Chapter 6 Section 2

Hospital Reimbursement - TRICARE DRG-Based Payment System (General Description Of System)

Issue Date: October 8, 1987
Authority: 32 CFR 199.14(a)(1)

1.0 APPLICABILITY

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

2.0 ISSUE

How is the TRICARE DRG-based payment system to be used in determining inpatient reimbursement for hospitals?

3.0 POLICY

3.1 Scope

The TRICARE DRG-based payment system applies only to hospitals. Under the TRICARE DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively determined rates and applied on a per discharge basis using DRGs. DRG payments will include an allowance for Indirect Medical Education (IDME) costs. Additional payments will be made for capital costs, direct medical education costs and outlier cases. Under the TRICARE DRG-based payment system, a hospital may keep the difference between its prospective payment rate and its operating costs incurred in furnishing inpatient services, and is at risk for operating costs that exceed its payment rate.

3.2 Modeled On Medicare's Prospective Payment System (PPS)

The TRICARE DRG-based payment system is modeled on the Medicare PPS. Although many of the procedures in the TRICARE DRG-based payment system are similar or identical to the procedures in the Medicare PPS, the actual payment amounts, DRG weights, and certain procedures are different. This is necessary because of the differences in the two programs, especially in the beneficiary population. While the vast majority of Medicare beneficiaries are over age 65, TRICARE beneficiaries are considerably younger and generally healthier. Moreover, some services, notably obstetric and pediatric services, which are nearly absent from Medicare claims comprise a large part of TRICARE services.

3.2.1 DRGs Used

With two exceptions, the TRICARE DRG-based payment system uses the same DRGs used in the current Medicare Grouper. Although claims may be grouped into either DRG 469, Principal diagnosis invalid as discharge diagnosis, or DRG 470, Ungroupable, claims in these DRGs must be denied without development.

- EXCEPTION 1. Beginning with admissions occurring on or after October 1, 1988, the TRICARE system has replaced DRG 435 (Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment Without Complications or Comorbidity) with two age-based DRGs. Any claim which groups into DRG 435 shall be grouped by the contractor into either DRG 900 (where the beneficiary is 21 years old or younger) or DRG 901 (where the beneficiary is over 21 years old). This grouping by the contractor shall be based on the patient's age, as shown on the claim, on the date of admission. Effective for admissions on or after October 1, 2001, DRG 435 has been replaced by DRG 523. Any claim which groups into DRG 523, shall be grouped by the contractor into either DRG 900 or 901 as specified above.

- EXCEPTION 2. For admissions occurring on or after April 1, 1989, the TRICARE DRG-based payment system uses Pediatric Modified-DRGs (PM-DRGs) for all neonatal claims except those classified to DRGs 103, 391, 480, 495, 512, and 513. The PM-DRGs are DRGs 600 - 636.

3.2.2 Assignment Of Discharges To DRGs

TMA uses a "Grouper" program to classify specific hospital discharges within DRGs so that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge. The TRICARE Grouper is developed by Health Information Systems, 3M Health Care, and is based on the Centers for Medicare and Medicaid Services (CMS) Grouper, but it also incorporates the PM-DRGs and DRGs 900 and 901.

3.2.2.1 The Medicare Code Editor (or other similar editor programs) is an integral part of the CMS Grouper and serves two functions. It helps to ensure that the claim discharge data is accurate and complete, so that it can be correctly grouped into a DRG. It also "edits" the claims data to identify cases which may not meet certain coverage requirements or which might involve inappropriate services. Contractors are not required to use any "Editor" program, but it is recommended since the first function will facilitate claims processing, and the second function may be useful in assessing coverage under TRICARE.

3.2.2.2 The classification of a particular discharge is based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status. (Contractors are required to use the expanded diagnosis and procedure code fields.) For neonatal claims (other than normal newborns), it also is based on the newborn's birth weight, surgery, and the presence of multiple, major and other problems which exist at birth. The birth weight is to be indicated through use of a fifth digit on the neonatal ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) diagnosis code.

3.2.2.2.1 In situations where the narrative diagnosis on the DRG claim does not correspond to the numerical diagnosis code, the contractor shall give precedence to the narrative and revise the numerical code accordingly. Contractors are not required to make this comparison on every claim. Precedence should be given to the narrative code in those cases where a difference is identified as the result of editing, prepayment review, or other action that would identify a discrepancy. If an adjustment is subsequently necessary because the numerical code was, in fact, correct, the adjustment should be submitted under a Record Processing Mode (RPM) a reason for adjustment code indicating that there was no contractor error.

