DEPARTMENT OF DEFENSE
TRICARE SUPPORT OFFICE
AURORA, COLORADO 80045-6900

PDD

CHANGE 22
OCHAMPUS 6010.47-M
NOVEMBER 12, 1997

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE/CHAMPUS POLICY MANUAL

THE DIRECTOR, OCHAMPUS, HAS AUTHORIZED THE FOLLOWING ADDITION(S)/REVISION(S) TO THE TRICARE/CHAMPUS POLICY MANUAL

REVISION(S):

CHAPTER 13: SECTION(S): 6.1D, 6.1E, 6.1F, 6.1H, 6.1J

REMOVE PAGES:

CHAPTER 13: SECTION(S): 6.1D, Pages 3-6, 6.1E, Pages 1-2, 6.1F, Pages 1-2, 6.1H, Pages 7-13, 6.1J, Pages 1-3

INSERT: Same pages as stated above.

SUMMARY OF ADDITIONS/REVISIONS: This revision is a correction to Change 21. The correction replaces the word "discharges" with the word "admissions". In Change 21, pages 12-13 of Section 6.1H of Chapter 13 referenced an incorrect change number, C-12 instead of C-21. These pages are being republished to reflect the correct change number.

EFFECTIVE DATE AND IMPLEMENTATION: October 1, 1997

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ATTACHMENT(S): 18 PAGE(S)
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be billed separately by the hospital under the same procedures for hospital-based professionals above.

NOTE: *As a general rule, TRICARE/CHAMPUS will only pay for one anesthesia claim per case. When an anesthesiologist is paid for anesthesia services, a nurse anesthetist is not authorized to bill for those same services. Services which support the anesthesiologist in the operating room fall within the DRG allowed amount and are considered to be already included in the facility fee, even if the support services are provided by a nurse anesthetist. Charging for such services is considered an inappropriate billing practice.*

9. All outpatient services related to inpatient stays.

10. For admissions occurring before April 1, 1989, all services related to discharges involving newborns and infants who are less than 29 days old upon admission, except for discharges which are grouped into DRG 391 (normal newborn). If any other DRG is assigned to the claim, the claim is exempt from the CHAMPUS DRG-based payment system. For claims involving DRGs other than 391, it is the patient's age when initially admitted to a hospital which is the factor to consider in determining if the inpatient stay is subject to DRG-based payment. If the patient is less than 29 days old upon admission and is subsequently transferred to another hospital, the inpatient stay in both the transferring hospital and the receiving hospital will be exempt from DRG-based payment. When a transfer is involved and the claim is grouped into DRGs 385-390, the contractor can assume that the patient was less than 29 days old upon admission to the initial hospital. All other claims involving transfers should be paid under the DRG-based payment system, unless information on the face of the claim clearly indicates that the patient was less than 29 days old when initially admitted to the hospital.

11. All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) bone marrow transplants which would otherwise be paid under DRG 481. This includes ICD-9-CM diagnosis code V42.4 and ICD-9 procedure codes 41.00, 41.01, 41.02, 41.03 and 41.91.

12. All services related to discharges involving children (beneficiary less than 18 years old upon admission) who have been determined to be HIV seropositive. This will be ICD-9-CM diagnosis codes 042 through 044 and 795.8.

13. All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) cystic fibrosis. This will be ICD-9-CM diagnosis code 277.0.

NOTE: *The services described in 10 through 13 above were exempted from DRG-based reimbursement under P.L. 100-202, the 1988 Department of Defense Appropriations Act. For 11, 12, and 13, the exemption applies whether the stated condition is the principal or a secondary diagnosis. The law required this exemption to be retroactive to October 1, 1987, and fiscal intermediaries shall adjust previously processed claims in these categories whenever, but only if, the provider or the beneficiary requests an adjustment. This exemption was initially based on a single year appropriation, but 11, 12, and 13 shall continue to be exempt until notice from TSO/OCHAMPUS.*

