Chapter 6 Section 8

Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment Amounts)

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 adjustments to the TRICARE DRG-based payment amounts?

3.0 POLICY

3.1 Adjustments to the DRG-Based Payment Amounts

There are several adjustments to the basic DRG-based amounts (the weight multiplied by the Adjusted Standardized Amount (ASA) which can be made.

3.2 Specific Adjustments

3.2.1 Capital Costs

TRICARE will reimburse hospitals for their capital costs as reported annually to the contractor (see below). Payment for capital costs will be made annually. See Chapter 3, Section 2 for the procedures for paying capital costs.

3.2.1.1 For October 1, 2003, through present, TRICARE will reimburse 100% of capital-related costs.

3.2.1.2 Allowable capital costs are those specified in Medicare Regulation Section 413.130 of Title 42 CFR.

3.2.1.3 To obtain the total allowable capital costs from the Medicare cost reports as of October 1992, the contractor shall add the figures from Worksheet D, Part 1, Columns 3 and 6, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, and line 33, to the figures from Worksheet D, Part II, Columns 1 and 2, lines 37-63.

3.2.1.4 The instructions outlined in paragraph 3.2.1.3 are effective for initial and amended requests received on or after October 1, 1998.

3.2.1.5 To obtain the total allowable capital costs from the Medicare cost reports as of May 1, 2010, the contractor shall add the figures from Worksheet D, Part I, Column 3, lines 30-33, lines 34 and 35 if the cost report reflects intensive care unit costs, and line 43, to the figures from Worksheet D, Part II, Column 1, lines 50-76 and 88-93.

3.2.1.6 The instructions outlined in paragraph 3.2.1.5, are effective for initial and amended requests received on or after May 1, 2010.

3.2.1.7 Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Section 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

3.2.1.7.1 The capital-related equipment is leased or rented by the provider;

3.2.1.7.2 The capital-related equipment is located on the provider's premises; and

3.2.1.7.3 The capital-related portion of the charge is separately specified in the charge to the provider.

3.2.2 Direct Medical Education Costs

TRICARE will reimburse hospitals their actual direct medical education costs as reported annually to the contractor (see below). Such direct medical education costs must be for a teaching program approved under Medicare Regulation Section 413.85. Payment for direct medical education costs will be made annually and will be calculated using the same steps required for calculating capital payments below. Allowable direct medical education costs are those specified in Medicare Regulation Section 413.85. See Chapter 3, Section 2 for the procedures for paying direct medical education costs.

3.2.2.1 Direct medical education costs generally include:

3.2.2.1.1 Formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution.

3.2.2.1.2 Nursing schools.

3.2.2.1.3 Medical education of paraprofessionals (e.g., radiological technicians).

3.2.2.2 Direct medical education costs do not include:

3.2.2.2.1 On-the-job training or other activities which do not involve the actual operation or support, except through tuition or similar payments, of an approved education program.

3.2.2.2.2 Patient education or general health awareness programs offered as a service to the community at large.

3.2.2.3 To obtain the total allowable direct medical education costs from the Medicare cost reports on all initial and amended requests, the contractor shall add the figures from Worksheet B, Part I, Columns 21-24, lines 25-28, lines 29 and 30 if the cost report reflects intensive care unit costs, line 33, and lines 37-63. These instructions are effective for all initial and amended requests received on or after October 1, 1998.

3.2.2.4 To obtain the total allowable direct medical education costs from the Medicare cost reports on all initial and amended requests as of May 1, 2010, the contractor shall add the figures from Worksheet B, Part I, Columns 20-23, lines 30-33, lines 34 and 35 if the cost report reflects intensive care unit costs, 43; and 50-76; and 88-93. These instructions are effective for all initial and amended requests received on or after May 1, 2010.

3.2.3 Determining Amount Of Capital And Direct Medical Education (CAP/DME) Payment

In order to account for payments by Other Health Insurance (OHI), TRICARE' payment amounts for CAP/DME will be determined according to the following steps. Throughout these calculations claims on which TRICARE made no payment because OHI paid the full TRICARE-allowable amount are not to be counted.

Step 1: Determine the ratio of TRICARE inpatient days to total inpatient days using the data described below. In determining total TRICARE inpatient days the following are not to be included:

- Any days determined to be not medically necessary, and
- Days included on claims for which TRICARE made no payment because OHI paid the full TRICARE-allowable amount.

