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 8 and 9 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 through September

30, 1998.

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

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.

For admissions occurring during FY 1999, the same formula shall be used except the first number shall be 1.21.

For admissions occurring during FY 2000, the same formula shall be used except the first number shall be 1.11.

For admissions occurring during FY 2001, and subsequent years, the same formula shall be used except the first number shall be 1.02.

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. Empty and low-volume DRGs. For any DRG with less than ten (10) occurrences in the CHAMPUS database, the Director, TMA, or designee, has the authority to consider alternative methods for estimating CHAMPUS weights in these low-volume DRG categories.

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 -

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

ISSUE

What are the adjusted standardized amounts under the CHAMPUS DRG-based payment system, and how are they used and calculated?

POLICY

A. General. The adjusted standardized amount (ASA) represents the adjusted average operating cost for treating all TRICARE/CHAMPUS beneficiaries in all DRGs during the database period. During FY 1988 the CHAMPUS DRG-based payment system used two ASAs--one for urban areas and one for rural areas. Beginning in FY 1989 (admissions on or after October 1, 1988), three ASAs are used--one for large urban areas, one for other urban areas, and one for rural areas. Effective October 1, 1994, rural hospitals will receive the same payment rate as other urban hospitals.

B. Calculation of the ASA. The following procedures will be followed in calculating the TRICARE/CHAMPUS ASA.

1. Apply the cost to charge ratio. In this step each charge is reduced to a representative cost by using the Medicare cost-to-charge ratio. The Medicare cost-to-charge ratio as published in the Federal Register on September 3, 1986, was .66, and this amount was used for FY 1988. For FY 1989 the cost to charge ratio used is .63. Effective FY 1994, the cost-to-charge ratio is 0.617. Effective FY 1995, the cost-to-charge ratio is 0.6293. Effective FY 1996, the cost-to-charge ratio is 0.6103. Effective FY 1997, the cost-to-charge ratio is 0.5895. Effective FY 1998, the cost-to-charge ratio is 0.5536. Effective FY 1999, the cost-to-charge ratio is 0.5562.

2. Increase for bad debts. The base standardized amount will be increased by .01 in order to reimburse hospitals for bad debt expenses attributable to TRICARE/CHAMPUS beneficiaries. The base standardized amount will be increased by .0075 for FY 1999, .0060 for FY 2000 and .0055 for FY 2001 and subsequent years.

3. Update for inflation. Each record in the database will be updated to fiscal year 1988 using a factor equal to 1.07. Thereafter, any recalculation of the adjusted standardized amount will use an inflation factor equal to the hospital market basket index used by HCFA in their Prospective Payment System.

4. Preliminary non-teaching standardized amount. At this point indirect medical education costs have been removed through standardization in the weight methodology and direct medical education costs have been removed through the application of the Medicare cost-to-charge ratio which does not include direct medical education costs. Therefore, a non-teaching standardized amount will be computed by dividing aggregate costs by the number of discharges in the database.

5. Preliminary teaching standardized amounts. A separate standardized amount will be calculated for each teaching hospital to reimburse for indirect medical education expenses. This will be done by multiplying the non-teaching standardized amount by 1.0 plus each hospital's indirect medical education factor (see Chapter 13, Section 6.1F).

6. System standardization. The preliminary standardized amounts will be further standardized using a factor which equals total DRG payments using the preliminary standardized amounts divided by the sum of all costs in the database (updated for inflation). To achieve standardization, each preliminary standardized amount will be divided by this factor. This step is necessary so that total DRG system outlays, given the same distribution among hospitals and diagnoses, are equal whether based on DRGs or on charges reduced to costs.

7. Labor-related and nonlabor-related portions of the adjusted standardized amount. The adjusted standardized amount shall be divided into labor-related and nonlabor-related portions according to the ratio of these amounts in the national ASA under the Medicare PPS.

