MEMORANDUM FOR: SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE
DIRECTOR TRICARE MANAGEMENT ACTIVITY
NETWORK DIRECTORS (10N1-23)
CHIEF OFFICERS

SUBJECT: Department of Veterans Affairs (VA)-Department of Defense (DoD) Health Care Resource Sharing Rates-Billing Guidance Inpatient Services

As part of the National Defense Authorization Act of fiscal year 2003, DoD and VA have been mandated to implement standardized billing rates for resource sharing agreements. This memorandum provides guidance on inpatient billing rates to be used for VA and DoD direct sharing agreements. It does not apply to agreements the VA may negotiate with managed care support contractors.

The guidance applies equally to VA and DoD. The method for calculating inpatient billing will, in general, follow the process used to calculate the institutional component of the TRICARE/Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) reimbursement, but will be discounted 10% to comply with current policy for VA/DoD sharing. Professional fees will follow the current policy of CHAMPUS/TRICARE maximum allowable charge (CMAC) rates less 10%. The attached guidance provides the detailed methodology. In accordance with the Memorandum of Agreement concerning reimbursement policy, a waiver may be requested. The attachment outlines the procedure to request a waiver.

This guidance will be reviewed annually by the VA/DoD Financial Management Working Group and updated as needed.

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Inpatient Billing Reimbursement Methodology
For Direct Sharing Agreements

1. **Introduction.** The VA and DoD have agreed to a reimbursement methodology for billing of inpatient care which uses two components. The first component is the institutional component, which reimburses for the hospital contribution to inpatient care (see paragraphs 2 and 3 for a discussion of the reimbursement methodology for the institutional component of inpatient billing). The second component is the professional services component, which reimburses for the non-institutional elements of Inpatient care (see paragraph 4 for a discussion of the reimbursement methodology for the professional services component). Inpatient hospital care is defined as treatment provided to an individual, other than a transient patient, who is admitted to the hospital, requiring the patient to be in the facility on a 24-hour a day basis. It does not include services such as partial hospitalization, observation, or ambulatory surgery (this is not a complete list).

2. **Institutional Component of Inpatient Care.** The base rate used in the TRICARE/CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including, but not limited to, the following:

a. Operating costs for routine services, such as the costs of room, board, therapy services (physical, speech, etc.), and routine nursing services as well as supplies necessary for the treatment of the patient;

b. Operating costs for technical components of ancillary services, such as radiology and laboratory services furnished to hospital inpatients (the professional component of these services is not included and can be billed separately);

c. ER facility/ancillary services which lead to hospitalization at the same facility;

d. Take-home drugs; and

e. Special care unit operating costs (intensive care type unit services).

3. **The institutional component of inpatient care will be reimbursed on the basis of Diagnosis Related Groups (DRGs).** A DRG is assigned, using a "grouper" software program, for each completed inpatient case. The DRG grouper software makes the DRG assignment based on characteristics of the patient and the case, including such data as the principal diagnosis, secondary diagnoses, procedures performed, discharge status, and patient demographics (e.g., age and gender).

a. The VA hospitals will use the Medicare DRG grouper to assign the DRG, and DoD hospitals will use the TRICARE DRG grouper implemented in conjunction with the Composite Health Care System (CHCS)/AHLTA to assign the DRG. There are minimal differences between the two DRG groupers when it comes to DRG assignment. The TRICARE DRG grouper contains two sets of DRGs created to address the unique nature of the beneficiary population served by TRICARE. These unique DRGs include special Pediatric Modified DRGs (DRGs 600 – 636) for newborns and DRGs 900 and 901, which simply split Medicare DRG into two separate age groups relevant to TRICARE.

b. The VA/DoD reimbursement for a DRG will use the basic TRICARE DRG payment approach, applying a 10 percent discount. The actual calculation of DRG reimbursement due for a specific case will use a modified version of the TRICARE DRG Payment Calculators maintained by TMA. DoD will provide the Modified TRICARE DRG Payment Calculators that will be used to determine the actual reimbursement due for the institutional component of a particular case. The Modified TRICARE DRG Payment Calculator will use the list of DRGs, as well as the rules for DRG weights, national TRICARE Adjusted Standardized Amount (ASA), and hospital-specific Wage Index in effect for the fiscal year in which the patient is discharged. These Modified TRICARE DRG Payment Calculators will be made available through the DoD/VA Program Coordination Office and Uniform Business Office web sites (specific web site addresses to be determined). Those websites will also contain links to information about fiscal year and zip code-specific wage index factors which are used in the calculation of reimbursement for a particular hospital based on its geographic location.

