



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

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2010

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SUMMARY OF CHANGE(S): This change contains the annual DRG updates for FY 2010.

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**Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch**

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Chapter 2

Section 1

Cost-Shares And Deductibles

Issue Date: December 16, 1983

Authority: [32 CFR 199.4](#), [32 CFR 199.5](#), [32 CFR 199.17](#), and [32 CFR 199.18](#)

1.0 POLICY

1.1 General

1.1.1 TRICARE Standard program deductible and cost-share amounts are defined in [32 CFR 199.4](#). They are identical to those applied under TRICARE Basic.

1.1.2 TRICARE Extra program deductible and cost-share amounts are defined in [32 CFR 199.17](#).

1.1.3 TRICARE Prime program enrollment fees and copayments are defined under the Uniform Health Maintenance Organization (HMO) Benefit Schedule of Charges in [32 CFR 199.18](#). For information on fees for Prime enrollees choosing to receive care under the Point of Service (POS) option, refer to [32 CFR 199.17](#).

1.1.4 Fees under the Extended Care Health Option (ECHO) are defined in [32 CFR 199.5](#).

1.1.5 [Addendum A](#) contains a complete listing of cost-share and deductible information.

1.1.6 Waiver of Cost-Sharing and Deductible

1.1.6.1 Operation Desert Shield/Desert Storm

1.1.6.1.1 The Operation Desert Shield/Desert Storm Supplemental Appropriations Act of 1991, Public Law 102-28, April 10, 1991, allowed medical providers to voluntarily waive the patient cost-share and/or deductible for medical services provided family members of active duty personnel from August 2, 1990, until the date the "Persian Gulf conflict" ends as prescribed by Presidential proclamation or by law.

1.1.6.1.1.1 Operation Desert Storm. Operations of the United States Armed Forces conducted as a consequence of the invasion of Kuwait by Iraq (including operations known as Operation Desert Shield and Operation Desert Storm).

1.1.6.1.1.2 Persian Gulf Conflict. The period beginning on August 2, 1990, and ending thereafter on the date prescribed by Presidential proclamation or by law.

1.1.6.1.1.3 A Civilian Health Care (CHC) provider may voluntarily waive, in whole or in part, the cost-share and/or deductible of Active Duty Family Members (ADFM) if the provider certifies in

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writing that the amount charged the federal government for such health care was not increased above the amount that the health care provider would have charged the federal government for such health care had the payment not been waived.

1.1.6.1.1.3.1 The legislation only provides a temporary exemption to the cost-sharing provisions. Once the President officially proclaims an end to the "Persian Gulf conflict", the cost-sharing provision will be reinstated.

1.1.6.1.1.3.2 The legislation will not require modification of the existing claims processing guidelines. The contractors will process the claims normally, reflecting the appropriate deductible, cost-share, and catastrophic cap on the claims history, payment records, TRICARE Explanation of Benefits (EOB), etc. The waiver of cost-sharing is between the ADFM and the provider and does not affect the contractor's claims processing procedures, except as prescribed in the Program Integrity provisions in the TRICARE Operations Manual (TOM).

1.1.6.1.1.3.3 The waiver of cost-sharing will be based on the dates of care/service.

1.1.6.1.1.3.4 The waiver applies to both the Basic Program and the ECHO and is applicable to both inpatient and outpatient care.

1.1.6.1.1.3.5 The waiver of cost-sharing only applies to family members of active duty personnel. The other categories of TRICARE beneficiaries are still subject to the cost-sharing and deductible requirements set forth in 10 USC 1079 and 1086.

1.1.6.1.2 The exception to the cost-sharing requirements is effective for services rendered from August 2, 1990, until the date the "Persian Gulf conflict" ends as prescribed by Presidential proclamation or by law.

1.1.6.2 Operation Joint Endeavor

1.1.6.2.1 Under legislation passed for Operation Joint Endeavor, the TRICARE Standard deductible has been waived for family members of certain reserve members called to active duty. However, this provision does not provide for voluntary waiver of cost-shares or the deductibles by providers allowed under Operation Desert Storm. If the family is enrolled in TRICARE Prime, the deductible for POS is not waived for this provision.

1.1.6.2.2 The exception to the deductible requirements under Operation Joint Endeavor for TRICARE Standard and Extra is effective for services rendered from December 8, 1995 until such time as Executive Order 12982 expires.

1.1.6.3 Operation Noble Eagle/Operation Enduring Freedom

1.1.6.3.1 The TRICARE Standard and Extra deductible is waived for family members of members of the reserves or National Guard who have been ordered to active duty in support of operations that result from the terrorist attacks on the World Trade Center (WTC) and the Pentagon on September 11, 2001.

1.1.6.3.2 The cost-share is partially waived in certain cases for these beneficiaries. On claims from non-participating professional providers for services rendered to Standard beneficiaries, the

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allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CHAMPUS Maximum Allowable Charge (CMAC)). In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

1.1.6.3.3 The exception to the deductible and cost-share requirements under Operation Noble Eagle/Operation Enduring Freedom for TRICARE Standard and Extra is effective for services rendered from September 14, 2001, through October 31, 2009.

1.1.6.4 For Certain Reservists

The Director, TRICARE Management Activity (TMA), may waive the individual or family deductible for family members of a Reserve Component (RC) member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a RC member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 United States Code (USC) 101(a)(13). Also, for this purpose a family member is a lawful husband or wife of the member or an eligible child.

1.2 TRICARE Prime

1.2.1 Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See [Addendum A](#) for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act, [Public Law 106-398](#), for services provided on or after April 1, 2001, a \$0 copayment shall be charged to TRICARE Prime ADFMs of active duty service members (ADSMs) who are enrolled in TRICARE Prime. Pharmacy copayments and POS charges are not waived by the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2001.

1.2.2 In instances where the CMAC or allowable charge is less than the copayment shown on [Addendum A](#), network providers may only collect the lower of the allowable charge or the applicable copayment.

1.2.3 The TRICARE Prime copayment requirement for emergency room services is on a PER VISIT basis; this means that only one copayment is applicable to the entire emergency room episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers.

1.2.4 Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply):

1.2.4.1 Diagnostic radiology and ultrasound services included in the CPT¹ procedure code range from 70000-76999, or any other code for associated contrast media;

1.2.4.2 Diagnostic nuclear medicine services included in the CPT¹ procedure code range from 78000-78999;

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1.2.4.3 Pathology and laboratory services included in the CPT² procedure code range from 80000-89399; and

1.2.4.4 Cardiovascular studies included in the CPT² procedure code range from 93000-93350.

1.2.4.5 Venipuncture included in the CPT² procedure code range from 36400-36416.

1.2.4.6 Collection of blood specimens in the CPT² procedure codes 36591 and 36592.

1.2.4.7 Fetal monitoring for CPT² procedure codes 59020, 59025, and 59050.

Note: Multiple discounting will not be applied to the following CPT² procedure codes for venipuncture, fetal monitoring, and collection of blood specimens; 36400-36416, 36591, 36592, 59020, 59025, and 59050.

1.2.5 POS option. See [Section 3](#).

1.3 Basic Program: TRICARE Standard

1.3.1 Deductible Amount: Outpatient Care

1.3.1.1 For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

1.3.1.1.1 Deductible, Individual: Each beneficiary is liable for the first fifty dollars (\$50.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

1.3.1.1.2 Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

1.3.1.2 For care rendered on or after April 1, 1991, for all TRICARE beneficiaries except family members of active duty sponsors of pay grade E-4 or below.

1.3.1.2.1 Deductible, Individual: Each beneficiary is liable for the first \$150.00 of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

1.3.1.2.2 Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed \$300.00.

1.3.1.3 TRICARE-Approved Ambulatory Surgery Centers (ASCs), Birthing Centers, or Partial Hospitalization Programs (PHPs). No deductible shall be applied to allowable amounts for services or items rendered to ADFMs or authorized NATO family members.

1.3.1.4 Allowable Amount Does Not Exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (or \$300.00 if [paragraph 1.3.1.2](#), applies), and no one beneficiary's allowable amounts exceed \$50.00 (or \$150.00 if

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1.3.3.3.7 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:

- The treatment is otherwise allowable as a benefit; and,
- Delay of the treatment until after the conclusion of the pregnancy is medically contraindicated; and,
- The illness or condition is, or increases the likelihood of, a threat to the life of the mother; or,
- The illness or condition will cause, or increase the likelihood of, a stillbirth or newborn injury or illness; or,
- The usual course of treatment must be altered or modified to minimize a defined risk of newborn injury or illness.

1.3.3.4 Cost-Shares: DRG-Based Payment System

1.3.3.4.1 General

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

1.3.3.4.2 TRICARE Standard

1.3.3.4.2.1 Cost-shares for ADFMs.

1.3.3.4.2.1.1 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.

1.3.3.4.2.1.2 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.

1.3.3.4.2.2 Cost-shares for beneficiaries other than ADFMs.

1.3.3.4.2.2.1 The cost-share will be the lesser of:

1.3.3.4.2.2.1.1 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.

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- For FY 2007, the daily rate is capped at the FY 2006 level of \$535, per Section 704 of NDAA FY 2007.
- For FYs 2008 , 2009, and 2010, the daily rate is \$535.

1.3.3.4.2.2.1.1.1 The per diem amount will be calculated as follows:

- 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.
- Add in the allowance for Capital and Direct Medical Education (CAP/DME) which have been paid to hospitals during the same database period used for determining the DRG weights and rates.
- 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.
- Multiply this amount by 0.25. In this way total cost-sharing amounts will continue to be 25% of the allowable amount.
- Determine any cost-sharing amounts which exceed 25% of the billed charge (see [paragraph 1.3.3.4.2.2.1.2](#)) and divide this amount by the total number of patient days in [paragraph 1.3.3.4.2.2.1.1](#). Add this amount to the amount in [paragraph 1.3.3.4.2.2.1.1](#). This is the per diem cost-share to be used for these beneficiaries.

1.3.3.4.2.2.1.1.2 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 Peer Review Organization (PRO), no cost-share will be required for those days, since payment for such days will be the beneficiary's responsibility entirely.

1.3.3.4.2.2.1.2 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.

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

1.3.3.4.2.2.3 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.

1.3.3.4.3 TRICARE Extra

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

1.3.3.4.3.2 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.

1.3.3.4.4 TRICARE Prime

There is no cost-share for ADFMs. For beneficiaries other than ADFMs, the cost-sharing provision 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.

1.3.3.4.5 Maternity Services

See [paragraph 1.3.3.3](#), for the cost-sharing provisions for maternity services.

1.3.3.5 Cost-Shares: Inpatient Mental Health Per Diem Payment System

1.3.3.5.1 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 1.3.3.2](#) or [1.3.3.4](#) are to be followed.

1.3.3.5.2 Cost-shares for ADFMs. 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. This \$20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any RTC, any Substance Use Disorder Rehabilitation Facility (SUDRF), 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 [Addendum A](#) for further information.

1.3.3.5.3 Cost-shares for beneficiaries other than ADFMs.

1.3.3.5.3.1 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.

1.3.3.5.3.2 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 1.3.3.5.3.2.1](#) or [paragraph 1.3.3.5.3.2.2](#):

1.3.3.5.3.2.1 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

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contractors by TMA. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

- Fiscal Year 2000 - \$144 per day.
- Fiscal Year 2001 - \$149 per day.
- Fiscal Year 2002 - \$154 per day.
- Fiscal Year 2003 - \$159 per day.
- Fiscal Year 2004 - \$164 per day.
- Fiscal Year 2005 - \$169 per day.
- Fiscal Year 2006 - \$175 per day.
- Fiscal Year 2007 - \$181 per day.
- Fiscal Year 2008 - \$187 per day.
- Fiscal Year 2009 - \$193 per day.
- **Fiscal Year 2010 - \$197 per day.**

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

1.3.3.5.4 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.

1.3.3.5.5 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.

1.3.3.5.6 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.

1.3.3.6 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, 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.

Chapter 6

Diagnostic Related Groups (DRGs)

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C (FY 2008)	Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2008
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C (FY 2010)	Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2010

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Hospital Reimbursement - TRICARE DRG-Based Payment System (Basis Of Payment)

3.4.2.1 Criteria for qualifying for interim payments. In order to qualify for interim payments the following conditions must be met. If a condition is not met, e.g., the claim is received out of chronological order, the claim is to be denied.

- The patient has been in the hospital at least 60 days.
- Multiple claims for single individuals must be submitted in chronological order.

3.4.2.2 A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill.

3.4.2.3 Contractor actions on interim claims. Contractors will process the initial claim as a complete claim and each subsequent claim as an adjustment. However, the interim claims are only a method of facilitating cash flow to providers, and the final bill is still the final accounting on the hospital stay. Therefore, upon receipt of the final bill, the contractor is required to review the entire claim to ensure that it has been correctly paid and to ensure that the cost-share has been correctly determined.

3.5 Inpatient Operating Costs

The TRICARE DRG-based payment system provides a payment amount for inpatient operating costs, including:

3.5.1 Operating costs for routine services, such as the costs of room, board, therapy services (physical, speech, etc.), and routine nursing services as well as supplies (e.g., pacemakers) necessary for the treatment of the patient;

3.5.2 Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients (the professional component of these services is not included and can be billed separately);

3.5.3 Take-home drugs for less than \$40;

3.5.4 Special care unit operating costs (intensive care type unit services); and

3.5.5 Malpractice insurance costs related to services furnished to inpatients.

3.6 Discharges And Transfers

3.6.1 Discharges

Subject to the provisions of [paragraphs 3.6.2](#) and [3.6.3](#), a hospital inpatient is considered discharged from a hospital paid under the TRICARE DRG-based payment system when:

3.6.1.1 The patient is formally released from the hospital; or

3.6.1.2 The patient dies in the hospital.

3.6.1.3 The patient is transferred to a hospital or unit that is excluded from the TRICARE DRG-based payment system under the provisions of [Section 4](#). Such cases can be identified by Form

Locator (FL) 17 on the CMS 1450 UB-04 claim form. For discharges with an admission date on or after October 1, 1998, such cases shall be processed as a transfer, if the claim contains one of the qualifying DRGs listed in [paragraph 3.6.4](#), and the patient is transferred to one of the settings outlined in [paragraph 3.6.3](#).

