

Chapter 7

Addendum B

Guidelines For The Calculation Of Individual Psychiatric Residential Treatment Center (RTC) Per Diem Rates

Revision: C-51, December 18, 2020

1.0 DATA COLLECTION FORM

1.1 The Defense Health Agency (DHA) Form 771 is designed for the collection of reimbursement data used in the calculation of prospective all-inclusive per diem rates for RTCs seeking certification under the TRICARE RTC program. The form will be sent out as part of the RTC certification package encouraging the facility to conduct a preliminary review of the reimbursement methodology prior to completion of the program certification portion of the application. Refer to attached DHA Form 771.

1.2 After submission of the DHA Form 771 to the TRICARE Quality Monitoring Contractor (TQMC), contractors should anticipate that the TQMC will, if needed, contact the facility, assist with gathering any additional information needed and calculate the initial per diem RTC reimbursement rate. When the rate is calculated, the TQMC will return the rate to the requesting contractor via secured means and provide the rate to the Government for posting on <https://health.mil>. Receipt of the calculated rate should be acknowledged to the TQMC at the address provided by the Contracting Officer Representative (COR) or the TQMC. The rate calculation process will begin with the contractor's submission of DHA Form 771 to the TQMC. A complete or substantially complete DHA Form 771 will expedite the rate calculation process.

1.3 If an RTC requests an initial per diem reimbursement rate calculation before submitting a request for TRICARE participation, the RTC should be referred by the contractor to this chapter. An RTC shall use this guidance to determine the approximate rate.

1.4 The DHA Form 771 is divided into two distinct data collection areas, one dealing with administrative information and the other with reimbursement information.

1.4.1 Administrative Information. Items 1 through 8 of the form identify the facility and establish the base year period over which the reimbursement data was collected. The Employer Identification Number (EIN) is of particular importance since it identifies the RTC for payment.

1.4.2 Reimbursement Information. Items 9 through 11 provide the reimbursement data necessary to calculate an all-inclusive prospective per diem rate for applying RTCs. The data represents those reimbursement levels that the RTC was willing to accept from other third-party payers during its base period. This allows the establishment of a per diem rate which reflects a reasonable amount consistent with rates charged by its peers nationally and with reimbursement it is accepting from other third-party payers.

2.0 ADMINISTRATIVE SUPPORT

2.1 The reviewer will provide the name and telephone number of a contact person that can provide additional help and instruction in filling out the data request form.

2.2 Examples of rate calculations are useful in establishing a conceptual understanding of the per diem methodology and for allowing the RTC to approximate its rates. These examples should include, but not be limited to, the following reimbursement concepts/issues:

- 33-1/3% rule.
- All-inclusive rate.
- Charges allowed outside all-inclusive rate.
- Rate updates.
- Open vs. closed staffing models.

3.0 REVIEW AND ANALYSIS OF SUBMITTED INFORMATION

3.1 Conduct a preliminary review of the information/data submitted on the DHA Form 771 paying particular attention to the opening and data collection start dates. The data collection start date for RTCs which were in operation during the entire base period (July 1, 1987 - June 30, 1988) will be July 1, 1987. The data collection start date will be the same as the opening date for facilities who began operation after June 30, 1988, or began operation before July 1, 1988, but had less than six months of operation by July 1, 1988, since the RTC's base period will be its first 12 months of operation. If the dates are not the same, follow the guidelines below:

3.1.1 Contact the person designated in Item #4 of DHA Form 771 for clarification regarding the discrepancy.

3.1.2 If the discrepancy resulted from a transcription error, correct the error and proceed with the review.

3.1.3 If the discrepancy **did not** result from a transcription error, have the RTC submit revised data encompassing the correct data collection period (i.e., data collected over the first 12 months of operation).

3.2 The reimbursement sections (Items 9 through 10) will be reviewed to make sure the submitted information is complete and correctly formatted. The data contained in these sections will be used to figure the RTC's prospective all-inclusive per diem rate and will be the basis for all future rates. The following are the data element requirements under each of these sections:

3.2.1 Item #9. This section requests information on all third-party payers establishing or affecting an RTC's rates during its specified base period. It includes the following reimbursement information:

3.2.1.1 Name, address and telephone number of each payer for whom a rate was established/accepted. This information is important for verification of rates under Items 9 through 11, especially in the case of state patients where there is often a negotiated contract. If the state rate represents 33-1/

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3% of total patient days, it is advisable for the reviewer to request copies of these contracts in order to verify the negotiated rates in effect during the RTCs base period. However, the reviewer will be given discretion in setting its own review parameters for requesting supporting documentation.

