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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 35
OCHAMPUS 6010.47-M
NOVEMBER 4, 1998

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE/CHAMPUS POLICY MANUAL

THE DIRECTOR, OCHAMPUS, HAS AUTHORIZED THE FOLLOWING ADDITION(S)/REVISION(S) TO THE TRICARE/CHAMPUS POLICY MANUAL

REVISION(S):
CHAPTER 1: SECTION: 25.1; CHAPTER 3: SECTION: 16.2; CHAPTER 13: SECTION(S): 6.1C and 6.1H, and ADDENDUM 2, TABLE 3 (FY 1999)

REMOVE AND INSERT: Attached Additional/Replacement Page(s): See page 2 of this transmittal.

SUMMARY OF ADDITIONS/REVISIONS: This change provides additional clarifying instructions for the CHAMPUS DRG based payment system including payment of transfer cases with cost outliers and reimbursement of capital and direct medical education costs, and corrects the footnote for the wage index for MSA 1650. This change also sets forth the payment conditions for corneal tissue used in a corneal transplant that is performed in an ambulatory surgery center, a physician's office, or on an outpatient basis. The physical therapy policy is being reissued to remove the diapulse criteria that was inadvertently left in a previous change.

EFFECTIVE DATE: October 1, 1998

IMPLEMENTATION DATE: 30 days after publication

Sheila H. Sparkman
Director, Program Development and Evaluation

ATTACHMENT(S): PAGE(S)
DISTRIBUTION: 6010.47-M

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

REMOVE PAGE(S)	REPLACE PAGE(S)
CHAPTER 1	
SECTION 25.1 *PAGES 3-16*	*SECTION 25.1* *PAGES 3-16*
CHAPTER 3	
SECTION 16.2 *PAGE 1*	*SECTION 16.2* *PAGE 1*
CHAPTER 13	
SECTION 6.1C *PAGES 3-10*	*SECTION 6.1C* *PAGES 3-10*
SECTION 6.1H *PAGES 1-17*	*SECTION 6.1H* *PAGES 1-17*
ADDENDUM 2, TABLE 3 (FY 1999) *PAGES 1-2*	*ADDENDUM 2, TABLE 3 (FY 1999)* *PAGES 1-2*

9. Charges for electrical stimulation (to control pain or to prevent disuse atrophy following prolonged immobilization, injury, or surgery) when rendered by a certified physical therapist practicing within the scope of state licensure where the services are rendered when determined to be medically necessary and appropriate.

10. Charges for a functional electrical stimulation (in spinal cord injury and other motor neuron conditions) when rendered by a certified physical therapist practicing within the scope of state licensure where the services are rendered when determined to be medically necessary and appropriate. Refer to Chapter 7, Section 3.17.

11. Charges for debridement when rendered by a certified physical therapist practicing within the scope of state licensure where the services are rendered when determined to be medically necessary and appropriate.

B. Claims submission:

1. Providers are to be encouraged to submit claims monthly for ongoing physical therapy services.

2. At a minimum, all claims must indicate the diagnosis and related functional impairment for which therapy is prescribed, the specific modalities or procedures performed and must identify the specific number of sessions per week, the dates of service, the provider name, and the provider address.

C. Claims adjudication:

1. Claims not containing the above minimum required medical information are to be denied.

2. Payment may be made for up to 20 physical therapy sessions, to include patient evaluation and any session for treatment plan development or adjustment, per calendar year without medical review.

3. Medical review is required for claims for treatment exceeding 20 sessions per calendar year limit, or 2 sessions per week, or for physical therapy treatment which is not completed within 60 days. The supervising physician or other authorized individual professional provider (acting within the scope of their license) is required to submit the medical documentation for any physical therapy treatment exceeding the 20 sessions per calendar year limit, or 2 sessions per week, or for physical therapy treatment not completed within 60 days. This medical documentation is to be used by the claims processors for their medical review. The following medical documentation is required:

a. Diagnosis and brief description of the related functional impairment(s) for which physical therapy is prescribed, including date of onset of the impairment;

b. A treatment plan which includes:

(1) Identification of long and short-term goals;

(2) Treatment objectives;

(3) Identification of the specific modalities and exercises to be used in treatment;

(4) The frequency of continued therapy sessions (length of sessions is not required);

(5) Duration of continued treatment;

(6) Documentation of continued progress. (TRICARE benefits cannot be extended beyond the point where the patient can reasonably be expected to benefit significantly from continued physical therapy).

4. Monthly medical review is required for subsequent claims which request additional physical therapy services beyond the initial medical review requirement outlined above. Documentation requirements for those claims requiring monthly medical reviews shall be the same as those required for the initial medical review.

D. Frequency of physical therapy.

Two physical therapy sessions per week are generally considered sufficient for most conditions. Payment may be made for more than 2 sessions per week if medical review determines it is medically necessary.

E. Duration of physical therapy.

Most physical therapy treatment should be completed within 60 days. In any case where physical therapy continues longer than 60 days, medical review is required to determine the medical necessity for additional care.

F. Condition and problem sets.

The following sets of conditions and associated problems will be used for screening claims. When a claim is received for one of the conditions listed, the initial qualified provider's certification should contain evidence of one or more of the problems in the corresponding list. (The problems can be associated with any of the conditions related to a specific dysfunction.) If a claim is received for a condition or a problem not listed, the claim should be submitted to medical review for an assessment of the necessity for physical therapy. Claims or initial qualified provider's certifications which contain documentation of one or more of the listed problems or conditions must also meet all other coverage requirements in order to be paid.

1. DYSFUNCTION: SPINAL COLUMN CONDITIONS

a. Conditions

(1) Compression fracture

(2) Degenerative osteoarthritis

(3) Flexion-extension injury

(4) Fusion

(5) Herniated nucleus pulposus

(6) Kyphosis

(7) Lordosis

(8) Nerve root compression

(9) Nerve root irritation

(10) Osteoporosis

(11) Paraplegia

(12) Post laminectomy

(13) Quadriplegia

(14) Radiculitis

(15) Radiculopathy

(16) Ruptured or prolapsed disc

(17) Sciatica

(18) Spina bifida

(19) Spondylolisthesis

(20) Spondylosis

(21) Strain or sprain

(22) Subluxation

(23) Torticollis

b. Associated Problems

(1) Abnormal gait pattern

(2) Degenerative disc disease

(3) Guarding

(4) Headaches

(5) Hypermobility or hypomobility of joints

(6) Improper posture and/or body mechanics

(7) Inadequate chest excursion

(8) Lack of functional range of motion, strength and/or motor control

(9) Lack of mobility skills for activities of daily living (ADL), transfers and gait.

