OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 86
6010.55-M
NOVEMBER 19, 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: **FISCAL YEAR (FY) 2009 MENTAL HEALTH REIMBURSEMENT UPDATE**

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides the FY 2009 reimbursement rates for inpatient mental health and partial hospitalization. It also contains a correction to the Diagnosis Related Group (DRG) outlier and the hospice hourly rate for FY 2009.

EFFECTIVE DATE: October 1, 2008.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

Reta Michak
Chief, Office of Medical Benefits and Reimbursement Branch

ATTACHMENT(S): 29 PAGE(S)
DISTRIBUTION: 6010.55-M

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

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UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS	
Use the daily charge (per diem rate) in effect for each day of the stay to calculate a cost-share for a stay which spans periods.	
PERIOD	**DAILY CHARGE**
October 1, 1997 - September 30, 1998	$10.20
October 1, 1998 - September 30, 1999	$10.45
October 1, 1999 - September 30, 2000	$10.85
October 1, 2000 - September 30, 2001	$11.45
April 1, 2001 (for Prime ADFMs only)	$0.00
October 1, 2001 - September 30, 2002 (for ADFMs not enrolled in Prime)	$11.90
October 1, 2002 - September 30, 2003 (for ADFMs not enrolled in Prime)	$12.72
October 1, 2003 - September 30, 2004 (for ADFMs not enrolled in Prime)	$13.32
October 1, 2004 - September 30, 2005 (for ADFMs not enrolled in Prime)	$13.90
October 1, 2005 - September 30, 2006 (for ADFMs not enrolled in Prime)	$14.35
October 1, 2006 - September 30, 2007 (for ADFMs not enrolled in Prime)	$14.80
October 1, 2007 - September 30, 2008 (for ADFMs not enrolled in Prime)	$15.15
October 1, 2008 - September 30, 2009 (for ADFMs not enrolled in Prime)	$15.65

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

c. Cost-Shares: Maternity.

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

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

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

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

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

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

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

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

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

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

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

(a) IN A DRG HOSPITAL:

1 Same newborn date of birth and date of admission.

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

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

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

(b) IN DRG EXEMPT HOSPITAL:

1 Same newborn date of birth and date of admission.

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

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

4 Different newborn date of birth and date of admission.

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

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

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

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

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

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

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

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

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

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

(2) TRICARE Standard.

(a) Cost-shares for ADFMs.

1 Except in the case of mental health services, ADFMs or their sponsors are responsible for the payment of the first $25 of the allowable institutional costs

incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

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

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

1 The cost-share will be the lesser of:

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

For FY 2005, the daily rate is $512.

For FY 2006, the daily rate is $535.

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

For FY 2008, the daily rate is $535.

For FY 2009, the daily rate is $535.

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

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

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

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

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

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

(2) The per diem amount will be required for each actual day of the beneficiary's hospital stay which the DRG-based payment covers except for the day of discharge. When the payment ends on a specific day because eligibility ends on either a long-stay or short-stay outlier day, the last day of eligibility is to be counted for determining the per diem cost-sharing amount. For claims involving a same-day discharge which qualify as an inpatient stay (e.g., the patient was admitted with the expectation of a stay of several days, but died the same day) the cost-share is to be based on a one-day stay. (The number of hospital days must contain one day in this situation.) Where long-stay outlier days are subsequently determined to be not medically necessary by a PRO, no cost-share will be required for those days, since payment for such days will be the beneficiary's responsibility entirely.

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

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

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

(3) TRICARE Extra.

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

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

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

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

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

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

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

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

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

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

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

a Fiscal Year 1998 - $137 per day.

b Fiscal Year 1999 - $140 per day.

c Fiscal Year 2000 - $144 per day.

d Fiscal Year 2001 - $149 per day.

e Fiscal Year 2002 - $154 per day.

f Fiscal Year 2003 - $159 per day.

g Fiscal Year 2004 - $164 per day.

h Fiscal Year 2005 - $169 per day.

i Fiscal Year 2006 - $175 per day.

j Fiscal Year 2007 - $181 per day.

k Fiscal Year 2008 - $187 per day.

! Fiscal Year 2009 - $193 per day.

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

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

(5) Cost-share whenever leave days are involved. There is no patient cost-share for leave days when such days are included in a hospital stay.

(6) Claims for services that are provided during an inpatient admission which are not included in the per diem rate are to be cost-shared as an inpatient claim if the contractor cannot determine where the service was rendered and the status of the patient when the service was provided. The contractor would need to examine the claim for place of service and type of service to determine if the care was rendered in the hospital while the beneficiary was an inpatient of the hospital. This would include non-mental health claims and mental health claims submitted by individual professional providers rendering medically necessary services during the inpatient admission.

f. Cost-Shares: Partial Hospitalization.

