICY

A. DRG Weighting Factors. The DRG weights reflect the relative resource consumption associated with each DRG. That is, the weight reflects the average resources required by all hospitals to treat a case classified as a specific DRG relative to the resources required to treat cases in each of the other DRGs. All weights are standardized to a theoretical average weight of 1.0 which is the average weight of all TRICARE/CHAMPUS claims in the data base. (This is the relative weight of the national average charge per discharge.)

B. Calculation of DRG weights. The TRICARE/CHAMPUS weights are derived from charges. They will not reflect standardization for capital or direct medical education expenses, but the charges on which they are based are standardized for indirect medical education differences. The TRICARE/CHAMPUS DRG weights will be discharge-weighted. Specifically, the denominator used to calculate each weight represents the national average charge per discharge for the average patient. In order to calculate the DRG relative weights the following procedures will be followed.

1. Grouping of charges. All discharge records in the database will be grouped by DRG using the current Medicare grouper program.

2. Remove DRGs that represent discharges with invalid data or diagnoses insufficient for DRG assignment purposes from the database.

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3. Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[ \left( 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

For admissions occurring during FY 2003 and FY 2004, the same formula shall be used except the first number shall be 1.02.

For admissions occurring during FY 2005, the same formula shall be used except the first number shall be 1.07.

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.

4. Calculation of DRG average charges. After the standardization for indirect medical education, an average charge for each DRG category will be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

5. Calculation of national average charge per discharge. A national average charge per discharge will be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

6. DRG relative weights. DRG relative weights will be calculated for each DRG category by dividing each DRG average charge by the national average charge.

C. Empty and low-volume DRGs. For any DRG with less than ten (10) occurrences in the TRICARE/CHAMPUS database, the Executive Director, TMA, or designee, has the authority to consider alternative methods for estimating TRICARE/CHAMPUS weights in these low-volume DRG categories.

D. Updating DRG weights. Medicare is required to adjust the DRG relative weights under the Prospective Payment System annually to ensure that the weights reflect the use of new technologies and other practice pattern changes that affect the relative use of hospital resources among DRG categories. Likewise, every year during the annual DRG update TMA will recalculate all DRG weights using TRICARE/CHAMPUS charge data and the methodology described above.

- END -

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(f) The contractor must make the capital and direct medical education payment to the hospital within 30 days of the amended request unless notification has been sent to the hospital regarding a discrepancy in the number of days as outlined in [paragraph III.B.4.c.\(2\)\(b\)](#) above.

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

(4) Requests for reimbursement of DRG capital and DME costs shall be paid as pass-through costs. The MCS contractors are non-financially underwritten for these costs.

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

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

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

5. Children's Hospital Differential.

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

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

c. Calculation of the children's hospital differentials. The differentials will be equal to the difference between a specially-calculated ASA for children's hospitals (using the procedures described in [Chapter 6, Section 7](#)) and the ASA for FY 1988 which would otherwise be applicable. They will be calculated so that they are "revenue neutral" for

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children's hospitals; that is, for FY 1988 overall TRICARE/CHAMPUS payments to children's hospitals under the DRG-based payment system would have been equal to those under the old payment system. To accomplish this, TMA (the Office of Program Development) calculated separate ASAs for children's hospitals. Normally in calculating ASAs, TMA reduces the adjusted charges according to the Medicare Cost-To-Charge Ratio (CCR) (0.66 during FY 1988). However, in recognition of the higher costs of children's hospitals, we do not use this step in calculating the children's hospital differentials. We subtract the appropriate ASA from the children's hospital ASAs, and these amounts are the children's hospital differentials. The differentials will not be subject to annual inflation updates nor will they be recalculated except as provided below.

d. Differential amounts.