3.2.1.2 The rates accepted from each third-party payer during the RTC's designated base period. The accepted rates should not be confused with actual charged amounts. It is not uncommon to bill third-party payers amounts in excess of their allowed charges knowing payment will be less than the charged amounts. The allowed charge represents the amount the facility is willing to accept from a payer for RTC care. A determination will be made whether the listed facility rates represent total daily charges (i.e., represent an all-inclusive rate) or only the institutional component of the accepted rate using the following guidelines:

3.2.1.2.1 If there are no additional charges listed under Item #10, the facility rates appearing in Item #9 will be determined as all-inclusive, and as such, represent payment in full for all mental health services provided within the RTC (both professional and institutional).

3.2.1.2.2 If additional charges are listed under Item #10, a determination will be made on whether they apply to all of the third-party payers appearing in Item #9; i.e., whether all of the third-party payers allow payment of additional services above the facility rates listed in Item #9. The reviewer will note that where state or local agencies are involved most of their reimbursement is based upon flat per diem rates. The reviewer will contact the RTC if there is any question regarding the applicability of Item #10 charges to any one of the listed third-party payers.

3.2.1.3 The number of patient days provided/paid at each accepted rate. Cumulative patient days will be used in determining the rate high enough to cover at least one-third of the total patient days subject to the cap amount.

3.2.2 Item #10. This section requests information on the payment of any additional services allowed outside the facility rates recorded under Item #9. The sum of these charges will be added to the facility rate in calculating the TRICARE all-inclusive per diem rate. The RTC shall provide the methodology (the actual calculations) used in establishing the charge Per Patient Day (PPD) for each of the services listed in this section.

3.2.2.1 Required data elements:

- The service for which additional payment is allowed.
- The frequency of the service.
- The accepted charge/rate per service.
- The accepted charge/rate PPD.

3.2.2.2 The following are examples of services which may be allowed for payment outside the facility rates reflected in Item #9:

- Admission history and physical.
- Medical visits for physical illness or injury.
- Lab drug testing.
- EKG.

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- Family therapy.
- Pharmaceuticals.
- Individual and group psychotherapy.

3.2.3 Item #11. This section pertains to the payment of educational services in an RTC. Educational charges are excluded from payment under the prospective per diem system. If the RTC indicates that educational charges are included within the facility rate, they will be removed prior to establishing the TRICARE all-inclusive rate. The educational rate/charge per patient per day reported in Item #11.b will be subtracted from the overall facility rate. Educational services shall be paid apart from the facility per diem only when the services have been authorized by the reviewer. The RTC may provide educational services to its children under the following arrangements:

- The RTC has its own educational program whereby it bills for the entire educational component, incorporating facility and professional costs (i.e., bills for teachers, books, supplies, classroom facilities, etc.).
- The RTC has an agreement with its local school district to share in the education of its children. In most cases the local school district agrees to supply the teachers while the RTC provides the classrooms. The RTC only bills for the facilities charges.
- The local school district accepts total responsibility for educating the RTC children. No educational charges are billed since the children attend public school during the day.

3.3 The data collected and used to establish RTC per diem rates will be retained indefinitely.

4.0 BASE YEAR CALCULATIONS

4.1 For RTCs new to the TRICARE program, one of the following two alternative methods will be used in determining their individual rates:

4.1.1 The rates for an RTC which was in operation during the base period (July 1, 1987 through June 30, 1988) will be calculated based on the actual charging practices of the RTC during the 12 months ending July 1, 1988. The individual RTC rate will be the lower of either the TRICARE rate in effect on June 30, 1988, or the rate high enough to cover at least one-third of the total patient days of care provided by the RTC during the 12 months ending July 1, 1988 subject to a maximum cap.

4.1.2 The rates for an RTC which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than six months of operation by July 1, 1988, will be based on the actual charging practices during its first six to 12 consecutive months, with six months being the minimum time in operation for authorization under the TRICARE program. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate will be recalculated using the additional reimbursement data. The rates will be calculated the same as in [paragraph 4.1.1](#), except a different base period will be used.