14. For admissions occurring on or after October 1, 1997, through September 30, 1998, an additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a TRICARE/CHAMPUS patient who is a hemophiliac.

a. For admissions occurring on or after October 1, 1994, and prior to admissions occurring on or after October 1, 1997, the cost of the blood clotting factor for hemophilia inpatients is no longer eligible for separate reimbursement.

b. For admissions occurring on or after October 1, 1990, and before October 1, 1994, and for admissions occurring on or after October 1, 1997, the blood clotting factor for hemophilia inpatients must be billed separately on the inpatient claim, and an additional payment shall be made to the hospital for each unit of factor. The payment for factor is to be added to the DRG-based payment on the same claim--it is not to be paid on a separate claim nor is the claim to be split. (The payment for factor is to be shown on a separate line on the EOB and summary voucher.) Payment rates have been established as indicated below.

For admissions occurring October 1, 1990, through September 30, 1991:

Factor VIII - $.64 per unit
Factor IX - $.26 per unit
Other Hemophilia Clotting Factors (for example, Anti-inhibitors) - $1.00 per unit

For admissions occurring October 1, 1991, through September 30, 1992:

Factor VIII - $.72 per unit
Factor IX - $.26 per unit
Other Hemophilia Clotting Factors (for example, Anti-inhibitors) - $1.11 per unit

For admissions occurring October 1, 1992, through September 30, 1993:

Factor VIII - $.76 per unit
Factor IX - $.30 per unit
Other Hemophilia Clotting Factors - $1.02 per unit

For admissions occurring October 1, 1993, through September 30, 1994:

Factor VIII - $.76 per unit
Factor IX - $.33 per unit
Other Hemophilia Clotting Factors - $1.02 per unit

For admissions occurring on or after October 1, 1997, through September 30, 1998:

Factor VIII (antihemophilic factor-human) - $.76 per unit
Factor VIII (antihemophilic factor-recombinant) - $1.00 per unit
Factor IX (complex) - $.32 per unit
Other Hemophilia Clotting Factors (for example, Anti-inhibitors) - $1.10 per unit

For admissions occurring on or after October 1, 1990 and before October 1, 1994, hospitals will use the following special procedure codes (and revenue code 636) to bill for blood clotting factor. These are the same codes used under the Medicare Prospective Payment System. However, these codes are not to be used for reporting payments for clotting factor in TRICARE/CHAMPUS payment records.

Factor VIII - J7190
Factor IX - J7194
All other factors - Q0048

For admissions occurring on or after October 1, 1997, through September 30, 1998, hospitals will use the following special procedure codes (and revenue code 636) to bill for blood clotting factor:

Factor VIII (antihemophilic factor-human) - J7190
Factor VIII (antihemophilic factor-recombinant) - J7192
Factor IX (complex) - J7194
All other factors - J7196

Each unit billed on the hospital claim represents 100 payment units. For example, if the hospital indicates that 25 units of Factor VIII were provided, this would represent 2,500 actual units of factor, and the payment would be $1,600 (paid at $.64/unit - Factor VIII).

NOTE: *Since the costs of blood clotting factor are reimbursed separately for admissions occurring on or after October 1, 1990, and before October 1, 1994, and for admissions occurring on or after October 1, 1997, through September 30, 1998, for these claims all charges associated with the factor are to be subtracted from the total charges in determining applicability of a cost outlier. However, the charges for the blood clotting factor are to be included when calculating the cost-share based on billed charges.*

15. All services related to a heart-lung transplantation.

16. All services related to a lung transplantation through September 30, 1994. Effective October 1, 1994, lung transplants will be paid under DRG 495. Acquisition costs related to the lung will continue to paid on a reasonable cost basis and are not included in the DRG.

17. All services related to a combined liver-kidney transplantation.

D. Hospitals subject to the CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are authorized to provide services to TRICARE/CHAMPUS beneficiaries are subject to the DRG-based payment system except for those hospitals and hospital units below.