Cost-sharing for partial hospitalization is on an inpatient basis. The inpatient cost-share also applies to the associated psychotherapy billed separately by the individual professional provider. These providers will have to identify on the claim form that the psychotherapy is related to a partial hospitalization stay so the proper inpatient cost-sharing can be applied. Effective for care on or after October 1, 1995 and on or prior to March 31, 2001, the cost-share for ADFMs for inpatient mental health services is $20 per day for each day of the inpatient admission. For care provided on or after April 1, 2001, the cost-share for ADFMs enrolled in Prime for inpatient mental health services is $0. For retirees and their family members, the cost-share is 25% of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for ADFMs is to be taken from the PHP claim.

g. Cost-Shares: Ambulatory Surgery.

For the basis of payment of ambulatory surgery, see Chapter 9, Section 1.

(1) ADFMs or Authorized NATO Beneficiary. For all services reimbursed as ambulatory surgery, the cost-share will be $25 and will be assessed on the facility claim. No cost-share is to be deducted from a claim for professional services related to ambulatory surgery. This applies whether the services are provided in a freestanding ASC, a hospital outpatient department or a hospital emergency room. So long as at least one procedure on the claim is reimbursed as ambulatory surgery, the claim is to be cost-shared as ambulatory surgery as required by this section-- that is, a $25 cost-share is to be assessed to the claim for the facility charges, and no cost-share is to be taken from any claim for related professional services.

(2) Other Beneficiaries. Since the cost-share for other beneficiaries is based on a percentage rather than a set amount, it is to be taken from all ambulatory surgery claims. For professional services, the cost-share is 25% of the allowed amount. For the facility claim, the cost-share is the lesser of:

(a) Twenty-five percent (25%) of the applicable group payment rate (see Chapter 9, Section 1); or

(b) Twenty-five percent (25%) of the billed charges; or

(c) Twenty-five percent (25%) of the allowed amount as determined by the contractor.

(d) The special cost-sharing provisions for beneficiaries other than ADFMs will ensure that these beneficiaries are not disadvantaged by these procedures. In most cases, 25% of the group payment rate will be less, but because there is some variation within each group, 25% of billed charges could be less in some cases. This will ensure that the beneficiaries get the benefit of the group payment rates when they are more advantageous, but they will never be disadvantaged by them. If there is no group payment rate for a procedure, the cost-share will simply be 25% of the allowed amount.

h. Cost-Shares and Deductible: Former Spouses.

(1) Deductible. In accordance with the FY 1991 Appropriations and Authorization Acts, Sections 8064 and 712 respectively, beginning April 1, 1991, an eligible former spouse is responsible for payment of the first one hundred and fifty dollars ($150.00) of the reasonable costs/charges for otherwise covered outpatient services and/or supplies provided in any one fiscal year. Although the law defines former spouses as family members of the member or former member, there is no legal familial relationship between the former spouse and the member or former member. Moreover, any TRICARE-eligible children of the former spouse will be included in the member's or former member's family deductible. Therefore, the former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of that of any TRICARE-eligible children. In other words, a former spouse must independently meet the $150.00 deductible in any fiscal year.

(2) Cost-Share. An eligible former spouse is responsible for payment of cost-sharing amounts identical to those required for beneficiaries other than ADFMs.

i. Cost-Share Amount: Under Discounted Rate Agreements. Under managed care, where there is a negotiated (discounted) rate agreed to by the network provider, the cost-share shall be based on the following:

(1) For noninstitutional providers providing outpatient care, and for institution-based professional providers rendering both inpatient and outpatient care; the cost-share (20%) for outpatient care to ADFMs, (25%) for care to all others) shall be applied to, (after duplicates and noncovered charges are eliminated), the lowest of the billed charge, the prevailing charge, the maximum allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge.

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:

Standard Cost = (Billed Charges x CCR)

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

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

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

(d) The CCR for admissions occurring on or after October 1, 2006, is 0.3967. The CCR for admissions occurring on or after October 1, 2007, is 0.3888. The CCR for admissions occurring on or after October 1, 2008, is 0.3796.

(e) The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2007 is 0.925, for FY 2008 is 0.925, and for FY 2009 is 0.925.

(2) 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).

(3) 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).

(4) For FY 2009, a fixed loss cost-outlier threshold is set of $20,185. Effective October 1, 2008, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $18,671 (also wage-adjusted).