3.6.2 Acute Care Transfers

A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this subsection if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital is:

3.6.2.1 Paid under the TRICARE DRG-based payment system (such instances will result in two or more claims); or

3.6.2.2 Excluded from being paid under the TRICARE DRG-based payment system because of participation in a statewide cost control program which is exempt from the TRICARE DRG-based payment system under [Section 4](#) (such instances will result in two or more claims); or

3.6.2.3 Authorized as a Designated Provider (DP) [formerly Uniformed Services Treatment Facilities (USTFs)] or a Department of Veterans Affairs (DVA) hospital.

3.6.3 Postacute Care Transfers

A discharge of a hospital inpatient is considered to be a transfer for purposes of this subsection when the patient's discharge is assigned to one of the qualifying DRGs listed in [paragraph 3.6.4](#), and the discharge is made under any of the following circumstances:

3.6.3.1 To a hospital or distinct part hospital unit excluded from the TRICARE DRG-based payment system as described in [Section 4](#). Claims shall be coded 05, 62, or 63 in FL 17 on the CMS 1450 UB-04 claim form. Effective April 1, 2004, claims shall be coded 65 in FL 17 for psychiatric hospitals and units.

3.6.3.2 To a Skilled Nursing Facility (SNF). Claims shall be coded 03 in FL 17 on the CMS 1450 UB-04 claim form.

3.6.3.3 To home under a written plan of care for the provision of home health services from a home health agency and those services begin within three days after the date of discharge. Claims shall be coded 06 in FL 17 on the CMS 1450 UB-04 claim form. Claims coded 06 with a condition code of 42 or 43 in FL 18 shall be processed as a discharge instead of a transfer.

3.6.4 Qualifying DRGs

The qualifying DRGs, for purposes of [paragraph 3.6.3](#), for discharges with an admission date:

3.6.4.1 On or after October 1, 2006, are listed on either the TRICARE DRG web site at <http://www.tricare.mil/drgates/> or listed in the applicable addendum for the respective fiscal year. Addendum C reflects the most recent fiscal year and the two prior fiscal years as indicated in the following paragraphs.

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3.6.4.2 On or after October 1, 2007, are listed in [Addendum C \(FY 2008\)](#).

3.6.4.3 On or after October 1, 2008, are listed in [Addendum C \(FY 2009\)](#).

3.6.4.4 On or after October 1, 2009, are listed in [Addendum C \(FY 2010\)](#).

3.6.5 Payment For Discharges

The hospital discharging an inpatient (under [paragraph 3.6.1](#)) is paid in full in accordance with [paragraph 3.4](#).

3.6.6 Payment For Transfers

3.6.6.1 General Rule. Except as provided in [paragraphs 3.6.6.2](#) and [3.6.6.5](#), a hospital that transfers an inpatient under circumstances described in [paragraphs 3.6.2](#) or [3.6.3](#), is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the TRICARE DRG-based payment amount that would have been paid if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate DRG rate by the geometric mean LOS for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG amount. For neonatal claims, other than normal newborns, payment is graduated by paying twice the per diem amount for the first day of the stay, and 125% of the per diem rate for each subsequent day, up to the full DRG amount.

3.6.6.2 Special rule for DRGs 209, 210, and 211 for Fiscal Years (FYs) prior to FY 2006. For fiscal years prior to FY 2006, a hospital that transfers an inpatient under the circumstances described in [paragraph 3.6.3](#) and the transfer is assigned to DRGs 209, 210, and 211 is paid as follows:

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

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

3.6.6.3 Special rule for DRGs meeting specific criteria. For discharges occurring on or after October 1, 2005, a hospital that transfers an inpatient under the circumstances described in [paragraph 3.6.3](#) and the transfer is assigned to DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, and 550 shall be paid under the provisions of [paragraphs 3.6.6.2.1](#) and [3.6.6.2.2](#). For discharges occurring on or after October 1, 2007, those DRGs subject to the special payment rule for transfers are listed in [Addendum C \(FY 2008\)](#). For discharges occurring on or after October 1, 2008, those DRGs subject to the special payment rule for transfers are listed in [Addendum C \(FY 2009\)](#). For discharges occurring on or after October 1, 2009, those DRGs subject to the special payment rule for transfers are listed in [Addendum C \(FY 2010\)](#).

3.6.6.4 Outliers.

- A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers as described in [Section 8](#),

[paragraph 3.2.6.1](#). For admissions on or after October 1, 1995, when calculating the cost outlier payment, if the LOS exceeds the geometric mean LOS, the cost outlier threshold shall be limited to the DRG-based payment plus the fixed loss amount. The contractor shall readjudicate claims affected by this change if brought to their attention by any source.

- Refer to <http://www.tricare.mil/drgrates/> for payment details associated with outliers.

3.6.6.5 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/>.

3.7 Leave Of Absence Days

3.7.1 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.

3.7.2 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.

3.7.3 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.

3.7.4 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.

3.7.5 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.

3.8 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.

3.9 Redesignation Of Certain Hospitals To Other Wage Index Areas

TRICARE is simply following this statutory requirement for the Medicare Prospective Payment System (PPS), and the Centers for Medicare and Medicaid Services (CMS) determines the areas affected and wage indexes used.

3.9.1 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.

3.9.2 Admissions occurring on or after April 1, 1990. In order to correct inequities resulting from application of the rules in [paragraph 3.9.1](#), CMS modified the rules for those rural hospitals deemed to be urban. TRICARE 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.

3.9.3 Admissions occurring on or after October 1, 1991. **Public Law 101-239** created the Medicare Geographic Classification Review Board (MGCRB) to reclassify individual hospitals to different wage index areas based on requests from the hospitals. These reclassifications are intended to eliminate the continuing inequities caused by the reclassification actions described in [paragraphs 3.9.1](#) and [3.9.2](#). TRICARE has adopted these hospital-specific reclassifications effective for admissions occurring on or after October 1, 1991.

3.9.4 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.

3.10 Admissions Occurring On Or After October 1, 2004

TRICARE 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.

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

- END -

Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjusted Standardized Amounts (ASAs))

Issue Date: October 8, 1987
Authority: [32 CFR 199.14\(a\)\(1\)](#)

1.0 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.

2.0 ISSUE

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

3.0 POLICY

3.1 General

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

3.2 Calculation Of The ASA

The following procedures will be followed in calculating the TRICARE ASA.

3.2.1 Apply the Cost-to-Charge Ratio (CCR). In this step each charge is reduced to a representative cost by using the Medicare CCR. Effective FY 2008, the CCR is 0.3888. Effective FY 2009, the CCR is 0.3796. **Effective FY 2010, the CCR is 0.3740.**

3.2.2 Increase for Bad Debts. The base standardized amount will be increased by 0.01 in order to reimburse hospitals for bad debt expenses attributable to TRICARE beneficiaries. The base

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

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

3.2.4 Preliminary Non-Teaching Standardized Amount. At this point Indirect Medical Education (IDME) costs have been removed through standardization in the weight methodology and direct medical education costs have been removed through the application of the Medicare CCR which does not include direct medical education costs. Therefore, a non-teaching standardized amount will be computed by dividing aggregate costs by the number of discharges in the database.

3.2.5 Preliminary Teaching Standardized Amounts. A separate standardized amount will be calculated for each teaching hospital to reimburse for IDME expenses. This will be done by multiplying the non-teaching standardized amount by 1.0 plus each hospital's IDME factor.

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

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

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

- END -

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3.2.6.4.1.3 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.

3.2.6.4.1.4 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. **The CCR for admissions occurring on or after October 1, 2009, is 0.3740.**

3.2.6.4.1.5 The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2008 is 0.925, for FY 2009 is 0.925, **and for FY 2009 is 0.923.**

3.2.6.4.2 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).

3.2.6.4.3 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 \$20,185 (also wage-adjusted).

3.2.6.4.4 For FY 2010, a fixed loss cost-outlier threshold is set of \$21,358. Effective October 1, 2009, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of \$21,358 (also wage-adjusted).

3.2.6.4.5 The cost-outlier threshold shall be calculated as follows:

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

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

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3.2.6.5 Burn Outliers

3.2.6.5.1 Burn outliers generally will be subject to the same outlier policies applicable to the TRICARE 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

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

3.2.6.5.3 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

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

3.2.6.5.3.2 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%.

3.2.6.5.3.3 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.

3.2.6.5.3.4 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%.

3.2.6.5.3.5 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.

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3.2.6.6 Children's Hospital Outliers

The following special provisions apply to cost outliers.

3.2.6.6.1 The threshold shall be the same as that applied to other hospitals.

3.2.6.6.2 Effective October 1, 2007, the CCR was 0.4198. (This is equivalent to the Medicare CCR increased to account for CAP/DME costs.) Effective October 1, 2008, the CCR was 0.4099. **Effective October 1, 2009, the standardized costs are calculated using a CCR of 0.4047.**

3.2.6.6.3 The marginal cost factor shall be 80%.

3.2.6.6.4 For admissions occurring during FY 2008, the marginal cost factor shall be adjusted by 1.26. For admissions occurring during FY 2009, the marginal cost factor shall be adjusted by 1.14. **For admissions occurring during FY 2010, the marginal cost factor shall be adjusted by 1.10.**

3.2.6.6.5 The NOSCASTC for calculating the cost-outlier threshold for FYs 2008 and 2009 is 0.925. **The NOSCASTC for calculating the cost-outlier threshold for FY 2010 is 0.923.**

3.2.6.6.6 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)]

3.2.6.7 Neonatal Outliers

Neonatal outliers in hospitals subject to the TRICARE 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

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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.

3.2.7 IDME adjustment

3.2.7.1 General

The DRG-based payments for any hospital which has a teaching program approved under Medicare Regulation Section 413.85, Title 42 CFR shall be adjusted to account for IDME costs. The adjustment factor used shall be the one in effect on the date of discharge (see below). The adjustment will be made by multiplying the total DRG-based amount by 1.0 plus a hospital-specific factor equal to:

$$1.04 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

- For admissions occurring during FY 2007, the same formula shall be used except the first number shall be 1.00.
- For admissions occurring during FYs 2008, 2009, and subsequent years, the same formula shall be used except the first number shall be 1.02.

3.2.7.2 Number of Interns and Residents

TRICARE will use the number of interns and residents from CMS most recently available Provider Specific File.

3.2.7.3 Number of Beds

TRICARE will use the number of beds from CMS' most recently available Provider Specific File.

3.2.7.4 Updates of IDME Factors

3.2.7.4.1 TRICARE will use the ration of interns and residents to beds from CMS' 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 provided with the annual DR update shall be applied to claims with a date of discharge on or after October 1 of each year.

3.2.7.4.2 Other updates of IDME factors. It is the contractor's responsibility to update the IDME factor if a hospital provides information (for the same base periods) which indicates that the IDME factor provided by TRICARE with the DRG update is incorrect or needs to be updated. An IDME factor is updated based on the hospital submitting CMS Worksheet showing the number of interns, residents, and beds. The effective date of these other updates shall be the date payment is made to

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the hospital (check issued) for its CAP/DME costs, but in no case can it be later than 30 days after the hospital submits the appropriate worksheet or information. The contractor shall notify TMA of such IDME updates.

3.2.7.4.3 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.

3.2.7.5 Adjustment for Children's Hospitals

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

3.2.7.5.1 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.

3.2.7.5.2 The contractors shall send the number of interns, residents, and beds and the updated ratios for children's hospitals to TMA, Medical Benefits and Reimbursement Branch (MB&RB), or designee, by April 1 of each year to be used in TMA's annual DRG update calculations. These updated amounts will be included in the files for the October DRG update.

3.2.7.6 TRICARE for Life (TFL)

No adjustment for IDME costs is to be made on any TFL claim on which Medicare has made any payment. If TRICARE is the primary payer (e.g., claims for stays beyond 150 days) payments are to be adjusted for IDME in accordance with the provisions of this section.

3.2.8 Present On Admission (POA) Indicators and Hospital Acquired Conditions (HACs)

3.2.8.1 Effective for admissions on or after October 1, 2009, those inpatient acute care hospitals that are paid under the TRICARE/CHAMPUS DRG-based payment system shall report a POA indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. Providers shall report POA indicators to TRICARE in the same manner they report to the CMS, and in accordance with the UB-04 Data Specifications Manual, and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and

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examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-9-CM Official Guidelines for Coding and Reporting.

3.2.8.2 There are five POA indicator reporting options, as defined by the ICD-9-CM Official Coding Guidelines for Coding and Reporting:

- Y = Indicates that the condition was present on admission.
- W = Affirms that the provider has determined based on data and clinical judgement that it is not possible to document when the onset of the condition occurred.
- N = Indicates that the condition was not present on admission.
- U = Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
- 1 = Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.

3.2.8.3 HACs. TRICARE shall adopt those HACs adopted by CMS. The HACs, and their respective diagnosis codes, are posted at <http://www.tricare.mil/drgrates/>.

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

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

3.2.8.6 Exempt providers.

3.2.8.6.1 The following hospitals are exempt from POA reports for TRICARE:

- Critical Access Hospitals (CAHs)
- Long-Term Care (LTC) Hospitals
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children's Inpatient Hospitals
- Inpatient Rehabilitation Hospitals
- Psychiatric Hospitals
- Sole Community Hospitals (SCHs)
- Department of Veterans Affairs (DVA) Hospitals

3.2.8.6.2 Contractors shall identify claims from those hospitals that are exempt from POA reporting, and shall take the actions necessary to be sure that the TRICARE grouper software does not apply HAC logic to the claim.