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

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

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

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

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

Large Urban Areas	
Labor portion	\$1,945.99
Non-labor portion	<u>689.42</u>
	\$2,635.41

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Other Areas	
Labor portion	\$1,483.21
Non-labor portion	<u>525.47</u>
	\$2,008.68

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

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

6. Outliers.

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

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

c. Provider Reporting of outliers. The provider is to identify outliers on the UB-92, form locator 24 - 30. Code 60 is to be used to report length-of-stay outliers, and code 66 is to be used to signify that a cost outlier is not being requested. If a claim qualifies as a cost

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outlier and code 66 is not entered in the appropriate form locator (i.e., it is blank or code 61), the contractor is to accept this as a request for cost outlier payment by the hospital.

d. Length-of-stay outliers. The TRICARE/CHAMPUS DRG-based payment system uses both short-stay and long-stay outliers, and both are reimbursed using a per diem amount. All length-of-stay 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 Length-Of-Stay (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 indirect medical education. 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 indirect medical education costs by dividing the amount by one (1) plus the hospital's

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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:

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

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

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

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, 2005, is 0.4130. The CCR for admissions occurring on or after October 1, 2006, is 0.3967. The CCR 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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The threshold shall be the greater of two times the DRG-based amount (wage-adjusted but prior to adjustment for 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 CCR was 0.4468. Effective October 1, 2006, the CCR was 0.4282. Effective October 1, 2007, the CCR 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 CCR  
(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the CCR.)
- STEP 2: Determination of Cost-Outlier Threshold:  
{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + [DRG Based Payment (wage-adjusted) x (1 + IDME)]}
- STEP 3: Determination of Cost Outlier Payment  
{[(Standardized costs - Cost-Outlier Threshold) x Marginal Cost Factor] x Adjustment Factor}
- STEP 4: Total Payments = Outlier Payments + [DRG Base Rate x (1 + IDME)]

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

7. Indirect medical education adjustment.

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

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

d. Updates of 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.

#### 8. Present on Admission (POA) Indicators and Hospital Acquired Conditions (HAC).

a. Effective for admissions on or after October 1, 2009, those inpatient acute care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a POA indicator for every diagnosis on inpatient acute care hospital claims. Providers shall report POA indicators to TRICARE in the same manner they report to the CMS.

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

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

d. The following hospitals are exempt from POA reports for TRICARE:

(1) Critical Access Hospitals (CAHs)

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- (2) Long Term Care (LTC) Hospitals
- (3) Maryland Waiver Hospitals
- (4) Cancer Hospitals
- (5) Children's Inpatient Hospitals
- (6) Inpatient Rehabilitation Hospitals
- (7) Psychiatric Hospitals
- (8) Sole Community Hospitals (SCHs)

- END -



## HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM

ISSUE DATE: November 28, 1988

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

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### I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

### II. ISSUE

How is the TRICARE inpatient mental health per diem payment system to be used in determining reimbursement for psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the DRG-based payment system?

### III. POLICY

#### A. Inpatient Mental Health Per Diem Payment System.

The inpatient mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the DRG-based payment system. The system uses two sets of per diems. One set of per diems applies to psychiatric hospitals and psychiatric units of general acute hospitals that have a relatively high number (25 or more per federal fiscal year) of TRICARE mental health discharges. For higher volume hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to psychiatric hospitals and units with a relatively low number (less than 25 per federal fiscal year) of TRICARE mental health discharges. For higher volume providers, the contractors are to maintain files which will identify when a provider becomes a high volume provider; the federal fiscal year when the provider had 25 or more TRICARE mental health discharges; the calculation of each provider's high volume rate; and the current high volume rate for the provider. For lower volume hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and indirect medical education costs and additional pass-through payments for direct medical education costs.

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##### B. Applicability of the Inpatient Mental Health Per Diem Payment System.

1. Facilities. The inpatient mental health per diem payment system applies to services covered that are provided in a Medicare DRG-exempt psychiatric hospitals and a Medicare DRG-exempt unit of a hospital. In addition, any psychiatric hospital that does not participate in Medicare, or any hospital that has a psychiatric unit that has not been so designated for exemption from Medicare DRG because the hospital does not participate in Medicare, must be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the inpatient mental health per diem payment system upon demonstrating that it meets the same Medicare criteria. The contractor is responsible for requesting from a hospital that does not participate in Medicare sufficient information from that hospital which will allow it to make a determination as to whether the hospital meets the Medicare criteria in order to designate it as a DRG-exempt hospital or unit. The inpatient mental health per diem payment system does not apply to mental health services provided in non-psychiatric hospitals or non-psychiatric units. Substance use disorder rehabilitation facilities are not reimbursed under the inpatient mental health per diem payment system (see [Chapter 7, Section 3](#)).