c. The Modified TRICARE DRG Payment Calculators use an ASA, which is the TRICARE basic national reimbursement rate for each fiscal year. The ASA is split into labor and non-labor components, and the labor component is used in conjunction with the wage index for hospital-specific reimbursement calculations. For DoD medical treatment facility (MTF) staff who work with VA/DoD Resource Sharing Agreement care, it is important to understand that the TRICARE ASA used in the Modified TRICARE DRG Payment Calculators is NOT the MTF-specific ASA used in various Uniform Business Office billing processes.

d. The general approach to calculation of reimbursement separates DRGs into four different categories: inlier cases, short-stay outlier cases, transfer cases, and long-stay outlier cases. Each category uses a specific reimbursement formula to calculate an appropriate

payment for a particular DRG (see Addendum 1 for examples of these calculations).

e. The reimbursement method for non-DRG patients in extended stay circumstances may be negotiated locally, such as, certain mental health patients or ventilator patients.

f. Care referred to the VA under a national agreement for Spinal Cord Injury, Traumatic Brain Injury and Blind Rehabilitation is reimbursed according to the national agreement, not this methodology.

4. **Services and items not included in the DRG-based component of inpatient care.** Services and items NOT included in the DRG basic rate for the hospitalization will be billed separately. Billing will be based on the rates in effect on the date of service. Examples include:

a. **Professional Services.** Professional services to include rounds, inpatient surgeries, and other inpatient procedures (e.g., reading an EKG) will be reimbursed at CMAC less 10%.

b. **Durable Medical Equipment.** DME items not included in the DRG rate, such as crutches that go home with the patient, will be reimbursed at cost.

c. **Ambulance services.** These services will be reimbursed at CMAC less 10%.

d. **Anesthesia Professional Services.** Anesthesia professional services, for each pre-intra-post anesthesia episode, including any anesthesia medical direction or supervision, will be reimbursed at CMAC less 10%.

e. **Purchased Care.** Any services purchased for the patient from an outside facility during the hospitalization will be reimbursed at cost for the professional fee portion of the care only. The technical portion of the fee is included in the DRG payment amount, for example, computed tomography services. If a providing medical facility determines that purchased care is creating a financial hardship, they may negotiate that item locally.

f. **Pharmaceuticals.** Drugs which are deemed medically necessary to permit or facilitate the patient's departure from the hospital, furnished in limited supply until a continuing supply can be obtained (i.e. take-home drugs) are included in the cost of the inpatient hospital service. However, drugs furnished by a hospital for use after an inpatient episode of care is completed, such as a 30-day supply, are not included as part of the inpatient hospital services and will be billed separately at the respective MTF's/Veterans Affairs Medical Center's (VAMC) cost.

g. **Pass-through Items.** Pass-through items with a "C" Healthcare Common Procedure Coding System (HCPCS) code will be billed at cost. This would include such things as implantable devices that are not yet incorporated into the DRG.

h. **Other.** Inpatient services not specifically addressed in this guidance may be negotiated locally based on direct variable cost (see Addendum 2 for cost definitions).

5. **Other Payment Considerations.** The Modified TRICARE DRG Payment Calculator used to calculate reimbursement will automatically apply the 10% discount. No charge for Graduate Medical Education (GME), either direct or indirect, will be added since the Memorandum of Agreement (MOA) governing standardized rates specifically excludes GME reimbursement in direct sharing agreements. No dispensing fee will be charged for pharmacy provided during the inpatient stay. If there is no CMAC or DRG rate available for a service, a Centers for Medicare and Medicaid Services (CMS) rate less 10% may be substituted; however, different methodologies such as CMAC and CMS shall not be combined. In cases where a CMS rate is substituted, CMS reimbursement policies concerning patient cost shares do not apply.

6. **Billing Period.** This rate methodology will be used for all new agreements or phased in as agreements are renewed or amended, but will be implemented no later than one year past the date of this guidance. Billing will be based on the agreement in place at the time services were rendered. Initial bills for inpatient care will be accepted for payment for up to one year after the date of discharge or end of encounter, unless the facilities agree to an extension due to local circumstances. Valid bills will be paid promptly.