8. Updating the standardized amounts. For years subsequent to the initial year, the standardized amounts will be updated by the final published Medicare annual update factor, unless the standardized amounts are recalculated.

- END -

Subject: HOSPITAL REIMBURSEMENT - CHAMPUS DRG-BASED PAYMENT SYSTEM (ADJUSTMENTS TO PAYMENT AMOUNTS)	Chapter: 13
Authority: DoD 6010.8-R, Chapter 14	Section: 6.1H
	Issue Date: October 8, 1987

ISSUE

What are the adjustments to the CHAMPUS DRG-based payment amounts?

POLICY

A. Adjustments to the DRG-Based Payment Amounts. There are several adjustments to the basic DRG-based amounts (the weight multiplied by the adjusted standardized amount) which can be made.

B. Specific Adjustments.

1. Capital costs. TRICARE/CHAMPUS will reimburse hospitals for their capital costs as reported annually to the contractor (see below). Payment for capital costs will be made annually. See the COM-FI Part Two, Chapter 4, Section II. and OPM Part Two, Chapter 4, Section II. for the procedures for paying capital costs. Also, see Chapter 13, Section 6.6 for information on the payment of capital costs, as well as direct medical education costs, under the Supplemental Health Care Program.

a. Required reductions in capital payments. The basic capital payments (as determined above) shall be reduced in accordance with the statutorily-required reductions for Medicare, and if they are legislatively-changed for Medicare, the TRICARE/CHAMPUS reductions will conform to the Medicare reductions. The required reductions and the periods to which they apply are:

3.5 percent for October 1 through November 20, 1987;

7 percent for November 21 through December 31, 1987;

12 percent for January 1 through September 30, 1988;

15 percent for FY 1989;

2 percent for October 1 through December 31, 1989;

15 percent for January 1, 1990, through September 30, 1992;

10 percent beginning October 1, 1992, through September 30. 1995; and

17.68 percent beginning October 1, 1997, through September 30, 2003.

The capital payments will be prorated for the different percentage reductions based on the days in the reporting period which fall into each category. For example, the capital costs for a cost-reporting period which runs from November 1, 1987, through October 31, 1988, would have the following reductions.

(1) November 1 through November 20 equals 5.5 percent of the year (20 days of 366 days).

(2) November 21 through December 31 equals 11.2 percent of the year (41 days of 366 days).

(3) January 1 through September 30 equals 74.9 percent of the year (274 days of 366 days).

(4) October 1 through October 31 equals 8.4 percent of the year (31 days of 366 days). Therefore, the contractor would determine the total capital amount applicable to TRICARE/CHAMPUS and reduce 5.5 percent of it by 3.5 percent, 11.2 percent of it by 7 percent, 74.9 percent of it by 12 percent, and 8.4 percent of it by 15 percent.

b. For days occurring on or after October 1, 1995, through September 30, 1997, TRICARE/CHAMPUS will reimburse 100% of capital-related costs.

c. Allowable capital costs are those specified in Medicare Regulation Section 413.130 of Title 42 CFR. Allowable capital costs include:

(1) Net depreciation expense.

(2) Leases and rentals (including license and royalty fees) for the use of assets that would be depreciable if the provider owned them outright (except in certain cases).

(3) Betterments and improvements that extend the estimated useful life of an asset at least 2 years beyond its original estimated useful life or increase the productivity of an asset significantly over its original productivity.

(4) The cost of minor equipment that are capitalized rather than charged off to expense.

(5) Interest expense incurred in acquiring land or depreciable assets (either through purchase or lease) used for patient care.

(6) Insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business.

(7) Taxes on land or depreciable assets used for patient care.

