Chapter 1   Section 34

Hospital Inpatient Reimbursement In Locations Outside The 50 United States (U.S.) And The District Of Columbia

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Revision:

1.0   APPLICABILITY

This policy is mandatory for reimbursement of all hospital inpatient services provided in the locations identified in paragraph 4.2. 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 U.S. and the District of Columbia.

2.0   ISSUE

How are specified inpatient hospital services reimbursed in the locations specified in paragraph 4.2?

3.0   POLICY

The institutional per diem for those specified locations outside the 50 U.S. 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 rates for those specified locations outside the 50 U.S. and the District of Columbia, shall be the lesser of (a) billed charges or; (b) the amount based on prospectively determined per diems which are adjusted by a country specific index factor.

4.0   BACKGROUND

Reimbursement Systems:

4.1   General

4.1.1   Payment for inpatient hospital stays in specified locations outside the 50 U.S. and the District of Columbia, are made utilizing the lesser of:

- Billed charges; or
- The prospectively determined per diems adjusted by a country specific index.

4.1.2   The prospectively determined per diem rates for specified locations outside the 50 U.S. and the District of Columbia, are developed into reimbursement groupings by utilizing diagnosis codes. For services provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, use diagnosis codes as contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, use diagnosis codes as contained in the ICD-10-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 U.S. and the District of Columbia is the product of the National U.S. per diem and the country specific index.

4.2   Applicability

4.2.1   This payment system applies to all hospitals providing services in:

- The Philippines.
- Panama.
- Other as designated by the Government.

4.2.2   This payment system will be applied by the foreign claims processor. It applies to hospital inpatient services furnished to retirees or their eligible family members or Standard Active Duty Family Members (ADFMs) falling under the claims processing jurisdiction of the foreign claims processor.

4.2.3   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 or other diagnostic procedures directly related to the inpatient Episode Of Care (EOC); 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; housekeeping items and services; and capital costs.

4.2.4   The per diem rates do not include such items as physicians' fees, irrespective of a physician's employment status with the hospital. The per diem rates do not include other professional providers (e.g., nurse anesthetist) recognized by TRICARE 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 for services provided before the mandated date, as directed by HHS, for ICD-10 implementation. A valid primary ICD-10-CM code or narrative description of services must be submitted by the hospital or institutional provider for services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation. The

medical description provided shall be able to support development of the claim by the overseas claims processor prior to reimbursement.

4.3   Country Specific Index

The country specific index is a factor obtained from the World Bank's International Comparison Program. The index factor, known as Purchasing Power Parity (PPP) conversion 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 World Bank defines PPP conversion factor as: "Number of units of a country's currency required to buy the same amount of goods and services in the domestic market that a U.S. dollar would buy in the U.S." 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 the World Bank's International Comparison Program country specific index as provided in Figure 1.34-1.

4.4   Institutional Payment Rates

4.4.1   For services provided before the mandated date, as directed by HHS, for ICD-10 implementation:

National per diems are included in Figure 1.34-2 and Figure 1.34-3. The figures contain the ICD-9-CM code, code 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 adjusted per diems will be available at: http://www.tricare.mil/tma/foreignfee/.

4.4.2   For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation:

National per diems are included in Figure 1.34-2. The figures contain the ICD-10-CM code, code range, or groups of related diagnosis codes. The first alpha character and two digits of the principal ICD-10-CM diagnosis code determines placement into a diagnosis group as well as a reimbursement group. The adjusted per diems will be available at: http://www.tricare.mil/tma/foreignfee/.

4.4.3   The rate setting methodology was developed as follows:

4.4.3.1   For services provided before the mandated date, as directed by HHS, for ICD-10 implementation:

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

- Eighteen diagnosis groupings were defined and designed based on 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 18 groups.

- 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, plus an add-on to reimburse for capital costs.

4.4.3.2   For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation:

- A rate setting methodology utilizing the first alpha character and two digits of a primary diagnosis code.

- Eighteen diagnosis groupings were defined and designed based on the groupings and definitions contained in the ICD-10-CM publication. For example, Group 1 is defined as ICD-10-CM codes A00 to B99, or Infectious and Parasitic Diseases. The first alpha character and two digits of a primary diagnosis code are utilized for placement into one of the 18 groups.