7. **Exceptions.** The facilities named on the attached list will utilize the memorandum's billing guidance as the foundation for the development of their agreements. They are permitted to negotiate rates other than the TRICARE DRG-cased payment methodology less 10% by adjusting the discount percentage to reflect the value of non-monetary contributions such as shared space or staff. If those facilities wish to adjust the discount for any other reason, they may submit a waiver. No other DoD or VA facilities are authorized an exception to the waiver process unless authorized by the Financial Management Work Group (FMWG).

8. **Waiver Process.**

a. Requests for waivers above or below the discount rate will contain the following information:

(1) VA Facility Name and Location
(2) VA POC (name, phone #, email)

(3) MTF Name and Location
(4) MTF POC (name, phone #, email)
(5) Date of request
(6) Description of waiver and the proposed alternative rate
(7) Reason for waiver request
(8) Benefits derived: Include significant tangible and intangible factors
(9) Impact if waiver is disapproved
(10) Calculations used to determine desired discount. Included data source(s)
(11) Copy of Resource Sharing MOU involved
(12) Facility Director/Commander signatures of both facilities

b. Waiver requests must have the appropriate leadership concurrence before submission to the Financial Management Work Group. Submission route is as follows:

(1) VA facilities will forward waiver requests through their VISN Director, who has 30 days to forward to the VA/DoD Sharing Office (10B4). The VA/DoD Sharing Office has 5 business days to review and forward the waiver to the VA/DoD Financial Management Work Group (FMWG).

(2) MTFs will forward waivers through their appropriate intermediate headquarters and their Service Surgeon General. The Service Surgeon General will forward to the Office of the Assistant Secretary of Defense (Health Affairs) who has 5 business days to review and forward the waiver to the VA/DoD FMWG.

c. The FMWG will review and will request facilities to provide additional supporting information if necessary. The VA/DoD FMWG will provide a decision within 30 calendar days of receipt of all pertinent information.

9. **Termination of Agreements.** VA medical facilities or MTFs may terminate the discount sharing agreements after giving at least 30 days notice. The reason for the termination will be sent to the VA/DoD FMWG through either the VA or Service DoD/VA Sharing Office.

10. **Questions.** VA medical facilities should contact the VA/DoD Sharing Office at (202) 273-8406. MTFs should go through their Service DoD/VA Sharing Office.

11. **Guidance Review.** This guidance will be reviewed annually by the VA/DoD FMWG and updated as needed.

Facilities Not Requiring Waivers
To Modify Discount
(Attachment 1)

Location: **Anchorage, Alaska (Elmendorf AFB)**
3rd Medical Group (Elmendorf AFB)/VA Alaska Health Care System - Elmendorf Air Force Hospital with VA inpatient services in Elmendorf Hospital

Location: **El Paso, Texas (Ft. Bliss)**
William Beaumont Army Medical Center and adjacent El Paso VA Health Care System, with VA inpatient services in Beaumont Hospital

Location: **Fairfield, California (Travis AFB)**
60th Medical Group David Grant Medical Center and VA Fairfield Outpatient Clinic with VA inpatient services in David Grant Hospital

Location: **Honolulu, Hawaii (Tripler Army Medical Center)**
Tripler Army Medical Center and adjacent VA Pacific Islands Health Care System with VA inpatient services in Tripler Hospital

Location: **Las Vegas, Nevada (Nellis AFB)**
99th Medical Group/VA Southern Nevada Health Care System - Mike O'Callaghan Federal Hospital houses both Air Force and VA inpatient services. VA Outpatient Clinic is located off the base.

Location: **Chicago, IL (North Chicago VAMC)**
VA Medical Center North Chicago and the Naval Hospital Great Lakes, with surgery and inpatient services at VAMC.

Addendum 1

Examples of Inpatient Institutional Component Payment Calculations for DoD/VA Direct Sharing Agreements

NOTE: These examples are for illustrative purposes only. Actual calculation of reimbursement will use the Modified TRICARE DRG Payment Calculators provided for use in pricing VA/DoD bills for hospitalization provided under Resource Sharing agreements. The specific Modified TRICARE DRG Payment Calculator to use is the one which corresponds to the fiscal year in which the patient was discharged.

Application of the Data to Examples

Example 1 – Inlier DRG

An Inlier DRG is any inpatient discharge that does not require payment adjustments related to consideration of the discharge as a Transfer Case; or consideration as a Short-Stay or Long-Stay Outlier Case. These cases will be reimbursed at the DRG Inlier Payment produced by the Modified TRICARE DRG Payment Calculator. The operation of the Modified TRICARE DRG Payment Calculator will include application of the 10 percent discount used in VA/DoD Resource Sharing Agreements.

