CHAPTER 6
SECTION 4

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

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## I. APPLICABILITY

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

## II. ISSUE

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

## III. POLICY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. All services related to Combined Liver-Kidney (CLKT) and Combined Heart-Kidney Transplant (CHKT) through July 31, 2003. Effective August 1, 2003, CLKTs and CHKTs shall be paid under the assigned DRG based on the procedure performed.

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

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

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

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

11. All outpatient services related to inpatient stays.

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

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

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

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

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

286.0 Congenital Factor VIII Disorder;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Hospitals within hospitals.

2. Psychiatric hospitals.

3. Rehabilitation hospitals.

4. Psychiatric and rehabilitation units (distinct parts).

5. Long-term hospitals.

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

7. Christian Science sanitariums.

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

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

10. Satellite facilities.

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

H. Critical Access Hospitals (CAHs). Prior to December 1, 2009, CAHs are subject to the DRG-based payment system. For additional information on CAHs, refer to Chapter 15, Section 1.

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