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3.2.8.7 The DRG payment is considered payment in full, and the hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complications or charges because the DRG was demoted to a lesser-severity level.

3.2.8.8 Effective October 1, 2009, claims will be denied if a non-exempt hospital does not report a valid POA indicator for each diagnosis on the claim.

3.2.8.9 Replacement Devices

3.2.8.9.1 TRICARE is not responsible for the full cost of a replaced device if a hospital receives a partial or full credit, either due to a recall or service during the warranty period. Reimbursement in cases in which an implanted device is replaced shall be made:

- At reduced or no cost to the hospital; or
- With partial or full credit for the removed device.

3.2.8.9.2 The following condition codes 49 and 50 allow TRICARE to identify and track claims billed for replacement devices:

- Condition Code 49. Product replacement within product lifecycle. Condition code 49 is used to describe replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly - warranty.
- Condition Code 50. Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly. Condition code 50 is used to describe that the manufacturer or the U.S. Food and Drug Administration (FDA) has identified the product for recall and, therefore, replacement.

3.2.8.9.3 When a hospital receives a credit for a replaced device that is 50% or greater than the cost of the device, hospitals are required to bill the amount of the credit in the amount portion for value code **FD**.

3.2.8.9.4 Beginning with admissions on or after October 1, 2009, the contractor shall reduce hospital reimbursement for those DRGs subject to the replacement device policy, by the full or partial credit a provider received for a replaced device. The specific DRGs subject to the replacement device policy will be posted on TRICARE's DRG web page at <http://www.tricare.mil/drgrates/>. As necessary, the DRGs subject to the replacement device policy will be updated as part of the annual DRG update.

3.2.8.9.5 Hospitals must use the combination of condition code 49 or 50, along with value code **FD** to correctly bill for a replacement device that was provided with a credit or no cost. The condition code 49 or 50 will identify a replacement device while value code **FD** will communicate to TRICARE the amount of the credit, or cost reduction, received by the hospital for the replaced device.

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3.2.8.9.6 The contractor shall deduct the partial/full credit amount, reported in the amount for value code **FD** from the final DRG reimbursement when the assigned DRG is one of the DRGs subject to the replacement device policy.

3.2.8.9.7 Once a DRG rate is determined, any full/partial credit amount is deducted from the DRG reimbursement rate. The beneficiary copayment/cost-share is then determined based on the reduced rate.

- END -

TRICARE Adjusted Standardized Amounts (ASAs) - FY 2010

These amounts are effective for admissions occurring on or after October 1, 2009 through September 30, 2010.

FIGURE 6.B.2010-1 69.7% LABOR SHARE/30.3% NON-LABOR SHARE IF WAGE INDEX GREATER THAN 1

LABOR RELATED	NON-LABOR RELATED	TOTAL
\$3,327.06	\$1,508.79	\$4,835.85

FIGURE 6.B.2010-2 62% LABOR SHARE/38% NON-LABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1

LABOR RELATED	NON-LABOR RELATED	TOTAL
\$2,998.23	\$1,873.62	\$4,835.85

FY 2010 cost-share per diem for beneficiaries other than dependents of active duty member.....\$535

Chapter 6

Addendum C (FY 2010)

Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2010

Effective for admissions on or after October 1, 2008. The second column labeled "PAC XFER" indicates whether the DRG is subject to the post acute care transfer policy. The third column labeled "PAC PAY" indicates whether the DRG is subject to the post acute care special payment provision.

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
1	No	No	Heart transplant or implant of heart assist system w MCC	23.1022	36.3	26.6	5
2	No	No	Heart transplant or implant of heart assist system w/o MCC	15.8832	28.3	20.3	3
3	No	Yes	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	18.7853	37.9	30.3	8
4	No	Yes	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	12.2743	30.5	23.6	5
5	No	No	Liver transplant w MCC or intestinal transplant	15.0007	24.2	16.9	3
6	No	No	Liver transplant w/o MCC	5.9473	8.9	8.3	4
7	No	No	Lung transplant	11.5348	20.1	17.1	4
8	No	No	Simultaneous pancreas/kidney transplant	5.6183*	12.3	10.4	2
9	No	No	Bone marrow transplant	7.6374	22.5	19.1	5
10	No	No	Pancreas transplant	4.7455*	10.0	8.9	1
11	No	No	Tracheostomy for face,mouth & neck diagnoses w MCC	4.8227	15.3	10.5	2
12	No	No	Tracheostomy for face,mouth & neck diagnoses w CC	3.1525	7.8	6.4	1
13	No	No	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	1.9931	5.8	4.8	1
20	No	No	Intracranial vascular procedures w PDX hemorrhage w MCC	8.6267	16.7	12.2	1
21	No	No	Intracranial vascular procedures w PDX hemorrhage w CC	6.7264	15.2	13.2	4
22	No	No	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	5.6245	9.9	8.1	1
23	No	No	Cranio w major dev impl/acute complex CNS PDX w MCC or chemo implant	6.0551	11.5	7.6	1
24	No	No	Cranio w major dev impl/acute complex CNS PDX w/o MCC	4.2286	8.6	6.1	1
25	No	Yes	Craniotomy & endovascular intracranial procedures age >17 w MCC	5.4358	12.2	8.9	1
26	No	Yes	Craniotomy & endovascular intracranial procedures age >17 w CC	3.2170	6.1	4.8	1

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

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Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2010

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
27	No	Yes	Craniotomy & endovascular intracranial procedures age >17 w/ o CC/MCC	2.4012	3.6	2.9	1
28	Yes	Yes	Spinal procedures w MCC	4.1648	9.4	6.9	1
29	Yes	Yes	Spinal procedures w CC or spinal neurostimulators	3.0856	5.8	4.2	1
30	Yes	Yes	Spinal procedures w/o CC/MCC	1.7646	3.3	2.5	1
31	No	Yes	Ventricular shunt procedures age >17 w MCC	5.4725	14.0	7.0	1
32	No	Yes	Ventricular shunt procedures age >17 w CC	1.8380	4.6	3.3	1
33	No	Yes	Ventricular shunt procedures age >17 w/o CC/MCC	1.5100	2.8	2.3	1
34	No	No	Carotid artery stent procedure w MCC	3.5409*	6.9	4.4	1
35	No	No	Carotid artery stent procedure w CC	2.1936	3.2	2.0	1
36	No	No	Carotid artery stent procedure w/o CC/MCC	1.7611	1.7	1.3	1
37	No	No	Extracranial procedures w MCC	3.2965	6.8	5.3	1
38	No	No	Extracranial procedures w CC	1.7460	3.5	2.6	1
39	No	No	Extracranial procedures w/o CC/MCC	1.2979	1.7	1.4	1
40	Yes	Yes	Periph/cranial nerve & other nerv syst proc w MCC	3.6703	12.8	7.7	1
41	Yes	Yes	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim	2.0782	4.8	3.3	1
42	Yes	Yes	Periph/cranial nerve & other nerv syst proc w/o CC/MCC	1.5236	2.5	2.0	1
52	No	No	Spinal disorders & injuries w CC/MCC	1.9030	6.8	4.8	1
53	No	No	Spinal disorders & injuries w/o CC/MCC	0.9923	2.9	2.3	1
54	No	Yes	Nervous system neoplasms w MCC	1.7606	6.7	4.7	1
55	No	Yes	Nervous system neoplasms w/o MCC	1.1804	4.6	3.2	1
56	No	Yes	Degenerative nervous system disorders w MCC	2.1327	7.5	5.3	1
57	No	Yes	Degenerative nervous system disorders w/o MCC	1.1272	5.5	3.7	1
58	No	No	Multiple sclerosis & cerebellar ataxia w MCC	2.6176	7.7	5.9	1
59	No	No	Multiple sclerosis & cerebellar ataxia w CC	0.9914	5.1	4.0	1
60	No	No	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	0.7941	3.5	3.0	1
61	No	No	Acute ischemic stroke w use of thrombolytic agent w MCC	3.2376*	8.7	6.5	2
62	No	No	Acute ischemic stroke w use of thrombolytic agent w CC	2.2116	6.3	5.1	1
63	No	No	Acute ischemic stroke w use of thrombolytic agent w/o CC/ MCC	1.6937	4.1	3.2	1
64	No	Yes	Intracranial hemorrhage or cerebral infarction w MCC	2.2135	7.2	4.8	1
65	No	Yes	Intracranial hemorrhage or cerebral infarction w CC	1.4074	4.9	3.9	1
66	No	Yes	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	1.0123	3.2	2.6	1
67	No	No	Nonspecific cva & precerebral occlusion w/o infarct w MCC	2.6564	7.8	7.6	4
68	No	No	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC	0.9641	2.7	2.2	1
69	No	No	Transient ischemia	0.8422	2.1	1.9	1

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

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Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2010