3.2.2.2.2 It is the hospital's responsibility to submit the information necessary for the contractor to assign a discharge to a DRG.

3.2.2.2.3 When the discharge data is inadequate (i.e., the contractor is unable to assign a DRG based on the submitted data), the contractor is to develop the claim for the additional information.

3.2.2.2.4 In some cases the "admitting diagnosis" may be different from the principal diagnosis. Although the admitting diagnosis is not required to assign a DRG to a claim, it may be needed to determine if a Non-Availability Statement (NAS) is required for mental health admissions (see the TRICARE Policy Manual (TPM), Chapter 1, Section 6.1).

3.2.2.2.5 For neonatal claims only (other than normal newborns), the following rules apply.

3.2.2.2.5.1 If a neonate (patient age 0 - 28 days at admission) is premature, the appropriate prematurity diagnosis code must be used as a principal or secondary diagnosis. The prematurity diagnosis codes are: ICD-9-CM code 764.0 - 764.9, slow fetal growth and fetal malnutrition, and 765.0 - 765.1, disorders relating to short gestation and unspecified low birth weight.

3.2.2.2.5.2 Where a prematurity diagnosis code is used, a fifth digit value of 1 through 9 must be used in the principal or secondary diagnosis to specify the birth weight. A value of 0 will result in the claim being grouped to DRG 470, and the claim will be denied. If no fifth digit is used, the Grouper will ignore that diagnosis code and the claim will be denied.

3.2.2.2.5.3 If a neonate is not premature, a prematurity diagnosis code must not be used. The Grouper will automatically assign a birth weight of "> 2,499 grams" and assign the appropriate PM-DRG. If the birth weight is less than 2,500 grams, the birth weight must be provided in the "remarks" section of the CMS 1450 UB-04.

3.2.2.2.5.4 If there is more than one birth weight on the claim, the Grouper will assign the claim to DRG 470, and the claim will be denied.

3.2.2.2.5.5 All claims for beneficiaries less than 29 days old upon admission (other than normal newborns) will be assigned to a PM-DRG, except those classified to DRGs 103, 480, 495, 512, and 513.

3.2.2.3 Each discharge will be assigned to only one DRG (related, except as provided in paragraphs 3.2.2.4 and 3.2.2.5, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

3.2.2.4 When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the contractor is to develop the claim to assure that the data are not the result of miscoding by either the contractor or the hospital. Where the procedure and medical condition are supported by the services and the procedure is unrelated to the principal diagnosis, the claim will be assigned to DRG 468, Unrelated OR Procedure.

3.2.2.5 When the discharge data submitted by a hospital result in assignment of a DRG which may need to be reviewed for coverage (e.g., DRG 380, abortion without dilation and curettage, which does not meet the TRICARE requirements for coverage), the contractor is to review the claim to determine if other diagnoses or procedures which were rendered concurrently are covered. If other covered services were rendered, the contractor shall change the principal diagnosis to the most logical alternative covered diagnosis, delete the abortion diagnosis and procedure from the claim so that it does not result in a more complex DRG, and regroup the claim.

Example: If a claim is grouped into DRG 380 and the abortion is not covered, but a tubal ligation was performed concurrently, the contractor should change the principal diagnosis to that for the tubal and delete the abortion from the procedures performed. If no covered services were rendered, the claim must be denied, and all related ancillary and professional services which are submitted separately must also be denied.

3.2.2.5.1 Contractors are not normally required to review all diagnoses and procedures to determine their coverage. Contractors are required to develop for medical necessity only if the principal diagnosis is generally not covered but potentially could be. Deletion of a diagnosis and/or procedure is required only when the principal diagnosis or procedure is not covered.

3.2.2.5.2 The only exception to the above paragraph is for abortions. Since abortions are statutorily excluded from coverage in most cases, the contractor is to ensure that payment is not affected by a noncovered abortion diagnosis or procedure whether it is principal or secondary. In all cases where payment would be affected, the abortion data is to be deleted from the claim.

3.3 Beneficiary Eligibility

3.3.1 Change Of Eligibility Status

3.3.1.1 Payment when eligibility changes. If a beneficiary is eligible for TRICARE coverage during any part of his/her inpatient confinement, except for the following cases, the claim shall be processed as if the beneficiary was eligible for the entire stay.