- The payment rate for each of the 18 diagnostic groups was the average allowed amount per day over all the ICD-10-CM codes in a diagnosis group, based upon the claim's primary diagnosis, plus an add-on to reimburse for capital costs.

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

4.4.3.4   Once the 18 groupings were defined, certain unique admissions were identified for reimbursement separately from the 18 groupings. These are listed in Figure 1.34-3.

4.5   Payments

4.5.1   General. For services provided before the mandated date, as directed by HHS, for ICD-10 implementation, the per diem group payment rate will be based on the first three digits of the primary diagnosis code. For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, the per diem group payment rate will be based on the first alpha character and two digits of the primary diagnosis code. The maximum amount allowed by TRICARE and the amount reimbursed for hospital inpatient care shall be the lesser of:

- Actual billed charges for hospital inpatient care; or

- The U.S. National per diem rate authorized under TRICARE, 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.

4.5.2   Only the primary diagnosis code, 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. For services provided before the mandated date, as directed by HHS, for ICD-10 implementation, 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. For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, each institutional claim for service reimbursement must contain a valid ICD-10-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.

4.6   Beneficiary - Change in Eligibility Status

Since payment is on a per diem basis, the hospital claim for services shall be paid for the days the beneficiary is TRICARE eligible and denied for the days the beneficiary is not TRICARE eligible.

4.7   Beneficiary Cost-Shares

Inpatient cost-shares as contained in Chapter 2, Section 1, for non-Diagnosis Related Group (DRG) facilities shall be applicable to the hospital allowable charge authorized under TRICARE.

4.8   Updating Payment Rates

4.8.1   For services provided before the mandated date, as directed by HHS, for ICD-10 implementation, 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.

4.8.2   For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, additions, changes, revisions, or deletions to the ICD-10-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 TOM, Chapter 1, Section 4, paragraph 2.4.

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

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

FIGURE 1.34-1   COUNTRY SPECIFIC INDEX FACTORS

	COUNTRY SPECIFIC INDEX FACTOR	EFFECTIVE
2008		
Philippines	0.52	November 1, 2008
Panama	0.70	February 1, 2009
2012		
Philippines	0.57	December 1, 2012
Panama	0.70	December 1, 2012

FIGURE 1.34-2   INSTITUTIONAL INPATIENT DIAGNOSTIC GROUPINGS FOR SPECIFIED LOCATIONS OUTSIDE THE 50 U.S. AND THE DISTRICT OF COLUMBIA - NATIONAL INPATIENT PER DIEM AMOUNTS

GROUP	DESCRIPTION	ICD-9-CM CODE RANGE (FOR SERVICES BEFORE THE MANDATED DATE, AS DIRECTED BY HHS, FOR ICD-10 IMPLEMENTATION)	ICD-10-CM CODE RANGE (FOR SERVICES ON OR AFTER THE MANDATED DATE, AS DIRECTED BY HHS, FOR ICD-10 IMPLEMENTATION)	NATIONAL INPATIENT PER DIEM
2008				
01	Infectious Disease	1 - 139	A00 - B99	$2,463
02	Cancer	140 - 239	C00 - D49	$2,576
03	Endocrine	240 - 289	D50 - D89, E00 - E89	$2,457
04	Mental Health	290 - 319	F01 - F99	$851
05	Nervous System	320 - 389	G00 - G99, H00 - H95	$2,212
06	Circulatory	390 - 459	I00 - I99	$3,810
07	Respiratory	460 - 519	J00 - J99	$1,972
08	Digestive	520 - 579	K00 - K95	$2,172
09	Genitourinary	580-629	N00 - N99	$2,482
10	Pregnancy, birth (mother)	630 - 679, V22 - V24, V27	O00 - O9A, Z34, Z37, Z39	$1,196
11	Musculoskeletal and skin	680 - 739	L00 - L99, M00 - M99	$4,304
12	Congenital abnormalities	740 - 759	Q00 - Q99	$3,570
13	Perinatal Fetus and infant	760 - 779, V21, V29 - V39	P00 - P96, Z00, Z37	$717
14	Signs, Symptoms, etc.	780 - 799	R00 - R99	$2,326
15	Injuries	800 - 959	S00 - T34	$2,689
16	Poisoning	960 - 995	T36 - T50	$2,302
17	Complications	996 - 999	T81 - T88	$3,022
18	All other "V" or "Z" based codes			$2,080
Note: Care delivered must be a benefit of TRICARE under 32 CFR 199.4 and 199.5.				

