CHAPTER 13
SECTION 6.1J

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (CHARGES TO BENEFICIARIES)

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I. ISSUE

What charges are the responsibility of the beneficiary?

II. POLICY

A. Cost-Shares. (Reference Chapter 13, Section 11.1.)

B. Services or Supplies Specifically Excluded from Payment.

1. Non-Covered DRGs. The contractor must ensure that TRICARE/CHAMPUS coverage requirements are met.

2. Services and Supplies Not Related to the Treatment Regimen. Charges for services and supplies specifically excluded from TRICARE/CHAMPUS payment and which are not related to the treatment regimen (e.g., private room accommodation differential if the private room was not medically necessary and was requested by the beneficiary, or television/telephone charges) will be the responsibility of the beneficiary. The contractor is not to reduce the DRG-based allowance for these items, since the DRG-based payment is the same whether or not the items are provided. However, the hospital is permitted to bill the beneficiary for the items.

3. Application of the 60-Day Limit to Mental Health Services Subject to the TRICARE/CHAMPUS DRG-Based Payment System.

a. General. TRICARE/CHAMPUS is not permitted to pay for inpatient mental health services in excess of 60 days in a calendar year. In those cases where services in excess of 60 days are rendered and the services are subject to the TRICARE/CHAMPUS DRG-based payment system, there will be no effect on the payment amount if no outlier days are paid and if some days of care on the claim were provided before the 60-day limit was reached. In addition, the 60-day limit applies to all mental health services provided to a beneficiary regardless of whether some days were subject to the TRICARE/CHAMPUS DRG-based payment system and some were not.

b. Payment where outlier days are involved. Since per diem amounts are paid for day outliers, payment can be terminated at a specific date when a day outlier is involved.

Thus, when days beyond the 60-day limit are provided, and any of those days are day outliers, the contractor shall deny the outlier days, and they will be the responsibility of the beneficiary. Similarly, when short-stay outlier days would result in the beneficiary exceeding the 60-day limit, payment will be limited to the short-stay outlier amounts within the limit, regardless of the actual length-of-stay.

NOTE: For admissions occurring on or after October 1, 1997, payment for long-stay outliers has been eliminated for all cases, except neonates and children's hospitals. For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated for neonates and children's hospitals.

c. Payment where a cost outlier is involved. If the claim is a cost outlier, the contractor may reimburse the full cost outlier amount and is not required to identify which outlier costs occurred after the 60-day limit was reached--even if the claim also qualifies as a day outlier.

d. Counting days when double coverage is involved. If TRICARE/CHAMPUS makes a DRG-based payment on a claim for mental health services for which other health insurance (OHI) has already made payment, all the days of care covered by the DRG-based payment shall count toward the 60-day limit. This applies even if the OHI has paid the full billed charge and the TRICARE/CHAMPUS payment is simply the difference between the billed charge and a higher DRG-based amount. (See Chapter 13, Section 12.1.)

e. Leave of absence days. Since no TRICARE/CHAMPUS payment can be made for leave of absence days, such days shall not be counted toward the 60-day limit.

C. Hospital Days Beyond that Deemed Medically Necessary. Under the TRICARE/CHAMPUS DRG-based payment system, the DRG amount is considered full payment for any hospital stay, regardless of length, up to the long-stay outlier cutoff as described in Chapter 13, Section 6.1H. If any days of a stay are subsequently determined to be medically unnecessary, the following actions are to be taken:

1. Medically unnecessary days which are the hospital's responsibility. If it is determined that certain days of care were medically unnecessary and the days are the fault of the hospital--that is, the hospital/physician made no attempt to discharge the patient--the unnecessary days shall be included in the DRG-based amount, and no additional payment can be made. Nor is the contractor to recoup any amount. However, if elimination of the unnecessary days causes the stay to become a short-stay outlier, the contractor is to recoup any excess amounts over the appropriate short-stay outlier payment. On the other hand, if the unnecessary days resulted in long-stay outlier payments, the outlier payments attributable to the unnecessary days are to be recouped from the hospital, and any charges for days beyond the long-stay outlier cutoff which are deemed not medically necessary will be the responsibility of the beneficiary.

2. Medically unnecessary days which are the beneficiary's responsibility. If medically unnecessary days of care were provided at the insistence of the beneficiary (or sponsor)--that is, the hospital/physician attempted to discharge the beneficiary, but the beneficiary insisted on remaining in the hospital--any charges for those days will be the responsibility of the beneficiary. This applies to all such days, whether or not the long-stay

outlier cutoff has been reached and to the difference between the normal DRG-based payment and the short-stay outlier payment if it is determined the stay should have been a short-stay outlier.

NOTE: For admissions occurring on or after October 1, 1997, payment for long-stay outliers has been eliminated for all cases, except neonates and children's hospitals. For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated for neonates and children's hospitals.

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