The cost-outlier threshold shall be calculated as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 7

MENTAL HEALTH

SECTION	SUBJECT
1	Hospital Reimbursement - TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System
2	Psychiatric Partial Hospitalization Program (PHP) Reimbursement Prior To Implementation Of OPPS, And Thereafter, Freestanding Psychiatric PHP Reimbursement
3	Substance Use Disorder Rehabilitation Facilities Reimbursement
4	Residential Treatment Center (RTC) Reimbursement
ADDENDUM A	Table Of Regional Specific Rates For Psychiatric Hospitals And Units With Low TRICARE Volume (FY 2007 - FY 2009)
ADDENDUM B	Table Of Maximum Rates For Partial Hospitalization Programs (PHPs) Prior To Implementation Of OPPS, And Thereafter, Freestanding Psychiatric PHP Reimbursement (FY 2007 - FY 2009)
ADDENDUM C	Participation Agreement For Substance Use Disorder Rehabilitation Facility (SUDRF) Services For TRICARE/CHAMPUS Beneficiaries
ADDENDUM D	TRICARE/CHAMPUS Standards For Inpatient Rehabilitation And Partial Hospitalization For The Treatment Of Substance Use Disorders (SUDRFs)
ADDENDUM E	Participation Agreement For Residential Treatment Center (RTC)
ADDENDUM F	Guidelines For The Calculation Of Individual Residential Treatment Center (RTC) Per Diem Rates
ADDENDUM G	(FY 2007) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2006
ADDENDUM G	(FY 2008) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2007
ADDENDUM G	(FY 2009) - TRICARE-Authorized Residential Treatment Centers - For Payment Of Services Provided On Or After 10/01/2008
ADDENDUM H	TRICARE/CHAMPUS Standards For Residential Treatment Centers (RTCs) Serving Children And Adolescents

SECTION	SUBJECT
ADDENDUM I	Participation Agreement For Hospital-Based Psychiatric Partial Hospitalization Program Services
ADDENDUM J	Participation Agreement For Freestanding Psychiatric Partial Hospitalization Program Services

CHAPTER 7
SECTION 1

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

ISSUE DATE: November 28, 1988
AUTHORITY: 32 CFR 199.14(a)

I. APPLICABILITY

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

II. ISSUE

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 Diagnosis Related Group (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 (IDME) costs and additional pass-through payments for direct medical education costs.

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.

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
645	10/01/1997 through 09/30/1998
660	10/01/1998 through 09/30/1999

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
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
917	10/01/2008 through 09/30/2009

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 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 IDME. 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 IDME 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.

a. 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, for area wage adjustment rates. The calculated adjusted regional per diem is not to be rounded up to the next whole dollar.

b. IDME Adjustment. The IDME 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 IDME 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 Fiscal Year (FY) 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 FY 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 FY 1995 shall remain frozen through FY 1997. For FY 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**. For FY 2007, Medicare has determined a market basket and subsequent update factor specific to psychiatric facilities.

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

F. Higher Volume Hospitals and Units.

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

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

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

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

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

b. The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE mental health discharges and the base period. The base period amount, however, can not exceed the cap described in this section. Once a statistically valid rate is established based on a year in which the hospital or unit had at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem.

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

(2) Percent of change and DF.

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 1992	85.81%	1.8581
September 30, 1993	94.48%	1.9448
September 30, 1994	106.94%	2.0694
September 30, 1995	117.20%	2.1720
September 30, 1996	123.83%	2.2383
September 30, 1997	126.20%	2.2620
September 30, 1998	116.93%	2.1693
September 30, 1999	129.19%	2.2919
September 30, 2000	128.82%	2.2882
September 30, 2001	131.83%	2.3183
September 30, 2002	141.57%	2.4157
September 30, 2003	159.90%	2.5990
September 30, 2004	171.39%	2.7139
September 30, 2005	185.93%	2.8593
September 30, 2006	200.58%	2.9724
September 30, 2007	205.85%	2.9785
September 30, 2008	203.63%	3.3363

3. New Hospitals and Units.

a. The inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under Tax Equity and Fiscal Responsibility Act (TEFRA) rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are DRG-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE mental health discharges. This provision also applies to the preceding fiscal year (if it had any TRICARE patients during the preceding fiscal year). A retrospective payment shall be required if payments were originally

made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the claims processing standards.

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

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

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

G. Payment for Hospital Based Professional Services.

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

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

H. Leave Days.

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

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

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

1. Providers Subject to the DRG-Based Payment System. Providers of inpatient care which are neither psychiatric hospitals nor psychiatric units as described earlier, or which

otherwise qualify under that discussion, are exempt from the inpatient mental health per diem payment system.