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
70	No	Yes	Nonspecific cerebrovascular disorders w MCC	2.2337	7.6	6.0	1
71	No	Yes	Nonspecific cerebrovascular disorders w CC	1.3526	5.3	3.7	1
72	No	Yes	Nonspecific cerebrovascular disorders w/o CC/MCC	0.8858	2.6	2.0	1
73	No	No	Cranial & peripheral nerve disorders w MCC	1.3732	5.4	4.4	1
74	No	No	Cranial & peripheral nerve disorders w/o MCC	0.9435	3.6	2.8	1
75	No	No	Viral meningitis w CC/MCC	1.0441	4.5	3.7	1
76	No	No	Viral meningitis w/o CC/MCC	0.7241	3.1	2.6	1
77	No	No	Hypertensive encephalopathy w MCC	2.1101	7.9	6.8	2
78	No	No	Hypertensive encephalopathy w CC	0.9649	3.0	2.6	1
79	No	No	Hypertensive encephalopathy w/o CC/MCC	0.8168*	3.2	2.7	1
80	No	No	Nontraumatic stupor & coma w MCC	1.3526	3.3	2.5	1
81	No	No	Nontraumatic stupor & coma w/o MCC	0.6882	2.4	1.8	1
82	No	No	Traumatic stupor & coma, coma >1 hr w MCC	3.2170	6.5	4.0	1
83	No	No	Traumatic stupor & coma, coma >1 hr w CC	1.5074	6.3	3.0	1
84	No	No	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	0.9198	2.3	1.8	1
85	No	Yes	Traumatic stupor & coma, coma <1 hr age >17 w MCC	2.5383	8.0	5.1	1
86	No	Yes	Traumatic stupor & coma, coma <1 hr age >17 w CC	1.2229	4.1	3.2	1
87	No	Yes	Traumatic stupor & coma, coma <1 hr age >17 w/o CC/MCC	0.7306	2.7	1.8	1
88	No	No	Concussion age >17 w MCC	1.4789	3.6	2.7	1
89	No	No	Concussion age >17 w CC	1.0736	2.4	2.0	1
90	No	No	Concussion age >17 w/o CC/MCC	0.8333	1.5	1.3	1
91	No	Yes	Other disorders of nervous system w MCC	1.4728	6.1	3.5	1
92	No	Yes	Other disorders of nervous system w CC	0.9178	3.9	2.8	1
93	No	Yes	Other disorders of nervous system w/o CC/MCC	0.7514	2.7	2.1	1
94	No	No	Bacterial & tuberculous infections of nervous system w MCC	3.7518	11.9	9.3	1
95	No	No	Bacterial & tuberculous infections of nervous system w CC	2.4090	7.8	6.3	1
96	No	No	Bacterial & tuberculous infections of nervous system w/o CC/MCC	2.1774	6.2	5.1	1
97	No	No	Non-bacterial infect of nervous sys exc viral meningitis w MCC	3.4569	11.1	7.7	1
98	No	No	Non-bacterial infect of nervous sys exc viral meningitis w CC	1.6796	9.5	6.3	1
99	No	No	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	1.0695	4.5	3.5	1
100	No	Yes	Seizures age >17 w MCC	1.6240	5.4	4.1	1
101	No	Yes	Seizures age >17 w/o MCC	0.7756	3.0	2.5	1
102	No	No	Headaches age >17 w MCC	1.0267	4.3	3.3	1
103	No	No	Headaches age >17 w/o MCC	0.7426	3.0	2.4	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
104	No	No	Craniotomy, ventricular shunt & endovasc intracranial proc age 0-17	2.3824	5.9	3.6	1
105	No	No	Traumatic stupor & coma, coma <1 hr age 0-17	0.5474	2.1	1.7	1
106	No	No	Concussion age 0-17	0.6492	1.5	1.3	1
107	No	No	Seizures & headaches age 0-17	0.5551	2.5	2.0	1
108	No	No	Extraocular procedures except orbit age 0-17	2.0418	7.7	2.6	1
109	No	No	Other disorders of the eye age 0-17	0.6444	3.3	2.2	1
110	No	No	Other ear, nose, mouth & throat O.R. procedures age 0-17	0.7123	2.2	1.7	1
111	No	No	Sinus & mastoid procedures age 0-17	2.2488	6.4	3.5	1
112	No	No	Otitis media & URI age 0-17	0.3207	2.2	1.8	1
113	No	No	Orbital procedures w CC/MCC	1.7369	3.6	3.1	1
114	No	No	Orbital procedures w/o CC/MCC	1.0337	2.3	2.0	1
115	No	No	Extraocular procedures except orbit age >17	1.1985	3.2	2.7	1
116	No	No	Intraocular procedures w CC/MCC	1.5997	6.1	4.0	1
117	No	No	Intraocular procedures w/o CC/MCC	0.8004	1.6	1.4	1
118	No	No	Other ear, nose, mouth & throat diagnoses age 0-17	0.4778	2.6	2.0	1
119	No	No	Dental & Oral Diseases age 0-17	0.4447	2.8	2.3	1
120	No	No	Respiratory infections & inflammations age 0-17	1.6102	8.4	6.3	1
121	No	No	Acute major eye infections w CC/MCC	0.7092	4.4	3.8	1
122	No	No	Acute major eye infections w/o CC/MCC	0.4475	2.7	2.4	1
123	No	No	Neurological eye disorders	0.7990	2.7	2.1	1
124	No	No	Other disorders of the eye age >17 w MCC	1.3146*	5.6	4.1	1
125	No	No	Other disorders of the eye age >17 w/o MCC	0.6068	2.8	2.3	1
129	No	No	Major head & neck procedures w CC/MCC or major device	2.0889	4.4	3.2	1
130	No	No	Major head & neck procedures w/o CC/MCC	1.4564	2.9	2.3	1
131	No	No	Cranial/facial procedures w CC/MCC	2.3163	4.4	3.3	1
132	No	No	Cranial/facial procedures w/o CC/MCC	1.4618	1.9	1.6	1
133	No	No	Other ear, nose, mouth & throat O.R. procedures age >17 w CC/MCC	1.3075	3.0	2.1	1
134	No	No	Other ear, nose, mouth & throat O.R. procedures age >17 w/o CC/MCC	0.8680	1.8	1.5	1
135	No	No	Sinus & mastoid procedures age >17 w CC/MCC	1.8883	6.1	2.8	1
136	No	No	Sinus & mastoid procedures age >17 w/o CC/MCC	1.2293	2.2	1.7	1
137	No	No	Mouth procedures w CC/MCC	1.0633	4.1	3.3	1
138	No	No	Mouth procedures w/o CC/MCC	0.9255	2.6	2.0	1
139	No	No	Salivary gland procedures	0.9105	1.6	1.4	1
140	No	No	Simple pneumonia & pleurisy age 0-17	0.4485	2.8	2.3	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
141	No	No	Bronchitis & asthma age 0-17	0.3749	2.4	2.0	1
142	No	No	Cardiac congenital & valvular disorders age 0-17	1.7243	5.5	2.9	1
143	No	No	Stomach, esophageal & duodenal proc age 0-17	0.9421	3.7	2.7	1
144	No	No	Hernia procedures age 0-17	0.7081	2.0	1.5	1
145	No	No	Esophagitis, gastroent & misc digest disorders age 0-17	0.3781	2.5	1.9	1
146	No	No	Ear, nose, mouth & throat malignancy w MCC	2.3633*	9.5	6.7	1
147	No	No	Ear, nose, mouth & throat malignancy w CC	1.0585	4.8	3.8	1
148	No	No	Ear, nose, mouth & throat malignancy w/o CC/MCC	0.7129	2.9	2.1	1
149	No	No	Dysequilibrium	0.7345	2.2	1.8	1
150	No	No	Epistaxis w MCC	1.4833*	5.4	4.0	1
151	No	No	Epistaxis w/o MCC	0.8437	2.7	2.2	1
152	No	No	Otitis media & URI age >17 w MCC	1.1680	4.1	3.0	1
153	No	No	Otitis media & URI age >17 w/o MCC	0.5333	2.3	2.0	1
154	No	No	Other ear, nose, mouth & throat diagnoses age >17 w MCC	1.4491	4.2	3.7	1
155	No	No	Other ear, nose, mouth & throat diagnoses age >17 w CC	0.9566	3.6	2.7	1
156	No	No	Other ear, nose, mouth & throat diagnoses age >17 w/o CC/MCC	0.5835	2.5	2.1	1
157	No	No	Dental & Oral Diseases age >17 w MCC	1.3475	6.2	4.3	1
158	No	No	Dental & Oral Diseases age >17 w CC	1.1101	4.9	3.5	1
159	No	No	Dental & Oral Diseases age >17 w/o CC/MCC	0.8185	3.0	2.2	1
160	No	No	Other digestive system diagnoses age 0-17	0.5667	2.7	1.9	1
161	No	No	Hip & femur procedures except major joint age 0-17	1.2575	3.1	2.5	1
162	No	No	Lower extrem & humer proc except hip,foot,femur age 0-17	0.9123	1.9	1.6	1
163	No	Yes	Major chest procedures w MCC	4.2659	11.9	9.6	2
164	No	Yes	Major chest procedures w CC	2.3976	6.9	5.7	1
165	No	Yes	Major chest procedures w/o CC/MCC	1.7087	4.5	3.8	1
166	No	Yes	Other resp system O.R. procedures w MCC	4.0895	11.8	8.7	1
167	No	Yes	Other resp system O.R. procedures w CC	2.1648	6.7	5.2	1
168	No	Yes	Other resp system O.R. procedures w/o CC/MCC	1.3718	3.8	3.0	1
169	No	No	Fx, sprn, strn & disl except femur, hip, pelvis & thigh age 0-17	0.4453	1.6	1.4	1
170	No	No	Cellulitis age 0-17	0.4108	2.7	2.3	1
171	No	No	Trauma to the skin, subcut tiss & breast age 0-17	0.5951	2.0	1.7	1
172	No	No	Nutritional & misc metabolic disorders age 0-17	0.3032	2.3	1.9	1
173	No	No	Urethral procedures age 0-17	0.7102#	3.1	2.7	1
174	No	No	Kidney & urinary tract infections age 0-17	0.3779	2.7	2.4	1
175	No	Yes	Pulmonary embolism w MCC	1.3731	5.5	4.6	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
176	No	Yes	Pulmonary embolism w/o MCC	0.9910	4.4	3.7	1
177	No	Yes	Respiratory infections & inflammations age >17 w MCC	2.3302	10.1	7.6	1
178	No	Yes	Respiratory infections & inflammations age >17 w CC	1.8230	7.7	6.0	1
179	No	Yes	Respiratory infections & inflammations age >17 w/o CC/MCC	1.0813	5.3	4.2	1
180	No	No	Respiratory neoplasms w MCC	2.0407	7.6	5.7	1
181	No	No	Respiratory neoplasms w CC	1.5145	5.6	4.2	1
182	No	No	Respiratory neoplasms w/o CC/MCC	0.8378	3.5	2.7	1
183	No	No	Major chest trauma w MCC	1.5297	5.8	4.9	1
184	No	No	Major chest trauma w CC	1.1237	3.9	2.9	1
185	No	No	Major chest trauma w/o CC/MCC	0.7889	2.2	1.9	1
186	No	Yes	Pleural effusion w MCC	1.9658	7.2	5.5	1
187	No	Yes	Pleural effusion w CC	0.8966	3.7	2.8	1
188	No	Yes	Pleural effusion w/o CC/MCC	0.7135	3.0	2.6	1
189	No	No	Pulmonary edema & respiratory failure	1.3904	5.4	4.2	1
190	No	Yes	Chronic obstructive pulmonary disease w MCC	1.2793	5.3	4.3	1
191	No	Yes	Chronic obstructive pulmonary disease w CC	1.0601	4.6	3.7	1
192	No	Yes	Chronic obstructive pulmonary disease w/o CC/MCC	0.7366	3.5	2.9	1
193	No	Yes	Simple pneumonia & pleurisy age >17 w MCC	1.4716	5.6	4.6	1
194	No	Yes	Simple pneumonia & pleurisy age >17 w CC	0.9743	4.2	3.5	1
195	No	Yes	Simple pneumonia & pleurisy age >17 w/o CC/MCC	0.7020	3.1	2.7	1
196	No	Yes	Interstitial lung disease w MCC	1.6664	6.3	5.3	1
197	No	Yes	Interstitial lung disease w CC	1.0904	4.9	3.7	1
198	No	Yes	Interstitial lung disease w/o CC/MCC	0.7285	2.7	2.2	1
199	No	No	Pneumothorax w MCC	1.5357	6.7	5.1	1
200	No	No	Pneumothorax w CC	0.9248	4.0	3.1	1
201	No	No	Pneumothorax w/o CC/MCC	0.5318	3.1	2.5	1
202	No	No	Bronchitis & asthma age >17 w CC/MCC	0.8630	4.1	3.2	1
203	No	No	Bronchitis & asthma age >17 w/o CC/MCC	0.5863	2.8	2.4	1
204	No	No	Respiratory signs & symptoms	0.6673	2.4	1.9	1
205	No	Yes	Other respiratory system diagnoses w MCC	1.1793	4.3	3.2	1
206	No	Yes	Other respiratory system diagnoses w/o MCC	0.7354	2.4	2.0	1
207	No	Yes	Respiratory system diagnosis w ventilator support 96+ hours	6.0587	15.8	13.3	4
208	No	No	Respiratory system diagnosis w ventilator support <96 hours	2.2185	6.0	4.3	1
209	No	No	Kidney & urinary tract signs & symptoms age 0-17	0.2999	1.6	1.4	1
210	No	No	Urethral stricture age 0-17	0.4704#	1.9	1.8	1
211	No	No	Other kidney & urinary tract diagnoses age 0-17	0.5053	2.7	2.2	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
212	No	No	Testes procedures age 0-17	0.6325	1.4	1.1	1
213	No	No	Splenectomy age 0-17	1.6345	4.4	3.6	1
214	No	No	Red blood cell disorders age 0-17	0.4942	3.4	2.6	1
215	No	No	Other heart assist system implant	14.2417*	14.4	7.0	1
216	No	Yes	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	9.5126	15.1	13.2	5
217	No	Yes	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	6.9155	10.7	9.4	3
218	No	Yes	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	4.8478	6.7	6.1	2
219	Yes	Yes	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	6.9024	9.6	8.1	2
220	Yes	Yes	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	5.3863	6.9	6.2	2
221	Yes	Yes	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	4.4776	5.2	5.0	2
222	No	No	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	9.4790	11.0	8.8	2
223	No	No	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	6.7218	5.0	3.7	1
224	No	No	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	8.5024	7.7	6.7	2
225	No	No	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	6.2849	4.8	3.8	1
226	No	No	Cardiac defibrillator implant w/o cardiac cath w MCC	5.9279	7.2	4.4	1
227	No	No	Cardiac defibrillator implant w/o cardiac cath w/o MCC	4.8647	2.3	1.7	1
228	No	Yes	Other cardiothoracic procedures w MCC	7.8327	14.8	10.5	2
229	No	Yes	Other cardiothoracic procedures w CC	4.5134	6.7	5.8	2
230	No	Yes	Other cardiothoracic procedures w/o CC/MCC	3.2091	4.8	4.1	1
231	No	No	Coronary bypass w PTCA w MCC	7.6359	10.4	8.7	2
232	No	No	Coronary bypass w PTCA w/o MCC	5.8658	7.8	7.4	3
233	No	Yes	Coronary bypass w cardiac cath w MCC	7.2000	12.0	10.6	4
234	No	Yes	Coronary bypass w cardiac cath w/o MCC	5.0092	7.5	7.2	3
235	No	Yes	Coronary bypass w/o cardiac cath w MCC	6.2099	10.4	9.0	3
236	No	Yes	Coronary bypass w/o cardiac cath w/o MCC	3.7700	5.5	5.2	2
237	No	No	Major cardiovasc procedures w MCC or thoracic aortic aneurysm repair	5.4149	9.7	6.7	1
238	No	No	Major cardiovasc procedures w/o MCC	3.0185	4.3	3.2	1
239	No	Yes	Amputation for circ sys disorders exc upper limb & toe w MCC	5.1329	19.1	12.7	2
240	No	Yes	Amputation for circ sys disorders exc upper limb & toe w CC	2.6321	9.8	8.0	2
241	No	Yes	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	1.2426	5.3	4.9	2
242	No	Yes	Permanent cardiac pacemaker implant w MCC	3.2950	6.6	4.7	1
243	No	Yes	Permanent cardiac pacemaker implant w CC	2.9907	4.4	3.4	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
244	No	Yes	Permanent cardiac pacemaker implant w/o CC/MCC	2.2368	2.6	2.1	1
245	No	No	AICD generator procedures	4.6999	2.3	1.9	1
246	No	No	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/ stents	3.5229	3.4	2.7	1
247	No	No	Perc cardiovasc proc w drug-eluting stent w/o MCC	2.5233	2.0	1.7	1
248	No	No	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents	3.2327	4.2	3.2	1
249	No	No	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	2.2530	2.3	2.0	1
250	No	No	Perc cardiovasc proc w/o coronary artery stent w MCC	2.7078	5.0	3.7	1
251	No	No	Perc cardiovasc proc w/o coronary artery stent w/o MCC	2.3260	2.1	1.7	1
252	No	No	Other vascular procedures w MCC	3.2828	7.8	5.0	1
253	No	No	Other vascular procedures w CC	2.3713	4.7	3.6	1
254	No	No	Other vascular procedures w/o CC/MCC	1.7962	2.3	1.8	1
255	No	Yes	Upper limb & toe amputation for circ system disorders w MCC	2.8181*	9.9	7.4	1
256	No	Yes	Upper limb & toe amputation for circ system disorders w CC	2.0591	8.1	6.4	1
257	No	Yes	Upper limb & toe amputation for circ system disorders w/o CC/ MCC	1.0577*	4.5	3.4	1
258	No	No	Cardiac pacemaker device replacement w MCC	3.1087*	6.8	5.0	1
259	No	No	Cardiac pacemaker device replacement w/o MCC	1.8980	1.5	1.4	1
260	No	No	Cardiac pacemaker revision except device replacement w MCC	5.6083	12.7	9.5	1
261	No	No	Cardiac pacemaker revision except device replacement w CC	1.7300	2.8	2.0	1
262	No	No	Cardiac pacemaker revision except device replacement w/o CC/MCC	1.0075	1.9	1.6	1
263	No	No	Vein ligation & stripping	1.4211	4.7	2.4	1
264	No	Yes	Other circulatory system O.R. procedures	2.6683	9.0	5.8	1
265	No	No	AICD lead procedures	2.1290	2.3	1.8	1
266	No	No	Acute leukemia w/o major O.R. procedure age 0-17	3.4644	12.0	6.7	1
267	No	No	Viral illness & fever age 0-17	0.3734	2.4	2.1	1
268	No	No	Septicemia or severe sepsis age 0-17	1.2135	5.9	4.3	1
269	No	No	Traumatic injury age 0-17	0.3370	1.5	1.3	1
270	No	No	Allergic reactions age 0-17	0.2595	1.8	1.6	1
271	No	No	Poisoning & toxic effects of drugs age 0-17	0.3798	1.7	1.4	1
280	No	Yes	Acute myocardial infarction, discharged alive w MCC	1.9815	5.6	4.4	1
281	No	Yes	Acute myocardial infarction, discharged alive w CC	1.3527	3.4	2.8	1
282	No	Yes	Acute myocardial infarction, discharged alive w/o CC/MCC	1.0609	2.2	1.9	1
283	No	No	Acute myocardial infarction, expired w MCC	2.1952	4.5	3.0	1
284	No	No	Acute myocardial infarction, expired w CC	0.8907*	2.7	1.9	1
285	No	No	Acute myocardial infarction, expired w/o CC/MCC	0.6218*	1.9	1.5	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
286	No	No	Circulatory disorders except AMI, w card cath w MCC	2.2359	6.2	4.3	1
287	No	No	Circulatory disorders except AMI, w card cath w/o MCC	1.2363	2.3	1.9	1
288	No	Yes	Acute & subacute endocarditis w MCC	2.3288	9.5	7.2	1
289	No	Yes	Acute & subacute endocarditis w CC	2.3521	7.7	5.8	1
290	No	Yes	Acute & subacute endocarditis w/o CC/MCC	1.3667*	5.5	4.5	1
291	No	Yes	Heart failure & shock w MCC	1.4872	6.0	4.5	1
292	No	Yes	Heart failure & shock w CC	0.9164	4.0	3.3	1
293	No	Yes	Heart failure & shock w/o CC/MCC	0.7176	3.0	2.5	1
294	No	No	Deep vein thrombophlebitis w CC/MCC	0.8294	3.8	3.1	1
295	No	No	Deep vein thrombophlebitis w/o CC/MCC	0.5192	3.2	2.8	1
296	No	No	Cardiac arrest, unexplained w MCC	1.6131	2.8	2.1	1
297	No	No	Cardiac arrest, unexplained w CC	0.7441*	1.8	1.4	1
298	No	No	Cardiac arrest, unexplained w/o CC/MCC	0.4961*	1.2	1.1	1
299	No	Yes	Peripheral vascular disorders w MCC	1.1870	4.9	4.1	1
300	No	Yes	Peripheral vascular disorders w CC	0.9063	4.5	3.6	1
301	No	Yes	Peripheral vascular disorders w/o CC/MCC	0.5992	3.2	2.6	1
302	No	No	Atherosclerosis w MCC	0.8977	3.0	2.4	1
303	No	No	Atherosclerosis w/o MCC	0.7094	2.1	1.7	1
304	No	No	Hypertension w MCC	1.2727	4.0	3.2	1
305	No	No	Hypertension w/o MCC	0.7033	2.4	1.9	1
306	No	No	Cardiac congenital & valvular disorders age >17 w MCC	1.1200	6.1	3.5	1
307	No	No	Cardiac congenital & valvular disorders age >17 w/o MCC	0.7764	2.2	1.8	1
308	No	No	Cardiac arrhythmia & conduction disorders w MCC	1.1964	4.4	3.4	1
309	No	No	Cardiac arrhythmia & conduction disorders w CC	0.7216	2.8	2.3	1
310	No	No	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.5516	2.0	1.7	1
311	No	No	Angina pectoris	0.5881	1.8	1.6	1
312	No	No	Syncope & collapse	0.7439	2.3	1.9	1
313	No	No	Chest pain	0.6259	1.6	1.4	1
314	No	Yes	Other circulatory system diagnoses w MCC	1.7676	6.7	4.9	1
315	No	Yes	Other circulatory system diagnoses w CC	0.9806	4.1	3.0	1
316	No	Yes	Other circulatory system diagnoses w/o CC/MCC	0.6690	2.3	1.8	1
326	No	Yes	Stomach, esophageal & duodenal proc age >17 w MCC	6.1102	15.7	11.2	2
327	No	Yes	Stomach, esophageal & duodenal proc age >17 w CC	2.2883	6.3	4.7	1
328	No	Yes	Stomach, esophageal & duodenal proc age >17 w/o CC/MCC	1.4408	3.1	2.3	1
329	No	Yes	Major small & large bowel procedures w MCC	4.9401	14.7	11.1	2
330	No	Yes	Major small & large bowel procedures w CC	2.4940	8.0	6.9	2