4.2 The following methods are used in establishing the maximum capped per diem amounts:

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4.2.1 Prior to April 6, 1995, the capped per diem amount was set at the 75th percentile of all established TRICARE RTC rates nationally and weighted by total TRICARE days provided at each rate during the base period (July 1, 1987, through June 30, 1988). The capped amount was adjusted annually by the designated update factor (currently the Medicare update factor as noted in [Chapter 7, Section 1](#)). The following are the capped amounts in effect for the past three fiscal years:

RTC CAPPED AMOUNTS

| DATES OF SERVICE | | CAPPED AMOUNTS |
|------------------|----------------------|----------------|
| October 1, 2018 | - September 30, 2019 | 967 |
| October 1, 2019 | - September 30, 2020 | 997 |
| October 1, 2020 | - September 30, 2021 | 1021 |

4.2.2 The 70th percentile of the day-weighted current (Fiscal Year (FY) 1995) per diems was used in establishing a new cap amount for services rendered on or after April 6, 1995. The following methodology was used in establishing the RTC cap and floor amounts:

4.2.2.1 RTC institutional claims data from the period October 1, 1993 to March 31, 1994 were used (the first half of FY 1994).

4.2.2.2 The FY 1994 per diems were merged onto the claims (from the RTC per diem list in the TRICARE Policy Manual (TPM)) and updated by 1.046 (the CPI-U) to represent FY 1995 per diems.

4.2.2.3 The 30th and 70th percentiles of the day-weighted FY 1995 per diems were calculated as \$429 and \$515. Any RTC per diem above \$515 was cut to \$515 as of April 6, 1995.

5.0 ADJUSTMENT OF BASE YEAR RATE

5.1 The base year rate is adjusted by the following annual inflation factors to bring it forward to the current fiscal year. See [Section 1, paragraph 3.5.3](#) for the update factors for FY 2006 and forward.

UPDATE FACTORS FOR RTC PER DIEM RATES

| TIME PERIOD | | CPI-U INFLATION FACTORS |
|---|----------------------|-------------------------|
| July 1, 1988 | - November 30, 1988 | 2.6% |
| December 1, 1988 | - July 30, 1989 | 4.9 |
| October 1, 1989 | - September 30, 1990 | 9.2 |
| October 1, 1990 | - September 30, 1991 | 8.6 |
| October 1, 1991 | - September 30, 1992 | 7.4 |
| October 1, 1992 | - September 30, 1993 | 6.0 |
| October 1, 1993 | - September 30, 1994 | 4.6 |
| October 1, 1994 | - September 30, 1995 | 4.4 |
| Note: The FY 1997 CPI-U for medical care is 2.6%. This inflation will be used in adjusting FY 1995 RTC rates falling below the 30th percentile of all established FY 1995 rates (\$429.00). See also Chapter 7, Section 1 , for FY 2006 and forward. | | |

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UPDATE FACTORS FOR RTC PER DIEM RATES (CONTINUED)

| October 1, 1995 | - September 30, 1996 | 3.6 |
|---|----------------------|------------------------|
| TIME PERIOD | | MEDICARE UPDATE FACTOR |
| October 1, 1997 | - September 30, 1998 | 2.4 |
| October 1, 1998 | - September 30, 1999 | 2.4 |
| October 1, 1999 | - September 30, 2000 | 2.9 |
| October 1, 2000 | - September 30, 2001 | 3.4 |
| October 1, 2001 | - September 30, 2002 | 3.3 |
| October 1, 2002 | - September 30, 2003 | 3.5 |
| October 1, 2003 | - September 30, 2004 | 3.4 |
| October 1, 2004 | - September 30, 2005 | 3.3 |
| October 1, 2005 | - September 30, 2006 | 3.8 |
| Note: The FY 1997 CPI-U for medical care is 2.6%. This inflation will be used in adjusting FY 1995 RTC rates falling below the 30th percentile of all established FY 1995 rates (\$429.00). See also Chapter 7, Section 1 , for FY 2006 and forward. | | |

5.2 If the RTC's base year falls within the previous year's reporting period, the inflation factor is prorated for the remaining time in that period. The updating process can best be demonstrated through the following example:

Example: RTC E is submitting reimbursement information as a final step in its authorization process. The data was collected over the facility's first 12 months of operation (April 1, 2013 - March 31, 2014). Since the RTC's base period extended six months (or 180 days, based on 30-day months and a 360-day year) into the inflation reporting period, the inflation factor for the subsequent update year (October 1 - September 30) was prorated for the remaining time period of April 1, 2014 - September 30, 2014 (six months or 180 days). The following are the calculations used in updating the RTC's all-inclusive base year per diem to FY 2015 (current year per diem amount):

| ADJUSTMENT OF BASE YEAR PER DIEM RATE | |
|--|----------|
| Derived rate at 33.33% of total patient days during base period of April 1, 2013 through March 31, 2014. | \$500.00 |
| Plus: | |
| An adjustment for the annual update factor, as listed in Chapter 7, Section 1, paragraph 3.5.3 | |
| For 6-month period ending September 30, 2014 ($2.5\% \times 6/12 = 1.25\%$) | 6.25 |
| Adjusted Rate | \$506.25 |
| For 12-month period ending September 30, 2015 (2.9%) | 14.68 |
| Adjusted Rate | \$520.93 |
| TRICARE all-inclusive per diem rate for services on or after October 1, 2015 | \$521.00 |