(10) Lack or, decreased, or changes in sensation

(11) Muscle spasm

(12) Muscular imbalance

(13) Need of equipment and/or adaptive devices

(14) Pain

(15) Paralysis

(16) Presence of trigger points

(17) Weakness

2. DYSFUNCTION: MUSCULOSKELETAL CONDITIONS

a. Conditions

(1) Acromioclavicular separation

(2) Adhesive capsulitis

(3) Arthrogryposis multiplex congenita

(4) Bone graft

(5) Bursitis

(6) Chondromalacia

(7) Crush injuries

(8) Dupuytren's contracture

(9) Fractures

(10) Frozen shoulder

(11) Hemarthrosis

(12) Internal derangement

(13) Mechanical low pack pain including that associated with pregnancy

(14) Post-dislocation

(15) Post-fractures

(16) Rotator cuff tear

(17) Ruptured ligaments, tendons, muscles

(18) Shoulder-hand syndrome

(19) Slipped epiphysis

(20) Strain or sprain

(21) Synovitis

(22) Tendonitis

b. Associated Problems

(1) Abnormal gait pattern

(2) Contractures

(3) Disuse atrophy - deconditioning

(4) Joint instability

(5) Lack of functional range of motion (ROM) and/or strength

(6) Lack of joint play

(7) Muscle guarding/spasm

(8) Muscular wasting

(9) Need for muscle re-education

(10) Pain

3. DYSFUNCTION: POST-SURGICAL CONDITIONS

a. Conditions

(1) Amputation

(2) Arthrodesis

(3) Arthrotomy

(4) Bunionectomy

(5) Cardiac surgery

(6) Disarticulation

(7) Hip prosthesis

(8) Joint fusion

(9) Joint manipulation

(10) Ligament and tendon repairs

(11) Mastectomy

(12) Open reduction--internal fixation

(13) Patellectomy

(14) Tendon transfer

(15) Thoracotomy

(16) Total ankle arthroplasty

(17) Total hip arthroplasty

(18) Total knee arthroplasty

(19) Total shoulder arthroplasty

(20) First rib resection

b. Associated Problems

(1) Abnormal gait pattern

(2) Contractures

(3) Decreased endurance

(4) General deconditioned state

(5) Improper posture and or body mechanics

(6) Inability or incapability of preserving functional ROM and/or strength

(7) Lack of mobility skills for ADL, transfers, gait

(8) Muscle guarding/spasm

(9) Need for equipment and/or adaptive devices

(10) Need for muscle re-education

(11) Need for pre/post prosthetic training

(12) Pain

(13) Stump and skin care

4. DYSFUNCTION: RESPIRATORY DISTURBANCES

a. Conditions

(1) Asthma

(2) Bronchiectasis

(3) Bronchitis

(4) Chronic obstructive pulmonary disease

(5) Cor pulmonale

(6) Cystic fibrosis

(7) Emphysema

(8) Empyema

(9) Lung infection

(10) Middle lobe syndrome

(11) Plural effusion

(12) Pneumonia

(13) Respiratory failure

(14) Tuberculosis

b. Associated Problems

(1) Decreased endurance

(2) Establish and review home program

(3) General deconditioned state

(4) Inability to mobilize secretions

(5) Inadequate breathing pattern

(6) Inadequate chest excursion

(7) Lack of skill to cope with shortness of breath

(8) Poor cough

(9) Shortness of breath with ADL

5. DYSFUNCTION: DECONDITIONED-DETERIORATED STATES

a. Conditions

(1) Alcoholism

(2) Cancer

(3) Neurological and cutaneous complication of diabetes mellitus

(4) Organ transplant

(5) Renal failure

b. Associated Problems

(1) Decreased endurance

(2) General deconditioned state

(3) Lack of functional ROM, strength and/or motor control

(4) Lack of mobility skills for ADL, transfer, gait

(5) Muscle alienation

(6) Pain

6. DYSFUNCTION: ARTHRITIS AND RHEUMATISM

a. Conditions

(1) Acute arthritis or polyarthritis due to infection

(2) Ankylosing spondylitis

(3) Degenerative arthritis

(4) Degenerative joint disease

(5) Dermatomyositis

(6) Juvenile rheumatoid arthritis

(7) Osteoarthritis

(8) Polymyositis

(9) Rheumatoid arthritis

(10) Scleroderma

(11) Synovitis

(12) Systemic lupus erythematosus

(13) Traumatic arthritis

b. Associated Problems

(1) Abnormal gait pattern

(2) Breathing difficulties secondary to deformities

(3) Contractures

(4) Decreased endurance

(5) General deconditioned state

(6) Improper posture and/or body mechanics

(7) Incapability of preserving ROM and/or strength

(8) Lack of functional ROM, strength, and or motor control

(9) Lack of knowledge of joint preservation

(10) Lack of mobility skills for ADL, transfers, or gait

(11) Muscle guarding/spasm

(12) Need for equipment and/or adaptive devices

(13) Pain

(14) Presence of inflammatory process

(15) Stress control - joint protection

7. DYSFUNCTION: VASCULAR DISEASE

a. Conditions

(1) Buerger's disease

(2) Cellulitis

(3) Congestive heart failure

(4) Gangrene

(5) Intermittent claudication

(6) Lymphedema

(7) Myocardial infarction

(8) Peripheral vascular disease

(9) Phlebitis

(10) Transient ischemic attacks

(11) Varicose veins

(12) Venous ulcers

b. Associated Problems

(1) Decreased endurance

(2) Edema

(3) General deconditioned state

(4) Pain

(5) Presence of inflammatory process

(6) Slow wound healing

(7) Wound infection

8. DYSFUNCTION: PERIPHERAL NERVE

a. Conditions

(1) Amyotrophic lateral sclerosis

(2) Bell's palsy

(3) Carpal tunnel syndrome

(4) Erb's palsy

(5) Guillain-Barre syndrome

(6) Herpes zoster

(7) Klumpke's paralysis

(8) Myasthenia gravis

(9) Neuralgia

(10) Neuritis

(11) Peripheral nerve injury

(12) Peripheral neuropathy

(13) Polio

(14) Polyneuritis

(15) Polyradiculitis

(16) Reflex sympathetic dystrophy

(17) Stretch palsies

(18) Thoracic outlet syndrome

b. Associated Problems

(1) Decreased coordination

(2) General deconditioned state

(3) Improper posture and or body mechanics

(4) Change or decrease in sensation

(5) Lack of functional ROM, strength and/or motor control for ADL

(6) Lack of mobility skills

(7) Muscle alienation

(8) Muscle guarding/spasm

(9) Need for equipment or adaptive devices

(10) Need for muscle re-education

(11) Pain

9. DYSFUNCTION: NERVOUS SYSTEM

a. Conditions

(1) Brain tumor

(2) Cerebral arterial sclerosis

(3) Cerebral atrophy

(4) Cerebral palsy

(5) Comatose/semi-comatose

(6) Concussion

(7) CVA (stroke, hemiparesis)