E. Substance Use Disorder Rehabilitation Facilities. With admissions on or after July 1, 1995, substance use disorder rehabilitation facilities, are subject to the DRG-based system.

F. Hospitals and hospital units exempt from the CHAMPUS DRG-based payment system. The following types of hospitals and hospital units are exempt. The contractor will be responsible for determining if a hospital or unit is exempt from the CHAMPUS DRG-based

payment system. When the exemption status of a hospital or unit changes, the effective date of the status is to be the date the status was granted by Medicare, or, if the hospital or unit is not Medicare-certified, the date of the determination by the contractor. In cases where the exemption status of a hospital or unit has changed, the exemption status on the date of discharge for inpatient stays prior to the change is to be used. For those claims for which the inpatient stay spans the date the exemption status changed, if the claim includes any days for which the hospital or unit was exempt, the entire stay is to be considered exempt. Designation by Medicare as one of these types of hospitals or units will result in automatic exemption under TRICARE/CHAMPUS, and a hospital which has been denied this status by Medicare cannot be exempt under TRICARE/CHAMPUS. Except for sole community hospitals and cancer hospitals, Medicare participating hospitals which have not applied for exempt or special status under Medicare may still be determined to be exempt under TRICARE/CHAMPUS. Nevertheless, it is strongly encouraged that hospitals first seek exempt or special status under Medicare. Exempt hospitals will be reimbursed under the procedures in Chapter 13, Section 6.2, Section 6.3, and Section 6.5.

G. Subject to the criteria set forth in paragraph G.1. below, a hospital within a hospital is excluded from the CHAMPUS DRG-based payment system if it meets the criteria for one or more of the excluded classifications described in paragraph G.2., G.3., G.7., G.10., or G.11. below.

1. Hospitals within hospitals. A hospital within a hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a hospital within a hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, the following criteria must be met:

a. Except as provided in paragraph G.1.b., below, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the CHAMPUS DRG-based payment system:

(1) Separate governing body. The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(2) Separate chief medical officer. The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(3) Separate medical staff. The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces bylaws governing

Subject: HOSPITAL REIMBURSEMENT - CHAMPUS DRG-BASED PAYMENT SYSTEM (DETERMINATION OF PAYMENT AMOUNTS)	Chapter: 13
Authority: DoD 6010.8-R, Chapter 14, A.	Section: 6.1E
	Issue Date: October 8, 1987

ISSUE

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

POLICY

A. Calculation of payment amounts.

1. The actual payment for an individual claim under the CHAMPUS DRG-based payment system, for admissions occurring prior to October 1, 1997, is calculated using the following steps. In performing these calculations, the contractor may either round the amounts or simply truncate them to two decimal places.

Step 1: Determine the DRG applicable to the claim.

Step 2: Determine if the hospital is 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 outlier amounts (using "C") and add them to "C" (this is "D").

Step 7: Multiply "D" by one (1) plus the indirect medical education adjustment factor if applicable (this is "E").

2. For admissions occurring on or after October 1, 1997, the actual payment for an individual claim, is calculated using Steps 1 through 5 above and Steps 6 and 7 as follows:

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

Step 9: Determine any outlier amount (using "C") and add it to "D" (this is "E").

These new payment calculations do not apply to cases for neonates or children’s hospitals. These shall continue to be calculated using Steps 1 through 7 above.

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

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

1. Records for exempt hospitals. Since certain hospitals will be exempt from the CHAMPUS DRG-based payment system (see Chapter 13, Section 6.1D) records from these hospitals will be deleted from the database.

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 length of stay, the interim bills will be deleted from the database and only final, total bills will be used.

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.

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

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 CHAMPUS 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.

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.

- END -

Subject: HOSPITAL REIMBURSEMENT - CHAMPUS DRG-BASED PAYMENT SYSTEM (DRG WEIGHTING FACTORS)	Chapter: 13
Authority: DoD 6010.8-R, Chapter 14, A.	Section: 6.1F
	Issue Date: October 6, 1987

ISSUE

What is the purpose of DRG weighting factors under the CHAMPUS DRG-based payment system, and how will they be calculated, used, and updated?