(8) For proprietary providers, a return on equity capital.

d. To obtain the total allowable capital costs from the Medicare cost reports prior to October 1992, the contractor shall add the figures from Worksheet D, Part I, Column 1, lines 25-28 and line 33, to the total figure for Ancillary costs from Worksheet D, Part II, Column 1, lines 37-59. The capital payment shall then be reduced by the applicable percentages and time periods outlined in paragraph B.1.a. above.

e. To obtain the total allowable capital costs from the Medicare cost reports as of October 1992, the contractor shall add the figures from Worksheet D, Part 1, Columns 3 and 6, lines 25-28 and line 33, to the figures from Worksheet D, Part II, Columns 1 and 2,

lines 37-59. The capital payment shall then be reduced by the applicable percentages and time periods outlined in paragraph B.1.a. above.

f. Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Section 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

(1) The capital-related equipment is leased or rented by the provider;

(2) The capital-related equipment is located on the provider's premises; and

(3) The capital-related portion of the charge is separately specified in the charge to the provider.

2. Direct medical education costs. TRICARE/CHAMPUS will reimburse hospitals their actual direct medical education costs as reported annually to the contractor (see below). Such direct medical education costs must be for a teaching program approved under Medicare Regulation Section 413.85. Payment for direct medical education costs will be made annually and will be calculated using the same steps required for calculating capital payments below. Allowable direct medical education costs are those specified in Medicare Regulation Section 413.85. (See the COM-FI Part Two, Chapter 4, Section II. and OPM Part Two, Chapter 4, Section II. for the procedures for paying direct medical education costs.)

a. Direct medical education costs generally include:

(1) Formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution.

(2) Nursing schools.

(3) Medical education of paraprofessionals (e.g., radiological technicians).

b. Direct medical education costs do not include:

(1) On-the-job training or other activities which do not involve the actual operation or support, except through tuition or similar payments, of an approved education program.

(2) Patient education or general health awareness programs offered as a service to the community at large.

c. To obtain the total allowable direct medical education costs from the Medicare cost reports prior to October 1992, the contractor shall add the figures from Worksheet D, Part I, Column 5, lines 25-28 and line 33, to the total figure for Ancillary costs from Worksheet D, Part II, Column 5, lines 37-59.

d. To obtain the total allowable direct medical education costs from the Medicare cost reports as of October 1992, the contractor shall add the figure from Worksheet D, part IV, Column 2, lines 25-28 and line 33, to the figure from Worksheet D, Part IV, Column 2, lines 37-59.

3. Determining amount of capital and direct medical education payment. In order to account for payments by other health insurance, TRICARE/CHAMPUS' payment amounts for capital and direct medical education will be determined according to the following steps. Throughout these calculations claims on which TRICARE/CHAMPUS made no payment because other health insurance paid the full TRICARE/CHAMPUS-allowable amount are not to be counted.

Step 1: Determine the ratio of TRICARE/CHAMPUS inpatient days to total inpatient days using the data described below. In determining total TRICARE/CHAMPUS inpatient days the following are not to be included:

(1) Any days determined to be not medically necessary, and

(2) Days included on claims for which TRICARE/CHAMPUS made no payment because other health insurance paid the full TRICARE/CHAMPUS-allowable amount.

Step 2: Multiply the ratio from STEP 1 by total allowable capital costs.

Step 3: Reduce the amount from STEP 2 by the appropriate capital reduction percentage(s). This is the total allowable TRICARE/CHAMPUS capital payment for DRG discharges.

Step 4: Multiply the ratio from STEP 1 by total allowable direct medical education costs. This is the total allowable TRICARE/CHAMPUS direct medical education payment for DRG discharges.

Step 5: Combine the amounts from STEP 3 and STEP 4.This is the amount of TRICARE/CHAMPUS payment due the hospital for capital and direct medical education.

4. Payment of capital and direct medical education costs.

a. General. All hospitals subject to the TRICARE/CHAMPUS DRG-based payment system, except for children's hospitals (see below), may be reimbursed for allowed capital and direct medical education (DME) costs by submitting a request and the applicable pages from the Medicare cost-report to the TRICARE/CHAMPUS contractor.