Data for use in Example 1 - Inlier DRG	
DRG 002, Craniotomy Age >17, without complications and comorbidities	
DRG Weight = 2.3684	TRICARE ASA = $4,265.70
Length of Stay = 5 days	Wage Index = 0.9000
Arithmetic Mean LOS = 6.3 days	Labor Portion = 62.0%
Geometric Mean LOS = 3.7 days	Non-Labor Portion = 38.0%
Short-Stay Threshold = 1 day	Wage Adjusted ASA = $4,001.23
Long-Stay Threshold = 22 days	

The formula for the Wage Adjusted Inlier DRG Reimbursement (i.e., DRG Inlier Payment) calculation applicable to VA and DoD Sharing is:

VA/DoD Sharing Inlier DRG Payment = DRG Base Payment x 90%,

DRG Base Payment = Wage Adjusted ASA x DRG Weight

Wage Adjusted ASA = ([ASA x Labor Portion x Wage Index]) + [ASA x Non-Labor Portion])

([$4,265.70 x 0.620 x 0.9]) + [4,265.70 x 0.380]) = $4,001.23

Calculation of the DRG Base Payment = $4,001.23 x 2.3684 = $9,476.51

VA/DoD Payment Amount = DRG Base Payment x 90 percent

VA/DoD Sharing Inlier DRG Payment = $9,476.51 x 0.90 = $8,528.86

Example 2 – Short-Stay Outlier DRG

A Short-Stay Outlier DRG is any discharge which has a length-of-stay (LOS) less than or equal to the Short-Stay Outlier Threshold identified in the TRICARE DRG data. In statistical terms, the Short-Stay Threshold for a DRG is determined as the greater of 1 day, or 1.94 standard deviations below the arithmetic mean LOS for that DRG. Any DRG with a LOS equal to or less than the Short-Stay Threshold will be considered a Short-Stay Outlier unless a major procedure was performed, in which case the full DRG will be billed. These cases will be reimbursed at the Short-Stay Outlier Payment amount calculated by the Modified TRICARE DRG Payment Calculator. The operation of the Modified TRICARE DRG Payment Calculator will include application of the 10 percent discount used in VA/DoD Resource Sharing Agreements. The basic calculation (before application of the 10 percent discount) will provide the treating hospital with reimbursement at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, but not to exceed the DRG Inlier Payment amount. The per diem rate used in this calculation is equal to the Wage-adjusted DRG amount divided by the arithmetic mean LOS for the DRG.

Data for use in Example 2 – Short-Stay Outlier DRG	
DRG 481, Bone Marrow Transplant	
DRG Weight = 8.3356	TRICARE ASA = $4,265.70
Length of Stay = 5 days	Wage Index = 0.9000
Arithmetic Mean LOS = 26.1 days	Labor Portion = 62.0%
Geometric Mean LOS = 21.3 days	Non-Labor Portion = 38.0%
Short-Stay Threshold = 6 days	Wage Adjusted ASA = $4,001.23
Long-Stay Threshold = 38 days	

The formula for the Wage Adjusted Short-Stay Outlier DRG Reimbursement (i.e., DRG Short-Stay Outlier Payment) calculation applicable to VA and DoD Sharing is shown below for a case with LOS = 5 days:

VA/DoD Sharing Short-Stay Outlier DRG Payment is the minimum of the DRG Inlier Payment, or the Short-Stay Per Diem Payment, multiplied by 90 percent

DRG Inlier Payment = Wage Adjusted ASA x DRG Weight

Wage Adjusted ASA = ([ASA x Labor Portion x Wage Index]) + [ASA x Non-Labor Portion])

([$4,265.70 x 0.620 x 0.9]) + [4,265.70 x 0.380]) = $4,001.23

Calculation of the DRG Inlier Payment = $4,001.23 x 8.3556 = $33,432.68

The Short-Stay Per Diem Payment is:

2 x LOS x Short-Stay Per Diem

Short-Stay Per Diem = (**DRG Inlier Payment** / Arithmetic Mean LOS)

Calculation of the Short-Stay Per Diem Payment is:

2 x 5 x ($33,432.68 / 26.1) = $12,809.46

The minimum in this case is the Short-Stay Per Diem Payment of $12,809.46

VA/DoD Sharing Short-Stay Outlier DRG Payment = Short-Stay Per Diem Payment x 90%

VA/DoD Sharing Short-Stay DRG Payment = $12,809.46 x 0.90 = $11,528.51

Example 3 – Transfer Case

a. Acute Care Transfers: Under the TRICARE DRG reimbursement approach, a discharge of a hospital patient is considered to be a transfer for purposes of payment if the patient is readmitted the same day to another hospital for an acute level of care.