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5.3 In a Final Rule published in the **Federal Register** (60 FR 12419) on March 7, 1995, TRICARE imposed a two-year moratorium on the annual updating of RTC per diems rates subject to the following provisions:

5.3.1 TRICARE payments will remain at FY 1995 rates for a two-year period beginning in FY 1996, for any RTC whose 1995 rate was at or above the 30th percentile of all established FY 1995 rates (\$429).

5.3.2 For any RTC whose FY 1995 rate was below that of the 30th percentile, the rate will be adjusted by the lesser of the CPI-U, or the amount that brings the rate up to the 30th percentile level.

5.3.3 For fiscal years after FY 1997, the individual facility rates and cap amount will be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system at the discretion of the Director, DHA or designee.

Note: The above provisions will lead to aggregate expenditures which approximate average facility costs. The 4.4% update factor was used in the RTC rate computation since its FY 1995 rate (\$368) was below the 30th percentile level (\$429).

6.0 CALCULATION OF RTC PER DIEM RATE

6.1 Array the rates accepted by other third-party payers (Item #9) in descending order from lowest to highest in the first column of the Reimbursement Information Work Sheet (see Attachment).

6.2 Place the number of days paid at each of the rates listed above in the second column of the work sheet.

6.2.1 If there is more than one rate with an individual third-party payer during the base period, the RTC shall provide the total number of patient days paid by the payer at each rate. Total patient days will be used in determining the most favored rate for the facility. The following is an example of multiple rates paid by an individual payer during the RTC's base period:

Example: RTC F has negotiated three separate rates with a third-party payer over its base period. The three rates were reported as follows:

1. \$295/day from July 2013, through October 31, 2013 - 2,000 patient days;
2. \$315/day from November 1, 2013, through February 29, 2014 - 3,000 patient days;
3. \$330/day from March 1, 2014, through June 30, 2014 - 2,000 patient days.

6.2.2 Each of the above negotiated rates shall be reported separately in Item #9 of the DHA Form 771 representing a blending of payments made by a particular payor over a facility's base period.

6.2.3 Patient days will be combined in those situations where third-party payers were paying the same rate for RTC care. This will represent the cumulative frequency of payments made at each reported reimbursement level in Item #9 of the data collection form.

6.2.4 The following examples represent the methodology used in calculating the TRICARE base year facility rate from data provided under Item #9 of the DHA Form 771:

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Example: RTC G provided the following third-party reimbursement data under Item #9 of the DHA Form 771 as part of the certification process:

ITEM #9 OF DHA FORM 771 (MODIFIED FOR EXAMPLE)

| THIRD-PARTY PAYERS | RATE ACCEPTED | PATIENT DAYS |
|---|---------------|--------------|
| AA | \$253 | 312 |
| BB | 527 | 207 |
| CC | 402 | 163 |
| DD *** | 212 | 198 |
| EE | 454 | 371 |
| FF | 603 | 118 |
| GG | 317 | 446 |
| HH | 489 | 538 |
| II | 552 | 319 |
| JJ | 503 | 132 |
| *** - State or local Government agency. | | |

Step 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate:

| (1) RATES | (2) PATIENT DAYS | (3) CUMULATIVE PATIENT DAYS | (4) PERCENT CUMULATIVE PATIENT DAYS |
|--------------|---------------------------|-----------------------------------|---|
| \$212 | 198 | 198 | 7.1 % |
| 253 | 312 | 510 | 18.2 |
| 317 | 446 | 956 | 34.1 |
| 402 | 163 | 1,119 | 39.9 |
| 454 | 371 | 1,490 | 53.1 |
| 489 | 538 | 2,028 | 72.3 |
| 503 | 132 | 2,160 | 77.0 |
| 527 | 207 | 2,367 | 84.4 |
| 552 | 319 | 2,686 | 95.8 |
| 603 | 118 | 2,804 | 100.0 |
| Total | 2,804 Patient Days | | |

Step 2: Sum the patient days in column 2, which in this particular example equals 2,804 patient days.