(1) Beginning October 1, 1998, initial requests for payment of capital and DME shall be filed with the TRICARE/CHAMPUS contractor on or before the last day of the twelfth month following the close of the hospitals' cost-reporting period. The request shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. Thus, for cost-reporting periods ending on or after September 30, 1998, requests for payment of capital and DME must be filed no later than 12 months following the close of the cost-reporting period. For example, if a hospital's cost-reporting period ends on September

30, 1998, the request for payment shall be filed on or before September 30, 1999. Those hospitals that are not Medicare participating providers are to use an October 1 through September 30 fiscal year for reporting capital and DME costs.

(a) An extension of the due date for filing the initial request may only be granted if an extension has been granted by HCFA due to a provider's operations being significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire, as described in Section 413.24 of Title 42 CFR.

(b) All costs reported to the TRICARE/CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. If the costs change as a result of a subsequent Medicare desk review, audit or appeal, the revised costs along with the applicable pages from the amended Medicare cost report shall be provided to the TRICARE/CHAMPUS contractor within 30 days of the date the hospital is notified of the change. The request must be signed by the hospital official responsible for verifying the amounts. Failure to report the changes could result in termination of the hospital's authorized provider status.

(2) Prior to October 1, 1998, TRICARE/CHAMPUS had no time limit for filing initial requests for reimbursement of capital and DME, other than the six-year statute of limitations. The time limitation for filing claims does not apply to capital and DME payment requests. To allow TRICARE/CHAMPUS contractors to close out prior year data, all initial payment requests for capital and DME for cost-reporting periods ending before September 30, 1998, shall be filed with the TRICARE/CHAMPUS contractor no later than 5 months after October 1, 1998. Requests for reimbursement for these periods must be post-marked on or before March 1, 1999. During this 5 month period, the following criteria apply:

(a) All costs reported to the contractor must correspond to the costs reported on the hospital's Medicare cost-report.

(b) The contractor may, but is not required, to provide inpatient day verification reports to hospitals prior to an initial request being submitted.

(c) If a hospital has documentation indicating it was underpaid based on the number of inpatient days reported on the initial request, the hospital may request separate reimbursement for these costs, however, it is the hospital's responsibility to provide documentation substantiating the number of CHAMPUS inpatient days.

(d) The contractor may, but is not required, to verify the number of inpatient CHAMPUS days on an amended payment request as this information would not change from the initial request.

(e) The contractor shall make the capital and DME payment to the hospital within 30 days of the initial or amended request based on the information contained in the report.

b. Information necessary for payment of capital and direct medical education costs. The following information must be reported to the contractor:

(1) The hospital's name.

(2) The hospital's address.

(3) The hospital's TRICARE/CHAMPUS provider number.

(4) The hospital's Medicare provider number.

(5) The period covered--this must correspond to the hospital's Medicare cost-reporting period.

(6) Total inpatient days provided to all patients in units subject to DRG-based payment.

(7) Total TRICARE/CHAMPUS inpatient days provided in units subject to DRG-based payment. (This is to be only days which were "allowed" for payment. Therefore, days which were determined to be not medically necessary are not to be included.)

(a) Total inpatient days provided to active duty members in units subject to DRG-based payment (see Chapter 13, Section 6.6).

(8) Total allowable capital costs. This must correspond with the applicable pages from the Medicare cost-report.

(9) Total allowable direct medical education costs. This must correspond with the applicable pages from the Medicare cost-report.

(10) Total full-time equivalents for:

(a) Residents,

(b) Interns (see below).

(11) Total inpatient beds (see below).

(12) Title of official signing the report.

(13) Reporting date.

(14) The report must contain a certification statement that any changes to items (6), (7), (8), (9), and (10), which are a result of an audit of the provider's Medicare cost-report, must be reported to the contractor within 30 days of the date the hospital is notified of the change.

c. Contractor actions.

(1) Initial requests for capital/direct medical education payment.