Step 2: Multiply the ratio from Step 1 by total allowable capital costs.

Step 3: Reduce the amount from Step 2 by the appropriate capital reduction percentage(s). This is the total allowable TRICARE capital payment for DRG discharges.

Step 4: Multiply the ratio from Step 1 by total allowable direct medical education costs. This is the total allowable TRICARE direct medical education payment for DRG discharges.

Step 5: Combine the amounts from Steps 3 and 4. This is the amount of TRICARE payment due the hospital for CAP/DME.

3.2.4 Payment Of CAP/DME Costs

3.2.4.1 General

All hospitals subject to the TRICARE DRG-based payment system, except for children's hospitals (see below), may be reimbursed for allowed CAP/DME costs by submitting a request and the applicable pages from the Medicare cost-report to the TRICARE contractor.

3.2.4.1.1 Beginning October 1, 1998, initial requests for payment of CAP/DME shall be filed with the TRICARE contractor on or before the last day of the 12th month following the close of the hospitals' cost-reporting period. The request shall cover the one year period corresponding to the hospital's Medicare cost-reporting period. Thus, for cost-reporting periods ending on or after March 1, 1998, requests for payment of CAP/DME must be filed no later than (NLT) 12 months following the close of the cost-reporting period. For example, if a hospital's cost-reporting period ends on June 30, 1998, the request for payment shall be filed on or before June 30, 1999. Those hospitals that are not Medicare participating providers are to use an October 1 through September 30 fiscal year for reporting CAP/DME costs.

3.2.4.1.1.1 An extension of the due date for filing the initial request may only be granted if an extension has been granted by the Centers for Medicare and Medicaid Services (CMS) due to a provider's operations being significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire, as described in Section 413.24 of Title 42 CFR.

3.2.4.1.1.2 All costs reported to the TRICARE contractor must correspond to the costs reported on the hospital's Medicare cost report. If the costs change as a result of a subsequent Medicare desk review, audit or appeal, the revised costs along with the applicable pages from the amended Medicare cost report shall be provided to the TRICARE contractor within 30 days of the date the hospital is notified of the change. The request must be signed by the hospital official responsible for verifying the amounts. The Medicare Notice of Program Reimbursement (NPR) letter should be submitted with the amended cost report.

3.2.4.1.1.3 The 30 day period is a means of encouraging hospitals to report changes in its CAP/DME costs in a timely manner. If the contractor receives an amended request beyond the 30 days, it shall process the adjustment and inform the provider of the importance of submitting timely amendments.

3.2.4.1.1.4 The hospital official is certifying in the initial submission of the cost report that any changes resulting from a subsequent Medicare audit will be promptly reported. Failure to promptly report the changes resulting from a Medicare audit is considered a misrepresentation of the cost report information. Such a practice can be considered fraudulent, which may result in criminal civil penalties or administrative sanctions of suspension or exclusion as an authorized provider.

3.2.4.1.2 Prior to October 1, 1998, TRICARE had no time limit for filing initial requests for reimbursement of CAP/DME, other than the six year statute of limitations. The time limitation for filing claims does not apply to CAP/DME payment requests. To allow TRICARE contractors to close out prior year data, all initial payment requests for CAP/DME for cost-reporting periods ending

before March 1, 1998, shall be filed with the TRICARE contractor NLT five months after October 1, 1998. Requests for reimbursement for these periods must be post-marked on or before March 1, 1999. During this 5 month period, the following criteria apply:

3.2.4.1.3 If a hospital has documentation indicating it was underpaid based on the number of inpatient days reported on the initial request, the hospital may request separate reimbursement for these costs, however, it is the hospital's responsibility to provide documentation substantiating the number of TRICARE inpatient days.

3.2.4.1.4 The contractor shall follow the instructions for processing initial requests as outlined in paragraph 3.2.4.3.1.

3.2.4.2 Information Necessary For Payment Of CAP/DME Costs

The following information must be reported to the contractor:

3.2.4.2.1 The hospital's name.

3.2.4.2.2 The hospital's address.

3.2.4.2.3 The hospital's TRICARE provider number.

3.2.4.2.4 The hospital's Medicare provider number.

3.2.4.2.5 The period covered--this must correspond to the hospital's Medicare cost-reporting period.

3.2.4.2.6 Total inpatient days provided to all patients in units subject to DRG-based payment.

3.2.4.2.7 Total TRICARE inpatient days provided in units subject to DRG-based payment. (This is to be only days which were "allowed" for payment. Therefore, days which were determined to be not medically necessary are not to be included.) Total inpatient days provided to active duty members in units subject to DRG-based payment.