POLICY

A. DRG Weighting Factors. The DRG weights reflect the relative resource consumption associated with each DRG. That is, the weight reflects the average resources required by all hospitals to treat a case classified as a specific DRG relative to the resources required to treat cases in each of the other DRGs. All weights are standardized to a theoretical average weight of 1.0 which is the average weight of all TRICARE/CHAMPUS claims in the data base. (This is the relative weight of the national average charge per discharge.)

B. Calculation of DRG weights. The TRICARE/CHAMPUS weights are derived from charges. They will not reflect standardization for capital or direct medical education expenses, but the charges on which they are based are standardized for indirect medical education differences. The TRICARE/CHAMPUS DRG weights will be discharge-weighted. Specifically, the denominator used to calculate each weight represents the national average charge per discharge for the average patient. In order to calculate the DRG relative weights the following procedures will be followed.

1. Grouping of charges. All discharge records in the database will be grouped by DRG using the current Medicare grouper program.

2. Remove DRGs 469 and 470. DRGs 469 and 470 represent discharges with invalid data or diagnoses insufficient for DRG assignment purposes. Therefore, these records are removed from the database.

3. Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

For admissions occurring during FY 1988, the same formula was used except the first number was 1.5 rather than 1.43.

For admissions occurring during FY 1998, the same formula was used except the

first number was 1.30 rather than 1.43.

4. Calculation of DRG average charges. After the standardization for indirect medical education, an average charge for each DRG category will be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

5. Calculation of national average charge per discharge. A national average charge per discharge will be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

6. DRG relative weights. DRG relative weights will be calculated for each DRG category by dividing each DRG average charge by the national average charge.

C. Procedures for DRGs for which a weight cannot be calculated. If there are any DRGs which have fewer than ten (10) occurrences in the database, the Medicare weight is to be used until TSO/OCHAMPUS is able to develop a weight based on TRICARE/CHAMPUS data. The only exception to this is for PM-DRGs between April 1, 1989, and September 30, 1989. During this period, any claim for a PM-DRG for which there is no weight is to be reimbursed based on billed charges.

D. Updating DRG weights. Medicare is required to adjust the DRG relative weights under the Prospective Payment System annually to ensure that the weights reflect the use of new technologies and other practice pattern changes that affect the relative use of hospital resources among DRG categories. Likewise, every year during the annual DRG update TSO/OCHAMPUS will recalculate all DRG weights using TRICARE/CHAMPUS charge data and the methodology described above.

- END -

procedures used for calculating the national differentials, except that the database used was limited to claims from the specific high-volume children's hospital.

(c) Administrative corrections. Any children's hospital that believed TSO/OCHAMPUS erroneously failed to classify the hospital as a high-volume hospital or correctly calculate (in the case of a high-volume hospital) the hospital's differential could obtain administrative corrections by submitting appropriate documentation to TSO/OCHAMPUS. The corrected differential was effective retroactively to April 1, 1989, so this process included adjustments, by the contractor, to any previously processed claims which were processed using an incorrect differential.

(2) Admissions on or after April 1, 1992. These claims are reimbursed using a single set of differentials which do not distinguish high-volume and low-volume children's hospitals. The differentials are:

Large Urban Areas	
Labor portion	$1,945.99
Non-labor portion	689.42
	$2,635.41
Other Areas	
Labor portion	$1,483.21
Non-labor portion	525.47
	$2,008.68

e. Hold harmless provision. At such time as the weights initially assigned to neonatal DRGs are recalibrated based on a sufficient volume of TRICARE/CHAMPUS claims records, TSO/OCHAMPUS will recalculate children's hospital differentials and appropriate retrospective and prospective adjustments will be made. To the extent possible, the recalculation will also include reestimated values of other factors (including, but not limited to, direct and indirect medical education and capital costs) for which more accurate data become available. This will probably occur about one year after implementation of the neonatal DRGs, and it will not require any actions by the contractors.