(a) The contractor must make the capital/direct medical education payment to the hospital within 30 days of the initial request as long as the financial amounts coincide with those listed in the Medicare cost report and the TRICARE/CHAMPUS and active duty inpatient days provided in units subject to DRG-based payment coincides with the contractor's data.

(b) The contractor shall verify the accuracy of the financial amounts listed for capital and DME with the applicable pages of the Medicare cost report.

(c) The contractor shall verify the total TRICARE/CHAMPUS and active duty inpatient days with their data.

(d) For those cases where the financial amounts do not match those listed in the Medicare cost report, and/or the TRICARE/CHAMPUS and active duty inpatient days do not match the contractor's data, the contractor shall notify the hospital of the discrepancy and inform them the payment will be based on the financial amounts in the Medicare cost report and the contractor's number of days unless they can substantiate different amounts or numbers. The notification to the hospital must be made within ten working days of identification of the discrepancy and include the inpatient day verification report.

(e) The contractor shall wait until the end of the following month to hear from the hospital, and if the hospital does not respond, the contractor shall make payment at that time (or advise TMA of the amount to pay in the case of payments under the SHCP) based on its totals.

(2) Amended Requests for Capital/DME.

(a) The contractor shall process amended payment requests based on changes in the Medicare cost-report as a result of desk reviews, audits and appeals. An adjustment will not be processed unless there are changes to items 6 through 10 on the initial capital and DME reimbursement request.

(b) The contractor must make the capital and DME payment to the hospital within 30 days of the request as long as the financial amounts coincide with those listed in the amended Medicare cost report.

(c) The contractor shall verify the accuracy of the financial amounts listed for capital and DME with the applicable pages of the amended Medicare cost report.

(d) The contractor is not required to verify the number of inpatient CHAMPUS days on an amended request, as this information would not change from the initial request.

(3) The contractor shall prepare a voucher in accordance with the requirements of the OPM Part Two, Chapter 4, Section II.B.7. and send it to the TMA Contract Resource Management Directorate for clearance before releasing the checks.

(4) Requests for reimbursement of DRG capital and DME costs shall be paid as pass-through costs. The MCS contractors are not at-risk for these costs.

d. Negotiated Rates. If a contract between the MCS prime contractor and a subcontractor or institutional network provider does not specifically state the negotiated rate includes all costs that would otherwise be eligible for additional payment, such as capital and DME, the MCS prime contractor is responsible for reimbursing these costs to the subcontractors and institutional network providers if a request for reimbursement is made.

e. Capital and direct medical education costs for children's hospitals. Amounts for capital and direct medical education are included in both the hospital-specific and the national children's hospital differentials (see below). The amounts are based on national average costs. No separate or additional payment is allowed.

5. Children's Hospital Differential.

a. General. All DRG-based payments to children's hospitals for admissions occurring on or after April 1, 1989, are to be increased by adding the applicable children's hospital differential to the appropriate adjusted standardized amount (ASA) prior to multiplying by the DRG weight.

b. Qualifying for the children's hospital differential. In order to qualify for a children's hospital differential adjustment, the hospital must be exempt from the Medicare PPS as a children's hospital. If the hospital is not Medicare-participating, it must meet the criteria in DoD 6010.8-R, Chapter 6, B.4.a. In addition, more than half of its inpatients must be individuals under the age of 18.

c. Calculation of the children's hospital differentials. The differentials will be equal to the difference between a specially-calculated ASA for children's hospitals (using the procedures described in Chapter 13, Section 6.1G) and the ASA for FY 1988 which would otherwise be applicable. They will be calculated so that they are "revenue neutral" for children's hospitals; that is, for FY 1988 overall TRICARE/CHAMPUS payments to children's hospitals under the DRG-based payment system would have been equal to those under the old payment system. To accomplish this, TSO/OCHAMPUS (the Office of Program Development) calculated separate ASAs for childrens' hospitals. Normally in calculating ASAs, TSO/OCHAMPUS reduces the adjusted charges according to the Medicare cost-to-charge ratio (.66 during FY 1988). However, in recognition of the higher costs of children's hospitals, we do not use this step in calculating the children's hospital differentials. We subtract the appropriate ASA from the children's hospital ASAs, and these amounts are the children's hospital differentials. The differentials will not be subject to annual inflation updates nor will they be recalculated except as provided below.

d. Differential amounts.