(8) Encephalitis

(9) Hydrocephalus

(10) Meningitis

(11) Mental retardation

(12) Multiple sclerosis

(13) Paralysis agitans

(14) Parkinsonism

(15) Subdural hematoma

b. Associated problems

(1) Spasticity, flaccidity

(2) Hypertonicity, hypotonicity, fluctuating tone, rigidity, athetosis

(3) Absence of righting reaction or equilibrium response

(4) Ataxia

(5) Contractures

(6) Decubitus ulcers

(7) Developmental sequence

(8) Disturbances of perception, sensation or proprioception

(9) Edema

(10) Impaired balance

(11) Lack of cognitive function (level of awareness)

(12) Lack of functional ROM, strength or motor control for ADL

(13) Lack of mobility skills

(14) Muscle imbalance

(15) Need for equipment or adaptive devices

(16) Poor coordination

(17) Presence of primitive or pathological reflexes

10. DYSFUNCTION: SKIN

a. Conditions

(1) Burns

(2) Decubitus ulcers

(3) Open wounds

(4) Psoriasis

(5) Soft tissue ulceration

b. Associated Problems

(1) Contractures

(2) General deconditioned state

(3) Improper posture or body mechanics

(4) Inability or incapability of preserving ROM or strength

(5) Lack of functional ROM, strength or motor control for ADL, transfers, or gait

(6) Lack of mobility skills

(7) Need for wound cleaning, debridement, or dressing

(8) Pain

(9) Presence of active inflammatory process

(10) Slow wound healing

(11) Splinting

(12) Wound infection

EXCLUSIONS

A. The following services are not covered:

1. Diathermy, ultrasound, and heat treatments for pulmonary conditions.

2. General exercise programs, even if recommended by a physician (or other authorized individual professional provider acting within the scope of their license).

3. Electrical nerve stimulation used in the treatment of upper motor neuron disorders such as multiple sclerosis.

4. Separate charges for instruction of the patient and family in therapy procedures.

5. Repetitive exercise to improve gait, maintain strength and endurance, and assistative walking such as that provided in support of feeble or unstable patients.

6. Range of motion and passive exercises which are not related to restoration of a specific loss of function, but are useful in maintaining range of motion in paralyzed extremities.

7. Gait analysis (also known as a walk study evaluation or electrodynogram) is considered unproven and is not covered.

8. Maintenance physical therapy after a therapy program has been designed.

9. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

B. The physical therapy limitations outlined in the Regulation should not be applied to osteopathic manipulation. (See Chapter 1, Section 25.2 on Osteopathic Manipulative Therapy.)

C. Services performed by a physical therapy assistant, who is employed by an independent professional provider, may not be cost-shared. Also, see Chapter 8, Section 11.1.

- END -

Subject: CORNEAL TRANSPLANTS	Chapter: 3
Authority: DoD 6010.8-R, Chapter 4, E.5.	Section: 16.2
	Issue Date: January 23, 1984

PROCEDURE CODE RANGE

65710 - 65775

DESCRIPTION

Corneal transplants (penetrating keratoplasty) are performed for scarring of the cornea or disease of the cornea which interfere with corneal function.

POLICY

A. A corneal transplant (keratoplasty) is a covered surgical procedure when medically necessary and appropriate.

B. When astigmatism follows a corneal transplant and the astigmatism is of such a degree that is not practically corrected with glasses or a contact lens, then a relaxing keratotomy (CPT code 65772) can be performed in an effort to relieve the astigmatism.

C. Corneal relaxing incisions to correct astigmatism following corneal transplant are not to be confused with radial keratotomy. Medical necessity must be determined on a case-by-case basis.

POLICY CONSIDERATIONS

A. When a corneal transplant is performed on an inpatient basis, eye bank charges are covered within the amount allowed under the CHAMPUS DRG-based payment system. Separate billings from the surgeon, the eye bank or the hospital for the corneal tissue are not acceptable.

B. When a corneal transplant is performed in an ambulatory surgery center, a physician's office, or on an outpatient basis, the corneal tissue may be reimbursed separately. Either the physician or the facility (as appropriate) may bill for the tissue (using procedure code V2785). Payment is limited to the acquisition cost of the tissue, and that cost must be documented by an invoice from the eye bank.

C. Eye banks themselves are not CHAMPUS authorized providers; therefore, payment can only be made through the DRG system for inpatient services or to the facility or physician for outpatient or ambulatory surgery services.

- END -

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;

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. Take-home drugs for less than $40;

4. Special care unit operating costs; and

5. Malpractice insurance costs related to services furnished to inpatients.

F. Discharges and transfers.

1. Discharges. Subject to the provisions of paragraph F.2. and below, a hospital inpatient is considered discharged from a hospital paid under the CHAMPUS DRG-based payment system when:

a. The patient is formally released from the hospital; or

b. The patient dies in the hospital; or

c. The patient is transferred to a hospital or unit that is excluded from the TRICARE/CHAMPUS DRG-based payment system under the provisions of Chapter 13, Section 6.1D. Such cases can be identified by form locator 22 on the UB-92 claim form. If anything other than "02" is entered, the contractor is to process the claim as a discharge. All claims coded "02" are to be processed as transfers unless there is specific reason for not doing so (e.g., the case is classified into DRG No. 601). For discharges with an admission date on or after October 1, 1998, such cases shall no longer be processed as a discharge, but as a transfer, if the claim contains one of the 10 qualifying DRGs listed in paragraph F.4. of this subsection, and the patient is transferred to one of the settings outlined in paragraph F.3. of this subsection.

2. Transfers - Basic rule. A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this subsection if the discharge is made under the following circumstances:

a. From a hospital included under the DRG-based payment system to the care of another hospital that is:

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

(2) Excluded from being paid under the CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS DRG-based payment system under Chapter 13, Section 6.1D (such instances will result in two or more claims); or

(3) Authorized as a uniformed services treatment facility or a Veterans Administration hospital.

b. From one inpatient area or unit of a hospital to another inpatient area or unit of the same hospital that is paid under the CHAMPUS DRG-based payment system (such instances will result in a single claim).

3. Transfers - Special 10 DRG rule. For discharges with an admission date on or after October 1, 1998, 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 F.4. below and the discharge is made under any of the following circumstances:

a. To a hospital or distinct part hospital unit excluded from the CHAMPUS DRG-based payment system as described in Chapter 13, Section 6.1D. Claims shall be coded 05 in form locator 22 on the UB-92 claim form.

b. To a skilled nursing facility. Claims shall be coded 03 in form locator 22 on the UB-92 claim form.

c. To a home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge. Claims shall be coded 06 in form locator 22 on the UB-92 claim form. Claims coded 06 with a condition code of 42 or 43 in form locator 24 shall be processed as a discharge instead of a transfer.