6. Outliers.

a. General. TRICARE/CHAMPUS will adjust the DRG-based payment to a hospital for atypical cases. These outliers are those cases that have either an unusually short length-of-stay or extremely long length-of-stay or that involve extraordinarily high costs when compared to most discharges classified in the same DRG. Recognition of these outliers is particularly important, since the number of TRICARE/CHAMPUS cases in many hospitals is relatively small, and there may not be an opportunity to “average out” DRG-based payments over a number of claims. Contractors will not be required to document or verify the medical necessity of outliers prior to payment, since outlier review will be part of the admission and quality review system. However, in determining additional cost outlier payments on all claims qualifying as a cost outlier, the contractor must identify and reduce the billed charge for any non-covered items such as comfort and convenience items (line N), as well as any duplicate charges (line X) and services which can be separately billed (line 7) such as professional fees, outpatient services, and kidney acquisition costs.

b. Payment of outliers. For all admissions occurring before October 1, 1988, if the claim qualifies as both a length-of-stay outlier and a cost outlier, payment shall be based on the length-of-stay outlier. For admissions occurring on or after October 1, 1988, claims which qualify as both a length-of-stay outlier and a cost outlier shall be paid at whichever outlier calculation results in the greater payment.

c. Provider Reporting of outliers. The provider is to identify outliers on the UB-92, form locator 24 - 30. Code 60 is to be used to report length-of-stay outliers, and code 66 is to be used to signify that a cost outlier is not being requested. If a claim qualifies as a cost outlier and code 66 is not entered in the appropriate form locator (i.e., it is blank or code 61), the contractor is to accept this as a request for cost outlier payment by the hospital.

d. Length-of-stay outliers. The CHAMPUS DRG-based payment system uses both short-stay and long-stay outliers, and both are reimbursed using a per diem amount. All length-of-stay outliers must be identified by the contractor when the claims are processed, and necessary adjustments to the payment amounts must be made automatically. 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.

(1) Short-stay outliers.

(a) Any discharge which has a length-of-stay (LOS) less than 1.94 standard deviations below the DRG's geometric LOS shall be classified as a short-stay outlier. In determining the actual short-stay threshold, the calculation will be rounded down to the nearest whole number, and any stay equal to or less than the short-stay threshold will be considered a short-stay outlier.

(b) Short-stay outliers will be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the wage-adjusted DRG amount divided by the geometric mean length-of-stay for the DRG. The per diem rate is to be calculated before the DRG-based amount is adjusted for indirect medical education.

(c) Any stay which qualifies as a short-stay outlier (a transfer cannot qualify as a short-stay outlier), even if payment is limited to the normal DRG amount, is to be considered and reported on the payment records as a short-stay outlier. This will ensure that outlier data is accurate and will prevent the beneficiary from paying an excessive cost-share in certain circumstances.

(2) Long-stay outliers.

(a) Long-stay outliers are determined by thresholds which are calculated from the length-of-stay (LOS) criteria below. In determining the actual long-stay threshold, the calculation will be rounded down to the nearest whole number, and any stay greater than the long-stay threshold will be considered a long-stay outlier.

For admissions occurring on or after October 1, 1987, the long-stay thresholds shall equal the lesser of 1.94 standard deviations or 17 days above the DRG's geometric LOS.

For admissions occurring on or after October 1, 1988, the long-stay thresholds shall equal the lesser of 3.0 standard deviations or 24 days above the DRG's geometric LOS.

For admissions occurring on or after October 1, 1990, the long-stay thresholds shall equal the lesser of 3.0 standard deviations or 29 days above the DRG's geometric LOS.

For admissions occurring on or after October 1, 1991, the long-stay thresholds shall equal the lesser of 3.0 standard deviations or 32 days above the DRG's geometric LOS.