3.3.1.1.1 Claims which qualify for the long-stay or short-stay outlier payment. The long-stay outlier was eliminated for all cases, except neonates and children's hospitals, for admissions occurring on or after October 1, 1997. The long-stay outlier was eliminated for neonates and children's hospitals for admissions occurring on or after October 1, 1998. See paragraph 3.3.1.3.

3.3.1.1.2 Claims which qualify for the cost outlier payment after August 1, 2003. See paragraph 3.3.1.3.

3.3.1.1.3 Claims where a beneficiary gains eligibility after admission. The DRG-based payment is calculated beginning on the first day of TRICARE eligibility.

3.3.1.1.4 Claims where the loss of TRICARE eligibility results from gaining Medicare eligibility. The claim may still be processed by TRICARE, but it must be submitted to Medicare first and TRICARE payment will be determined under the normal double coverage procedures.

3.3.1.2 Transfer payments when eligibility status changes. Since payments to a transferring hospital are always based on a per diem amount, if the beneficiary's eligibility status changes while an inpatient in a transferring hospital, payment shall be made only for those days for which the beneficiary was eligible. The procedures below shall be followed in paying outlier amounts in cases involving transfers.

3.3.1.3 Outlier payments when eligibility status changes. For admissions prior to August 1, 2003, when requested, cost outlier payments are to be made in cases where the beneficiary gains or loses eligibility during an inpatient stay, and the contractor will not be required to determine which costs occurred outside the beneficiary's TRICARE eligibility. Since both long-stay and short-stay outlier payments are made on a per diem basis, no payment is to be made for any days of care which occurred after loss of eligibility and which result from either the long-stay or short-stay outlier. The hospital may bill the beneficiary for any services which would result in long-stay or short-stay outlier payments were it not for the beneficiary's loss of eligibility. For admissions on or after August 1, 2003, when computing the standardized costs for the cost outlier payment, any charges that occur after a beneficiary loses TRICARE eligibility, shall be subtracted from the billed charges prior to multiplying the billed charges by the Cost-to-Charge Ratio (CCR) when calculating the cost outlier payment. The contractor shall request an itemized bill from the hospital to identify these charges.

Example 1: The beneficiary loses eligibility on day two where the short-stay outlier cutoff is three days. The beneficiary was discharged on the seventh day. TRICARE reimbursement will be made for two days on a short-stay outlier basis. The beneficiary's cost-share will be based on the two paid days. The hospital may bill the beneficiary for all days of care beyond the second day.

Example 2: The beneficiary is discharged on day 10 and lost eligibility on day six. The short-stay outlier cutoff is day 2. TRICARE reimbursement will be based on the normal DRG payment which will apply to the entire Length-Of-Stay (LOS) (nine days). The beneficiary cost-share for a retiree would be based on the total covered days (nine days times the per diem), assuming this is not greater than 25% of the billed charge. An active duty dependent's cost-share would be nine times the current active duty per diem amount. The hospital cannot bill the beneficiary for any costs other than the cost-share.

Example 3: The beneficiary gains eligibility after admission. The DRG calculation begins on the first day of TRICARE eligibility. For example, a beneficiary is admitted March 6, 1992 and discharged May 16, 1992, but was only TRICARE eligible starting May 10, 1992. The claim should be treated as if the beneficiary was admitted on May 10, 1992, and the base DRG rate calculated.

3.3.2 Change Of Sponsor Status From Active Duty To Retired During An Active Duty Family Member's (ADFM's) Inpatient Stay

An inpatient claim is to be cost-shared as active duty whenever there is evidence that the

sponsor was on active duty during any period of the ADFM's inpatient stay.

3.3.3 Change Of Sponsor Status From Active Duty To Retired During An Active Duty Member's Inpatient Stay

An inpatient claim is to be cost-shared as retired if an Active Duty Service Member's (ADSM's) status changes to retired during an inpatient stay.

3.3.4 Professional Claims

Since payment for related professional services are itemized and billed on a daily basis, the claim shall be paid for the days the beneficiary is TRICARE eligible and denied for the days the patient was not TRICARE eligible.

3.3.5 Infant Of An Unmarried Family Member

A child of an unmarried family member is not eligible, therefore, charges for an infant of an unmarried family member are not eligible for reimbursement.

- END -