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331	No	Yes	Major small & large bowel procedures w/o CC/MCC	1.6928	4.9	4.4	1
332	No	Yes	Rectal resection w MCC	4.6699	13.4	10.5	2
333	No	Yes	Rectal resection w CC	2.2288	6.8	5.9	1
334	No	Yes	Rectal resection w/o CC/MCC	1.6672	4.7	4.2	1
335	No	Yes	Peritoneal adhesiolysis w MCC	3.8804	12.2	9.9	2
336	No	Yes	Peritoneal adhesiolysis w CC	2.0335	6.8	5.5	1
337	No	Yes	Peritoneal adhesiolysis w/o CC/MCC	1.4756	4.0	3.2	1
338	No	No	Appendectomy w complicated principal diag w MCC	3.0593	7.7	6.2	1
339	No	No	Appendectomy w complicated principal diag w CC	1.8607	6.5	5.6	1
340	No	No	Appendectomy w complicated principal diag w/o CC/MCC	1.3024	3.8	3.2	1
341	No	No	Appendectomy w/o complicated principal diag w MCC	1.6130	4.6	3.5	1
342	No	No	Appendectomy w/o complicated principal diag w CC	1.2099	2.7	2.2	1
343	No	No	Appendectomy w/o complicated principal diag w/o CC/MCC	0.9757	1.6	1.4	1
344	No	No	Minor small & large bowel procedures w MCC	3.1571	10.5	7.5	1
345	No	No	Minor small & large bowel procedures w CC	1.3306	5.6	4.8	1
346	No	No	Minor small & large bowel procedures w/o CC/MCC	1.1181	4.6	3.9	1
347	No	No	Anal & stomal procedures w MCC	2.1061	7.8	5.8	1
348	No	No	Anal & stomal procedures w CC	1.2889	4.5	3.3	1
349	No	No	Anal & stomal procedures w/o CC/MCC	0.7493	2.4	2.0	1
350	No	No	Inguinal & femoral hernia procedures age >17 w MCC	2.5306*	7.8	5.7	1
351	No	No	Inguinal & femoral hernia procedures age >17 w CC	1.4725	4.0	2.7	1
352	No	No	Inguinal & femoral hernia procedures age >17 w/o CC/MCC	0.8796	1.7	1.5	1
353	No	No	Hernia procedures except inguinal & femoral age >17 w MCC	2.0229	5.9	4.9	1
354	No	No	Hernia procedures except inguinal & femoral age >17 w CC	1.4661	4.1	3.2	1
355	No	No	Hernia procedures except inguinal & femoral age >17 w/o CC/MCC	1.1429	2.5	2.2	1
356	No	Yes	Other digestive system O.R. procedures w MCC	4.3876	12.8	8.6	1
357	No	Yes	Other digestive system O.R. procedures w CC	2.1664	7.0	5.5	1
358	No	Yes	Other digestive system O.R. procedures w/o CC/MCC	1.3278	3.7	3.1	1
368	No	No	Major esophageal disorders w MCC	2.2803	6.7	5.0	1
369	No	No	Major esophageal disorders w CC	1.2163	3.9	3.1	1
370	No	No	Major esophageal disorders w/o CC/MCC	0.7299	2.8	2.3	1
371	No	Yes	Major gastrointestinal disorders & peritoneal infections w MCC	1.8597	7.7	5.5	1
372	No	Yes	Major gastrointestinal disorders & peritoneal infections w CC	1.2092	5.7	4.5	1
373	No	Yes	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	0.7413	3.8	3.2	1
374	No	Yes	Digestive malignancy w MCC	3.3698	11.8	7.8	1

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375	No	Yes	Digestive malignancy w CC	1.3271	5.5	4.2	1
376	No	Yes	Digestive malignancy w/o CC/MCC	0.8113	3.7	3.1	1
377	No	Yes	G.I. hemorrhage w MCC	1.8317	5.7	4.1	1
378	No	Yes	G.I. hemorrhage w CC	0.9727	3.5	2.9	1
379	No	Yes	G.I. hemorrhage w/o CC/MCC	0.6822	2.6	2.2	1
380	No	Yes	Complicated peptic ulcer w MCC	1.9745	8.1	5.8	1
381	No	Yes	Complicated peptic ulcer w CC	1.2597	4.9	3.8	1
382	No	Yes	Complicated peptic ulcer w/o CC/MCC	0.7443	3.0	2.6	1
383	No	No	Uncomplicated peptic ulcer w MCC	1.1391	4.7	4.1	1
384	No	No	Uncomplicated peptic ulcer w/o MCC	0.8842	3.0	2.6	1
385	No	No	Inflammatory bowel disease w MCC	1.7356	7.5	5.8	1
386	No	No	Inflammatory bowel disease w CC	1.0846	4.9	3.9	1
387	No	No	Inflammatory bowel disease w/o CC/MCC	0.7809	3.9	3.2	1
388	No	Yes	G.I. obstruction w MCC	1.7539	6.3	4.7	1
389	No	Yes	G.I. obstruction w CC	0.7913	3.8	3.0	1
390	No	Yes	G.I. obstruction w/o CC/MCC	0.6129	3.0	2.5	1
391	No	No	Esophagitis, gastroent & misc digest disorders age >17 w MCC	1.0672	4.3	3.3	1
392	No	No	Esophagitis, gastroent & misc digest disorders age >17 w/o MCC	0.7389	3.0	2.4	1
393	No	No	Other digestive system diagnoses age >17 w MCC	1.5060	6.5	4.5	1
394	No	No	Other digestive system diagnoses age >17 w CC	0.8858	3.9	3.1	1
395	No	No	Other digestive system diagnoses age >17 w/o CC/MCC	0.7099	2.8	2.3	1
405	No	Yes	Pancreas, liver & shunt procedures w MCC	5.3766	15.4	11.9	2
406	No	Yes	Pancreas, liver & shunt procedures w CC	2.7166	8.0	6.4	1
407	No	Yes	Pancreas, liver & shunt procedures w/o CC/MCC	1.9613	5.6	4.9	1
408	No	No	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	3.8609	14.5	12.1	3
409	No	No	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	1.8912	6.4	5.8	2
410	No	No	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	1.8492	5.5	4.8	1
411	No	No	Cholecystectomy w c.d.e. w MCC	2.3147	6.5	5.6	2
412	No	No	Cholecystectomy w c.d.e. w CC	2.6669	5.8	5.4	2
413	No	No	Cholecystectomy w c.d.e. w/o CC/MCC	1.3953	4.0	3.1	1
414	No	Yes	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	3.8771	10.2	8.0	2
415	No	Yes	Cholecystectomy except by laparoscope w/o c.d.e. w CC	1.9549	5.7	4.6	1
416	No	Yes	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	1.3924	3.9	3.3	1
417	No	No	Laparoscopic cholecystectomy w/o c.d.e. w MCC	2.1054	5.6	4.4	1

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418	No	No	Laparoscopic cholecystectomy w/o c.d.e. w CC	1.5693	3.8	3.2	1
419	No	No	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	1.1872	2.4	2.0	1
420	No	No	Hepatobiliary diagnostic procedures w MCC	3.6481	11.3	8.9	2
421	No	No	Hepatobiliary diagnostic procedures w CC	2.4704	9.8	7.2	1
422	No	No	Hepatobiliary diagnostic procedures w/o CC/MCC	1.0838	4.4	2.8	1
423	No	No	Other hepatobiliary or pancreas O.R. procedures w MCC	4.2885	11.3	8.0	1
424	No	No	Other hepatobiliary or pancreas O.R. procedures w CC	2.3095	7.4	5.9	1
425	No	No	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	1.6069*	5.2	3.9	1
432	No	No	Cirrhosis & alcoholic hepatitis w MCC	1.7332	6.9	5.1	1
433	No	No	Cirrhosis & alcoholic hepatitis w CC	1.0467	5.0	3.8	1
434	No	No	Cirrhosis & alcoholic hepatitis w/o CC/MCC	0.6515	2.9	2.3	1
435	No	No	Malignancy of hepatobiliary system or pancreas w MCC	1.8619	6.8	5.1	1
436	No	No	Malignancy of hepatobiliary system or pancreas w CC	1.1182	4.7	3.7	1
437	No	No	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	1.1362	3.4	2.9	1
438	No	No	Disorders of pancreas except malignancy w MCC	2.1860	8.2	5.9	1
439	No	No	Disorders of pancreas except malignancy w CC	1.2196	5.3	4.3	1
440	No	No	Disorders of pancreas except malignancy w/o CC/MCC	0.7626	3.5	2.9	1
441	No	Yes	Disorders of liver except malig,cirr,alc hepa w MCC	2.1474	7.8	5.3	1
442	No	Yes	Disorders of liver except malig,cirr,alc hepa w CC	0.9818	4.5	3.5	1
443	No	Yes	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	0.7117	3.1	2.5	1
444	No	No	Disorders of the biliary tract w MCC	1.4648	5.4	4.0	1
445	No	No	Disorders of the biliary tract w CC	1.0577	3.5	2.9	1
446	No	No	Disorders of the biliary tract w/o CC/MCC	0.6902	2.4	2.0	1
453	No	No	Combined anterior/posterior spinal fusion w MCC	10.5770	11.6	9.1	2
454	No	No	Combined anterior/posterior spinal fusion w CC	7.3128	5.5	4.7	1
455	No	No	Combined anterior/posterior spinal fusion w/o CC/MCC	5.8478	3.6	3.1	1
456	No	No	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC	8.5999	10.9	8.3	2
457	No	No	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC	6.8632	6.4	5.5	2
458	No	No	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC	5.2786	4.4	4.2	2
459	No	Yes	Spinal fusion except cervical w MCC	6.3189	8.4	6.9	2
460	No	Yes	Spinal fusion except cervical w/o MCC	4.0419	3.3	2.8	1
461	No	No	Bilateral or multiple major joint procs of lower extremity w MCC	4.9762	7.2	6.3	2
462	No	No	Bilateral or multiple major joint procs of lower extremity w/o MCC	3.3332	4.2	3.9	2
463	No	Yes	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	6.3989	18.5	12.5	2