For admissions occurring on or after October 1, 1993, the long-stay threshold shall equal the lesser of 3.0 standard deviations or 23 days above the DRG's geometric LOS.

For admissions occurring on or after October 1, 1994, the long-stay threshold shall equal the lesser of 3.0 standard deviations or 22 days above the DRG's geometric LOS.

For admissions occurring on or after October 1, 1995, the long-stay threshold shall equal the lesser of 3.0 standard deviations or 23 days above the DRG's geometric LOS.

For admissions occurring on or after October 1, 1996, the long-stay threshold shall equal the lesser of 3.0 standard deviations or 24 days above the DRG's geometric LOS.

(b) For admissions prior to October 1, 1994, long-stay outliers are reimbursed the DRG-based amount plus 60 percent of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold. The per diem rate will equal the wage-adjusted DRG amount divided by the geometric mean length-of-stay for the DRG. The per diem rate is to be calculated before the DRG-based amount is adjusted for indirect medical education.

(c) For admissions occurring on or after October 1, 1994, long-stay outliers will be reimbursed the DRG-based amount plus 47 percent of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold.

(d) For admissions occurring on or after October 1, 1995, long-stay outliers will be reimbursed the DRG-based amount plus 44 percent of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold.

(e) For admissions occurring on or after October 1, 1996, long-stay outliers will be reimbursed the DRG-based amount plus 33 percent of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold.

(f) For admissions occurring on or after October 1, 1997, payment for long-stay outliers has been eliminated for all cases, except neonates and childrens' hospitals.

e. Cost outliers.

(1) Any discharge which has standardized costs that exceed the thresholds outlined below, will be classified as a cost outlier.

(a) For admissions occurring prior to October 1, 1997, the standardized costs will be calculated by first subtracting the noncovered charges, multiplying the total charges (less lines 7, N, and X) by .64 (.67 for admissions occurring prior to November 21, 1988, .627 for admissions on or after October 1, 1993, and .6293 for admissions occurring on or after October 1, 1994, .6103 for admissions occurring on or after October 1, 1995, .5895 for admissions occurring on or after October 1, 1996) and adjusting this amount for indirect medical education costs by dividing the amount by one (1) plus the hospital's indirect medical education adjustment factor.

(b) For admissions occurring on or after October 1, 1997, the following steps shall be followed when calculating cost outlier payments for all cases other than neonates and children's hospitals:

Standard Cost = (Billed Charges x Cost-to-Charge Ratio)
Outlier Payment = 80 percent of (Standard Cost - Threshold)
Total Payments = Outlier Payments + (DRG Base Rate x (1+ IDME))

(c) For admissions occurring on or after October 1, 1997, the costs for indirect medical education are no longer standardized.

(d) The cost-to-charge ratio for admissions occurring on or after October 1, 1997, is .5536.

(e) Cost outliers will be reimbursed the DRG-based amount plus 80 percent effective 10/1/94 (75 percent effective l0/1/93 and 60 percent for admissions occurring prior to November 21, 1988) of the standardized costs exceeding the threshold.

(2) For admissions prior to November 21, 1988, through September 30, 1994, the cost outlier thresholds shall be the greater of two times the DRG-based amount (wage-adjusted but prior to adjustment for indirect medical education) or the amount shown below.

$13,500 for admissions occurring prior to November 21, 1988;

$28,000 for admissions occurring on or after November 21, 1988, and prior to October 1, 1990;

$35,000 for admissions occurring on or after October 1, 1990, and prior to October 1, 1991;

$40,100 for admissions occurring on or after October 1, 1991, and prior to October 1, 1993;

$33,000 for admissions occurring on or after October 1, 1993 through September 30, 1994.

(3) For FY 1995, a fixed loss cost-outlier threshold is set of $18,800. Effective October 1, 1994, the cost outlier threshold shall be the DRG-payment amount (wage-adjusted but prior to adjustment for indirect medical education) plus the flat rate of $18,800 (also wage adjusted).