3.2.4.2.8 Total allowable capital costs. This must correspond with the applicable pages from the Medicare cost-report.

3.2.4.2.9 Total allowable direct medical education costs. This must correspond with the applicable pages from the Medicare cost-report.

3.2.4.2.10 Total full-time equivalents for:

- Residents,
- Interns (see below).

3.2.4.2.11 Total inpatient beds (see below).

3.2.4.2.12 Title of official signing the report.

3.2.4.2.13 Reporting date.

3.2.4.2.14 The report must contain a certification statement that any changes to items in paragraphs 3.2.4.2.6, 3.2.4.2.7, 3.2.4.2.8, 3.2.4.2.9, and 3.2.4.2.10, which are a result of a review, audit, or appeal of the provider's Medicare cost-report, must be reported to the contractor within 30 days of the date the hospital is notified of the change.

3.2.4.2.15 All cost reports must be certified by an officer or administrator of the provider. The general concept is to notify the certifying official that misrepresentation or falsification of any of the information in the cost report is punishable by fine and/or imprisonment. The signing official must acknowledge this as well as certify that the cost report filed, together with any supporting documentation, is true, correct and complete based upon the books and records of the provider.

3.2.4.3 Contractor Actions

3.2.4.3.1 Initial requests for CAP/DME payment.

3.2.4.3.1.1 The contractor may, but is not required, to provide inpatient day verification reports to hospitals prior to an initial request being submitted.

3.2.4.3.1.2 The contractor shall verify the number of TRICARE and active duty inpatient days with its data. If the contractor's data represents a greater number of days than submitted on the hospital's request, payment shall be based on the contractor's data. If the hospital's request represents a greater number of days than the contractor's data, the contractor shall notify the hospital of the discrepancy and inform them payment will be based on the number of days it has on file unless they can provide documentation substantiating the additional days. The notification to the hospital must be made within 10 working days of identification of the discrepancy and include the inpatient day verification report.

3.2.4.3.1.3 The contractor shall wait until the end of the following month to hear from the hospital. If the hospital does not respond, the contractor shall make payment based on its totals.

3.2.4.3.1.4 The contractor shall verify the accuracy of the financial amounts listed for CAP/DME with the applicable pages of the Medicare cost report. If the financial amounts do not match, the contractor shall reimburse the hospital based on the figures in the cost-report and notify the hospital of the same.

3.2.4.3.1.5 The contractor must make the CAP/DME payment to the hospital within 30 days of the initial request unless notification has been sent to the hospital regarding a discrepancy in the number of days as outlined in paragraph 3.2.4.3.1.2.

3.2.4.3.2 Amended Requests for CAP/DME.

3.2.4.3.2.1 The contractor may, but is not required, to provide inpatient day verification reports to hospitals prior to an amended request being submitted.

3.2.4.3.2.2 The contractor shall process amended payment requests based on changes in the Medicare cost-report as a result of desk reviews, audits and appeals. An adjustment will not be processed unless there are changes to items 6 through 10 on the initial CAP/DME reimbursement request. The contractor will not process amended requests for days only.

3.2.4.3.2.3 The contractor shall verify the number of TRICARE and active duty inpatient days with its data. If the contractor's data represents a greater number of days than submitted on the hospital's request, payment shall be based on the contractor's data. If the hospital's request represents a greater number of days than the contractor's data, the contractor shall notify the hospital of the discrepancy and inform them payment will be based on the number of days it has on file unless they can provide documentation substantiating the additional days. The notification to the hospital must be made within 10 working days of identification of the discrepancy and include the inpatient day verification report.

3.2.4.3.2.4 The contractor shall wait until the end of the following month to hear from the hospital. If the hospital does not respond, the contractor shall make payment based on its totals.

3.2.4.3.2.5 The contractor shall verify the accuracy of the financial amounts listed for CAP/DME with the applicable pages of the amended Medicare cost report. If the financial amounts do not match, the contractor shall reimburse the hospital based on the figures in the cost-report and notify the hospital of the same.