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
464	No	Yes	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	2.9502	8.9	6.8	1
465	No	Yes	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	1.9878	4.6	3.5	1
466	No	Yes	Revision of hip or knee replacement w MCC	4.7382	8.7	7.1	1
467	No	Yes	Revision of hip or knee replacement w CC	3.1397	4.4	3.9	1
468	No	Yes	Revision of hip or knee replacement w/o CC/MCC	2.6717	3.2	2.9	1
469	No	Yes	Major joint replacement or reattachment of lower extremity w MCC	3.0824	5.5	4.9	1
470	No	Yes	Major joint replacement or reattachment of lower extremity w/o MCC	2.1598	3.2	3.0	1
471	No	No	Cervical spinal fusion w MCC	3.7081	5.5	3.6	1
472	No	No	Cervical spinal fusion w CC	2.5843	2.3	1.7	1
473	No	No	Cervical spinal fusion w/o CC/MCC	2.1380	1.4	1.2	1
474	No	Yes	Amputation for musculoskeletal sys & conn tissue dis w MCC	5.6406	16.1	11.6	2
475	No	Yes	Amputation for musculoskeletal sys & conn tissue dis w CC	1.8869	7.1	5.3	1
476	No	Yes	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	0.8264	2.8	2.4	1
477	Yes	Yes	Biopsies of musculoskeletal system & connective tissue w MCC	3.4791*	11.1	8.7	1
478	Yes	Yes	Biopsies of musculoskeletal system & connective tissue w CC	1.9877	5.3	4.1	1
479	Yes	Yes	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	1.4171	3.3	2.4	1
480	Yes	Yes	Hip & femur procedures except major joint age >17 w MCC	3.5131	8.4	7.1	2
481	Yes	Yes	Hip & femur procedures except major joint age >17 w CC	2.1667	5.8	4.9	1
482	Yes	Yes	Hip & femur procedures except major joint age >17 w/o CC/MCC	1.5280	3.4	2.9	1
483	No	Yes	Major joint & limb reattachment proc of upper extremity w CC/MCC	2.2412	3.2	2.6	1
484	No	Yes	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	1.8778	1.9	1.7	1
485	No	No	Knee procedures w pdx of infection w MCC	2.9996	11.3	10.2	4
486	No	No	Knee procedures w pdx of infection w CC	1.6817	5.8	4.4	1
487	No	No	Knee procedures w pdx of infection w/o CC/MCC	1.5487	4.7	4.0	1
488	No	Yes	Knee procedures w/o pdx of infection w CC/MCC	1.9991	4.1	3.0	1
489	No	Yes	Knee procedures w/o pdx of infection w/o CC/MCC	1.3756	2.2	1.8	1
490	No	No	Back & neck proc exc spinal fusion w CC/MCC or disc device/neurostim	2.2154	3.1	2.3	1
491	No	No	Back & neck proc exc spinal fusion w/o CC/MCC	1.1832	1.6	1.4	1
492	Yes	Yes	Lower extrem & humer proc except hip,foot,femur age >17 w MCC	3.0622	8.0	6.5	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
493	Yes	Yes	Lower extrem & humer proc except hip,foot,femur age >17 w CC	2.1768	4.8	3.7	1
494	Yes	Yes	Lower extrem & humer proc except hip,foot,femur age >17 w/o CC/MCC	1.3981	2.6	2.2	1
495	Yes	Yes	Local excision & removal int fix devices exc hip & femur w MCC	2.3038	7.5	5.9	1
496	Yes	Yes	Local excision & removal int fix devices exc hip & femur w CC	1.5270	4.1	3.2	1
497	Yes	Yes	Local excision & removal int fix devices exc hip & femur w/o CC/MCC	1.1698	2.3	1.8	1
498	No	No	Local excision & removal int fix devices of hip & femur w CC/MCC	1.8550	5.6	4.4	1
499	No	No	Local excision & removal int fix devices of hip & femur w/o CC/MCC	0.9538	2.4	1.7	1
500	Yes	Yes	Soft tissue procedures w MCC	3.2927	11.4	7.7	1
501	Yes	Yes	Soft tissue procedures w CC	1.4603	4.5	3.4	1
502	Yes	Yes	Soft tissue procedures w/o CC/MCC	0.9738	2.2	1.8	1
503	No	No	Foot procedures w MCC	2.4237*	8.8	6.7	1
504	No	No	Foot procedures w CC	1.8687	4.9	3.9	1
505	No	No	Foot procedures w/o CC/MCC	1.1507	2.4	2.0	1
506	No	No	Major thumb or joint procedures	1.2013	3.7	3.1	1
507	No	No	Major shoulder or elbow joint procedures w CC/MCC	1.5361	3.4	2.7	1
508	No	No	Major shoulder or elbow joint procedures w/o CC/MCC	1.5484	2.2	1.8	1
509	No	No	Arthroscopy	1.2511	3.2	2.3	1
510	No	Yes	Shoulder,elbow or forearm proc,exc major joint proc w MCC	2.6340	5.5	4.6	1
511	No	Yes	Shoulder,elbow or forearm proc,exc major joint proc w CC	1.9490	3.9	3.1	1
512	No	Yes	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	1.0392	1.7	1.5	1
513	No	No	Hand or wrist proc, except major thumb or joint proc w CC/MCC	1.3545	3.7	2.8	1
514	No	No	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	0.9264	2.0	1.7	1
515	Yes	Yes	Other musculoskelet sys & conn tiss O.R. proc w MCC	5.4813	10.6	6.8	1
516	Yes	Yes	Other musculoskelet sys & conn tiss O.R. proc w CC	2.0871	4.8	3.6	1
517	Yes	Yes	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	1.6846	2.9	2.2	1
533	No	Yes	Fractures of femur w MCC	1.7352*	6.9	5.0	1
534	No	Yes	Fractures of femur w/o MCC	0.5547	2.2	1.6	1
535	No	Yes	Fractures of hip & pelvis w MCC	1.1158	4.7	3.8	1
536	No	Yes	Fractures of hip & pelvis w/o MCC	0.7289	3.5	2.9	1
537	No	No	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	0.9802*	4.3	3.7	1
538	No	No	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0.4499	1.4	1.3	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
539	No	Yes	Osteomyelitis w MCC	2.0032	9.0	6.7	1
540	No	Yes	Osteomyelitis w CC	1.2800	6.3	5.0	1
541	No	Yes	Osteomyelitis w/o CC/MCC	0.6722	3.3	2.8	1
542	No	Yes	Pathological fractures & musculoskelet & conn tiss malig w MCC	2.8125	9.2	6.5	1
543	No	Yes	Pathological fractures & musculoskelet & conn tiss malig w CC	1.4263	6.6	4.9	1
544	No	Yes	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	1.0665	4.3	3.3	1
545	No	Yes	Connective tissue disorders w MCC	2.5778	9.5	6.7	1
546	No	Yes	Connective tissue disorders w CC	1.2852	5.2	3.8	1
547	No	Yes	Connective tissue disorders w/o CC/MCC	0.7706	3.2	2.6	1
548	No	No	Septic arthritis w MCC	2.1402*	9.0	6.7	1
549	No	No	Septic arthritis w CC	0.9678	4.4	3.9	1
550	No	No	Septic arthritis w/o CC/MCC	0.6666	3.4	2.9	1
551	No	Yes	Medical back problems w MCC	1.3313	4.6	3.5	1
552	No	Yes	Medical back problems w/o MCC	0.7415	2.9	2.3	1
553	No	No	Bone diseases & arthropathies w MCC	0.7671	3.9	3.4	1
554	No	No	Bone diseases & arthropathies w/o MCC	0.7454	2.9	2.4	1
555	No	No	Signs & symptoms of musculoskeletal system & conn tissue w MCC	1.4700	4.1	3.0	1
556	No	No	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC	0.6802	2.6	2.1	1
557	No	Yes	Tendonitis, myositis & bursitis w MCC	1.4157	6.1	4.4	1
558	No	Yes	Tendonitis, myositis & bursitis w/o MCC	0.6671	3.5	2.7	1
559	No	Yes	Aftercare, musculoskeletal system & connective tissue w MCC	1.5481	11.5	6.2	1
560	No	Yes	Aftercare, musculoskeletal system & connective tissue w CC	1.2083	6.1	4.2	1
561	No	Yes	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	0.5418	2.2	1.8	1
562	No	Yes	Fx, sprn, strn & disl except femur, hip, pelvis & thigh age >17 w MCC	1.1249	4.3	3.3	1
563	No	Yes	Fx, sprn, strn & disl except femur, hip, pelvis & thigh age >17 w/o MCC	0.6780	2.4	1.9	1
564	No	No	Other musculoskeletal sys & connective tissue diagnoses w MCC	1.0832	4.5	3.0	1
565	No	No	Other musculoskeletal sys & connective tissue diagnoses w CC	0.8974	3.7	2.4	1
566	No	No	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	0.5967	2.7	1.9	1
573	No	Yes	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	3.3135	13.0	10.0	2
574	No	Yes	Skin graft &/or debrid for skn ulcer or cellulitis w CC	2.0611	9.1	6.8	1
575	No	Yes	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	1.1071	4.3	3.7	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
576	No	No	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	2.8801	11.8	8.7	1
577	No	No	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	1.6941	4.4	2.9	1
578	No	No	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	1.4078	2.6	2.1	1
579	No	Yes	Other skin, subcut tiss & breast proc w MCC	2.8935	9.4	6.8	1
580	No	Yes	Other skin, subcut tiss & breast proc w CC	1.5489	3.9	2.8	1
581	No	Yes	Other skin, subcut tiss & breast proc w/o CC/MCC	1.2993	2.4	1.9	1
582	No	No	Mastectomy for malignancy w CC/MCC	1.5071	2.0	1.8	1
583	No	No	Mastectomy for malignancy w/o CC/MCC	1.5008	2.0	1.7	1
584	No	No	Breast biopsy, local excision & other breast procedures w CC/MCC	1.7165	4.9	3.0	1
585	No	No	Breast biopsy, local excision & other breast procedures w/o CC/MCC	1.3185	1.9	1.5	1
592	No	Yes	Skin ulcers w MCC	1.7714	10.8	6.8	1
593	No	Yes	Skin ulcers w CC	0.8829	6.0	4.6	1
594	No	Yes	Skin ulcers w/o CC/MCC	0.7403	5.3	4.0	1
595	No	No	Major skin disorders w MCC	3.2061	10.4	7.1	1
596	No	No	Major skin disorders w/o MCC	0.8606	4.1	3.1	1
597	No	No	Malignant breast disorders w MCC	1.8095*	8.0	5.6	1
598	No	No	Malignant breast disorders w CC	0.8219	3.8	2.5	1
599	No	No	Malignant breast disorders w/o CC/MCC	0.6773*	3.5	2.6	1
600	No	No	Non-malignant breast disorders w CC/MCC	0.7033	4.0	2.9	1
601	No	No	Non-malignant breast disorders w/o CC/MCC	0.5858	3.0	2.6	1
602	No	Yes	Cellulitis age >17 w MCC	1.3742	6.3	5.0	1
603	No	Yes	Cellulitis age >17 w/o MCC	0.6622	3.6	3.0	1
604	No	No	Trauma to the skin, subcut tiss & breast age >17 w MCC	1.2161	3.3	2.5	1
605	No	No	Trauma to the skin, subcut tiss & breast age >17 w/o MCC	0.8337	2.0	1.6	1
606	No	No	Minor skin disorders w MCC	1.1577	5.8	4.4	1
607	No	No	Minor skin disorders w/o MCC	0.4524	2.7	2.2	1
608	No	No	BPD & oth chronic respiratory diseases arising in perinatal period	1.3635	10.1	6.6	1
609	No	No	Other respiratory problems after birth	1.2071	5.8	3.7	1
610	No	No	Neonate, died w/in one day of birth	0.1554	1.0	1.0	1
611	No	No	Neonate, transferred <5 days old	0.2534	1.2	1.1	1
612	No	No	Neonate, birthwt <750g, discharged alive	20.1220	73.8	39.0	1
613	No	No	Neonate, birthwt <750g, died	2.6958	6.8	2.5	1
614	No	No	Adrenal & pituitary procedures w CC/MCC	2.3836	5.9	4.6	1
615	No	No	Adrenal & pituitary procedures w/o CC/MCC	1.5168	2.7	2.3	1