(4) For FY 1996, a fixed loss cost-outlier threshold is set of $13,800. Effective October 1, 1995, the cost outlier threshold shall be the DRG-payment amount (wage-adjusted but prior to adjustment for indirect medical education) plus the flat rate of $13,800 (also wage adjusted).

(5) For FY 1997, a fixed loss cost-outlier threshold is set of $8,850. Effective October 1, 1996, the cost outlier threshold shall be the DRG-payment amount (wage-adjusted but prior to adjustment for indirect medical education) plus the flat rate of $8,850 (also wage adjusted).

(6) For FY 1998, a fixed loss cost-outlier threshold is set of $10,180. Effective October 1, 1997, the cost outlier threshold shall be the DRG-payment amount (wage-adjusted) plus the IDME payment, plus the flat rate of $10,180 (also wage adjusted).

f. Burn outliers. Burn outliers generally will be subject to the same outlier policies applicable to the CHAMPUS DRG-based payment system except as indicated below. There are six DRGs related to burn cases which are affected by this. They are:

456 - Burns, transferred to another acute care facility
457 - Extensive burns w/o O.R. procedure
458 - Non-extensive burns with skin graft
459 - Non-extensive burns with wound debridement or other O.R. procedure
460 - Non-extensive burns w/o O.R. procedure
472 - Extensive burns with O.R. procedure

(1) For burn cases with admissions occurring prior to October 1, 1988, there are no special procedures. The marginal cost factor for outliers for all such cases will be 60 percent.

(2) Burn cases which qualify as short-stay outliers, regardless of the date of admission, will be reimbursed according to the procedures for short-stay outliers.

(3) Burn cases with admissions occurring on or after October 1, 1988, which qualify as cost outliers will be reimbursed using a marginal cost factor of 90 percent.

(4) Burn cases which qualify as long-stay outliers will be reimbursed as follows.

(a) Admissions occurring from October 1, 1988, through September 30, 1990 will be reimbursed using a marginal cost factor of 90 percent.

(b) Admissions occurring on or after October 1, 1990, will be reimbursed using a marginal cost factor of 60 percent.

(5) For a burn outlier in a children's hospital, the appropriate children's hospital outlier threshold is to be used (see below), but the marginal cost factor is to be either 60 or 90 percent according to the criteria above.

g. Children's hospital outliers. Children's hospitals will be subject to the same outlier policies applicable to other hospitals except that:

(1) For long-stay outliers the threshold shall be the lesser of 1.94 standard deviations or 17 days from the DRG's geometric mean LOS. (See the addenda to this chapter for the actual outlier thresholds and their effective dates.)

(2) The following special provisions apply to cost outliers.

(a) The threshold shall be the greater of two times the DRG-based amount (wage adjusted but prior to adjustment for indirect medical education) or $13,500.

(b) Effective October 1, 1997, the standardized costs are calculated using a cost-to-charge ratio of .6027. For FY 97, the cost-to-charge ratio was .6459. For FY 96, the cost-to-charge ratio was .6691. For FY 95, the cost-to-charge ratio was .6900. For FY 94, the cost-to-charge ratio was .684. Prior to FY 94, the cost-to-charge ratio was .70. (This is equivalent to the Medicare cost-to-charge ratio increased to account for capital and direct medical education costs.)

(c) The marginal cost factor shall be 80 percent.

h. Neonatal outliers. Neonatal outliers in hospitals subject to the CHAMPUS DRG-based payment system (other than children's hospitals) shall be determined under the same rules applicable to children's hospitals, except that the standardized costs for cost outliers shall be calculated using the cost-to-charge ratio of .64.

7. Indirect medical education adjustment.

a. General. The DRG-based payments for any hospital which has a teaching program approved under Medicare Regulation Section 413.85 shall be adjusted to account for indirect medical education costs. The adjustment factor used shall be the one in effect on the date of discharge (see below). The adjustment will be made by multiplying the total DRG-based amount by 1.0 plus a hospital-specific factor equal to:

$$1.43 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

For admissions occurring during FY 1988, the same formula was used except that the first number was 1.5 rather than 1.43.