4. Qualifying DRGs. The qualifying DRGs for purposes of paragraph F.3. of this subsection are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

5. Payment for discharges. The hospital discharging an inpatient (under paragraph F.1.) is paid in full in accordance with paragraph D. of this Policy.

6. Payment for transfers.

a. General Rule. Except as provided in paragraph F.6.b. and paragraph F.6.d. below, a hospital that transfers an inpatient under circumstances described in paragraph F.2. or paragraph F.3. of this subsection, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the CHAMPUS 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 length of stay 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 percent of the per diem rate for each subsequent day, up to the full DRG amount.

b. Special rule for DRGs 209, 210, and 211. A hospital that transfers an inpatient under the circumstances described in paragraph F.3. of this subsection and the transfer is assigned to DRGs 209, 210, and 211 is paid as follows:

(1) 50 percent 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).

(2) 50 percent of the per diem for each subsequent day up to the full DRG payment.

c. 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 Chapter 13, Section 6.1H, paragraph B.6.a. However, the total payment cannot exceed what would be paid under the provisions of paragraph F.5., above. For admissions on or after October 1, 1998, payment for transfer cases with cost outliers shall be calculated as follows.

Step 1: DRG Base Payment = ASA x DRG Weight x (Labor-Related Portion x Wage Index + Non-Labor Portion)

Step 2: DRG Base Payment ÷ Geometric Mean Length of Stay

Step 3: Calculation of Cost Outlier Threshold:

1. For all cases except DRGs 209, 210 and 211

   A = DRG Base Payment x (1 + IDME Factor)

   B = (Fixed Loss Threshold x [(Labor-Related Share x Wage Index) + Non-Labor–Related Share] x National Operating Standard Costs as a Share of Total Costs)

   C = LOS ÷ Geometric Mean

   Cost Outlier Threshold = (A + B) x C

2. For DRGs 209, 210 and 211

   A = DRG Base Payment x (1 + IDME Factor)

   B = (Fixed Loss Threshold x [(Labor-Related Share x Wage Index) + Non-Labor–Related Share] x National Operating Standard Costs as a Share of Total Costs)

   C = ((LOS ÷ Geometric Mean) + 1) x 0.5

   Cost Outlier Threshold = (A + B) x C

Step 4: Calculation of Cost Outlier Payment:

1. For all cases except DRGs 209, 210 and 211

   ((Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold) x Marginal Cost Factor

2. For DRGs 209, 210 and 211

   ((Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold) x Marginal Cost Factor

3. For Children's Hospitals using Cost Outlier Threshold for all cases except DRGs 209, 210 and 211

   ((Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold) x Marginal Cost Factor x Adjustment Factor

4. For Children's Hospitals using Cost Outlier Threshold for DRGs 209, 210 and 211

   ((Billed Charges x Cost-to-charge Ratio – Cost Outlier Threshold) x Marginal Cost Factor x Adjustment Factor

NOTE: *Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the cost-to-charge ratio.*

Step 5: DRG payment:

1. For all transfer cases except DRGs 209, 210 and 211

   Cost outlier payment + the minimum of:

   a. DRG Base Payment x (1 + IDME Factor), or

   b. ((2 x Per Diem) + [(LOS-1) x Per Diem]) x (1 + IDME Factor)

2. For DRGs 209, 210 and 211

   Cost outlier payment + the minimum of:

   a. DRG Base Payment, or

   b. ((DRG Base Payment x 0.5) + Per Diem) + ((LOS-1) x Per Diem x 0.5))

Following is an example transfer case with cost outlier:

Billed Charges	$30,000
Cost-to-charge Ratio	0.5562
Cost-to-charge Ratio for Children's Hospitals	0.6085
Adjustment Factor for Children's Hospitals	1.37
Fixed Loss Threshold	$10,129
LOS	5
Geometric Mean	10.0
Marginal Cost Factor	0.8
Wage Index	0.9000
IDME Factor	20.0%
Labor Portion	71.1%
Non-Labor Portion	28.9%
ASA	$3,000
DRG Weight	2.0000
National Operating Standard Cost as a Share of Total Costs	0.9130

Step 1: DRG Base Payment = ASA x DRG Weight x (Labor-Related Portion x Wage Index + Non-Labor Portion)

$3,000 x 2 x (0.711 x 0.9 + 0.289) = $5,573.40

Step 2: Per Diem = DRG Base Payment ÷ Geometric Mean Length of Stay

$5,573.40 ÷ 10 = $557.34

Step 3: Calculation of Cost Outlier Threshold:

1. For all cases except DRGs 209, 210 and 211

   A = DRG Base Payment x (1 + IDME Factor)

   $5,573.40 x (1 + 0.2) = $6,688.08

   B = (Fixed Loss Threshold x [(Labor-Related Share x Wage Index) + Non-Labor–Related Share] x National Operating Standard Costs as a Share of Total Costs)

   $10,129 x [(0.711 x 0.9) + 0.289] x 0.913 = $8,590.26

   C = LOS ÷ Geometric Mean

   5 ÷ 10 = 0.5

   Cost Outlier Threshold = (A + B) x C

   ($6,688.08 + $8,590.26) x 0.5 = $7,639.17

2. For DRGs 209, 210 and 211

   A = DRG Base Payment x (1 + IDME Factor)

   $5,573.40 x (1 + 0.2) = $6,688.08

   B = (Fixed Loss Threshold x [(Labor-Related Share x Wage Index) + Non-Labor–Related Share] x National Operating Standard Costs as a Share of Total Costs)

   10,129 x [(0.711 x 0.9) + 0.289] x 0.913 = $8,590.26

   C = ((LOS ÷ Geometric Mean) + 1) x 0.5

   ((5 ÷ 10) + 1) x 0.5 = 0.75

   Cost Outlier Threshold = (A + B) x C

   ($6,688.08 + $8,590.26) x 0.75 = $11,458.76

Step 4: Calculation of Cost Outlier Payment:

1. For all cases except DRGs 209, 210 and 211

   [(Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold] x Marginal Cost Factor

[($30,000 x 0.5562) – $7,639.17] x 0.8 = $7,237.46

2. For DRGs 209, 210 and 211

   [(Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold] x Marginal Cost Factor

   [($30,000 x 0.5562) – $11,458.76] x 0.8 = $4,181.79

3. For Children's Hospitals using Cost Outlier Threshold for all cases except DRGs 209, 210 and 211

   [(Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold] x Marginal Cost Factor x Adjustment Factor

   [($30,000 x 0.6085) – $7,639.17] x 0.8 x 1.37 = $11,634.95

4. For Children's Hospitals using Cost Outlier Threshold for DRGs 209, 210 and 211

   [(Billed Charges x Cost-to-charge Ratio) – Cost Outlier Threshold] x Marginal Cost Factor x Adjustment Factor

   [($30,000 x 0.6085) – $11,458.76] x 0.8 x 1.37 = $7,448.68

NOTE: *Non-covered Charges Shall Be Subtracted From The Billed Charges Prior To Multiplying The Charges By The Cost-to-charge Ratio.*