These cases will be reimbursed at the Transfer Case Payment amount calculated by the Modified TRICARE DRG Payment Calculator. The operation of the Modified TRICARE DRG Payment Calculator will include application of the 10 percent discount used in VA/DoD Resource Sharing Agreements. The basic calculation (before application of the 10 percent discount) will provide the treating hospital with reimbursement at 200 percent of the per diem rate for the DRG for the day one and 100% of the per diem for each additional day of the hospital stay, but not to exceed the DRG Inlier Payment amount. The Transfer Per Diem

rate used in this calculation is equal to the Wage-adjusted DRG amount divided by the geometric mean LOS for the DRG.

Data for use in Example 3 - Transfer DRG	
DRG 002, Craniotomy Age >17, without complications and comorbidities	
DRG Weight = 2.3684	TRICARE ASA = $4,265.70
Length of Stay = 1 days	Wage Index = 0.9000
Arithmetic Mean LOS = 6.3 days	Labor Portion = 62.0%
Geometric Mean LOS = 3.7 days	Non-Labor Portion = 38.0%
Short-Stay Threshold = 1 day	Wage Adjusted ASA = $4,001.23
Long-Stay Threshold = 22 days	

The formula for the Wage Adjusted Short-Stay Outlier DRG Reimbursement (i.e., DRG Transfer Case Payment) calculation applicable to VA and DoD Sharing is:

VA/DoD Sharing Transfer DRG Payment is the minimum of the DRG Inlier Payment, or the Transfer DRG Per Diem Payment, multiplied by 90 percent

The DRG Inlier Payment is = $9,476.51 (see Example 1 for calculation)

The Transfer DRG Per Diem Payment is two (2) times the Transfer Per Diem for the first day of the stay, plus the Transfer Per Diem for each additional day of the inpatient stay, not to exceed the DRG Base Payment

([2 x Transfer Per Diem] + ([LOS-1] x Transfer Per Diem))

Transfer Per Diem = (DRG Inlier Payment / Geometric Mean LOS)

Calculation of the Transfer Per Diem Payment is:

2 x 1 x ($9,476.51 / 3.1) + (0 x (9476.51 / 3.1) = $6,113.88

The minimum in this case is the Transfer DRG Per Diem Payment of $6,113.88

VA/DoD Sharing Transfer DRG Payment = Transfer DRG Payment x 90%

VA/DoD Sharing Transfer DRG Payment = $6,113.88 x 0.90 = $5,502.58

b. Post-Acute Care Transfers: In some cases, a hospital that transfers an inpatient to a post-acute setting is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the TRICARE/CHAMPUS DRG-based payment amount that would have been paid if the patient had been discharged to another setting. In general, the per diem rate is determined by dividing the appropriate DRG rate by the geometric mean length of stay for the

specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG amount. For neonatal claims, other than normal newborns, payment is graduated by paying twice the per diem amount for the first day of the stay, and 125 percent of the per diem rate for each subsequent day, up to the full DRG amount.

These cases will be reimbursed at the Post-Acute Transfer Payment amount calculated by the TRICARE DRG Payment Calculator. The operation of the Modified TRICARE DRG Payment Calculator will include application of the 10 percent discount used in VA/DoD Resource Sharing Agreements. The calculations involved for the Post-Acute Care Transfer Payment are those shown above as Example 3.

Example 4 – Long-Stay Outlier DRG*

A Long-Stay Outlier DRG is any discharge which has a length-of-stay (LOS) greater than the TRICARE Long-Stay Threshold for the fiscal year in which the patient is discharged.

These cases will be reimbursed the Long-Stay Outlier Payment amount calculated by the Modified TRICARE DRG Payment Calculator. The operation of the Modified TRICARE DRG Payment Calculator will include application of the 10 percent discount used in VA/DoD Resource Sharing Agreements. The basic calculation (before application of the 10 percent discount) will provide the treating hospital with reimbursement at the sum of the Inlier DRG Payment plus 33 percent of the Long-Stay Outlier Per Diem for each Long-Stay Outlier day.