For admissions occurring on or after October 1, 1997, the same formula will be used except that the first number is 1.30 rather than 1.43.

b. Number of interns and residents. Initially, the number of interns and residents will be derived from the most recently available audited HCFA cost-report data (1984). Subsequent updates to the adjustment factor will be based on the count of interns and residents on the annual reports submitted by hospitals to the contractors (see above). The number of interns and residents is to be as of the date the report is submitted and is to include only those interns and residents actually furnishing services in the reporting hospital and only in those units subject to DRG-based reimbursement. The percentage of time used in calculating the full-time equivalents is to be based on the amount of time the interns and residents spend in the portion of the hospital subject to DRG-based payment or in the outpatient department of the hospital on the reporting date.

c. Number of beds. Initially, the number of beds will be those reported on the most recent AHA Annual Survey of Hospitals (1986). Subsequent updates to the adjustment factor will be based on the number of beds reported annually by hospitals to the contractors (see above). The number of beds in a hospital is determined by counting the number of available bed days during the period covered by the report, not including beds or bassinets assigned to healthy newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the reporting period.

d. Updates of indirect medical education factors. It is the contractor's responsibility to update the adjustment factors based on the data contained in the annual report. The effective date of the updated factor shall be the date payment is made to the hospital (check issued) for its capital and direct medical education costs, but in no case can it be later than thirty (30) days after the hospital submits its annual report. The updated factor shall be applied to claims with a date of discharge on or after the effective date. Similarly, contractors may correct initial factors if the hospital submits information (for the same base periods) which indicates the factor provided by TSO/OCHAMPUS is incorrect.

e. Adjustment for children's hospitals. An indirect medical education adjustment factor will be applied to each payment to qualifying children's hospitals. The factors for children's hospitals will be calculated using the same formula as for other hospitals. The initial factor will be based on the number of interns and residents and hospital bed size as reported by the hospital to the contractor. If the hospital provides the data to the contractor after payments have been made, the contractor will not make any retroactive adjustments to previously paid claims, but the amounts will be reconciled during the “hold harmless” process. At the end of its fiscal year, a children's hospital may request that its adjustment factor be updated by providing the contractor with the necessary information regarding its number of interns and residents and beds. The number of interns, residents, and beds must conform to the requirements above. The contractor is required to update the factor within thirty (30) days of receipt of the request from the hospital, and the effective date shall conform to the policy contained above.

- END -

Subject: HOSPITAL REIMBURSEMENT - CHAMPUS DRG-BASED PAYMENT SYSTEM (CHARGES TO BENEFICIARIES)	Chapter: 13
Authority: DoD 6010.8-R, Chapter 14, A.	Section: 6.1J
	Issue Date: October 8, 1988

ISSUE

What charges are the responsibility of the beneficiary?

POLICY

A. Cost-Shares. See the Chapter 13, Section 11.2 for cost-sharing procedures under the CHAMPUS DRG-based payment system.

B. Services or Supplies Specifically Excluded from Payment.

1. Non-Covered DRGs. The contractor is not required to review claims for medical necessity--this is a function of the admission and quality review program. However, the contractor must review claims to ensure that CHAMPUS coverage requirements are met. For example, all claims which are grouped into an abortion DRG must be reviewed to ensure that the abortion meets the specific coverage criteria. When the DRG is not covered, the claim is to be denied (see Chapter 13, Section 6.1B). Payment of such claims will be the responsibility of the beneficiary.

2. Services and Supplies Not Related to the Treatment Regimen. Charges for services and supplies specifically excluded from 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 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 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 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.*

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 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 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 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 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.

HOSPITAL REIMBURSEMENT - CHAMPUS DRG-BASED PAYMENT SYSTEM (CHARGES TO BENEFICIARIES)	Chapter: 13
	Section: 6.1J

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.*

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