3.2.4.3.2.6 The contractor must make the CAP/DME payment to the hospital within 30 days of the amended request unless notification has been sent to the hospital regarding a discrepancy in the number of days as outlined in paragraph 3.2.4.3.2.2.

3.2.4.3.2.7 The TRICARE/CHAMPUS contractor shall be responsible for proactively researching the Medicare web site (http://www.cms.hhs.gov/costreports/) to identify hospitals in their region that submitted amended Medicare cost reports, obtaining copies of the amended cost reports from hospitals that failed to submit them to the TRICARE contractor as required, recalculating the CAP/DME costs based on the revised cost report data, and initiating a collection action or notifying the hospital if an underpayment was identified based on the results of recalculation. The CMS post the Hospital Cost Report files 30 days after the end of each quarter.

3.2.4.3.2.8 The contractor shall complete the "Annual Capital and Direct Medical Education Report" as described in the Contract Data Requirements List (CDRL) DD Form 1423, and submit the information to the Contractor Officer (CO) and Contracting Officer's Representative (COR) identifying the hospitals that submitted amended Medicare cost reports directly to the TRICARE contractor and those hospitals which the TRICARE contractor identified on the CMS web site.

3.2.4.3.2.9 For a period of one year following the report period, the "Quarterly Capital and Direct Medical Education Over and Under Payment Report" as described in the CDRL, DD Form 1423, shall be updated on a calendar quarterly basis to reflect collections that are received, or underpayments refunded at the hospital's request, after the end of the previous calendar year report. The quarterly reports shall pertain only to cases initiated in the calendar year being reported.

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

3.2.4.5 CAP/DME costs for children's hospitals. Amounts for CAP/DME are included in both the hospital-specific and the national children's hospital differentials (see below). The amounts are based on national average costs. No separate or additional payment is allowed.

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

3.2.5 Children's Hospital Differential

3.2.5.1 General

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

3.2.5.2 Qualifying for the Children's Hospital Differential

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

3.2.5.3 Calculation of the Children's Hospital Differentials

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

3.2.5.4 Differential Amounts

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

3.2.5.4.1.1 Calculation of the national children's hospital differentials. These differentials are calculated using the procedures described in paragraph 3.2.5.3, but based on a database of only low-volume children's hospitals. They were calculated initially using a database of claims processed from July 1, 1987, through June 30, 1988 and updated to FY 1988 using the hospital market basket. They were subsequently finalized based on claims processed from April 1, 1989, through March 31, 1990.

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

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

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

Large Urban Areas	
Labor portion	$1,945.99
Non-labor portion	+ 689.42
	$2,635.41
Other Areas	
Labor portion	$1,483.21
Non-labor portion	525.47
	$2,008.68

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

3.2.5.5 Hold Harmless Provision

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

3.2.6 Outliers

3.2.6.1 General

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

3.2.6.2 Provider Reporting of Outliers

The provider is to identify outliers on the CMS 1450 UB-04, Form Locator (FL) 24 - 30. Code 60 is to be used to report LOS outliers, and code 66 is to be used to signify that a cost outlier is not being requested. If a claim qualifies as a cost outlier and code 66 is not entered in the appropriate FL (i.e., it is blank or code 61), the contractor is to accept this as a request for cost outlier payment by the hospital.

3.2.6.3 Short-Stay Outliers

The TRICARE DRG-based payment system uses short-stay outliers and are reimbursed using a per diem amount. All short-stay outliers must be identified by the contractor when the claims are processed, and necessary adjustments to the payment amounts must be made automatically.

- Any discharge which has a LOS less than or equal to the greater of 1 or 1.94 standard deviations below the arithmetic mean LOS for that DRG shall be classified as a short-stay outlier. In determining the actual short-stay threshold, the calculation will be

rounded down to the nearest whole number, and any stay equal to or less than the short-stay threshold will be considered a short-stay outlier.

- Short-stay outliers will be reimbursed at 200% of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the wage-adjusted DRG amount divided by the arithmetic mean LOS for the DRG. The per diem rate is to be calculated before the DRG-based amount is adjusted for IDME. Cost outlier payments shall be paid on short stay outlier cases that qualify as a cost outlier.