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Step 3: Calculate 33-1/3% of the total patient days by multiplying total patient days figured in Step 2 by 0.3333.

(2,804 patient days x 0.3333 = 934.57 patient days)

Step 4: Go down in the cumulative patient day column (column 3) to where 33-1/3% of the patient days lie (934.57).

Step 5: Go across to the rate in column 1 in which 33-1/3 of the cumulative patient days fall. This represents the base year/period facility rate. The base year/period rate in this example would be **\$317** (refer to table above).

Example: RTC H provided the following third-party reimbursement data under Item #9 of the DHA Form 771 as part of the certification process:

ITEM #9 OF DHA FORM 771 (MODIFIED FOR EXAMPLE)

| THIRD-PARTY PAYERS | RATE ACCEPTED | PATIENT DAYS |
|---|---------------|--------------|
| AA | \$425 | 201 |
| BB *** | 288 | 600 |
| CC *** | 235 | 63 |
| DD *** | 215 | 1,040 |
| EE | 365 | 276 |
| FF | 515 | 168 |
| GG *** | 288 | 346 |
| HH | 489 | 538 |
| II | 425 | 319 |
| JJ | 450 | 132 |
| *** - State or local Government agency. | | |

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Step 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate:

| (1) RATES | (2) PATIENT DAYS | (3) CUMULATIVE PATIENT DAYS | (4) PERCENT CUMULATIVE PATIENT DAYS |
|--------------|---------------------------|-----------------------------------|---|
| \$215 | 1,040 | 1,040 | 28.2 % |
| 235 | 63 | 1,103 | 29.9 |
| 288 | 946 | 2,049 | 55.6 |
| 365 | 276 | 2,325 | 63.1 |
| 425 | 520 | 2,845 | 77.2 |
| 450 | 132 | 2,977 | 80.8 |
| 489 | 538 | 3,515 | 95.4 |
| 515 | 168 | 3,683 | 100.0 |
| Total | 3,683 Patient Days | | |

Step 2: Sum the patient days in column 2, which in this particular example equals **3,683** patient days.

Step 3: Calculate 33-1/3% of the total patient days by multiplying total patient days figured in Step 2 by 0.3333.

$$(3,683 \text{ patient days} \times 0.3333 = 1,227.54 \text{ patient days})$$

Step 4: Go down in the cumulative patient day column (column 3) to where 33-1/3% of the patient days lie (1,227.54).

Step 5: Go across to the rate in column 1 in which 33-1/3 of the cumulative patient days fall. This represents the base year/period facility rate. The base year/period rate in this example would be **\$288** (refer to table above).

6.3 The above methodology for deriving the rate at 33-1/3 of the total patient days will only be applicable under the following conditions:

6.3.1 If the rates in Item #9 were all-inclusive for payment of RTC care (i.e., included all payments for institutional and professional services), no additional charges will be added on to the facility rates from Item #10 of the data collection form. The rate established in Step 5 of the above examples will represent the all-inclusive base year rate prior to the inflationary adjustment.

6.3.2 If the charges for additional services listed in Item #10 applied to all of the third-party payers identified in Item #9 (i.e., all of the third-party payers listed in Item #9 allowed payment for additional services outside the facility rate- rate derived at 33-1/3% of total RTC patient days during the base period-- at the charges PPD established in Item #10), the sum of these charges are added to the facility rate prior to inflationary adjustment.

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6.4 In cases where payment of additional services listed in Item #10 do not apply to all of the third-party payers listed in Item #9, or payments vary among the payers for the same services, the sum of the charges PPD for additional services (reported in the last column of Item #10) will be added to the facility rate prior to establishing the rate derived at 33-1/3% of the total patient days. The following example provides the methodology for incorporating these additional charges into the base year rate computations:

Example: RTC I has provided a revised DHA Form 771 indicating that payments for additional services had been overlooked in completing its initial form. The following service charges PPD were provided under Item #10 with the proviso that the additional payments were not allowed by the three state agencies and two private third-party providers. The payers were identified in Item #9 of the form.

ITEM #10 OF DHA FORM 771 (MODIFIED FOR EXAMPLE)

| PATIENT SERVICE | FREQUENCY OF SERVICE | CHARGE PER SERVICE | CHARGE PER DAY (PPD) |
|--------------------------------|-----------------------|--------------------|----------------------|
| Individual Therapy | 1/week | \$120.00 | \$17.14 |
| Group Therapy | 2/week | 45.00 | 12.86 |
| Admission History and Physical | 1/stay | 150.00 | 1.43 |
| Pharmacy | (\$10,438/2,498 days) | | 4.18 |
| Psych. Testing | 28 | 650.00 | 7.29 |
| | | | Total \$42.90 |

Note: The RTC's Average Length-Of-Stay (ALOS) was 105 days during its base period.