Step 5: DRG payment:

1. For all transfer cases except DRGs 209, 210 and 211

   Cost outlier payment + the minimum of:

   a. DRG Base Payment x (1 + IDME Factor), or

      $5,573.40 x (1 + 0.2) = $6,688.08

   b. ((2 x Per Diem) + [(LOS-1) x Per Diem]) x (1 + IDME Factor)

      ((2 x $557.34) + [(5-1) x $557.34]) x (1 + 0.2) = $4,012.85

   $7,237.46 + $4,012.85 = $11, 250.31

2. For DRGs 209, 210 and 211

   Cost outlier payment + the minimum of:

   a. DRG Base Payment x (1 + IDME Factor), or

      $5,573.40 x (1 + 0.2) = $6,688.08

   b. ([(DRG Base Payment x 0.5) + Per Diem] + ((LOS-1) x Per Diem x 0.5)) x (1 + IDME Factor)

([($5,573.40 x 0.5) + 557.34] + ((5-1) x 557.34 x 0.5)) x (1 + 0.2) = $5,350.46

$4,181.79 + $5,350.46 = $9,532.25

d. 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. For admissions prior to October 1, 1998, if a discharge is classified into DRG 456 (Burns, Transferred to another acute care facility) the transferring hospital is paid in full. DRG 456 is no longer valid as of October 1, 1998.

G. Leave of Absence Days.

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

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

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

4. Services received while on leave of absence. The technical component of laboratory tests obtained while on a leave of absence would be included in the DRG-based payment to the hospital. The professional component is to be cost-shared as inpatient. Tests performed in a physician's office or independent laboratory are to be denied using EOB message 64, "Payment determined under DRG-based payment system - amount allowed is payment in full".

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

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

I. Redesignation of Certain Hospitals to Other Wage Index Areas. TRICARE/CHAMPUS is simply following this statutory requirement for the Medicare Prospective Payment System, and the Health Care Financing Administration determines the areas affected and wage indexes used.

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

2. Admissions occurring on or after April 1, 1990. In order to correct inequities resulting from application of the rules in paragraph I.1. above, the Health Care Financing Administration modified the rules for those rural hospitals deemed to be urban. TRICARE/CHAMPUS has also adopted these changes. Some of these hospitals continue to use the urban area wage index, others use a wage index computed specifically for the rural county, and others use the statewide rural wage index. The appropriate wage indexes are provided in the addendums to this Chapter which provide the annual updated rates and weights.

3. Admissions occurring on or after October 1, 1991. P.L. 101-239 created the Medicare Geographic Classification Review Board (MGCRB) to reclassify individual hospitals to different wage index areas based on requests from the hospitals. These reclassifications are intended to eliminate the continuing inequities caused by the reclassification actions described in paragraph I.1. and paragraph I.2. above. TRICARE/CHAMPUS has adopted these hospital-specific reclassifications effective for admissions occurring on or after October 1, 1991. Effective with this change there are no longer any counties whose hospitals are deemed urban.

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.

- END -

Subject: HOSPITAL REIMBURSEMENT - CHAMPUS DRG-BASED PAYMENT SYSTEM (ADJUSTMENTS TO PAYMENT AMOUNTS)	Chapter: 13
Authority: DoD 6010.8-R, Chapter 14	Section: 6.1H
	Issue Date: October 8, 1987

ISSUE

What are the adjustments to the CHAMPUS DRG-based payment amounts?

POLICY

A. 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) which can be made.

B. Specific Adjustments.

1. Capital costs. TRICARE/CHAMPUS will reimburse hospitals for their capital costs as reported annually to the contractor (see below). Payment for capital costs will be made annually. See the OPM Part Two, Chapter 4, Section II. for the procedures for paying capital costs. Also, see Chapter 13, Section 6.6 for information on the payment of capital costs, as well as direct medical education costs, under the Supplemental Health Care Program.

a. Required reductions in capital payments. The basic capital payments (as determined above) shall be reduced in accordance with the statutorily-required reductions for Medicare, and if they are legislatively-changed for Medicare, the TRICARE/CHAMPUS reductions will conform to the Medicare reductions. The required reductions and the periods to which they apply are:

3.5 percent for October 1 through November 20, 1987;

7 percent for November 21 through December 31, 1987;

12 percent for January 1 through September 30, 1988;

15 percent for FY 1989;

2 percent for October 1 through December 31, 1989;

15 percent for January 1, 1990, through September 30, 1992;

10 percent beginning October 1, 1992, through September 30. 1995; and

17.68 percent beginning October 1, 1997, through September 30, 2003.

The capital payments will be prorated for the different percentage reductions based on the days in the reporting period which fall into each category. For example, the capital costs for a cost-reporting period which runs from November 1, 1987, through October 31, 1988, would have the following reductions.

(1) November 1 through November 20 equals 5.5 percent of the year (20 days of 366 days).

(2) November 21 through December 31 equals 11.2 percent of the year (41 days of 366 days).

(3) January 1 through September 30 equals 74.9 percent of the year (274 days of 366 days).

(4) October 1 through October 31 equals 8.4 percent of the year (31 days of 366 days). Therefore, the contractor would determine the total capital amount applicable to TRICARE/CHAMPUS and reduce 5.5 percent of it by 3.5 percent, 11.2 percent of it by 7 percent, 74.9 percent of it by 12 percent, and 8.4 percent of it by 15 percent.

b. For days occurring on or after October 1, 1995, through September 30, 1997, TRICARE/CHAMPUS will reimburse 100% of capital-related costs.

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

(1) Net depreciation expense.

(2) Leases and rentals (including license and royalty fees) for the use of assets that would be depreciable if the provider owned them outright (except in certain cases).

(3) Betterments and improvements that extend the estimated useful life of an asset at least 2 years beyond its original estimated useful life or increase the productivity of an asset significantly over its original productivity.

(4) The cost of minor equipment that are capitalized rather than charged off to expense.

(5) Interest expense incurred in acquiring land or depreciable assets (either through purchase or lease) used for patient care.

(6) Insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business.

(7) Taxes on land or depreciable assets used for patient care.

(8) For proprietary providers, a return on equity capital.

d. To obtain the total allowable capital costs from the Medicare cost reports prior to October 1992, the contractor shall add the figures from Worksheet D, Part I, Column 1, lines 25-28 and line 33, to the total figure for Ancillary costs from Worksheet D, Part II, Column 1, lines 37-59. The capital payment shall then be reduced by the applicable percentages and time periods outlined in paragraph B.1.a. above.

e. 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 and line 33, to the figures from Worksheet D, Part II, Columns 1 and 2,

lines 37-59. The capital payment shall then be reduced by the applicable percentages and time periods outlined in paragraph B.1.a. above.

f. The instructions outlined in paragraph B.1.a. and paragraph B.1.e. above, are effective for initial and amended requests received on or after October 1, 1998.

g. 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:

(1) The capital-related equipment is leased or rented by the provider;

(2) The capital-related equipment is located on the provider's premises; and

(3) The capital-related portion of the charge is separately specified in the charge to the provider.