2. DRGs. All psychiatric hospitals' and psychiatric units' covered inpatient claims which are classified into a mental health DRG of 425 - 432 or a substance use disorder DRG of 433, DRGs 521 - 523, and DRGs 900 and 901 shall be subject to the TRICARE inpatient mental health per diem payment system. **Effective October 1, 2008, all psychiatric hospitals and psychiatric units covered claims which are classified into a mental health DRG of 880 - 887 or a substance use disorder DRG of 894, 895, 898, and 899 shall be subject to the TRICARE inpatient mental health per diem system.**

3. State Waivers. The DRG-based payment system provides for state waivers for states utilizing state developed rates applicable to all payers, i.e., Maryland. Psychiatric hospitals and units in these states, may also qualify for the waiver; however, the per diem may not exceed the cap amount applicable to other higher volume hospitals.

##### C. Hospital-Specific Per Diems for Higher Volume Psychiatric Hospitals and Units.

1. Hospital-Specific Per Diem. A hospital-specific per diem amount shall be calculated for each hospital or unit with a higher volume of TRICARE mental health discharges. The base period per diem amount shall be equal to the hospital's average daily charge for charges allowed by the government in the base period (July 1, 1987 through May 31, 1988). The average daily charge in the base period shall be calculated by reference to all TRICARE claims paid (processed) during the base period. The base period amount, however, may not exceed the cap.

2. Cap Amount. Effective for care on or after April 6, 1995, the cap amount is established at the 70th percentile.

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CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
645	10/01/1997 through 09/30/1998
660	10/01/1998 through 09/30/1999
679	10/01/1999 through 09/30/2000
702	10/01/2000 through 09/30/2001
725	10/01/2001 through 09/30/2002
750	10/01/2002 through 09/30/2003
776	10/01/2003 through 09/30/2004
802	10/01/2004 through 09/30/2005
832	10/01/2005 through 09/30/2006
860	10/01/2006 through 09/30/2007
889	10/01/2007 through 09/30/2008

3. Request for Recalculation of Per Diem Amount. Any psychiatric hospital or unit which has determined TMA calculated a hospital-specific per diem which differs by more than five (\$5) dollars from that calculated by the hospital or unit, may apply to the appropriate contractor for a recalculation unless the calculated rate has exceeded the cap amount described in the previous paragraph. The recalculation does not constitute an appeal, as the per diem rates are not appealable. Unless the provider can prove that the contractor calculation is incorrect, the contractor's calculation is final. The burden of proof shall be on the hospital or unit.

D. Regional Per Diems for Lower Volume Psychiatric Hospitals and Units.

1. Regional Per Diem. Hospitals and units with a lower volume of TRICARE patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and indirect medical education. Base period regional per diems shall be calculated based upon all TRICARE/ lower volume hospitals' and units' claims paid (processed) during the base period. Each regional per diem amount shall be the quotient of all covered charges (without consideration of other health insurance payments) divided by all covered days of care, reported on all TRICARE claims from lower volume hospitals and units in the region paid (processed) during the base period, after having been standardized for indirect medical education costs, and area wage indexes. Direct medical education costs shall be subtracted from the calculation. The regions shall be the same as the federal census regions. See [Chapter 7, Addendum A](#), for the regional per diems used for hospitals and units with a lower volume of TRICARE patients.

2. Adjustments to Regional Per Diem Rates. Two adjustments shall be made to the regional per diem rates when applicable.

o. Wage Portion or Labor-Related Share. The wage portion or labor-related share is adjusted by the DRG-based area wage adjustment. See [Chapter 7, Addendum A](#). The calculated adjusted regional per diem is not to be rounded up to the next whole dollar.