ITEM #9 OF DHA FORM 771 (MODIFIED FOR EXAMPLE)

| THIRD-PARTY PAYERS | RATE ACCEPTED | PATIENT DAYS |
|--------------------|---------------|--------------|
| AA | \$383 | 114 |
| BB ** | 165 *** | 313 |
| CC ** | 268 | 102 |
| DD ** | 204 *** | 485 |
| EE | 365 | 232 |
| FF | 471 *** | 117 |
| GG ** | 265 *** | 346 |
| HH | 489 | 338 |
| II | 425 *** | 319 |
| JJ | 425 | 132 |

**** - State or local Government agency.**

***** - Rates represent entire payment for RTC services. Charges for additional services reported in Item #10 not applied to these designated third-party payer rates.**

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| (1) RATES | (2) ADDITIONAL PAYMENTS | (3) PATIENT DAYS | (4) CUMULATIVE PATIENT DAYS | (5) PERCENT CUMULATIVE PATIENT DAYS |
|--------------|-------------------------------|---------------------------|-----------------------------------|---|
| \$165 | \$N.A. | 313 | 313 | 12.5 % |
| 204 | N.A. | 485 | 798 | 31.9 |
| 265 | N.A. | 346 | 1,144 | 45.8 |
| 268 | 42.90 | 102 | 1,246 | 49.9 |
| 365 | 42.90 | 232 | 1,478 | 59.2 |
| 425 | N.A. | 319 | 1,797 | 71.9 |
| 383 | 42.90 | 114 | 1,911 | 76.5 |
| 425 | 42.90 | 132 | 2,043 | 81.8 |
| 471 | N.A. | 117 | 2,160 | 86.5 |
| 489 | 42.90 | 338 | 2,498 | 100.0 |
| Total | | 2,498 Patient Days | | |

Step 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate.

Step 2: Sum the patient days in column 3, which in this particular example equals **2,498** patient days.

Step 3: Calculate 33-1/3% of the total patient days by multiplying total patient days figured in Step 2 by 0.3333.

$$(2,498 \text{ patient days} \times 0.3333 = 832.58 \text{ patient days})$$

Step 4: Go down in the cumulative patient day column (column 4) to where 33-1/3% of the patient days lie (832.48).

Step 5: Go across to the rates in column 1 and 2 in which 33-1/3 of the accumulative patient days fall. This represents the TRICARE **all-inclusive** base year/period rate. The base year/period rate in this example would be **\$265** (refer to table above).

6.5 If the RTC answers **no** to Item #11.a., the educational rate/charge PPD reported in Item #11.b will be subtracted from the overall facility base year/period rate.

6.6 Personal item charges will also be subtracted from the all-inclusive base year/period prior to inflationary adjustment.

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Example: RTC J checked no in Item #11.a. of the DHA Form 771 reporting an educational rate/charge PPD in Item #11.b. The RTC also reported a \$1 PPD charge for personal items.

| | |
|---|-----------|
| Accepted Rate at 1/3 of Patient Day | \$350 |
| Plus: | |
| Other Service Charges | 45 |
| Less: | |
| Personal Items | 1 |
| Education | 20 |
| All-Inclusive Base Period Rate Prior to Inflationary Adjustment | \$374/day |

6.7 The following is a detailed example of an RTC per diem calculation incorporating all of the data elements reported on the DHA Form 771 including inflationary adjustments:

Example: RTC K submitted the following reimbursement information as part of the certification process:

DATA REVIEW & ANALYSIS

| ITEM | DATA REQUESTED | DATA REPORTED |
|------|--------------------------------|-----------------------------|
| 2 | EIN | 38-1734578 |
| 5 | Opening Date | June 1, 2010 |
| 6 | Joint Commission Accreditation | October 31, 2012 |
| 7 | Data Collection Dates | June 1, 2010 - May 31, 2011 |

ITEM #9 OF DHA FORM 771 (MODIFIED FOR EXAMPLE)

| THIRD-PARTY PAYERS | RATE ACCEPTED | PATIENT DAYS |
|--------------------|---------------|--------------|
| AA | \$285 | 214 |
| BB | 453 | 102 |
| CC | 314 | 371 |
| DD | 388 | 163 |
| EE | 502 | 118 |
| FF | 314 | 246 |
| GG | 489 | 138 |
| HH | 402 | 319 |