(1) Admissions prior to April 1, 1992. High volume children's hospitals (those children's hospitals with 50 or more TRICARE/CHAMPUS discharges during FY 1988) have a hospital-specific differential for a three-year transition period ending April 1, 1992. All other children's hospitals use national differentials. There are two national differentials--one for large urban areas and one for other urban areas.

(a) Calculation of the national children's hospital differentials. These differentials are calculated using the procedures described in paragraph B.5.c., above, but based on a database of only low-volume children's hospitals. They were calculated initially using a database of claims processed from July 1, 1987, through June 30, 1988 and updated to FY 1988 using the hospital market basket. They were subsequently finalized based on claims processed from April 1, 1989, through March 31, 1990. (See Chapter 13, Addendum 2, Table 2 (FY 1989) for these amounts.)

(b) Calculation of the hospital-specific differentials for high-volume children's hospitals. The hospital-specific differentials were calculated using the same 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 solid organ transplant 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.

(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. For admissions occurring on or after October 1, 1998, the per diem rate shall equal the wage adjusted DRG amount divided by the arithmetic 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, 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 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.

(c) 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.

(d) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated for all 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 the cost-to-charge ratio of .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. For admissions occurring on or after October 1, 1997, the costs for indirect medical education are no longer standardized.

(b) Cost outliers will be reimbursed the DRG-based amount plus 80 percent effective 10/1/94 of the standardized costs exceeding the threshold.

(c) 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))

NOTE: *Noncovered charges should continue to be subtracted from the billed charges prior to multiplying the billed charges by the cost-to-charge ratio.*

(d) The cost-to-charge ratio for admissions occurring on or after October 1, 1997, is .5536. The cost-to-charge ratio for admissions occurring on or after October 1, 1998, is .5562.

(2) 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-based amount (wage-adjusted but prior to adjustment for indirect medical education) plus the flat rate of $8,850.

(3) 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-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $10,180.

(4) For FY 1999, a fixed loss cost-outlier threshold is set of $10,129. Effective October 1, 1998, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $10,129 (also wage adjusted).

The cost-outlier threshold shall be calculated as follows:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x National Operating Standard Cost as a Share of Total Costs] + (DRG Base Payment x (1+IDME))}

EXAMPLE: Using FY99 figures {[10,129 x ((.7110 x Applicable wage index) + .2890) x 0.9130] + (DRG Based Payment x (1+IDME))}

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 eight DRGs related to burn cases which are affected by this. They are:

504 - Extensive 3rd degree burn w skin graft
505 - Extensive 3rd degree burn w/o skin graft
506 - Full thick burn w sk graft or inhal inj w cc or sig tr
507 - Full thick burn w sk graft or inhal inj w/o cc or sig tr
508 - Full thick burn w/o sk graft or inhal inj w cc or sig tr
509 - Full thick burn w/o sk graft or inhal inj w/o cc or sig tr
510 - Non-extensive burns w cc or significant trauma
511 - Non-extensive burns w/o cc or significant trauma

(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.) For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated.

(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, 1998, the threshold shall be the same as that applied to other hospitals.

(c) Effective October 1, 1998, the standardized costs are calculated using a cost-to-charge ratio of .6085. For FY 98, the cost-to-charge ratio was .6027. For FY 97, the cost-to-charge ratio was .6459. (This is equivalent to the Medicare cost-to-charge ratio increased to account for capital and direct medical education costs.)