FIGURE 1.34-2   INSTITUTIONAL INPATIENT DIAGNOSTIC GROUPINGS FOR SPECIFIED LOCATIONS OUTSIDE THE 50 U.S. AND THE DISTRICT OF COLUMBIA - NATIONAL INPATIENT PER DIEM AMOUNTS (CONTINUED)

GROUP	DESCRIPTION	ICD-9-CM CODE RANGE (FOR SERVICES BEFORE THE MANDATED DATE, AS DIRECTED BY HHS, FOR ICD-10 IMPLEMENTATION)	ICD-10-CM CODE RANGE (FOR SERVICES ON OR AFTER THE MANDATED DATE, AS DIRECTED BY HHS, FOR ICD-10 IMPLEMENTATION)	NATIONAL INPATIENT PER DIEM
DECEMBER 1, 2012				
01	Infectious Disease	1 - 139	A00 - B99	$2,475
02	Cancer	140 - 239	C00 - D49	$3,220
03	Endocrine	240 - 289	D50 - D89, E00 - E89	$2,389
04	Mental Health	290 - 319	F01 - F99	$978
05	Nervous System	320 - 389	G00 - G99, H00 - H95	$2,181
06	Circulatory	390 - 459	I00 - I99	$3,407
07	Respiratory	460 - 519	J00 - J99	$1,977
08	Digestive	520 - 579	K00 - K95	$2,309
09	Genitourinary	580-629	N00 - N99	$2,510
10	Pregnancy, birth (mother)	630 - 679, V22 - V24, V27	O00 - O9A, Z34, Z37, Z39	$1,525
11	Musculoskeletal and skin	680 - 739	L00 - L99, M00 - M99	$4,691
12	Congenital abnormalities	740 - 759	Q00 - Q99	$4,282
13	Perinatal Fetus and infant	760 - 779, V21, V29 - V39	P00 - P96, Z00, Z37	$1,094
14	Signs, Symptoms, etc.	780 - 799	R00 - R99	$2,143
15	Injuries	800 - 959	S00 - T34	$3,573
16	Poisoning	960 - 995	T36 - T50	$2,287
17	Complications	996 - 999	T81 - T88	$2,951
18	All other "V" or "Z" based codes			$2,352
Note: Care delivered must be a benefit of TRICARE under 32 CFR 199.4 and 199.5.				

FIGURE 1.34-3   UNIQUE ADMISSIONS - NATIONAL INPATIENT PER DIEM AMOUNTS

DESCRIPTION	ICD-9-CM CODE (FOR SERVICES BEFORE THE MANDATED DATE, AS DIRECTED BY HHS, FOR ICD-10 IMPLEMENTATION)	ICD-10-CM CODE (FOR SERVICES ON OR AFTER THE MANDATED DATE, AS DIRECTED BY HHS, FOR ICD-10 IMPLEMENTATION)	NATIONAL INPATIENT PER DIEM
2008			
Heart Transplant	V42.1	Z94.1	$9,819
Kidney Transplant	V42.0	Z94.0	$8,017
Combined Small Intestine/Liver (SI/L) Transplant	V42.7	Z94.4	$5,055
Lung Transplant	V42.6	Z94.2	$9,915
Simultaneous Pancreas-Kidney (SPK) Transplant	V42.89	Z94.89	$6,590
Pancreas Transplant	V42.83	Z94.83	$3,807
Coronary Artery Bypass Grafts (CABG)	V43.4	Z95.828	$5,351
Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty (PTCA)	V45.82	Z98.61	$5,475
DECEMBER 1, 2012			
Heart Transplant	V42.1	Z94.1	$9,817
Kidney Transplant	V42.0	Z94.0	$4,993
Combined Small Intestine/Liver (SI/L) Transplant	V42.7	Z94.4	$5,765
Lung Transplant	V42.6	Z94.2	$7,221
Simultaneous Pancreas-Kidney (SPK) Transplant	V42.89	Z94.89	$4,525
Pancreas Transplant	V42.83	Z94.83	$5,167
Coronary Artery Bypass Grafts (CABG)	V43.4	Z95.828	$4,823
Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty (PTCA)	V45.82	Z98.61	$6,076

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

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