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ITEM #10 OF DHA FORM 771 (MODIFIED FOR EXAMPLE)

| PATIENT SERVICE | FREQUENCY OF SERVICE | CHARGE PER SERVICE | CHARGE PER DAY (PPD) |
|------------------------------|----------------------|--------------------|----------------------|
| Individual Therapy | 1/week | \$90.00 | \$12.86 |
| Group Therapy | 1/week | 45.00 | 6.43 |
| Family Therapy | 1/2 weeks | 65.00 | 4.64 |
| Admission History & Physical | 1/stay | (\$175/120) (ALOS) | 1.46 |
| Pharmacy | (\$5,638/1,671 days) | | 3.38 |
| Psych. Testing | 28 | 650.00 | 6.28 |
| Total \$35.05 | | | |

Item #11. EDUCATIONAL CHARGES:

6.7.1 Are educational charges excluded from the daily rate when billing TRICARE?

YES X NO ____

6.7.2 What is the educational rate/charge per patient per day in your facility?

\$37.00 PPD

BASE YEAR/PERIOD RATE CALCULATION

Step 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate:

| (1) RATES | (2) PATIENT DAYS | (3) CUMULATIVE PATIENT DAYS | (4) PERCENT CUMULATIVE PATIENT DAYS |
|--------------|---------------------------|-----------------------------------|---|
| \$285 | 214 | 214 | 12.8 % |
| 314 | 617 | 831 | 49.7 |
| 388 | 163 | 994 | 59.5 |
| 402 | 319 | 1,313 | 78.6 |
| 453 | 102 | 1,415 | 84.7 |
| 489 | 138 | 1,553 | 92.9 |
| 502 | 118 | 1,671 | 100.0 |
| Total | 1,671 Patient Days | | |

Step 2: Sum the patient days in column 2, which in this particular example equals **1,671** patient days.

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- Step 3:** Calculate 33-1/3% of the total patient days by multiplying total patient days figured in Step 2 by 0.3333.
- (1,671 patient days x 0.3333 = 556.94 patient days)
- Step 4:** Go down in the cumulative day column (column 3) to where 33-1/3% of the patient days lie (556.94).
- Step 5:** Go across to the rate in column 1 in which 33-1/3 of the cumulative patient days fall. This represents the base year/period **facility** rate. The base year/period facility rate in this example would be **\$314** (refer to table above).
- Step 6:** Add the sum of the charges PPD reported in Item #10 of the Form 771 (\$35.05/patient day) to the base year/period facility rate figured in Step 5 since additional payments are allowed for all the listed third party payers in Item #9. The base year/period all-inclusive per diem rate is \$349.05.
- Step 7:** Subtract any educational and/or personal item charges which are included in the all-inclusive base year/period rate calculated in Step 6. This does not apply in this particular example since there are no personal item and/or educational charges included in the base year/period facility rate.

INFLATIONARY ADJUSTMENTS

- Step 1:** Adjust the base year rate by the annual inflation factors to bring it forward to the current fiscal year as follows:

| ADJUSTMENT OF BASE YEAR PER DIEM RATE | |
|---|----------|
| Derived rate at 33.33% of total patient days during base period of June 1, 2010 - May 31, 2011. | \$349.05 |
| Plus: | |
| Update Factors: | |
| For 4-month period ending September 30, 2011 (0.87%) (2.6% x 4/12 = 8.7%) | 3.04 |
| Adjusted Rate | \$352.09 |
| For 12-month period ending September 30, 2012 (3.0%) | 10.56 |
| Adjusted Rate | \$362.65 |
| For 12-month period ending September 30, 2013 (2.6%) | 9.43 |
| Adjusted Rate | \$372.08 |
| For 12-month period ending September 30, 2014 (2.5%) | 9.30 |
| Adjusted Rate | \$381.38 |

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| ADJUSTMENT OF BASE YEAR PER DIEM RATE | |
|---|----------|
| For 12-month period ending September 30, 2015 (2.9%) | 11.06 |
| Adjusted Rate | \$392.44 |
| TRICARE all-inclusive per diem rate for services on or after October 1, 2015. | \$393.00 |
| Note: The rate is the lessor of the calculated per diem or the capped per diem rate, as noted in paragraph 4.2.1 . | |
| ATTACHMENT: DHA Form 771 | |

