CHAPTER 1
SECTION 34

HOSPITAL INPATIENT REIMBURSEMENT IN LOCATIONS OUTSIDE THE 50 UNITED STATES AND THE DISTRICT OF COLUMBIA

ISSUE DATE: September 9, 2004
AUTHORITY: 32 CFR 199.1(b) and 32 CFR 199.14(m), (n), and (o)

I. APPLICABILITY

This policy is mandatory for reimbursement of all hospital inpatient services provided in the locations identified in paragraph IV.B. This policy revises, replaces, and supersedes the previously issued policy, effective October 1, 2004, for hospital reimbursement in the Philippines. Puerto Rico follows Continental United States (CONUS) based reimbursement methodologies used for the 50 United States and the District of Columbia.

II. ISSUE

How are specified inpatient hospital services reimbursed in the locations specified in paragraph IV.B.?

III. POLICY

The institutional per diem for those specified locations outside the 50 United States and the District of Columbia is the maximum amount TRICARE will authorize to be paid for inpatient services on a per diem basis. The allowable Institutional per diem rates for those specified locations outside the 50 United States and the District of Columbia, shall be the lesser of (a) daily billed charges or; (b) the prospectively determined per diems adjusted by a country specific index factor.

IV. BACKGROUND

Reimbursement Systems:

A. General.

1. Payment for inpatient hospital stays in specified locations outside the 50 United States and the District of Columbia, are made utilizing the lesser of (a) billed charges or (b) the prospectively determined per diems adjusted by a country specific index.

2. Payment for OCONUS hospital inpatient services shall be made using prospectively determined per diem rates. The per diem rates for specified locations outside the 50 United States and the District of Columbia, were developed into reimbursement groupings by utilizing diagnosis codes as contained in the International Classification of

Diseases, 9th Revision, and Clinical Modification (ICD-9-CM). The per diem rates are the maximum allowable amounts that TRICARE shall reimburse and the amount on which patient cost-shares are calculated. The National U.S. per diem rate is multiplied by a unique country specific index factor which adjusts the National U.S. per diems for the applicable country. The country specific hospital per diem, for those specified locations outside the 50 United States and the District of Columbia is the product of the National U.S. per diem and the country specific index.

B. Applicability.

1. This payment system applies to all hospitals providing inpatient services in:

a. The Philippines.

b. Panama.

c. Other as designated by the Government.

2. Institutional providers accepting, admitting and treating TRICARE beneficiaries will receive the per diem reimbursement on applicable hospital services included on inpatient claims. This payment system is to be used regardless of the type of hospital inpatient services provided. The prospectively determined per diem rates established under this system are all-inclusive and are intended to include, but not be limited to, a standard amount for nursing and technician services; room, board, and meals; drugs including any take home drugs; biologicals; surgical dressings, splints, casts, Durable Medical Equipment (DME) for use in the hospital and is related to the provision of a surgical service, procedure or procedures, equipment related to the provision and performance of surgical procedures; laboratory services and testing, X-ray and other diagnostic services directly related to the inpatient episode of care; special unit operating costs, such as intensive care units; malpractice costs, if applicable, or other administrative costs related to the services furnished to the patients, recordkeeping and the provision of records; and housekeeping items and services.

3. The per diem rates do not include such items as physician fees, irrespective of the physician's employment status with the hospital. The per diem rates do not include other professional providers (i.e., nurse anesthetist) recognized by TRICARE and who render directly related inpatient services and bill independently from the hospital for them. A valid primary ICD-9-CM code or narrative description of services must be submitted by the hospital or institutional provider. The medical description provided shall be able to support development of the claim by the overseas claims processor prior to reimbursement.

C. Exceptions. None

D. Country Specific Index. The country specific index is a factor obtained from the World Bank's International Comparison Program. The index factor is based on a large array of goods and services or market basket within the specific country which is then standardized and weighted to a U.S. standard and currency. The use of the country specific index enables a

conversion and therefore creates parity between the U.S. and the specific country in the purchasing of the same amount and type of medical services. TRICARE is utilizing a two year phase in approach for the implementation of the World Bank's International Comparison Program country specific index.

	COUNTRY SPECIFIC INDEX FACTOR*	COUNTRY SPECIFIC INDEX FACTOR EFFECTIVE MARCH 1, 2009
Philippines	0.52	0.229
Panama	0.70	0.60

* Effective data as directed by Contracting Officer (CO) through February 28, 2009.