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FISCAL YEAR	WAGE PORTION
1990	73.84%
1991	71.40%
1992	71.40%
1993	71.40%
1994	71.40%
1995	71.40%
1996	71.40%
1997	71.40%
1998	71.10%
1999	71.10%
2000	71.10%
2001	71.553%
2002	71.553%
2003	71.556%
2004	71.56%
2005	71.56%
2006	71.035%
2007	75.665%
2008	75.788%

b. Indirect Medical Education Adjustment. The indirect medical education adjustment factors shall be calculated for teaching hospitals in the same manner as in the DRG-based payment system and applied to the applicable regional per diem rate for each day of the admission. For an exempt psychiatric unit in a teaching hospital, there should be a separate indirect medical education adjustment factor for the unit (separate from the rest of the hospital) when medical education applies to the unit.

3. Reimbursement of Direct Medical Education Costs. In addition to payments made to lower volume hospitals and units, the government shall annually reimburse hospitals for actual direct medical education costs associated with TRICARE beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the DRG-based payment system.

NOTE: No additional payment is to be made for capital costs. Such costs have been covered in the regional per diem rates which are based on charges.

E. Base Period and Update Factors.

1. Hospital-Specific Per Diem Calculated Using Date of Payment. The base period for calculating the hospital-specific and regional per diems, as described above is federal

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fiscal year 1988. The base period calculations shall be based on actual claims paid (processed) during the period July 1, 1987 through May 31, 1988, trended forward to September 30, 1988, using a factor of 1.1%.

2. Hospital-Specific Per Diem Calculated Using Date of Discharge. Upon application by a higher volume hospital or unit to the appropriate contractor, the hospital or unit may have its hospital-specific base period calculations based on TRICARE claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988, if it has generally experienced unusual delays in TRICARE claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least \$5.00 with the revised per diem not exceeding the cap amount. For this purpose, the unusual delays mean that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations (204 days) longer than the national average (94 days). The burden of proof shall be on the hospital.

3. Updating Hospital-Specific and Regional Per Diems. The hospital-specific per diems and the regional per diems calculated for the base period shall be in effect for admissions on or after January 1, 1989; there will be no additional update for fiscal year 1989. For subsequent fiscal years, each per diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare DRG payment system. In accordance with the final rule published March 7, 1995, in the Federal Register, all per diems in effect at the end of fiscal year 1995 shall remain frozen through fiscal year 1997. For fiscal year 1998 and thereafter the per diems shall be updated by the Medicare update factor. Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each federal fiscal year by the contractors. New hospitals shall be notified by the contractor at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the Federal Register prior to the start of that fiscal year. Initiating FY 2007, Medicare has determined a market basket and subsequent update factor specific to psychiatric facilities.

UPDATE FACTOR	FISCAL YEAR	DATE PUBLISHED
4.7%	1992	10/30/1991
4.2%	1993	12/16/1992
4.3%	1994	09/30/1993
3.7%	1995	10/03/1994
0%	1996	Frozen
0%	1997	Frozen
0%	1998	10/06/1997
2.4%	1999	09/28/1998
2.9%	2000	08/31/1999
3.4%	2001	10/18/2000
3.3%	2002	10/18/2001
3.5%	2003	09/16/2002

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UPDATE FACTOR	FISCAL YEAR	DATE PUBLISHED
3.4%	2004	09/29/2003
3.3%	2005	08/11/2004
3.8%	2006	08/11/2005
3.4%	2007	08/01/2006
3.4%	2008	08/04/2007

F. Higher Volume Hospitals and Units.

1. Higher Volume of TRICARE Mental Health Discharges During the Base Period. 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 fiscal year 1989 and all subsequent fiscal years.

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. 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.

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 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.

g. 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.

Percent of change and deflator factor (DF).

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<b>FOR 12 MONTHS ENDED:</b>	<b>PERCENT OF CHANGE</b>	<b>DF</b>
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

3. New Hospitals and Units. 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 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 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.

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.

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

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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.

#### 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.

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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 Fifty (50) States, D.C. or Puerto Rico. A hospital is exempt if it is not located in one of the 50 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.

- END -