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616	No	Yes	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	5.3876*	16.8	13.2	1
617	No	Yes	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	2.2954	8.2	6.6	1
618	No	Yes	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	1.4111*	6.1	5.0	1
619	No	No	O.R. procedures for obesity w MCC	3.6869	5.7	4.3	1
620	No	No	O.R. procedures for obesity w CC	1.9379	2.8	2.3	1
621	No	No	O.R. procedures for obesity w/o CC/MCC	1.7138	1.7	1.6	1
622	No	Yes	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	5.6755	14.9	12.5	3
623	No	Yes	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	2.0092	7.1	6.3	2
624	No	Yes	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC	1.2547*	5.6	4.5	1
625	No	No	Thyroid, parathyroid & thyroglossal procedures w MCC	1.9477	4.3	2.9	1
626	No	No	Thyroid, parathyroid & thyroglossal procedures w CC	1.2119	2.3	1.8	1
627	No	No	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	0.9342	1.4	1.3	1
628	No	Yes	Other endocrine, nutrit & metab O.R. proc w MCC	5.9563	17.8	11.4	1
629	No	Yes	Other endocrine, nutrit & metab O.R. proc w CC	2.1196	7.4	5.9	1
630	No	Yes	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	1.6235	3.0	2.5	1
631	No	No	Neonate, birthwt 750-999g, discharged alive	15.3730	68.3	57.7	15
632	No	No	Neonate, birthwt 750-999g, died	6.8817	14.2	6.1	1
633	No	No	Neonate, birthwt 1000-1499g, w signif O.R. proc, discharged alive	15.5787	56.2	50.8	19
634	No	No	Neonate, birthwt 1000-1499g, w/o signif O.R. proc, discharged alive	7.3512	39.3	33.1	8
635	No	No	Neonate, birthwt 1000-1499g, died	10.5451	26.1	4.5	1
636	No	No	Neonate, birthwt 1500-1999g, w signif O.R. proc, w mult major prob	13.3753	56.4	48.1	13
637	No	Yes	Diabetes w MCC	1.1942	4.4	3.4	1
638	No	Yes	Diabetes w CC	0.7260	3.3	2.7	1
639	No	Yes	Diabetes w/o CC/MCC	0.4761	2.3	2.0	1
640	No	Yes	Nutritional & misc metabolic disorders age >17 w MCC	1.2179	4.9	3.5	1
641	No	Yes	Nutritional & misc metabolic disorders age >17 w/o MCC	0.6529	2.9	2.3	1
642	No	No	Inborn errors of metabolism	0.8089	4.4	3.0	1
643	No	Yes	Endocrine disorders w MCC	1.6016	6.3	4.3	1
644	No	Yes	Endocrine disorders w CC	0.9337	4.2	3.2	1
645	No	Yes	Endocrine disorders w/o CC/MCC	0.5227	2.2	1.9	1
646	No	No	Neonate, birthwt 1500-1999g, w signif O.R. proc, w/o mult major prob	4.7535#	25.2	22.8	11

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647	No	No	Neonate, birthwt 1500-1999g, w/o signif O.R. proc, w mult major prob	5.0280	28.2	23.7	6
648	No	No	Neonate, birthwt 1500-1999g, w/o signif O.R. proc, w major prob	3.1501	19.5	15.9	3
649	No	No	Neonate, birthwt 1500-1999g, w/o signif O.R. proc, w minor prob	2.7035	18.2	15.9	5
650	No	No	Neonate, birthwt 1500-1999g, w/o signif O.R. proc, w other prob	1.8869	14.1	11.0	2
651	No	No	Neonate, birthwt 2000-2499g, w signif O.R. proc, w mult major prob	9.7064	39.3	26.0	5
652	No	No	Kidney transplant	3.3633	7.4	6.6	2
653	No	Yes	Major bladder procedures w MCC	4.7110	14.8	12.5	4
654	No	Yes	Major bladder procedures w CC	2.5036	8.2	6.9	2
655	No	Yes	Major bladder procedures w/o CC/MCC	2.0613	4.9	3.8	1
656	No	No	Kidney & ureter procedures for neoplasm w MCC	3.0678	7.2	6.1	1
657	No	No	Kidney & ureter procedures for neoplasm w CC	1.9089	4.8	4.2	1
658	No	No	Kidney & ureter procedures for neoplasm w/o CC/MCC	1.5136	3.1	2.8	1
659	No	Yes	Kidney & ureter procedures for non-neoplasm w MCC	2.7310	8.2	6.1	1
660	No	Yes	Kidney & ureter procedures for non-neoplasm w CC	1.4401	3.6	2.9	1
661	No	Yes	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	1.2412	2.6	2.2	1
662	No	No	Minor bladder procedures w MCC	3.0806*	10.2	7.4	1
663	No	No	Minor bladder procedures w CC	1.2217	2.4	2.0	1
664	No	No	Minor bladder procedures w/o CC/MCC	1.0620	1.6	1.4	1
665	No	No	Prostatectomy w MCC	3.1138*	11.4	9.0	1
666	No	No	Prostatectomy w CC	1.7212*	6.1	4.1	1
667	No	No	Prostatectomy w/o CC/MCC	0.7859	1.5	1.4	1
668	No	No	Transurethral procedures w MCC	1.7857	5.4	3.9	1
669	No	No	Transurethral procedures w CC	1.0282	2.4	1.9	1
670	No	No	Transurethral procedures w/o CC/MCC	0.8523	1.7	1.5	1
671	No	No	Urethral procedures age >17 w CC/MCC	1.6315*	6.0	4.0	1
672	No	No	Urethral procedures age >17 w/o CC/MCC	1.0740	2.1	1.8	1
673	No	No	Other kidney & urinary tract procedures w MCC	3.5104	9.4	5.4	1
674	No	No	Other kidney & urinary tract procedures w CC	1.9989	5.5	4.0	1
675	No	No	Other kidney & urinary tract procedures w/o CC/MCC	1.8749	2.8	2.0	1
676	No	No	Neonate, birthwt 2000-2499g, w signif O.R. proc, w/o mult major prob	3.8437#	19.5	15.2	4
677	No	No	Neonate, birthwt 2000-2499g, w/o signif O.R. proc, w mult major prob	3.0085	15.2	12.3	3

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
678	No	No	Neonate, birthwt 2000-2499g, w/o signif O.R. proc, w major prob	2.0860	12.5	9.9	2
679	No	No	Neonate, birthwt 2000-2499g, w/o signif O.R. proc, w minor prob	1.6935	11.3	8.8	1
680	No	No	Neonate, birthwt 2000-2499g, w/o signif O.R. proc, w other prob	0.8166	6.5	4.7	1
681	No	No	Neonate, birthwt >2499g, w signif O.R. proc, w mult major prob	10.5841	29.2	18.2	2
682	No	Yes	Renal failure w MCC	1.8835	6.7	4.9	1
683	No	Yes	Renal failure w CC	1.0468	4.6	3.6	1
684	No	Yes	Renal failure w/o CC/MCC	0.6465	2.8	2.4	1
685	No	No	Admit for renal dialysis	0.7805	2.8	2.3	1
686	No	No	Kidney & urinary tract neoplasms w MCC	1.4897	6.4	4.3	1
687	No	No	Kidney & urinary tract neoplasms w CC	1.1750	4.1	3.4	1
688	No	No	Kidney & urinary tract neoplasms w/o CC/MCC	1.0547	2.2	1.9	1
689	No	Yes	Kidney & urinary tract infections age >17 w MCC	1.0462	4.8	3.7	1
690	No	Yes	Kidney & urinary tract infections age >17 w/o MCC	0.7053	3.2	2.7	1
691	No	No	Urinary stones w esw lithotripsy w CC/MCC	1.4319	3.1	2.5	1
692	No	No	Urinary stones w esw lithotripsy w/o CC/MCC	1.0972	2.8	2.0	1
693	No	No	Urinary stones w/o esw lithotripsy w MCC	0.9919	3.4	2.8	1
694	No	No	Urinary stones w/o esw lithotripsy w/o MCC	0.6229	1.9	1.6	1
695	No	No	Kidney & urinary tract signs & symptoms age >17 w MCC	1.3760*	5.7	4.2	1
696	No	No	Kidney & urinary tract signs & symptoms age >17 w/o MCC	0.5606	2.5	2.0	1
697	No	No	Urethral stricture age >17	0.9035*	3.5	2.5	1
698	No	Yes	Other kidney & urinary tract diagnoses age >17 w MCC	1.4309	5.6	4.3	1
699	No	Yes	Other kidney & urinary tract diagnoses age >17 w CC	1.0552	3.9	3.0	1
700	No	Yes	Other kidney & urinary tract diagnoses age >17 w/o CC/MCC	0.6264	2.6	2.1	1
707	No	No	Major male pelvic procedures w CC/MCC	2.0549	3.7	3.0	1
708	No	No	Major male pelvic procedures w/o CC/MCC	1.4949	1.9	1.6	1
709	No	No	Penis procedures w CC/MCC	1.4829	3.4	2.3	1
710	No	No	Penis procedures w/o CC/MCC	1.2498	1.9	1.5	1
711	No	No	Testes procedures age >17 w CC/MCC	2.0824	8.7	4.3	1
712	No	No	Testes procedures age >17 w/o CC/MCC	0.8219	1.7	1.5	1
713	No	No	Transurethral prostatectomy w CC/MCC	1.1514	3.9	3.0	1
714	No	No	Transurethral prostatectomy w/o CC/MCC	0.8002	1.5	1.4	1
715	No	No	Other male reproductive system O.R. proc for malignancy w CC/MCC	1.9381*	6.3	4.1	1
716	No	No	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	1.1193	1.6	1.3	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
717	No	No	Other male reproductive system O.R. proc exc malignancy w CC/MCC	1.8628*	6.8	4.8	1
718	No	No	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	0.8792*	2.7	2.0	1
722	No	No	Malignancy, male reproductive system w MCC	1.6608*	7.0	5.4	1
723	No	No	Malignancy, male reproductive system w CC	1.0803*	5.1	3.9	1
724	No	No	Malignancy, male reproductive system w/o CC/MCC	0.6980*	2.8	2.1	1
725	No	No	Benign prostatic hypertrophy w MCC	1.1860*	5.1	3.9	1
726	No	No	Benign prostatic hypertrophy w/o MCC	0.7747*	3.5	2.8	1
727	No	No	Inflammation of the male reproductive system w MCC	1.4610*	6.4	5.0	1
728	No	No	Inflammation of the male reproductive system w/o MCC	0.6615	3.2	2.6	1
729	No	No	Other male reproductive system diagnoses w CC/MCC	0.8590	3.9	3.3	1
730	No	No	Other male reproductive system diagnoses w/o CC/MCC	0.5757	2.9	2.2	1
734	No	No	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	2.5080	6.3	4.8	1
735	No	No	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	1.3473	2.6	2.3	1
736	No	No	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	3.9918	11.8	10.0	3
737	No	No	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	2.1541	6.2	5.3	1
738	No	No	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	1.2852	3.0	2.7	1
739	No	No	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	3.4345	8.8	6.4	1
740	No	No	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	1.6740	4.0	3.2	1
741	No	No	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	1.1941	2.1	1.9	1
742	No	No	Uterine & adnexa proc for non-malignancy w CC/MCC	1.3412	3.1	2.6	1
743	No	No	Uterine & adnexa proc for non-malignancy w/o CC/MCC	1.0611	1.9	1.8	1
744	No	No	D&C, conization, laparoscopy & tubal interruption w CC/MCC	1.2353	3.0	2.2	1
745	No	No	D&C, conization, laparoscopy & tubal interruption w/o CC/MCC	0.8660	1.7	1.5	1
746	No	No	Vagina, cervix & vulva procedures w CC/MCC	1.2053	2.8	2.2	1
747	No	No	Vagina, cervix & vulva procedures w/o CC/MCC	1.0371	1.7	1.5	1
748	No	No	Female reproductive system reconstructive procedures	1.0238	1.5	1.3	1
749	No	No	Other female reproductive system O.R. procedures w CC/MCC	1.9995	5.6	4.3	1
750	No	No	Other female reproductive system O.R. procedures w/o CC/MCC	1.2795	3.0	2.5	1
754	No	No	Malignancy, female reproductive system w MCC	1.5586	6.3	4.7	1
755	No	No	Malignancy, female reproductive system w CC	1.0080	4.5	3.6	1
756	No	No	Malignancy, female reproductive system w/o CC/MCC	0.6530*	2.9	2.2	1

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
757	No	No	Infections, female reproductive system w MCC	1.5238	5.8	5.0	1
758	No	No	Infections, female reproductive system w CC	1.0108	4.1	3.2	1
759	No	No	Infections, female reproductive system w/o CC/MCC	0.5481	2.8	2.4	1
760	No	No	Menstrual & other female reproductive system disorders w CC/MCC	0.7579	2.7	2.2	1
761	No	No	Menstrual & other female reproductive system disorders w/o CC/MCC	0.5433	1.8	1.5	1
765	No	No	Cesarean section w CC/MCC	0.8404	4.3	3.6	1
766	No	No	Cesarean section w/o CC/MCC	0.6613	3.0	2.8	1
767	No	No	Vaginal delivery w sterilization &/or D&C	0.6743	2.3	2.2	1
768	No	No	Vaginal delivery w O.R. proc except steril &/or D&C	0.9562	3.6	2.7	1
769	No	No	Postpartum & post abortion diagnoses w O.R. procedure	1.2853	3.5	2.7	1
770	No	No	Abortion w D&C, aspiration curettage or hysterotomy	0.6465	1.6	1.4	1
774	No	No	Vaginal delivery w complicating diagnoses	0.4773	2.6	2.3	1
775	No	No	Vaginal delivery w/o complicating diagnoses	0.3881	2.1	2.0	1
776	No	No	Postpartum & post abortion diagnoses w/o O.R. procedure	0.5095	2.7	2.2	1
777	No	No	Ectopic pregnancy	0.8435	1.9	1.6	1
778	No	No	Threatened abortion	0.4433	3.9	2.3	1
779	No	No	Abortion w/o D&C	0.4254	2.0	1.6	1
780	No	No	False labor	0.2071	1.4	1.2	1
781	No	No	Other antepartum diagnoses w medical complications	0.4352	2.8	2.1	1
782	No	No	Other antepartum diagnoses w/o medical complications	0.3919	2.8	1.9	1
787	No	No	Neonate, birthwt >2499g, w signif O.R. proc, w/o mult major prob	1.5352	7.5	4.3	1
788	No	No	Neonate, birthwt >2499g, w minor abdom procedure	0.5822	2.5	2.4	1
789	No	No	Neonate, birthwt >2499g, w/o signif O.R. proc, w mult major prob	2.5402	9.8	6.4	1
790	No	No	Neonate, birthwt >2499g, w/o signif O.R. proc, w major prob	0.7437	4.8	3.6	1
791	No	No	Neonate, birthwt >2499g, w/o signif O.R. proc, w minor prob	0.3623	3.2	2.6	1
792	No	No	Neonate, birthwt >2499g, w/o signif O.R. proc, w other prob	0.1972	2.5	2.3	1
793	No	No	Neonatal aftercare for weight gain	0.4762#	7.1	7.0	6
794	No	No	Neonatal diagnosis, age > 28 days	2.0424	12.0	6.5	1
795	No	No	Normal newborn	0.1083	2.0	1.9	1
796	No	No	Multiple, other and unspecified congenital anomalies, w CC/MCC	1.2226#	8.4	5.1	2
797	No	No	Multiple, other and unspecified congenital anomalies, w/o CC/MCC	0.7715#	5.8	4.3	2
799	No	No	Splenectomy age >17 w MCC	3.4792	9.6	8.6	3