Data for use in Example 4 – Long-Stay Outlier DRG	
DRG 481, Bone Marrow Transplant	
DRG Weight = 8.3356	TRICARE ASA = $4,265.70
Length of Stay = 40 days	Wage Index = 0.9000
Arithmetic Mean LOS = 26.1 days	Labor Portion = 62.0%
Geometric Mean LOS = 21.3 days	Non-Labor Portion = 38.0%
Short-Stay Threshold = 6 days	Wage Adjusted ASA = $4,001.23
Long-Stay Threshold = 38 days	

The formula for the Wage Adjusted Long-Stay Outlier DRG Reimbursement (i.e., DRG Long-Stay Outlier Payment) calculation applicable to VA and DoD Sharing is:

Inlier DRG Payment + (0.33 x Long-Stay Outlier Per Diem x [LOS – Long-Stay Threshold])

Inlier DRG Payment = $33,432.68 (see Example 2 for calculation)

Long-Stay Outlier Per Diem = (DRG Inlier Payment / Geometric Mean LOS)

Calculation of the Long-Stay Outlier DRG Payment is:

$$\$33,432.68 + (0.33 \times [\$33,432.68 / 21.3] \times [40 - 38]) = \$34,468.62$$

VA/DoD Sharing Long-Stay Outlier DRG Payment = Long-Stay DRG Payment x 90%
VA/DoD Sharing Long-Stay DRG Payment = $34,468.62 x 0.90 = $31,021.76

**This long-stay outlier methodology is only being used for DoD/VA direct sharing agreements, and is not used for TRICARE network agreements.*

Addendum 2
OPERATION OF THE MODIFIED TRICARE DRG PAYMENT CALCULATOR

1. The version of the Modified TRICARE DRG Payment Calculator to be used for determining reimbursement for inpatient care is the one in effect for the Fiscal Year in which the patient was discharged. The Modified TRICARE DRG Payment Calculator requires four items of input from users:

a. The Length of Stay of the inpatient case. This input will be obtained from the clinical record of the inpatient case.
b. The Diagnosis Related Group (DRG) number assigned for the inpatient case. This input will be obtained from the DRG grouping software used by VA and DoD hospitals.
c. The Disposition Status of the inpatient case. This input will be obtained from the clinical record of the case. The specific Disposition Status Code data values used by the Modified TRICARE DRG Payment Calculator are:

Disposition Status Code and Meaning

01=Home, self-care
02=Short term hospital
03=SNF
04=ICF
05=Other facility
06=Home health service
07=Against medical advice
20=Died
30=Still a patient
50= Hospice-home
51= Hospice-medical facility
61= Swing bed
62= Rehab facility/rehab unit
63= Long term care hospital
65= Psych. hospital or unit
66= Discharge/Transfer to CAH
71= OP services - other facility
72= OP services - this facility

d. The Area Wage Index Number for the discharging hospital. This input will be obtained from the treating hospital.

2. When the required inputs are entered into the Modified TRICARE DRG Payment Calculator, the calculator will calculate the appropriate reimbursement for the case. The Payment Summary portion of the calculator output will display the total payment due for the inpatient case, taking into account the 10 percent discount applied for VA/DoD Resource Sharing agreements. The Payment Details portion of the calculator output will display the details of the calculation before application of the 10 percent discount.

Addendum 3
COST DEFINITIONS

A. Direct Costs

Costs directly associated with providing patient services. Examples of Direct Costs are labor by caregivers, e.g. Physicians, Nurses, Social Workers, Purchased Care, Supplies and Services consumed by patients. Direct Costs are further split as Fixed and Variable.

B. Indirect Costs

Costs not directly related to patient care that cannot be specifically traced to or identified with an individual patient or group of patients. Examples of indirect costs are Human Resources, Housekeeping and Utilities. All Indirect Costs are also classified as Fixed Costs.

C. Variable Costs

Cost that varies directly and proportionately with volume. Many direct costs, such as supplies, are examples of pure variable costs since the increase is in direct proportion to the number of services performed such as pharmaceuticals. All variable costs are also classified as Direct. Other examples are Physician Time on a ward or clinic, and lab tech labor.

D. Fixed Costs

Costs that do not vary in direct proportion to the volume of patient activity. The word "fixed" does not mean that the costs cannot be changed, but rather they do not change as a result of volume. Fixed costs can be either direct or indirect. Examples of Fixed Direct would include supervision on a hospital ward and depreciation on specific patient care equipment (e.g., lab equipment). All indirect costs are classified as fixed.