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FIGURE 7.B-1 DHA FORM 771

| INSTRUCTIONS FOR SUBMITTING REIMBURSEMENT INFORMATION FOR PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS | |
|--|---|
| <p>This reimbursement information will be used to compute a Residential Treatment Center's (RTC) all-inclusive rate under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This rate of reimbursement will reflect a reasonable amount consistent with rates charged by RTCs nationally and with reimbursement already accepted from other third-party payors. All requested information will be subject to on-site verification by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) or its representatives. In accordance with Article 6 of the current CHAMPUS RTC participation agreement, failure to provide all the requested information may result in denial of an application for CHAMPUS certification or termination of a current agreement.</p> <p>Administrative Information:</p> <p>Items 1 through 8 identify the facility and establish the base period parameters for calculating the individual RTC's rate. It is important that the contact person designated in item 2 be familiar with the methodology used in collection of the data. This person may be contacted at a future date if OCHAMPUS should have any questions regarding the submitted information. In items 5 through 7, provide the most recent/current dates for the information requested. Failure to do so may result in a base period that is inconsistent with the operation of your facility.</p> <p>Reimbursement Information:</p> <p>Item 9: For the period July 1, 1987, through June 30, 1988, provide the name, mailing address, and telephone number of all third-party payors for whom a rate was established and what the accepted rate was, and the number of patient days actually provided at that rate. At a minimum, this is to include all federal, state or local government agencies (including CHAMPUS), and other private third-party payors. Also include the rate charged the general public and the number of days actually provided at that rate. Individual private payors do not need to be identified.</p> | <p>The data requirements for RTCs beginning operation after July 1, 1988, or beginning operation <u>before</u> July 1, 1988, but having less than 12 months of operation by July 1, 1988, are identical to the data requirements for those facilities in operation during the entire base period, with the exception of the time frame for which the data is to be provided. The data must be provided for the first 6 to 12 months of operation, with 6 months being the absolute minimum for new facilities. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available the rate shall be recalculated and applied prospectively. If the data only covers a portion of the base period, <u>give the dates</u>. If there is more than one rate with an individual third-party payor during the base period, provide the <u>total</u> number of patient days paid by that payor at each rate during the base period. Total patient days will be used in determining the most favored rate for your facility. The following is an example of how to handle multiple third-party rates over your base period:</p> <p>An RTC had negotiated three separate rates with a third-party payor over its base period. The three rates would be reported as follows:</p> <ol style="list-style-type: none">(1) \$195/day from July 1, 1987, through October 31, 1987 - 2000 patient days;(2) \$215/day from November 1, 1987, through February 29, 1988 - 3000 patient days;(3) \$230/day from March 1, 1988, through June 30, 1988 - 2000 patient days. <p>In this example the total number of days paid by the third-party payor is 7000.</p> <p>If the RTC was in operation during the base period, provide the requested data for the entire period regardless of change in ownership; for example, if your facility was in operation during the base period (July 1, 1987, through June 30, 1988), but was taken over by a national mental health corporation as of January 1, 1988, provide the requested data from July 1, 1987, through June 30, 1988, along with date of change of ownership. Failure to provide the entire base period data will result in delay in establishing your new rate.</p> |

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FIGURE 7.B-1

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| | | |
|---|-----------------------------------|---|
| REIMBURSEMENT INFORMATION | | OMB No: 0704-0295 Expires: 31 January 1994 |
| PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS | | |
| Public reporting bureau for this collection of information is estimated to average 12 hours per response, including the time for reviewing instructions, searching existing data sources, and gathering and maintain the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Washington Headquarters Services, Directorate for information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204 Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0295) Washington, DC 20503. | | |
| 1. FACILITY NUMBER: | 2. EIN: | |
| 3. FACILITY NAME AND ADDRESS: | 4. NAME OF PERSON PREPARING DATA: | |
| TELEPHONE NUMBER: () | TITLE: | |
| 5. DATE CURRENT RTC PROGRAM OFFICIALLY OPENED FOR BUSINESS: | | |
| 6. DATE OF MOST RECENT ACCREDITATION: | | |
| 7. DATE OF CURRENT AUTHORIZATION AS A TRICARE APPROVED RTC: | | |
| 8. DATES OVER WHICH DATA WAS COLLECTED _____ TO _____ | | |
| 9. THIRD PARTY PAYERS ESTABLISHING OR AFFECTING RATES: Data requirements should be carefully reviewed and presented in the following format. (If additional sheets are required, copy the format and attach all completed sheets.) | | |
| NAME, ADDRESS AND TELEPHONE NUMBER OF EACH PAYER | RATE ACCEPTED | PATIENT DAYS PROVIDED AT EACH RATE |
| | | |

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FIGURE 7.B-1 **DHA FORM 771**

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