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

(e) Effective October 1, 1998, the marginal cost factor shall be adjusted by 1.37 to ensure budget neutrality is maintained.

The following calculation shall be used in determining cost outlier payments for children's hospitals and neonates:

Step 1: Computation of Standardized Costs:

Billed Charges x Cost to Charge Ratio
(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the cost-to-charge ratio.)

Step 2: Determination of Cost Outlier Threshold:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x National Operating Standard Cost as a Share of Total Costs] + [DRG Base Payment x (1+IDME)]}

Step 3: Determination of Cost Outlier Payment

[{(Standardized costs - Cost Outlier Threshold) x Marginal Cost Factor} x Adjustment Factor]

Step 4: Total Payments = Outlier Payments + [DRG Base Rate x (1 + IDME)]

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, Title 42 CFR 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.

For admissions occurring during FY 1999, the same formula shall be used except the first number shall be 1.21.

For admissions occurring during FY 2000, the same formula shall be used except the first number shall be 1.11.

For admissions occurring during FY 2001, the same formula shall be used except the first number shall be 1.02.

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. Beginning in FY 1999, TRICARE/CHAMPUS will use the number of interns and residents from HCFA's most recently available Provider Specific File.

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. Beginning in FY 1999, TRICARE/CHAMPUS will use the number of beds from HCFA's most recently available Provider Specific File.

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.

(1) Beginning in FY 1999, TRICARE/CHAMPUS will use the ratio of interns and residents to beds from HCFA's most recently available Provider Specific File to update the IDME adjustment factors. The ratio will be provided to the contractors to update each hospital's IDME adjustment factor at the same time as the annual DRG update. The updated factors shall be applied to claims with a date of discharge on or after October 1 of each year.

(2) This alternative updating method shall only apply to those hospitals subject to the Medicare PPS as they are the only ones included in the Provider Specific File.

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.

(1) Beginning in August 1998, and each subsequent year, the contractor shall send a notice to each children's hospital in its Region, who have not provided the contractor with updated information on its number of interns, residents and beds since the previous October 1 and advise them their IDME factor will be eliminated at the beginning of the new fiscal year if they fail to provide the updated information by October 1 of that same year.

(2) The contractors shall send the updated ratios for children's hospitals to TMA, MB&RS, or designee, by April 1 of each year to be used in our annual DRG update calculations.

- END -

Subject: HOSPITAL REIMBURSEMENT - CHAMPUS DRG-BASED PAYMENT SYSTEM (INFORMATION PROVIDED BY OCHAMPUS)	Chapter: 13
Authority: DoD 6010.8-R, Chapter 14, A.	Section: 6.1I
	Issue Date: October 8, 1987

ISSUE

What information will be provided by TMA concerning the CHAMPUS DRG-based payment system?

POLICY

A. Information provided by TMA. The following specific data, which is necessary to determine the payment amount under the CHAMPUS DRG-based payment system, will be provided to the MCS contractors by TMA. Updates to these data will be provided during September of each year.

1. DRG weighting factors.

2. Adjusted standardized amounts (urban and rural), including the labor-related and nonlabor-related portions.

3. Area wage indexes.

4. Outlier cutoffs for each DRG.

5. Children's hospital outlier cutoffs.

6. Geometric mean length-of-stay for each DRG.

7. Per diem cost-share for beneficiaries other than dependents of active duty members.

8. Children's hospital differentials (national and hospital-specific).

9. The most current Medicare list of sole community hospitals.

10. The ratio of interns and residents to beds for those hospitals subject to the Medicare PPS, as listed in HCFA's most recently available Provider Specific File.

B. TMA will provide the MCS contractors with corrected wage indexes when applicable.

C. Addendums. The addendums to this chapter lists these data.

- 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. 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 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. For admissions occurring on or after October 1, 1998, payment for long-stay outliers has been eliminated for neonates and children's hospitals.*

- END -