- Any stay which qualifies as a short-stay outlier (a transfer cannot qualify as a short-stay outlier), even if payment is limited to the normal DRG amount, is to be considered and reported on the payment records as a short-stay outlier. This will ensure that outlier data is accurate and will prevent the beneficiary from paying an excessive cost-share in certain circumstances.

3.2.6.4 Cost Outliers

3.2.6.4.1 Any discharge which has standardized costs that exceed the thresholds outlined below, will be classified as a cost outlier.

3.2.6.4.1.1 For admissions occurring prior to October 1, 1997, the standardized costs will be calculated by first subtracting the noncovered charges, multiplying the total charges (less lines 7, N, and X) by the CCR and adjusting this amount for IDME costs by dividing the amount by one plus the hospital's IDME adjustment factor. For admissions occurring on or after October 1, 1997, the costs for IDME are no longer standardized.

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

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:

Standard Cost = (Billed Charges x CCR)

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

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

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

3.2.6.4.1.4 The CCR for admissions occurring on or after October 1, 2010, is 0.3664. The CCR for admissions occurring on or after October 1, 2011, is 0.3460. The CCR for admissions occurring on or after October 1, 2012, is 0.2979.

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 2011 is 0.920, for FY 2012 is 0.919, and for FY 2013 is 0.920.

3.2.6.4.2 For FY 2011, a TRICARE fixed loss cost-outlier threshold is set at $21,229. Effective October 1, 2010, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $21,229 (also wage-adjusted).

3.2.6.4.3 For FY 2012, a TRICARE fixed loss cost-outlier threshold is set at $21,482. Effective October 1, 2011, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $21,482 (also wage-adjusted).

3.2.6.4.4 For FY 2013, a TRICARE fixed loss cost-outlier threshold is set at $20,075. Effective October 1, 2012, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $20,075 (also wage-adjusted).

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

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

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

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.

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, 2010, the standardized costs are calculated using a CCR of 0.3974. Effective October 1, 2011, the standardized costs are calculated using a CCR of 0.3757. Effective October 1, 2012, the standardized costs are calculated using a CCR of 0.3231. (This is equivalent to the Medicare CCR increased to account for CAP/DME costs.)

3.2.6.6.3 The marginal cost factor shall be 80%.

3.2.6.6.4 For admissions occurring during FY 2011, the marginal cost factor shall be adjusted by 1.00. For admissions occurring during FY 2012, the marginal cost factor shall be adjusted by 1.02. For admissions occurring during FY 2013, the marginal cost factor shall be adjusted by 1.03.

3.2.6.6.5 The NOSCASTC for calculating the cost-outlier threshold for FY 2011 is 0.920. The NOSCASTC for calculating the cost-outlier threshold for FY 2012 is 0.919. The NOSCASTC for calculating the cost-outlier threshold for FY 2013 is 0.920.

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 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:

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

- For admissions occurring during FYs 2008 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 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:

3.2.8.1.1 For services provided on or before September 30, 2014:

3.2.8.1.1.1 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 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.

3.2.8.1.1.2 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 judgment 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 = (Definition prior to FY 2011.) 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.

1 = (Definition for FY 2011 and subsequent years.) Unreported/not used. Exempt from POA reporting.
(This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.)

3.2.8.1.2 For services provided on or after October 1, 2014:

3.2.8.1.2.1 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, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting. See the complete instructions in the UB-04 Data Specifications Manual for specific instructions and examples. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-10-CM Official Guidelines for Coding and Reporting.

3.2.8.1.2.2 There are five POA indicator reporting options, as defined by the ICD-10-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 judgment 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 = (Definition prior to FY 2011.) Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-10-CM diagnosis codes is available in the ICD-10-CM Official Coding Guidelines.

1 = (Definition for FY 2011 and subsequent years.) Unreported/not used. Exempt from POA reporting. (This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.)

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

3.2.8.3 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.

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

3.2.8.5 Exempt providers.

3.2.8.5.1 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 and Psychiatric Units
- Department of Veterans Affairs (DVA) Hospitals

3.2.8.5.2 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.

3.2.8.6 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.

3.2.8.7 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.

3.2.8.8 Replacement Devices

3.2.8.8.1 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.

3.2.8.8.2 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.

3.2.8.8.3 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**.

3.2.8.8.4 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.

3.2.8.8.5 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.

3.2.8.8.6 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.

3.2.8.8.7 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.

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