2. Direct medical education costs. TRICARE/CHAMPUS 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 the OPM Part Two, Chapter 4, Section II. for the procedures for paying direct medical education costs.)

a. Direct medical education costs generally include:

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

(2) Nursing schools.

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

b. Direct medical education costs do not include:

(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.

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

c. 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 25-30, 33, and 37-59. These

instructions are effective for all initial and amended requests received on or after October 1, 1998.

3. Determining amount of capital and direct medical education payment. In order to account for payments by other health insurance, TRICARE/CHAMPUS' payment amounts for capital and direct medical education will be determined according to the following steps. Throughout these calculations claims on which TRICARE/CHAMPUS made no payment because other health insurance paid the full TRICARE/CHAMPUS-allowable amount are not to be counted.

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

(1) Any days determined to be not medically necessary, and

(2) Days included on claims for which TRICARE/CHAMPUS made no payment because other health insurance paid the full TRICARE/CHAMPUS-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/CHAMPUS 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/CHAMPUS direct medical education payment for DRG discharges.

Step 5: Combine the amounts from STEP 3 and STEP 4.This is the amount of TRICARE/CHAMPUS payment due the hospital for capital and direct medical education.

4. Payment of capital and direct medical education costs.

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

(1) Beginning October 1, 1998, initial requests for payment of capital and DME shall be filed with the TRICARE/CHAMPUS contractor on or before the last day of the twelfth 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 September 30, 1998, requests for payment of capital and DME must be filed no later than 12 months following the close of the cost-reporting period. For example, if a hospital's cost-reporting period ends on September 30, 1998, the request for payment shall be filed on or before September 30, 1999. Those

hospitals that are not Medicare participating providers are to use an October 1 through September 30 fiscal year for reporting capital and DME costs.

(a) An extension of the due date for filing the initial request may only be granted if an extension has been granted by HCFA 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.

(b) All costs reported to the TRICARE/CHAMPUS 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/CHAMPUS 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.

(c) The 30 day period is a means of encouraging hospitals to report changes in its capital and 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.

(d) 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.

(2) Prior to October 1, 1998, TRICARE/CHAMPUS had no time limit for filing initial requests for reimbursement of capital and DME, other than the six-year statute of limitations. The time limitation for filing claims does not apply to capital and DME payment requests. To allow TRICARE/CHAMPUS contractors to close out prior year data, all initial payment requests for capital and DME for cost-reporting periods ending before September 30, 1998, shall be filed with the TRICARE/CHAMPUS contractor no later than 5 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:

(a) 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 CHAMPUS inpatient days.

(b) The contractor shall follow the instructions for processing initial requests as outlined in paragraph B.4.c.(1) below.

b. Information necessary for payment of capital and direct medical education costs. The following information must be reported to the contractor:

(1) The hospital's name.

(2) The hospital's address.

(3) The hospital's TRICARE/CHAMPUS provider number.

(4) The hospital's Medicare provider number.

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

(6) Total inpatient days provided to all patients in units subject to DRG-based payment.

(7) Total TRICARE/CHAMPUS 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.)

(a) Total inpatient days provided to active duty members in units subject to DRG-based payment (see Chapter 13, Section 6.6).

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

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

(10) Total full-time equivalents for:

(a) Residents,

(b) Interns (see below).

(11) Total inpatient beds (see below).

(12) Title of official signing the report.

(13) Reporting date.

(14) The report must contain a certification statement that any changes to items (6), (7), (8), (9), and (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.

(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.

c. Contractor actions.

(1) Initial requests for capital/direct medical education payment.

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

(b) The contractor shall verify the number of TRICARE/CHAMPUS 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 ten working days of identification of the discrepancy and include the inpatient day verification report.

(c) 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.

(d) The contractor shall verify the accuracy of the financial amounts listed for capital and 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.

(e) The contractor must make the capital and direct medical education 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 B.4.c.(1)(b) above.

(2) Amended Requests for Capital/DME.

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

(b) 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 capital and DME reimbursement request. The contractor will not process amended requests for days only.

(c) The contractor shall verify the number of TRICARE/CHAMPUS 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 ten working days of identification of the discrepancy and include the inpatient day verification report.

(d) 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.

(e) The contractor shall verify the accuracy of the financial amounts listed for capital and 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.

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

(3) The contractor shall prepare a voucher in accordance with the requirements of the OPM Part Two, Chapter 4, Section II.B.7. and send it to the TMA Contract Resource Management Directorate for clearance before releasing the checks.

(4) Requests for reimbursement of DRG capital and DME costs shall be paid as pass-through costs. The MCS contractors are not at-risk for these costs.

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

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

5. Children's Hospital Differential.

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

b. Qualifying for the children's hospital differential. In order to qualify for a children's hospital differential adjustment, the hospital must be exempt from the Medicare PPS as a children's hospital. If the hospital is not Medicare-participating, it must meet the criteria in DoD 6010.8-R, Chapter 6, B.4.a. In addition, more than half of its inpatients must be individuals under the age of 18.

c. Calculation of the children's hospital differentials. The differentials will be equal to the difference between a specially-calculated ASA for children's hospitals (using the procedures described in Chapter 13, Section 6.1G) and the ASA for FY 1988 which would otherwise be applicable. They will be calculated so that they are “revenue neutral” for children's hospitals; that is, for FY 1988 overall TRICARE/CHAMPUS payments to children's

hospitals under the DRG-based payment system would have been equal to those under the old payment system. To accomplish this, TSO/OCHAMPUS (the Office of Program Development) calculated separate ASAs for childrens' hospitals. Normally in calculating ASAs, TSO/OCHAMPUS reduces the adjusted charges according to the Medicare cost-to-charge ratio (.66 during FY 1988). However, in recognition of the higher costs of children's hospitals, we do not use this step in calculating the children's hospital differentials. We subtract the appropriate ASA from the children's hospital ASAs, and these amounts are the children's hospital differentials. The differentials will not be subject to annual inflation updates nor will they be recalculated except as provided below.

d. Differential amounts.

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

(a) Calculation of the national children's hospital differentials. These differentials are calculated using the procedures described in paragraph B.5.c., above, but based on a database of only low-volume children's hospitals. They were calculated initially using a database of claims processed from July 1, 1987, through June 30, 1988 and updated to FY 1988 using the hospital market basket. They were subsequently finalized based on claims processed from April 1, 1989, through March 31, 1990. (See Chapter 13, Addendum 2, Table 2 (FY 1989) for these amounts.)