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DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
800	No	No	Splenectomy age >17 w CC	2.4219	5.3	4.6	1
801	No	No	Splenectomy age >17 w/o CC/MCC	1.5845	3.9	3.4	1
802	No	No	Other O.R. proc of the blood & blood forming organs w MCC	4.6901	15.0	11.7	2
803	No	No	Other O.R. proc of the blood & blood forming organs w CC	1.4050	3.4	2.7	1
804	No	No	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	1.0716	2.6	2.2	1
808	No	No	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	2.0762	7.9	6.2	1
809	No	No	Major hematol/immun diag exc sickle cell crisis & coagul w CC	1.1086	4.5	3.6	1
810	No	No	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	0.7769	3.6	2.9	1
811	No	No	Red blood cell disorders age >17 w MCC	1.5317	6.2	4.5	1
812	No	No	Red blood cell disorders age >17 w/o MCC	0.7241	3.3	2.5	1
813	No	No	Coagulation disorders	1.2874	3.4	2.5	1
814	No	No	Reticuloendothelial & immunity disorders w MCC	1.9832	7.7	5.3	1
815	No	No	Reticuloendothelial & immunity disorders w CC	0.7779	3.3	2.8	1
816	No	No	Reticuloendothelial & immunity disorders w/o CC/MCC	0.5907	2.7	2.2	1
820	No	No	Lymphoma & leukemia w major O.R. procedure w MCC	10.6746	29.4	20.2	3
821	No	No	Lymphoma & leukemia w major O.R. procedure w CC	2.8870	6.7	4.2	1
822	No	No	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	1.2611	3.0	2.4	1
823	No	No	Lymphoma & non-acute leukemia w other O.R. proc w MCC	5.9602	16.9	12.7	3
824	No	No	Lymphoma & non-acute leukemia w other O.R. proc w CC	3.2703	9.3	6.6	1
825	No	No	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	1.5007	3.9	2.8	1
826	No	No	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	5.4034	15.0	11.4	2
827	No	No	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	2.5202	7.1	5.0	1
828	No	No	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	1.4568	3.7	2.6	1
829	No	No	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	3.4789	11.7	5.6	1
830	No	No	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	0.8913	2.5	1.9	1
834	No	No	Acute leukemia w/o major O.R. procedure age >17 w MCC	8.6220	22.3	12.7	1
835	No	No	Acute leukemia w/o major O.R. procedure age >17 w CC	4.1207	15.0	8.4	1
836	No	No	Acute leukemia w/o major O.R. procedure age >17 w/o CC/MCC	1.7393	7.8	4.6	1
837	No	No	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	6.3185	20.6	14.9	2
838	No	No	Chemo w acute leukemia as sdx w CC or high dose chemo agent	3.1406	11.4	7.0	1

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839	No	No	Chemo w acute leukemia as sdx w/o CC/MCC	1.0023	4.4	3.6	1
840	No	Yes	Lymphoma & non-acute leukemia w MCC	3.8650	13.0	8.9	1
841	No	Yes	Lymphoma & non-acute leukemia w CC	1.9451	6.8	5.1	1
842	No	Yes	Lymphoma & non-acute leukemia w/o CC/MCC	1.3101	4.2	3.2	1
843	No	No	Other myeloprolif dis or poorly diff neopl diag w MCC	2.6935	9.7	6.1	1
844	No	No	Other myeloprolif dis or poorly diff neopl diag w CC	1.3837	4.8	3.5	1
845	No	No	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC	1.1935	3.3	2.2	1
846	No	No	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	2.6995	8.0	6.0	1
847	No	No	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	1.0641	3.5	3.0	1
848	No	No	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	0.8626	2.9	2.3	1
849	No	No	Radiotherapy	0.9988	4.9	3.2	1
853	No	Yes	Infectious & parasitic diseases w O.R. procedure w MCC	6.6421	15.9	11.5	2
854	No	Yes	Infectious & parasitic diseases w O.R. procedure w CC	2.2855	7.1	5.8	1
855	No	Yes	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC	1.7114	5.1	4.0	1
856	No	Yes	Postoperative or post-traumatic infections w O.R. proc w MCC	3.5933	11.3	9.2	2
857	No	Yes	Postoperative or post-traumatic infections w O.R. proc w CC	1.6950	6.1	4.8	1
858	No	Yes	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	1.2165	4.5	3.7	1
862	No	Yes	Postoperative & post-traumatic infections w MCC	1.9167	7.2	5.4	1
863	No	Yes	Postoperative & post-traumatic infections w/o MCC	0.8268	4.2	3.4	1
864	No	No	Fever age >17	0.7651	3.3	2.7	1
865	No	No	Viral illness age >17 w MCC	1.3127	5.3	3.8	1
866	No	No	Viral illness age >17 w/o MCC	0.6502	2.9	2.4	1
867	No	Yes	Other infectious & parasitic diseases diagnoses w MCC	2.5375	8.0	6.1	1
868	No	Yes	Other infectious & parasitic diseases diagnoses w CC	1.0613	4.9	3.7	1
869	No	Yes	Other infectious & parasitic diseases diagnoses w/o CC/MCC	0.6110	3.0	2.6	1
870	No	Yes	Septicemia or severe sepsis w MV 96+ hours age >17	8.2236	16.1	13.4	4
871	No	Yes	Septicemia or severe sepsis w/o MV 96+ hours age >17 w MCC	2.0886	6.8	4.9	1
872	No	Yes	Septicemia or severe sepsis w/o MV 96+ hours age >17 w/o MCC	1.1503	4.8	3.9	1
876	No	No	O.R. procedure w principal diagnoses of mental illness	2.8740*	13.1	8.0	1
880	No	No	Acute adjustment reaction & psychosocial dysfunction	0.6169	2.9	2.2	1
881	No	No	Depressive neuroses	0.3641	3.8	2.8	1
882	No	No	Neuroses except depressive	0.3852	3.9	2.9	1
883	No	No	Disorders of personality & impulse control	1.3090	11.6	7.0	1

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884	No	Yes	Organic disturbances & mental retardation	0.8221	5.9	2.9	1
885	No	No	Psychoses	0.6158	6.6	5.0	1
886	No	No	Behavioral & developmental disorders	0.6696	7.9	5.8	1
887	No	No	Other mental disorder diagnoses	1.2267	11.9	6.0	1
894	No	No	Alcohol/drug abuse or dependence, left AMA	0.4753	4.5	2.7	1
895	No	No	Alcohol/drug abuse or dependence w rehabilitation therapy	0.8389	16.1	13.2	3
896	No	Yes	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	1.3382	5.0	3.7	1
898	No	No	Alcohol/drug abuse or dependence w/o rehabilitation therapy age >21 w/o MCC	0.3689	4.1	3.2	1
899	No	No	Alcohol/drug abuse or dependence w/o rehabilitation therapy age <=21 w/o MCC	0.2628	5.0	3.5	1
901	No	No	Wound debridements for injuries w MCC	4.7492	18.3	8.6	1
902	No	No	Wound debridements for injuries w CC	1.2278	5.5	3.9	1
903	No	No	Wound debridements for injuries w/o CC/MCC	1.1427	3.9	2.6	1
904	No	No	Skin grafts for injuries w CC/MCC	2.5557	9.5	5.4	1
905	No	No	Skin grafts for injuries w/o CC/MCC	1.4632	3.5	2.9	1
906	No	No	Hand procedures for injuries	1.0887	2.7	2.1	1
907	No	Yes	Other O.R. procedures for injuries w MCC	4.5015	11.6	7.4	1
908	No	Yes	Other O.R. procedures for injuries w CC	1.9566	5.3	3.9	1
909	No	Yes	Other O.R. procedures for injuries w/o CC/MCC	1.0527	2.7	2.1	1
913	No	No	Traumatic injury age >17 w MCC	1.4955*	6.0	4.2	1
914	No	No	Traumatic injury age >17 w/o MCC	0.6997	2.0	1.6	1
915	No	No	Allergic reactions age >17 w MCC	1.9197	6.0	3.9	1
916	No	No	Allergic reactions age >17 w/o MCC	0.4363	1.9	1.5	1
917	No	Yes	Poisoning & toxic effects of drugs age >17 w MCC	1.5767	4.4	3.2	1
918	No	Yes	Poisoning & toxic effects of drugs age >17 w/o MCC	0.5048	2.0	1.6	1
919	No	No	Complications of treatment w MCC	1.5391	5.6	3.9	1
920	No	No	Complications of treatment w CC	0.8306	3.8	3.0	1
921	No	No	Complications of treatment w/o CC/MCC	0.5356	2.6	2.1	1
922	No	No	Other injury, poisoning & toxic effect diag w MCC	1.7700	5.9	3.6	1
923	No	No	Other injury, poisoning & toxic effect diag w/o MCC	0.6197	2.0	1.5	1
927	No	No	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	10.2870	21.3	17.3	3
928	No	No	Full thickness burn w skin graft or inhal inj w CC/MCC	2.9604	13.9	10.6	2
929	No	No	Full thickness burn w skin graft or inhal inj w/o CC/MCC	1.6119	7.1	4.4	1
933	No	No	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	2.5620*	5.7	2.4	1

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

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Chapter 6, Addendum C (FY 2010)

Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2010

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
934	No	No	Full thickness burn w/o skin grft or inhal inj	0.8502	3.9	2.7	1
935	No	No	Non-extensive burns	0.9473	4.1	2.3	1
939	No	No	O.R. proc w diagnoses of other contact w health services w MCC	3.8764	16.7	10.4	1
940	No	No	O.R. proc w diagnoses of other contact w health services w CC	2.0660	6.2	3.0	1
941	No	No	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	1.4159	2.6	2.1	1
945	No	Yes	Rehabilitation w CC/MCC	2.2226	16.1	11.1	1
946	No	Yes	Rehabilitation w/o CC/MCC	0.9415	8.4	7.1	2
947	No	Yes	Signs & symptoms w MCC	1.2872	4.9	3.5	1
948	No	Yes	Signs & symptoms w/o MCC	0.6645	2.9	2.2	1
949	No	No	Aftercare w CC/MCC	1.0134	4.8	2.7	1
950	No	No	Aftercare w/o CC/MCC	0.5150	3.0	1.8	1
951	No	No	Other factors influencing health status	0.5362	3.0	2.0	1
955	No	No	Craniotomy for multiple significant trauma	6.3256	14.1	8.5	1
956	No	Yes	Limb reattachment, hip & femur proc for multiple significant trauma	6.5882	12.4	9.2	2
957	No	No	Other O.R. procedures for multiple significant trauma w MCC	8.3720	16.2	10.9	1
958	No	No	Other O.R. procedures for multiple significant trauma w CC	3.8359	8.9	7.0	1
959	No	No	Other O.R. procedures for multiple significant trauma w/o CC/MCC	3.3822	6.2	5.2	1
963	No	No	Other multiple significant trauma w MCC	3.2211	8.8	5.3	1
964	No	No	Other multiple significant trauma w CC	1.5923	5.5	4.0	1
965	No	No	Other multiple significant trauma w/o CC/MCC	1.3038	3.7	2.9	1
969	No	No	HIV w extensive O.R. procedure w MCC	6.1132*	18.8	13.2	1
970	No	No	HIV w extensive O.R. procedure w/o MCC	2.8446*	8.9	6.1	1
974	No	No	HIV w major related condition w MCC	3.1329	10.4	7.8	1
975	No	No	HIV w major related condition w CC	1.8788	6.2	5.1	1
976	No	No	HIV w major related condition w/o CC/MCC	0.9953*	4.7	3.7	1
977	No	No	HIV w or w/o other related condition	1.3347	6.1	5.0	1
981	No	Yes	Extensive O.R. procedure unrelated to principal diagnosis w MCC	5.8763	14.3	10.2	1
982	No	Yes	Extensive O.R. procedure unrelated to principal diagnosis w CC	2.3233	6.6	4.6	1
983	No	Yes	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.4159	3.0	2.4	1
984	No	No	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	3.7122*	14.6	11.7	1
985	No	No	Prostatic O.R. procedure unrelated to principal diagnosis w CC	2.1624*	8.7	6.2	1

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Chapter 6, Addendum C (FY 2010)

Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2010

DRG #	PAC XFER	PAC PAY	DESCRIPTION	TRICARE WEIGHT	ARITH MEAN LOS	GEOM MEAN LOS	SHORT-STAY THRESHOLD
986	No	No	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.2298*	4.3	2.9	1
987	No	Yes	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	4.0574	12.6	8.7	1
988	No	Yes	Non-extensive O.R. proc unrelated to principal diagnosis w CC	1.7981	5.7	4.2	1
989	No	Yes	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	1.1117	3.3	2.3	1
998	No	No	Principal diagnosis invalid as discharge diagnosis	0.0000*	0.0	0.0	1
999	No	No	Ungroupable	0.0000*	0.0	0.0	1

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