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

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

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

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

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

- END -

CHAPTER 7
ADDENDUM A

TABLE OF REGIONAL SPECIFIC RATES FOR PSYCHIATRIC HOSPITALS AND UNITS WITH LOW TRICARE VOLUME (FY 2007 - FY 2009)

UNITED STATES CENSUS REGIONS	FY 2007 REGIONAL RATES 10/01/06 - 09/30/07	FY 2008 REGIONAL RATES 10/01/07 - 09/30/08	FY 2009 REGIONAL RATES 10/01/08 - 09/30/09
Northeast:			
New England (ME, NH, VT, MA, RI, CT)	$684	$707	$730
Mid-Atlantic (NY, NJ, PA)	$659	$681	$703
Midwest:			
East North Central (OH, IN, IL, MI, WI)	$569	$588	$607
West North Central (MN, IA, MO, ND, SD, NE, KS)	$537	$555	$573
South:			
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	$678	$701	$723
East South Central (KY, TN, AL, MS)	$725	$750	$774
West South Central (AR, LA, TX, OK)	$618	$639	$659
West:			
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	$617	$638	$658
Pacific (WA, OR, CA, AK, HI)	$729	$754	$778
Puerto Rico	$465	$481	$496

NOTE: This table reflects maximum rates.

FOR FY 2009: For wage index values greater than 1.0, the wage portion or labor related share subject to the area wage adjustment is 69.7%. The non-labor related share is 30.3%. For wage index values less than or equal to 1.0, the wage portion or labor related share subject to the area wage adjustment is 62%. The non-labor related share is 38%. Utilize the appropriate year DRG wage index file for area wage adjustment calculations.

FOR FY 2009/BENEFICIARY COST-SHARE: Beneficiary cost-share (other than active duty members) for care paid on a basis of a regional per diem rate is the lower of $193 per day or 25% of the hospital billed charges effective for services rendered on or after October 1, 2008.

- END -

CHAPTER 7
ADDENDUM B

TABLE OF MAXIMUM RATES FOR PARTIAL HOSPITALIZATION PROGRAMS (PHPS) PRIOR TO IMPLEMENTATION OF OPPS, AND THEREAFTER, FREESTANDING PSYCHIATRIC PHP REIMBURSEMENT (FY 2007 - FY 2009)

UNITED STATES CENSUS REGIONS	FULL-DAY RATE (6 HOURS OR MORE)			HALF-DAY RATE (3-5 HOURS)		
	10/01/06-09/30/07	10/01/07-09/30/08	10/01/08-09/30/09	10/01/06-09/30/07	10/01/07-09/30/08	10/01/08-09/30/09
Northeast:						
New England (ME, NH, VT, MA, RI, CT)	$275	$284	$293	$207	$214	$221
Mid-Atlantic (NY, NJ, PA)	$298	$308	$318	$224	$232	$239
Midwest:						
East North Central (OH, IN, IL, MI, WI)	$262	$271	$280	$196	$203	$209
West North Central (MN, IA, MO, ND, SD, NE, KS)	$262	$271	$280	$196	$203	$209
South:						
South Atlantic (DE, MD, DC, VA, WV, NC, SC, GA, FL)	$282	$292	$301	$212	$219	$226
East South Central (KY, TN, AL, MS)	$305	$315	$325	$229	$237	$245
West South Central (AR, LA, TX, OK)	$305	$315	$325	$229	$237	$245
West:						
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	$308	$318	$328	$232	$240	$248
Pacific (WA, OR, CA, AK, HI)	$302	$312	$322	$226	$234	$241
Puerto Rico	$196	$203	$209	$148	$153	$158
Days of 3 hours or less: no payment authorized.						

NOTE: This table reflects maximum rates.

- END -

CHAPTER 11
ADDENDUM A (FY 2009)

FISCAL YEAR 2009 RATES FOR HOSPICE CARE

The following national hospice rates are for care and services provided on or after October 1, 2008, through September 30, 2009. The hospice rates applicable to the above period are:

DESCRIPTION	RATE	WAGE COMPONENT SUBJECT	UNWEIGHTED AMOUNT
Routine Home Care	$139.97	$96.17	$43.80
Continuous Home Care	$816.94 full rate = 24 hours of care/$34.04 hourly rate	$561.32	$255.62
Inpatient Respite Care	$144.79	$78.37	$66.42
General Inpatient Care	$622.66	$398.56	$224.10
Allow the provider to split bills if they span the effective date. Use the previous year's rates if the provider chooses not to split the bill.			
Hospice Cap Amount:	The latest hospice cap amount, for the cap year ending October 31, 2008, is **$22,386.15**.		

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