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

(c) Administrative corrections. Any children's hospital that believed TSO/OCHAMPUS 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 TSO/OCHAMPUS. The corrected differential was effective retroactively to April 1, 1989, so this process included adjustments, by the contractor, to any previously processed claims which were processed using an incorrect differential.

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

Large Urban Areas	
Labor portion	$1,945.99
Non-labor portion	689.42
	$2,635.41

Other Areas	
Labor portion	$1,483.21
Non-labor portion	525.47
	$2,008.68

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

6. Outliers.

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

b. Payment of outliers. For all admissions occurring before October 1, 1988, if the claim qualifies as both a length-of-stay outlier and a cost outlier, payment shall be based on the length-of-stay outlier. For admissions occurring on or after October 1, 1988, claims which qualify as both a length-of-stay outlier and a cost outlier shall be paid at whichever outlier calculation results in the greater payment.

c. Provider Reporting of outliers. The provider is to identify outliers on the UB-92, form locator 24 - 30. Code 60 is to be used to report length-of-stay outliers, and code 66 is to be used to signify that a cost outlier is not being requested. If a claim qualifies as a cost outlier and code 66 is not entered in the appropriate form locator (i.e., it is blank or code 61), the contractor is to accept this as a request for cost outlier payment by the hospital.

d. Length-of-stay outliers. The CHAMPUS DRG-based payment system uses both short-stay and long-stay outliers, and both are reimbursed using a per diem amount. All length-of-stay outliers must be identified by the contractor when the claims are

processed, and necessary adjustments to the payment amounts must be made automatically.

(1) Short-stay outliers.

(a) Any discharge which has a length-of-stay (LOS) less than 1.94 standard deviations below the DRG's geometric LOS shall be classified as a short-stay outlier. In determining the actual short-stay threshold, the calculation will be rounded down to the nearest whole number, and any stay equal to or less than the short-stay threshold will be considered a short-stay outlier.

(b) Short-stay outliers will be reimbursed at 200 percent 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 geometric mean length-of-stay for the DRG. For admissions occurring on or after October 1, 1998, the per diem rate shall equal the wage adjusted DRG amount divided by the arithmetic mean length of stay for the DRG. The per diem rate is to be calculated before the DRG-based amount is adjusted for indirect medical education.

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

(2) Long-stay outliers.

(a) Long-stay outliers are determined by thresholds which are calculated from the length-of-stay (LOS) criteria below. In determining the actual long-stay threshold, the calculation will be rounded down to the nearest whole number, and any stay greater than the long-stay threshold will be considered a long-stay outlier.

For admissions occurring on or after October 1, 1996, the long-stay threshold shall equal the lesser of 3.0 standard deviations or 24 days above the DRG's geometric LOS.

(b) For admissions occurring on or after October 1, 1996, long-stay outliers will be reimbursed the DRG-based amount plus 33 percent of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold.

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

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

e. Cost outliers.

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

(a) For admissions occurring prior to October 1, 1997, the standardized costs will be calculated by first subtracting the noncovered charges, multiplying the total charges (less lines 7, N, and X) by the cost-to-charge ratio of .5895 for admissions occurring on or after October 1, 1996 and adjusting this amount for indirect medical education costs by dividing the amount by one (1) plus the hospital's indirect medical education adjustment factor. For admissions occurring on or after October 1, 1997, the costs for indirect medical education are no longer standardized.

(b) Cost outliers will be reimbursed the DRG-based amount plus 80 percent effective 10/1/94 of the standardized costs exceeding the threshold.

(c) For admissions occurring on or after October 1, 1997, the following steps shall be followed when calculating cost outlier payments for all cases other than neonates and children's hospitals:

Standard Cost = (Billed Charges x Cost-to-Charge Ratio)
Outlier Payment = 80 percent 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 cost-to-charge ratio.*

(d) The cost-to-charge ratio for admissions occurring on or after October 1, 1997, is .5536. The cost-to-charge ratio for admissions occurring on or after October 1, 1998, is .5562.

(2) For FY 1997, a fixed loss cost-outlier threshold is set of $8,850. Effective October 1, 1996, the cost outlier threshold shall be the DRG-based amount (wage-adjusted but prior to adjustment for indirect medical education) plus the flat rate of $8,850.

(3) For FY 1998, a fixed loss cost-outlier threshold is set of $10,180. Effective October 1, 1997, the cost outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $10,180.

(4) For FY 1999, a fixed loss cost-outlier threshold is set of $10,129. Effective October 1, 1998, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $10,129 (also wage adjusted).

The cost-outlier threshold shall be calculated as follows:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x National Operating Standard Cost as a Share of Total Costs] + (DRG Base Payment x (1+IDME))}

EXAMPLE: Using FY99 figures {[10,129 x ((.7110 x Applicable wage index) + .2890) x 0.9130] + (DRG Based Payment x (1+IDME))}

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The threshold shall be the greater of two times the DRG-based amount (wage adjusted but prior to adjustment for indirect medical education) or $13,500.

(b) Effective October 1, 1998, the threshold shall be the same as that applied to other hospitals.

(c) Effective October 1, 1998, the standardized costs are calculated using a cost-to-charge ratio of .6085. For FY 98, the cost-to-charge ratio was .6027. For FY 97, the cost-to-charge ratio was .6459. (This is equivalent to the Medicare cost-to-charge ratio increased to account for capital and direct medical education costs.)

(d) The marginal cost factor shall be 80 percent.

(e) Effective October 1, 1998, the marginal cost factor shall be adjusted by 1.37 to ensure budget neutrality is maintained.

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 Cost to Charge Ratio
(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the cost-to-charge ratio.)

Step 2: Determination of Cost Outlier Threshold:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x National Operating Standard Cost as a Share of Total Costs] + [DRG Base Payment x (1+IDME)]}

Step 3: Determination of Cost Outlier Payment

[{(Standardized costs - Cost Outlier Threshold) x Marginal Cost Factor} x Adjustment Factor]

Step 4: Total Payments = Outlier Payments + [DRG Base Rate x (1 + IDME)]

h. Neonatal outliers. Neonatal outliers in hospitals subject to the CHAMPUS DRG-based payment system (other than children's hospitals) shall be determined under the same rules applicable to children's hospitals, except that the standardized costs for cost outliers shall be calculated using the cost-to-charge ratio of .64.

7. Indirect medical education adjustment.

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

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

For admissions occurring during FY 1988, the same formula was used except that the first number was 1.5 rather than 1.43.

For admissions occurring on or after October 1, 1997, the same formula will be used except that the first number is 1.30 rather than 1.43.

For admissions occurring during FY 1999, the same formula shall be used except the first number shall be 1.21.

For admissions occurring during FY 2000, the same formula shall be used except the first number shall be 1.11.

For admissions occurring during FY 2001, the same formula shall be used except the first number shall be 1.02.