E. Institutional Payment Rates.

1. TMA shall annually calculate the U.S. National group payment rates and provide them electronically to the overseas claims processor. The provided data will contain the ICD-9-CM range or groups of related diagnosis codes. The first three digits of the principal ICD-9-CM diagnosis code determines placement into a diagnosis group as well as a reimbursement group. The data will also contain a description of the diagnosis ICD-9-CM groups. The rate for each group is the average U.S. allowed amounts per day in short-stay hospitals for all ICD-9-CM diagnoses in the particular group. The file will also designate the effective date of the per diem rates. Additions, deletions, corrections, and updates shall be communicated to the overseas claims processor at least annually, or as specifics may dictate. TMA shall also communicate the country specific factor to the overseas claims processor every three years or as dictated by the World Bank's International Comparison Program or as determined by TRICARE.

2. The rates setting methodology was developed as follows:

a. A rate setting methodology utilizing the first three digits of a primary diagnosis code.

b. Eighteen diagnosis groupings were defined and designed to coincide with the groupings and definitions contained in the ICD-9-CM publication. For example, Group 1 is defined as ICD-9-CM codes 001 to 139, or Infectious and Parasitic Diseases. The first three digits of a primary diagnosis code are utilized for placement into one of the eighteen groups.

c. The payment rate for each of the 18 diagnostic groups was the average allowed amount per day over all the ICD-9-CM codes in a diagnosis group, based upon the claim's primary diagnosis.

d. Group payments were calculated by dividing total allowed charges by total inpatient days for the group.

F. Payments.

1. General. The per diem group rate will be based upon the first three digits of the primary diagnosis code. The TRICARE allowable charge and amount reimbursed for hospital inpatient care shall be the lesser of:

a. Actual billed charge for hospital inpatient care; or

b. The TRICARE U.S. National per diem rate multiplied by the country specific index factor is the country specific hospital per diem. This per diem is multiplied by the number of covered days of hospital inpatient care and equals the maximum amount allowed by TRICARE to be paid for the episode on inpatient care.

2. Only the primary diagnosis, on the date of admission, will be taken into consideration when determining the group for a payment rate. Only one payment group can be assigned to each independent episode of inpatient care. Each institutional claim for service reimbursement must contain a valid ICD-9-CM code or narrative description of services, and must be used to represent the primary diagnosis for inpatient admission. If a valid diagnosis code or narrative description is not supplied by the institutional provider it must be developed and supported by the overseas claims processor. Development of an institutional claim should contain the necessary elements to satisfy TRICARE Encounter Data (TED) requirements.

G. Beneficiary Change in Eligibility Status. Since payment is on a per diem basis, the hospital claims for services shall be paid for the days the beneficiary is TRICARE eligible and denied for the days the beneficiary is not TRICARE eligible.

H. Beneficiary Cost-Shares. Inpatient cost-shares as contained in Chapter 2, Section 1, for non-Diagnosis Related Group (DRG) facilities shall be applicable to TRICARE's hospital allowable charge.

I. Updating Payment Rates. Additions, changes, revisions or deletions to the ICD-9-CM codes or country specific index shall be communicated to the overseas claims processor and be considered as routine updates to this payment system and processed under TRICARE Operations Manual (TOM), Chapter 1, Section 4, paragraph 2.4.

J. The overseas claims processor shall maintain the current year and two immediate past years' iterations of the TRICARE U.S. National per diems and the country specific index factors.

K. There is no TRICARE waiver process applicable to hospitals in specified locations outside the 50 United States and the District of Columbia for institutional inpatient rates.

FIGURE 1-34-1 INSTITUTIONAL INPATIENT DIAGNOSTIC GROUPINGS FOR SPECIFIED LOCATIONS OUTSIDE THE 50 UNITED STATES AND THE DISTRICT OF COLUMBIA - NATIONAL INPATIENT PER DIEM AMOUNTS

GROUP	DESCRIPTION	ICD-9-CM CODE RANGE	NATIONAL INPATIENT PER DIEM
01	Infectious Disease	1 - 139	$1,847
02	Cancer	140 - 239	$2,136
03	Endocrine	240 - 289	$2,119
04	Mental Health	290 - 319	$909
05	Nervous System	320 - 389	$1,906
06	Circulatory	390 - 459	$3,044
07	Respiratory	460 - 519	$1,828
08	Digestive	520 - 579	$1,888
09	Genitourinary	580-629	$1,980
10	Pregnancy, birth (mother)	630 - 679, V22 - V24, V27	$1,076
11	Musculoskeletal and skin	680 - 739	$3,079
12	Congenital abnormalities	740 - 759	$2,916
13	Perinatal Fetus and infant	760 - 779, V21, V29 - V39	$731
14	Signs, Symptoms, etc.	780 - 799	$1,950
15	Injuries	800 - 959	$2,246
16	Poisoning	960 - 995	$1,801
17	Complications	996 - 999	$2,333
18	All other "V" based codes		$1,640

NOTE: Care delivered must be a benefit of TRICARE under 32 CFR 199.4 and 199.5.

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