Chapter 6 Section 5

Hospital Reimbursement - TRICARE DRG-Based Payment System (Determination Of Payment Amounts)

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 will the payment amounts under the TRICARE DRG-based payment system be determined?

3.0 POLICY

3.1 Calculation Of Payment Amounts

3.1.1 The actual payment for an individual claim (except for short-stay outliers and transfers) under the TRICARE DRG-based payment system is as follows:

3.1.1.1 For admissions occurring prior to October 1, 1997, the following steps shall be used to calculate the payment amount. In performing these calculations, the contractor may either round the amounts or simply truncate them to two decimal places when calculating the DRG-based payment amount. (All other calculations shall not be rounded or truncated.)

Step 1: Determine the DRG applicable to the claim.

Step 2: Determine if the hospital is large urban or other.

Step 3: Multiply the labor-related portion of the adjusted standardized amount (ASA) and the labor-related portion of the children's hospital differential if the hospital is a children's hospital by the wage index applicable to the hospital which provided the services (this is "A").

Step 4: Add the nonlabor-related portion of the ASA and the nonlabor-related portion of the children's hospital differential if the hospital is a children's hospital to "A" (this is "B").

Step 5: Multiply "B" by the DRG weight (this is "C").

Step 6: Determine any cost or long-stay outlier amounts (using "C") and add them to "C" (this is "D").

Step 7: Multiply "D" by one plus the Indirect Medical Education (IDME) adjustment factor if applicable (this is "E").

3.1.1.2 For admissions occurring on or after October 1, 1997, the actual payment for an individual claim except for neonates and children's hospitals, is calculated using Steps 1 through 5 and Steps 8 and 9 as follows:

Step 8: Multiply "C" by one (1) plus the IDME adjustment factor if applicable (this is "D").

Step 9: Determine any cost outlier payment amount as outlined in Section 8 and add it to "D" if the hospital is a teaching hospital, or "C" if it is not a teaching hospital (this is "E").

3.1.1.3 For admissions occurring on or after October 1, 1998, the actual payment for an individual claim for all hospitals, including children's hospitals and neonates, shall be calculated using Steps 1 through 5 and Steps 8 and 9.

3.1.2 Calculation of Short-Stay Outlier

Step 1: Calculate the DRG Basic Amount as outlined in Steps 1 through 5 in paragraph 3.1.1.1 (this is "A").

Step 2: Divide "A" by the Arithmetic Mean Length-of-Stay (LOS) for the applicable DRG to determine the DRG per diem rate (this is "B").

Step 3: Multiple "B" by the number of eligible days to determine the DRG Per Diem Amount (this is "C").

Step 4: Multiple "C" by the Short-Stay Marginal Cost Factor of 2.00 to determine the Short-Stay Outlier Basic Amount (this "D").

Step 5: Compare "D" to "A", if "D" is less than "A", multiple "D" by one (1) plus the IDME adjustment factor if applicable, to arrive at the Short-Stay Outlier Allowed Amount (this is "E"). If "D" is greater than "A", calculate the DRG payment amount as outlined in paragraphs 3.1.1.2 or 3.1.1.3.

3.1.3 Calculation of Transfer Payment Amounts. Refer to Section 3, paragraph 3.6 for information on calculating payment amounts for transfers.

3.1.4 Calculation of Outlier Payments. Refer to Section 8, paragraph 3.2.6 for information on calculating outlier payments.

3.2 Data Sources

In order to calculate the initial DRG weights and adjusted standardized amounts for the TRICARE DRG-based payment system, TMA will use data collected for all TRICARE hospital claims for the 12 month period from July 1, 1986, through June 30, 1987.

3.3 Development Of The Database

Before calculating the DRG weights and standardized amount, certain modifications to the database of hospital claims will be made.

3.3.1 Records for exempt hospitals. Since certain hospitals will be exempt from the TRICARE DRG-based payment system (see Section 4) records from these hospitals will be deleted from the database.

3.3.2 Interim bills. The DRG payment will be full payment for a complete hospital stay. Therefore, in those instances where a hospital has submitted one or more interim bills for a long LOS, the interim bills will be deleted from the database and only final, total bills will be used.

3.3.3 Unallowable charges. All charges relating to services which are not included in the DRG payment will be removed from the database. These services include emergency room, outpatient services, ambulance, home health visits, professional fees, and other similar services.

3.3.4 Exempt services. All charges related to exempt services, primarily psychiatric and substance abuse DRGs, will be removed from the database.

3.3.5 Combined mother/newborn bills. During at least part of the initial database period, hospitals were permitted to bill maternity services on a single claim. Since the TRICARE DRG-based payment system has separate DRGs for deliveries (the mother's care) and for newborn care, those claims for which the services were combined into a single charge will be removed from the database.

3.3.6 Record errors. All records which contain errors of any type (e.g., the record cannot positively be matched to a specific hospital because of an error in the provider name or number) will be removed from the database.

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