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

c. Number of beds. Initially, the number of beds will be those reported on the most recent AHA Annual Survey of Hospitals (1986). Subsequent updates to the adjustment

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

d. Updates of indirect medical education factors. It is the contractor's responsibility to update the adjustment factors based on the data contained in the annual report. The effective date of the updated factor shall be the date payment is made to the hospital (check issued) for its capital and direct medical education costs, but in no case can it be later than thirty (30) days after the hospital submits its annual report. The updated factor shall be applied to claims with a date of discharge on or after the effective date. Similarly, contractors may correct initial factors if the hospital submits information (for the same base periods) which indicates the factor provided by TSO/OCHAMPUS is incorrect.

(1) Beginning in FY 1999, TRICARE/CHAMPUS will use the ratio of interns and residents to beds from HCFA's most recently available Provider Specific File to update the IDME adjustment factors. The ratio will be provided to the contractors to update each hospital's IDME adjustment factor at the same time as the annual DRG update. The updated factors shall be applied to claims with a date of discharge on or after October 1 of each year.

(2) This alternative updating method shall only apply to those hospitals subject to the Medicare PPS as they are the only ones included in the Provider Specific File.

e. Adjustment for children's hospitals. An indirect medical education adjustment factor will be applied to each payment to qualifying children's hospitals. The factors for children's hospitals will be calculated using the same formula as for other 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 thirty (30) days of receipt of the request from the hospital, and the effective date shall conform to the policy contained above.

(1) Beginning in August 1998, and each subsequent year, the contractor shall send a notice to each children's hospital in its Region, who have not provided the contractor with updated information on its number of interns, residents and beds since the previous October 1 and advise them their IDME factor will be eliminated at the beginning of the new fiscal year if they fail to provide the updated information by October 1 of that same year.

(2) The contractors shall send the updated ratios for children's hospitals to TMA, MB&RS, or designee, by April 1 of each year to be used in our annual DRG update calculations.

- END -

CHAPTER 13 ADDENDUM 2, TABLE 3 (FY 1999)

EFFECTIVE FOR ADMISSIONS ON OR AFTER 10/1/98
(Large urban areas are designated with an asterisk)

WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage Index	GAF
0040 Abilene, TX	0.8083	0.8644
Taylor, TX		
0060 Aguadilla, PR	0.4738	0.5996
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9954	0.9968
Portage, OH		
Summit, OH		
0120 Albany, GA	0.7993	0.8578
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8629	0.9040
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.8632	0.9042
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8544	0.8978
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	1.0226	1.0154
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9355	0.9554
Blair, PA		
0320 Amarillo, TX	0.8509	0.8953
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.3007	1.1973
Anchorage, AK		
0440 Ann Arbor, MI	1.1057	1.0712
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8676	0.9073
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8844	0.9193
Calument, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.4878	0.6117
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.8960	0.9276
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.8692	0.9085
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 [1]Atlanta, GA	0.9936	0.9956
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
De Kalb, GA		
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
0560 Altantic-Cape May, NJ	1.0377	1.0257
Atlantic, NJ		
Cape May, NJ		
0600 Augusta-Aiken, GA-SC	0.9253	0.9482
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 [1]Austin-San Marcos, TX	0.8442	0.8905
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 [2]Bakersfield, CA	0.9959	0.9972
Kern, CA		
0720 [1]Baltimore, MD	0.9663	0.9768
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9495	0.9651
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.5415	1.3449
Barnstable, MA		
0760 Baton Rouge, LA	0.8891	0.9227
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.9071	0.9354
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1459	1.0978
Whatcom, WA		
0870 [2]Benton Harbor, MI	0.8903	0.9235
Berrien, MI		
0875 [1]Bergen-Passaic, NJ	1.1774	1.1183
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.9162	0.9418
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8294	0.8798
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.9078	0.9359
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9092	0.9369
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.8042	0.8614
Burleigh, ND		

[1] Large Urban Area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 1999.

WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS-Continued

Urban area (constituent counties or county equivalents)	Wage Index	GAF
Morton, ND		
1020 Bloomington, IN	0.8984	0.9293
Monroe, IN		
1040 Bloomington-Normal, IL	0.8870	0.9212
McLean, IL		
1080 Boise City, ID	0.9209	0.9451
Ada, ID		
Canyon, ID		
1123 [1]Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1307	1.0878
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	1.0059	1.0040
Boulder, CO		
1145 Brazoria, TX	0.8925	0.9251
Brazoria, TX		
1150 Bremerton, WA	1.1079	1.0727
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8255	0.8769
Cameron, TX		
1260 Bryan-College Station, TX	0.8084	0.8645
Brazos, TX		
1280 [1]Buffalo-Niagara Falls, NY	0.9607	0.9729
Erie, NY		
Niagara, NY		
1303 Burlington, VT	0.9616	0.9735
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4419	0.5716
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.8827	0.9181
Carroll, OH		

[1] Large Urban Area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 1999.

WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS-Continued

Urban area (constituent counties or county equivalents)	Wage Index	GAF
Stark, OH		
1350 Casper, WY	0.9170	0.9424
Natrona, WY		
1360 Cedar Rapids, IA	0.8833	0.9185
Linn, IA		
1400 Champaign-Urbana, IL	0.8789	0.9154
Champaign, IL		
1440 Charleston-North Charleston, SC	0.9134	0.9399
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9009	0.9310
Kanawha, WV		
Putnam, WV		
1520 [1]Charlotte-Gastonia-Rock Hill, NC-SC	0.9562	0.9698
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0294	1.0200
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN-GA	0.9093	0.9370
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2]Cheyenne, WY	0.8787	0.9153
Laramie, WY		
1600 [1]Chicago, IL	1.0469	1.0319
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0167	1.0114
Butte, CA		

[1] Large Urban Area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 1999.

WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS-Continued

Urban area (constituent counties or county equivalents)	Wage Index	GAF
1640 [1]Cincinnati, OH-KY-IN	0.9615	0.9735
Dearborn, IN		
Ohio, IN		
Bonne, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
1660 Clarksville-Hopkinsville, TN-KY	0.8231	0.8752
Christian, KY		
Montgomery, TN		
1680 [1]Cleveland-Lorain-Elyria, OH	0.9907	0.9936
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9410	0.9592
El Paso, CO		
1740 Columbia, MO	0.8961	0.9276
Boone, MO		
1760 Columbia, SC	0.9310	0.9522
Lexington, SC		
Richland, SC		
1800 Columbus, GA-AL	0.8529	0.8968
Russell, AL		
Chattanoochee, GA		
Harris, GA		
Muscogee, GA		
1840 [1]Columbus, OH	0.9802	0.9864
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8549	0.8982
Nueces, TX		
San Patricio, TX		
1900 [2]Cumberland, MD-WV (Maryland Hospitals	0.8574	0.9000
Allegany, MD		
Mineral, WV		

[1] Large Urban Area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 1999.